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Nei

Western Norway University of Applied Sciences

MASTER THESIS

Patients' experiences and expectations with self-treatment following day surgery for Carpal Tunnel Syndrome (CTS).

Pasienters opplevelser og erfaringer med egenbehandling etter dagkirurgi for Karpaltunnelsyndrom.

Candidate Number: 432 & 480

Master in Clinical Nursing- Surgical Nursing

Western Norway University of Applied Sciences- FHS, Department of Health and Care Sciences

Supervisor: Ms. Petrin Hege Eide

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Vi bekrefter at arbeidet er selvstendig utarbeidet, og at referanser/kildehenvisninger til alle kilder som er brukt i arbeidet er oppgitt, *jf. Forskrift om studium og eksamen ved Høgskulen på Vestlandet, § 10.*

1.0 Preface

During our surgical nursing training, a great deal of emphasis had been placed upon evidence-based practice. Hearing about the day surgery project, triggered an interest to gain more knowledge about this subject.

Our study is a sub-project under the research group POPS (Pasient opplevelse og Pasient sikkerhet) at the Western Norway University of Applied Sciences (HVL). POPS are conducting various studies to examine the experiences and expectations of various patient groups in a day surgery setting. This master thesis is part of the faculty of Master in clinical nursing and the study gathered information from patents operated in the plastic day surgery section at a local university hospital.

We would like to say thank you to all the informants for their participation in the interview and a special thank you to Ms. Petrin Hege Eide with her continuous support as our supervisor and Ms. Inge Margarethe from the plastic day surgery section for her assistance in recruiting members for our study. Finally, we would like to thank each other, family and friends who have been patient with us during this process.

Abstract

Background: It is a known fact the demand for elective day surgery is increasing. A wide range of literature focusing on patients 'experiences and expectations after day surgery in general could be found. However, limited literature was available for the Carpal Tunnel Syndrome (CTS) patient group regarding their experiences and expectations of self- care after day surgery.

Purpose: The purpose of this master thesis is to gain an insight into the experiences and expectations of self- care, after CTS day surgery. By investigating this topic, we aim to find out what functioned well, and the challenges faced by this patient group, to achieve optimal recovery after day surgery.

Method: A qualitative research method with the help of semi-structured in- depth interviews from six participants were used to carry out this study. The interviews were then transcribed and analyzed by Malteruds´ (2017), systematic text condensation.

Results: Findings from the material gathered illustrates that his patient group faced challenges with self-care. Participants expressed unsatisfactory pain management, feelings of being handicapped and being ill equipped with adequate knowledge to execute various postoperative phases and activities of daily living. However, insufficient information was seen as the "key element" joining these various challenges together.

Conclusion: The general feedback from the participants in this study was that day surgery was the correct choice for them, however, there is a need for improvement regarding pain relief management, support/follow-up and adequate information of the postoperative phase and rehabilitation to achieve optimal recovery.
We hope the findings from our study can contribute to the implications of future practice by improving the care and information given to these individuals undergoing CTS in a day surgery setting.

Abstrakt

Bakgrunn: Det er et kjent faktum at etterspørselen etter valgfri dagkirurgi øker, dette viser også tidligere litteratur. Et bredt spekter av litteratur med fokus på pasienters erfaringer og opplevelse etter dagkirurgi generelt er lett tilgjengelig. Videre var det begrenset litteratur tilgjengelig for pasientgruppen med Karpaltunnelsyndrom (CTS) og deres erfaringer og opplevelser av egen behandling etter dagkirurgi.

Formål: Formålet med denne studien er å få et innblikk i opplevelsene og erfaringene rundt egenomsorg etter dagkirurgisk behandling av CTS. Ved å undersøke dette temaet, tar vi sikte på å finne ut hva som fungerte bra og utfordringene denne pasientgruppen står overfor, for å oppnå gunstig bedring etter dagkirurgisk behandling.

Metode: En kvalitativ forskningsmetode ved hjelp av semistrukturerte dybdeintervjuer av seks deltakere ble benyttet for å gjennomføre denne studien. Intervjuene ble deretter transkribert og analysert av Malteruds´ (2017), systematisk tekst kondensasjon.

Resultater: Funn fra det innsamlede materialet viser at denne pasientgruppen møter utfordringer med egenomsorg. Deltakerne uttrykte utilfredsstillende smertebehandling, følelser av å være funksjonshemmet og har ikke tilstrekkelig kunnskap for å gjennomgå de ulike postoperative fasene og aktiviteter i det daglige. Imidlertid ble utilstrekkelig informasjon sett på som "nøkkelelementet" som forbinder disse utfordringene.

Konklusjon: Den generelle tilbakemeldingen fra deltakerne i denne studien var at dagkirurgisk behandling var det riktige valget for dem, men det er behov for forbedring når det gjelder smertelindring, oppfølging, støtte og tilstrekkelig informasjon om den postoperative fasen og rehabilitering for å oppnå gunstig bedring. Vi håper funnene fra studien kan bidra til forbedring av fremtidig praksis ved å gi bedre omsorg og informasjon til denne pasientgruppen som gjennomgår CTS ved dagkirurgisk behandling.

Contents Page

2.0 Introduction

Day surgery is a relatively new form of treatment that is increasing worldwide, mostly because it's a safe, effective, and a low-cost procedure preferred by the government and patients (Dahl, 2020, Fischer & Zachmeister-Koss, 2014).

Outpatient clinics gained its popularity in the Norwegian healthcare system in the 1990's and now provide more than 70.6% of all elective surgery, with a 2.1% increase since 2019 (Helsedirektoratet, 2021). This rapid growth had been greatly influenced by developments in surgical technologies, advancement in short acting anesthetics (Lemos, Jarrett, & Phillip, 2006, p. 24), shorter hospital stays, less postoperative pain, lower risk of postoperative infection, increased patient satisfaction, downsizing and minimising hospital expenditure (Fischer & Zachmeister-Koss, 2014) forming a pathway for many different patient groups. Another reason for this increase could be that in the 1990´s medical doctors decided which patient groups were to undergo day surgery, but nowadays, it is the government who makes these decisions. Therefore, it has become politically controlled, not professionally controlled and hospitals in the district are criticized if they do not meet the numbers required by the government (Dahl, 2020).

Day surgery is a procedure whereby patients are discharged within 24hours postoperatively (Ræder & Nordentoft, 2010). Traditionally, patients were hospitalized often before and after surgery, receiving nursing care tailored to their needs. However, after the introduction of day surgery, support and care from healthcare professionals, are only provided for a few hours after surgery. Patients are then sent home, where relatives or friends are required to be the primary caregiver for at least 24hr postoperatively. This places a substantial responsibility on patients demanding they oversee their self-treatment after surgery, taking into consideration; wound management, administering medications and other measures that have previously been reserved for the nurse (Jaensson, Dahlberg, & Nilsson, 2019).

Knowledge and professional judgement have been gained throughout our nursing studies from England and Norway, as well as our nursing career and now as surgical

nurses. We are aware that nurses play a crucial part in caring for patients, before, during and after surgical treatment.

Nightingale's environmental theory places an emphasis on the role of care to provide holistic care to help patients achieve, maintain, and restore what they regard as the best health. Nightingale´s description of nursing work included adapting to each individual patient's needs, mentoring, and providing support (Jones, 2010). Our previous experience will therefore have a weight on our study. We are aware of the pressures that healthcare professionals are subjected to regarding time constraints, leaving room for little improvement in pre and postoperative care provided to patients. However, as a surgical nurse, one must be able to assess the patients´ needs safely while providing holistic care (Dåvøy, Eide, & Hansen, 2018, p. 28). To strengthen the patient's self-care and to limit the extent of stress and strain, the surgical nurse must ensure that the patient receives information, teaching and guidance, providing assurance (Dåvøy, Eide, & Hansen, 2019. p. 38).

By focusing on this specific patient group, we hope to discover the professional care that had been provided by health care professionals pre and postoperatively to enable sufficient and successful self-care at home, as educating patients prior to surgery regarding management of recovery is crucial (Berg, Årestedt, & Kjellgren, 2013). We hope the research we conduct will be beneficial to healthcare providers who perform CTS operations in day surgery.

3.0 Background

3.1 Key concepts

3.1.1 Day surgery

In this research project, day surgery is understood as surgical procedures usually performed without the need for hospital stay. This increasingly popular type of surgery has reformed elective surgery and led to a decrease in the need for monitoring and nursing-led treatment of the patient after the procedure (Ræder & Nordentoft, 2010).

3.1.2 Carpal Tunnel Syndrome

The Carpal tunnel is located in the wrist, it is a narrow passage where one of the large nerves of the hand, called the median nerve, passes under a tight connective tissue band (ligament). Carpal tunnel syndrome is due to the large nerve in the hand being subjected to prolonged pressure (Alfonso, Jann, Massa, & Torreggiani, 2010) causing tingling, pain, and numbness to the hand (Genova, Dix, Saefan, Thakur, & Hassen, 2020).

3.1.3 Self care

The World Health Organization (2020) defines selfcare as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider". The successfulness of self-care relies on the prerequisites and opportunities a person has. The components of effective self-care include good nutrition, personal hygiene and being able to partake in physical activity.

In this study patients are expected to assess their own state of health regarding management of, pain, wound, their homes, as well as taking care of their nutritional needs and clothing themselves to maintain life, health, and wellbeing (Orem, 2001, p. 117). Activities of daily living are fundamental skills which are compulsory to manage basic physical needs, these include personal hygiene, continence, dressing, managing and nutritional needs (Gregersen, 2010, p. 172). The inability to partake in these essentials of living may lead to poor quality of life and it is imperative for

healthcare professionals to address the needs of vulnerable individuals (Nestler, 2019).

3.1.4 Clinical Pathway for CTS day surgery patients

These patients are usually referred to the plastic surgery outpatient department by their general practitioner and the patient's health is assessed (Schlichting, 2020) if eligible for day surgery, then an appointment is made to see the surgeon and an anesthesiologist (Ræder & Nordentoft, 2010). The patient arrives at the hospital on the operation day, where a preoperative conversation takes place with the surgeon and a nurse.

Information about the surgery is given to the patient by the surgeon. The operation is performed in either local or general anesthesia which numbs sensation to the operating site or puts the patient to sleep completely for a short time span (Kirkebøen, Lindholm, & Ræder, 2010). According to Schlichting (2020), patients often experience relatively few side effects after anesthesia but research by Stessel et al., (2015) shows that surgery causes a certain amount of fatigue, pain, and nausea in patients. After the operation the patient is allowed to rest in the postoperative ward, the patient is in the hospital for less than 24 hours after the surgical procedure (Ræder & Nordentoft, 2010) and is seen by the surgeon and a nurse before discharge.

4.0 Florence Nightingale

Florence Nightingale was considered as the pioneer of modern nursing and was of the opinion, environmental factors had a huge impact on patient outcomes; many principles of her environmental theory are still relevant in modern nursing.

Many believe the nurses role is to help relieve patients' workload physically, however, their actual role is to lighten patients' worries so they concentrate on recovery (Nightingale, 1997, p. 124). She affirms nursing is not just the treatment of a patient's illness, e.g. giving medication, but learning, what and how to observe symptoms, indicating improvement. Failure to acknowledge these factors results in unnecessary pain, suffering and a delayed healing process. Nightingale's principles can be used to assess the ramifications day surgery has on patients only relying on themselves/family without the assistance of a nurse, and the factors that enable healing (Nightingale, 1997, p. 31-32).

Nightingale's book "Notes on nursing" in which she describes what constitutes to good nursing and what she regards as the cause of illness is specifically aimed at those caring for a sick person at home, which makes the theory even more relevant for outpatient surgery. Nevertheless, Nightingale (1997, p. 169) believed that good nursing is unable to be learnt through a book but through experience. Her book which is used as a foundation in today's nursing, contains four themes; the environment, the person receiving care, health and nursing which is regarded as basic nursing today.

Shiver & Eitel (2017) stated Nightingale utilized the environment of the patient to assist recovery. She was further of the opinion that disease is often not related to the illness itself but other factors, such as lack of fresh air, light, warmth, tranquility, cleanliness, and the composition of a healthy diet (Nightingale, 1997, p. 31-32). The absence of these factors caused feelings of stress and anxiety in their recovery, hindering the recovery process so therefore good routines should be established in the home and hospital (Nightingale, 1997, p. 36). Nightingale describes that heat, ventilation, light, nutrition, medicine, stimuli, room temperature and activity are crucial for a good physical environment for the patient (Nightingale, 1997 p.37-50).

Moreover, Nightingale explains no home can be healthy if these requirements are not catered for (Nightingale, 1995, p.134). She believed the nurse had to observe and assist the patient without burdening them unnecessarily (Nightingale, 1997, p. 32). Nortvedt (2019) stated Nightingale was of the opinion it was the nurse's role to observe nutritional status, sleep, elimination, respiration, administering and observing the effects of medication and the role of the nurse to interpret all challenges patients face.

Nightingale claims a good nurse must ask themselves what happens in their absence and a nurse must ensure the patients always receive the same high-quality care (Nightingale, 1997, p. 73-75). Hegge (2013) affirms Nightingale believed it is the nurse's job to observe the patient and to gain information about their condition, as well as supporting the healing power of the patient's body through good hygiene, adequate nutrition, and plenty of sleep. She further claimed that patients who return home to their overburdened household and exhausted resources are unable to meet their need for care, proper nutrition, comfort, and this vulnerable patient group will end up overworking themselves (Nightingale, 1997, p. 191). A lack of knowledge or attention will lead to pain, suffering or in the worst case the whole recovery process will be halted (Nortvedt, 2019).

A surgical nurse plays a central role in organizing and coordinating operational activities. They advocate for patients during surgery, prevent injuries, complications, and infections to ensure optimal surgical results. To strengthen the patient's self-care and limit the extent of stress and strain, the surgical nurse must ensure patients and relatives receive information, teaching and guidance (Dåvøy et al, 2018. p. 37). Due to advancement in surgical treatment a greater importance should be placed on pedagogy as a tool, so the operative nurse takes on more responsibility as an educator and supervisor (Dåvøy et al, 2018, 2018. P. 42). Therefore, it is important to gain knowledge about this patient group to develop an understanding of their challenges and experiences.

5.0 Previous Literature

Prior to starting the project, we researched previous literature to find out what was already known about CTS day surgery and where further research was needed to form a background for our thesis, regarding the experiences of individuals around this subject group. We began with searching for quantitative research to gain an understanding of CTS day surgery before searching for qualitative research.

Research used consists of qualitative and quantitative literature, obtained through databases; Cinahl, Medline and Pubmed. Keywords: day surgery, outpatient combined with self-care, carpal tunnel syndrome and postoperative, produced relevant research for the study. Checklists for quality and reliability were used (Helsebiblioteket, 2020). Nevertheless, limited literature regarding patients´ experiences and expectations following day surgery were available.

A literature review on CTS carried out by (Genova et al, 2020) found CTS to be a nerve compression disorder causing tingling, pain and numbness to the hand, and these sensations can be felt in the thumb, index finger, middle finger, and the radial side of the ring finger. A study by Conzen, Conzen, Rübsamen, & Mikolajczyk (2016) found severe conditions varied from patient to patient with an estimate of 4-5% of the world's population being affected by CTS, and individuals aged between 40-60 were more susceptible with the prevalence higher amongst women. They further claim that surgery is recommended when non-invasive techniques fail, and there are the risks associated with surgery e.g., bleeding, infection, and injury to surrounding nerves.

Carpal Tunnel Release (CTR) is the surgical method used to relieve pressure in the carpal tunnel which is carried out on patients who have not responded to conservative treatments. There are two types of surgery available for these individuals, one is where the surgeon can operate through an incision of about five centimeters to the wrist to cut the carpal ligament to enlarge the carpal tunnel. The other is an endoscopic CTR where a small incision is made, and a camera attached to a narrow tube is inserted into the incision, which guides the surgeon as they cut the carpal ligament. Both operations provide equal results, although with the

endoscopic surgery patients may be able to return to work earlier (Peters, Johnston, Hines, Ross, & Coppieters, 2016).

During the CTR procedure patients are usually awake after having received local anesthesia before the operation (Tulipan & Ilyas, 2020). Although they are discharged on the same day there are risks of complications such as nerve damage, numbness, weakness in the hand as well as pain in the operating site. Nevertheless, CTR has been described to be effective in this group of patients (Tulipan & Ilyas, 2020).

The qualitative study by Jerosch-Herold, Mason, & Chojnowski (2008) focuses on the experiences and expectations of patients after surgery for CTS. They found that all participants expressed their wish for more information regarding relief of pain, tingling, numbness, sleep disturbance and participants conveyed their interest to be able to begin carrying out self-care and household chores again. They further disclosed that all their participants regarded CTS to have a huge impact on their lives and if this debilitating disorder could be resolved by surgery, then their lives would resume to some level of "normality". Similarly, Genova et al. (2020) found pain, numbness in the fingers and sleep disturbance have a major impact on the functioning of the patient and their quality of life.

The study by Newington, Brooks, Warwick, Adams, & Walker-Bone, (2019) examined individuals after returning to work following CTR surgery, they found recurring themes between all 14 respondents they interviewed. These were the degree of functional disability experienced right away after surgery. There was an assumption that CTR surgery would be a ´minor surgery´ but this was not the case, and it did not correspond with the informant's expectations. They also discussed how participants wanted to know for sure when they will be able to return to work after surgery, as well as concerns regarding how much the operated hand can be used and the weight it can bear. The participants also expressed the need for specific information regarding their return to work. Newington et al, (2019) argue that surgery may be perceived as a "minor" surgery but this patient group is in fact subjected to postoperative challenges after being discharged.

As mentioned earlier the advancement in surgical and anesthetic techniques as well as pressure from the government for increasing elective day surgery has become a common practice worldwide as it offers a range of benefits to both patients and the healthcare system. Day surgery allows patients to recuperate at home in a familiar environment, being able to recover around family and friends (Quemby & Stocker, 2014), as well as a cost minimizing technique from the government (Dahl, 2020). Numerous studies show the high levels of satisfaction among patients who have undergone day surgery. Mitchell´s (2015) cross sectional study investigated patients' experience of home recovery following day surgery, found although patients favored day surgery, more could be done to provide adequate information and insight into the postoperative recovery pathway. This is regarded as especially important as inadequate pain control and limited support once home can cause anxiety.

Furthermore, it was emphasized that for the purpose of a smooth postoperative recovery it is fundamental for placing importance on good quality information which should be provided to patients and their families. Walker (2002) further highlights the significance of preoperative information being essential to the practice of good nursing to surgical patients, but also to reduce the patients experience of anxiety and to provide holistic care. Walker (2007) stated that relevant information reduced postoperative pain, arguing that a patient’s ability to understand information also depended significantly on healthcare providers experience and capacity to communicate. Further emphasizing that a patient’s stress level drops if they are well informed about the procedure.

A qualitative phenomenological study by Berg et al, (2013) which utilized semi-structured interviews concluded respondents expressed satisfaction with the efficiency and teamwork of the multidisciplinary team enabling prompt discharge. Nevertheless, stress was associated with tight timeslots, feelings of being “kicked out” armed with limited information of post-operative expectations. They were further of the opinion that the postoperative phase was a weak link in day surgery, due to insecurities regarding poor preparation at home, uninformed difficulties associated with, i.e., personal hygiene, basic housekeeping, and increased responsibilities for family members. This led to feelings of abandonment surfacing regarding medical

challenges associated with postoperative recovery, e.g. pain management and bleeding.

Similarly, Mitchell (2013), who reviewed the nursing support needed by day surgery patients to manage their postoperative recovery, found reoccurring themes that were identified, these were pain management, information provision and anxiety following discharge. A previous study by Mitchell (2003) investigated the impact of discharge from day surgery which was placed on patients and caretaker's underling three key challenges, which were inadequate pain relief, community care and ways for recovery. Bjorvatn (2012) argues that if more than 50% of all elective surgery is to be performed in a day surgery setting, additional consideration needs to be placed on the ability of the patients to manage home recovery effectively, as a failure to do so will result in a limited growth in the day surgery sector. Implementation of these interventions should place an emphasis on pain management, district nursing and pathways of recovery (Mitchell, 2003), as regardless of the advances in anesthesia and analgesia, reports of high pain levels remain following day surgery (Barthelsson, Lützén, Anderberg, & Nordström, 2003).

Although day surgery is evaluated regularly regarding infection, deaths, and patient satisfaction, it also presents challenges that mainly rotate around discharge and recovery of patients at home. Following day surgery, care is transferred to patients and their careers, which means that they do not have the advantage of healthcare professionals monitoring and facilitating their recovery. Mottram (2011a) conducted a qualitative grounded theory, similarly, to Berg et al., (2013) where a comparison was made between the popularity of day surgery against a background of desire for speed-efficiency and timesaving. Further, outlining four main aspects associated with day surgery, similar to the success of the McDonalds organization: efficiency, predictability, calculability and control. Outpatient surgery meets these demands even though patients have a greater responsibility for self-care post-discharge.

Another grounded theory study by Mottram (2011b) found extreme stress, anxiety and feelings of helplessness were encountered, due to the minimalistic information received regarding expectations post-surgery. The main concern raised was pain, wound care and returning to normal life. Mottram (2011b) concluded more

information should be provided to patients regarding community services and educating them on symptoms affecting self-care. Further, suggesting peri-operative and district nurses are given a greater ethical responsibility to provide follow-up care.

Jaensson et al., (2019) carried out a narrative review study and similar findings emerged regarding demands on day surgery patients, self-managing their postoperative recovery. Patients' presumptions of day surgery associated with minimal pain, discomfort, and the ability to carry out normal housework is dispirited when they find this is not the case. To enhance home recovery the provision of relevant pre- and postoperative information to each individual should be supplied.

Similarly, Mitchell (2015) expressed the same while they examined patients' experiences of psychosocial recovery, dissatisfaction was associated with the lack of information and awareness of the postoperative recovery path, pain management, insufficient assistance at home and feelings of anxiety. By concentrating on these discrepancies to ensure support once discharged, may help aid recovery in outpatients.

Due to the dissatisfaction of postoperative support received, the study by Jaensson et al., (2019), expressed loneliness and insecurities felt amongst patients regarding their healing process. They found the importance of outpatients feeling safe, reassured, and acknowledged during recovery at home can be achieved by the patients themselves being independent. Nevertheless acknowledgement, information, reassurance and support from healthcare workers and families are of great importance postoperatively.

Although patients seem to be satisfied with day surgery, the postoperative phase does not come without its challenges. Recurring themes in these articles note challenges experienced by outpatients during home recovery, expectations, and limited information. Postoperative vomiting, nausea, dizziness, pain, and cognitive dysfunction were some of the symptoms subjected to patients. The impression gained from the above literature studies is that limited information and advice is passed on to the patient and family regarding the symptoms of anesthesia, surgery, and self-care after day surgery.

Patients have great expectations which arise from the alluring characteristics of day surgery comparing it to a conveyor belt in a factory, efficient and effective, (Mottram, 2011b). In preparation for the increasing demands of day surgery, nurses need to adapt the services offered and enhance communication between the patient and healthcare professionals to defer the disappearance into a commercial healthcare system.

Coping with postoperative recovery is an individual process, therefore multidisciplinary teams should provide information tailored to meet each individual's comprehension of holistic care, raising awareness of expected symptoms, to take a more proactive attitude towards discharge planning. The nurse's role is to inform patients of what to expect, giving them the opportunity to prepare their homes taking into consideration; hygiene (i.e., having clean bedlinen and clothing) as well as assembling a nutritious diet to their disposition. Reviews examining patients' experiences can help identify important information about discharge and recovery at home, which can be useful for healthcare professionals, specifically nurses, in understanding how to best prepare patients and their careers postoperatively.

6.0 Purpose and Problem

The purpose of the project is to shed light on day surgery patients' subjective experience with self-care after CTS. Previous research shows that we know little about how these patients feel at home after the operation. By gaining insight on patients ‘experiences we hope to find concrete points for improvement in today's specialist nursing care for the CTS patients.

6.1 Research question

“What experiences and expectations do the CTS patients have for self- care in connection with day surgery?”

7.0 Pre-understanding

We as researchers with a Bachelor of Nursing from England and Norway have limited knowledge and preconceptions regarding qualitative studies. One of us has previously worked at the Orthopedic outpatient clinic where CTS patients would come to have their initial consultation with the surgeon and the other has worked at a local hospital which specializes in day surgery and rehabilitation, we both currently work at the University Hospital where this study is being conducted as surgical nurses. Although, through our previous work experience we may have come across this patient group we did not have the opportunity to meet these individuals after surgery and therefore have no idea what the postoperative phase was like for these individuals. However, after researching CTS and day surgery we did have an idea what this surgery entails and the challenges that arise with it. These preconceptions and interpretations may be a risk while analyzing the interviews, resulting in biased results. Malterud, (2017, p. 41) states it is imperative that preconceptions are clarified beforehand and set aside during interviews. The preconceptions we had were noted down before the interviews took place and consisted of our predictions of the outcomes of the study. Our initial thoughts of these individuals' experiences´ after CTS surgery could be described as the standard of care received was adequate as the cases of day surgery operations have increased dramatically in the past couple of years. However, during the interviews we could see that although some of our predictions were to be expected, we were wrong about the true experiences and feelings of our subject group.

8.0 Method

In this chapter of the thesis, the choice of method and our research process are presented.

8.1 Choice of Methodical Approach

A qualitative design was chosen to gain answers to our research question of patients' experiences with self-care at home after CTS surgery. Qualitative semi- structured in depth interviews were utilized following Malteruds´ (2017) approach and text condensation to explore each individual's progress regarding recovery after CTS surgery. The basic principle of a qualitative method is that it has a phenomenon that all people experience a situation or events in their own way based on their lives and the way they perceive the world (Hammarberg, Kirkman, & De Lacey, 2016).

Qualitative methods have its roots in phenomenology where it recognizes that different people have different perspectives in which they view and understand things, so therefore, they will not experience the same event in the same manner (Creswell, 2013). In qualitative research, by asking the same question about a particular event or phenomenon to many different people we are able to find something common even though each individual views things differently and by doing this we were able to develop our knowledge. We had six participants in our study, some of which are operated on their right hand, or left hand, some who were operated for CTS for the first time, some the second, some were operated on the hand they use the most, others the hand they use the least, but after having analyzed and transcribed the interviews, we were able to see recurring themes.

8.2 Selection

Due to the scope of the study, a sample size of six is recommended by the study coordinators. Although this is not regarded as a sufficient number to attain representation of the research group, respondents will be able to shed light providing valid data (Malterud, 2017, p. 112). The sample consists of individuals who have undergone operative surgery for CTS in a day surgery setting, at their local university hospital, in the period between December 2020 and March 2021, a random controlled

sample is needed to gain an insight on the experiences of these individuals after day surgery (Malterud, 2017, p. 58).

During our random controlled selection, we did not select the participants based on age, level of education, previous experience with day surgery, ability to self- care etc. All relevant participants received information about the project. The participants were randomly selected to ensure validity and variety in the project.

Our study included participants who had undergone day surgery, must be over 18years old, must be able to speak, read and write Norwegian, and must be able to provide informed consent to the study. Participants who experienced complications in connection with the operation and transferred as an inpatient were excluded from the study.

8.3 Data collection

8.3.1 Recruitment

Suitable candidates were found by our contact person, Ms. Inge Margrethe using the hospital's operating database “Orbit” taking into consideration the inclusion and exclusion criteria for our study group. Eligible candidates were contacted, those who gave their verbal consent to partake in the study were informed they would be contacted by the researchers soon with more information about the study, and a consent form (Appendix 1) that would be sent in the post would need to be brought in on the day of surgery.

Our participants were sent an information sheet on the study (Appendix 2) a questionnaire (that was required to be sent to the project leader of POPS after the interview), a consent form and two envelopes one of which was pre stamped and addressed. Those wishing to partake in the study would need to return the consent form in the unstamped envelope provided to the outpatient clinic.

8.3.2 The Interview Situation

The initial plan was to visit the participants on their 3-5 postoperative day at a place of their choosing, preferably their house, assuming this will allow respondents to relax hence, ensuring the quality of the interview data (McGrath, Palmgren, & Liljedahl, (2019). Due to unforeseeable circumstances brought about by COVID 19, our original plan of face to face in person interviews was not feasible with patients and therefore interviews were conducted over facetime, zoom and phone call. We implemented four out of six interviews over video calls and the remaining two phone calls, as the participants did not have access to video calls. We were aware that executing our interview over the phone, with the inability to see the patient may result in them withholding information from us. Furthermore, participants may not have been as open with us regarding their experiences and feelings compared to face-to-face interviews. However, we gained a great deal of information from these two participants, and they felt at ease portrayed by expressing jokes, laughing and were able to voice their opinions.

Literature by Gissum & Dragset (2020), states “due to today's challenge with Covid 19, it is highly relevant and feasible to use video conferencing within health research. They further argue interviews can be conducted as video conferencing without the quality of research being worse than if you meet physically. Finally, they concluded that interviews undertaken as a video conference in research can be recommended although it can be challenging and requires good preparation.

Prior to this study neither of us researchers had any experience with research studies and interview situations. We had to therefore understand what to consider whilst interviewing respondents and how to filter out the important and necessary knowledge received. Before conducting these interviews, we had assumed this patient group would have numerous problems following discharge e.g. wound care, bleeding and pain, which was the impression we gained whilst reading through previous literature on day surgery. We had to make sure we avoid steering the questioning in the direction towards our views and our expectations of these outcomes, we needed to have an open mind and listen to what the respondent had to say, this is necessary to avoid an interviewer bias and therefore we allowed them to respond freely, branching off to discover relevant information (Polit & Beck, 2017. p. 510).

The precautions we had to take into consideration when preparing the safety routines included; how the interviews were to be carried out, the location, so that informants while being interviewed shouldn't be seen or heard by others, as well as information regarding tape recording and its storage on a safe database.

We conducted a pilot interview lasting approximately 30-60minutes, with two respondents, who had undergone CTS in a day surgery setting, to smooth out any discrepancies (McGrath et al., 2019). This enabled us to test the interview setting and questions for clarity and understandability (Polit & Beck, 2017. p. 624).

We started off by presenting ourselves in the interview, before informing participants about the study, e.g. confidentiality and tape recording. We explained that the tape recorder used during interviews, will be listened to, transcribed for validity, (Malterud, 2017, p. 77) anonymized and text condensation will be performed. We hoped the "small talk" would help establish a bond between us and the respondent leading to relaxation. We began by asking simple questions and filled out the background form, creating a bond with respondents, making them feel comfortable in confiding in us before we proceeded to more sensitive topics (Polit & Beck, 2017, p. 511-515). Neutral body language, facial expressions such as nodding and looking interested established the mood for the interview (Polit and Beck, 2017, p.516).

We were aware it was natural for our respondents to feel nervous when informed of being tape recorded, however, these are non-avoidable and paramount in determining what was said and what wasn't (Polit & Beck, 2017, p. 521). Observational notes on facial expressions and body language of participants were taken and written down immediately after the interview to avoid distraction and insecurities for both parties.

Polit & Beck (2017, p. 511) state group samples in this design are usually small, information is studied intensively, and findings cannot be generalized, but contributes to a deeper understanding of this research group's self-treatment (Sutton & Austin, 2015). However, since this study is part of a larger project where several day surgery procedures are included, findings can be summarized in relation to experiences of self-care.

8.3.3 The Interview guide

Semi- structured interviews were conducted using the interview guide, which was obtained through our supervisor, who is one of the leaders of the day surgery project. The interview guide contained the same specific topics which were discussed throughout all six interviews. It acted as a guide to help keep us on track during the interview process, yet allowed the respondents to speak freely providing us with the information we needed. Each topic in the interview guide had several subtopics allowing the respondent to elaborate on their answers all the while sticking to the guide. The themes can be described as the best possible way to capture the descriptions of the patients experience of self-care at home. We were able to gather interesting statements and versions of events by each individual forming new and relevant issues regarding their experience and the interview guide helped keep us in focus during the interview.

The interview guide we used contained keywords to help us focus on open-ended questions, encouraging participants to discuss openly about their expectations and experiences in their postoperative journey, ensuring relevant data is gathered (Appendix 3).

Theme one - Based on how patients have prepared themselves for surgery, inspired by Florence Nightingale, hygiene preparations at home? Due to risks associated with wound infection postoperatively. Arrangements for food purchases beforehand? Whether they had prepared for assistance? The question of preparation is relevant as studies show outpatients face challenges following surgery i.e., pain management. Did participants look for information via the internet, friends and was the information enough?

Theme two- Focuses on the participants' first postoperative days. The impact of anesthetics, feelings of nauseousness on the way home? What was their mode of transport? Were they accompanied by anyone or placed in collective patient transport? What was their sleep and food consumption pattern like? In order for the healing process to take place the body must have these, amongst other things. Furthermore, did they present feelings of stress? Many find the newly operated outpatient phase stressful, due immense responsibilities placed on observing and initiating measures associated with exercise, wound care and pain management without the input of

healthcare professionals which in return causes anxiety (Bellani, 2008). This theme was inspired by “Recovery after day surgery scale” which is a questionnaire which has been used to carry out a study of symptoms patients had after day surgery, which included feelings of nauseousness, pain, need for help and support, etc. and the leaders of the day surgery project we are under are of the meaning that by asking open questions many of these symptoms and challenges will come to light.

Theme three- Was the respondent in need of help and support? It is a prerequisite that patients´ have adult assistance the first 24 hours at home, to qualify as a day surgery patient. However, many of these “assistants” may have jobs and cannot stay with the patient over many days. It could perhaps take several days, if not weeks before the swelling and pain from surgery subsides. Therefore, it is relevant to access patients´ need for further help and support. The performance of daily life activities (ADLs) can be significantly reduced due to the intake of strong painkillers and the operation site (hand) being one of the most used body parts for the individual. It is reasonable to assume patients will face challenges after such an operation e.g. cooking and housework. This theme will aim to identify what help they needed, who helped them, how much and whether they have contacted the health care service. This question was inspired by earlier respondents who describe difficulties of carrying out self-care and it became obvious that they had misunderstood what they should do, e.g., misunderstanding of when pain medication should be taken, changing of bandages.

Theme four- Participants were asked to describe the kind of self-care they were advised to follow and how this was performed? i.e., administration of painkillers, observation of health conditions and wound care. Respondents would have been instructed to exercise the operated hand quite early in the postoperative phase. We are interested to hear if patients tried these exercises, whether they remembered how, due to receiving instructions under the haze of anesthesia. If exercises were delayed due to pain? This is an important theme regarding feedback to hospitals following our study, relating to postoperative exercise, and how measures can be adjusted to facilitate patients’ successful training.

Each subtopic was utilized in the interview guide allowing respondents to answer freely, yet in a structured manner. The results were used to gain insight into

preparations undertaken prior to surgery, experiences of self-care and treatment is acknowledged following CTS surgery.

Finally, respondents were thanked for their cooperation and asked if there were any areas we did not address, this helped uncover new information that may not have been foreseen (Polit & Beck, 2017, p. 516).

8.3.4 Transcription of Data

Following the competition of the interviews verbatim transcriptions and translation were performed of the content. Transcription was done to capture the participants word by mouth into a written form (Polit & Beck, 2017, p. 531). The analysis was a complex and dynamic process as the transcription had to be verbatim and must include pauses and non-verbal remarks (Malterud, 2017, p. 77-78, Polit & Beck, 2017, p. 557). We transcribed therefore everything that could be heard on the audio recorder, such as speech, laughter, sounds, pauses and so on. When the interviews are transcribed material is structured in the form of text, making it easier to get an overview at the start of the actual analysis (Kvale & Brinkmann, 2009, p. 188-189). We transcribed continuously and began the analysis process shortly after the first couple of interviews. By starting the analysis process early, enabled us to adjust the interview focus along the way as we learned more about the empirical data material (Malterud, 2017, p. 97-115), and systematic text condensation was suitable in the development of new concepts and phenomena (Malterud, 2017, p. 78-80). Following transcription of the interviews each respondent was given a code to correspond with their transcribed interview for anonymity.

We researchers have English as our primary language, so all interviews were carried out in Norwegian and later translated to English. Transcription of the interviews were largely time consuming as a great deal of timing was placed upon translating and validating the meaning of Norwegian phrases into English. An advantage of this was that the more time we spent re- reading and analyzing the six interview transcripts we became well acquainted with the material. To begin with, one of us transcribed an interview, then the observer read through the transcript and added their interpretations and observations, this was done throughout the whole transcription

process. Initially, 5-6 key findings were found from each interview, once these were put together, we were able to define the three prominent recurring themes that arose: “experience of pain”, “experience of peri and post-operative information” and “experience of having functional disability”. In addition, we wrote down notes during and after each interview to record observations and impressions of the participants which was then added to the transcribed interview. We underlined all key points and color-coded key information (Thagaard, 2013, p. 158). The different color codes were allocated to these key findings, to aid us in answering our research question.

8.3.5 Text Condensation

We then began the coding process of the transcribed material and followed Malterud systematic text condensation (Malterud, 2017, p. 97-115). This was done by analyzing the transcribed material and forming an overall impression, leading to the formation of meaningful units, drawing the content of the individual meaningful units, and lastly summarizing its significance. This process enabled the focus between different parts of the research material, proving an opportunity for the discovery of the unexpected material during the analysis and by repeating these steps the analysis signified what was to be explored (Malterud, 2017, p. 112-114).

Each step of the text condensation process was followed in all the interviews conducted. Below is an explanation of each step:

1)**Overall impression:** During the first step we formed an overall impression and made ourselves familiar with the material. We read the transcribed material several times in order to obtain a general sense of experience enabling us to become acquainted with the material which allowed us to pick out the phrases that stood out. The advantage of two researchers on a study is that material can be distributed amongst them where input can be provided if material has been overseen. After careful examination of the transcription the key findings were noted. Although the use of the interview guide resulted in many of the same topics emerging during the interview, this was not unexpected, as the respondents had undergone the same surgical procedure. Nevertheless, there were differences in experiences that emerged. The preliminary topics which arose were pain, lack of sleep, nutrition,

support, disability, information, anxiety, previous experience with surgery, self-care, wound care, training, pain management, medication management, infection risks.

2**)Meaningful units:** Step two consisted of reviewing the transcripts to uncover the meaningful units which were identified using the preliminary topics. After careful consideration and discussion, we ended up with 4-5 preliminary topics per interview. We then began to note down on a word document the recurring topics. The meaningful units were copied from the transcripts and placed under a new document where they were sorted in relation to their topics. This is what Malterud (2017, p.101) states is coding. The codes that were formed were pain, disability and varied information, these codes were then given subgroups such as description of pain, need for help and support and lack/ diverse information received by each individual. The meaningful units were coded so the participants' recollection of common events were placed under the same code group or subgroup.

3)**Text condensation**: This third step consisted of summarizing the meaningful units into a quote. By using the same expression and phrases as the respondents we are able to relay what they have confided. By doing this we are able to summarize what was expressed under each of the codes (Malterud, 2017, p. 107) e.g. “I don’t know when I can use or strain my hand “fell under the subgroup “variation of given information” below the code group “lack/ diverse information received by each individual”.

4)**Synthesis**: The aim was to summarize and recite the content of the subgroups. We condensed the opinions in the subgroups and for each of the subgroups and code groups we developed an artificial quote in the “I” form. We found a quote from the interviews for each subgroup and made a content description of them in step 4. This was done with help of the artificial quotes and selected quotes from the interviews. We found quotes from the meaningful units that described the summary we had made. Appropriate headings were made for the subgroups describing the content (Malterud, 2017, p.108-110).

9.0 Ethical considerations

Ethical considerations were taken in this research study. According to Norwegian Helseforskningsloven, (2008), we as researchers, are obliged to safeguard respondents´ integrity, anonymity, and confidentiality. Malterud (2018, p. 218) further highlights the importance of pre- approving all medical and health research projects.

The regional committees for medical and health research ethics (REK) evaluate research projects that handle health information (Salbu, 2014). This research study has been approved by REK (31143, Appendix 4), Norwegian Center for Research Data (NSD, 2019, 298519, Appendix 5) and was conducted in accordance with the Helsinki Declaration (2018). Results from the interviews and questionnaires were stored at a secure research server at HVL, to comply with these guidelines.

The day surgery department had to consent for us to partake in the study before our contact person was allowed to source participants for our study. Our supervisor who is one of the project leaders for the bigger study we are a part of organized the paperwork which was handed to the department in order for us to do the study.

We made sure that all respondents gave their informed consent, and it is a key requirement in a research study. Participants agreed to consent to the study verbally to our contact person at the day surgery unit as well as receiving a consent form to sign prior to the interview. Consent must be voluntary and an option of withdrawing from the study was possible at any given point, this was made aware to them repeatedly during the duration of our communication with the participants.

Qualitative data is often sensitive and personal since it is people's life experiences and thoughts that are collected. We informed the participants that no personal information or anything that could be linked back to them would be presented in our study, making sure no personal information was recorded on the tape recorder and anonymized each interview by using numbering instead of names. Factors that can increase the risk of recognition are expressions, the age of the participant, profession, the name of the hospital where the participants were operated and stories that could be linked back to the specific event (Malterud, 2017, s. 214)

All data collected during the study will be placed in a research server at HVL to safeguard sensitive information. During qualitative studies sensitive information is often shared, therefore anonymity of respondents will be ensured from risk of recognition e.g., through reciting specific events (Surmiak, 2018).

It is imperative for our integrity in the ethical decisions made in our study. There is a need for empathy, and sensitivity with regards to each individual respondent's feelings. We need to be conscious as researchers with a nursing background. Patients may be vulnerable, reduced physically and psychologically postoperatively during the interview, and may lead to ethical dilemmas if we are confronted with health-related queries (Polit & Beck, 2017, p.139). Nevertheless, the Health Personal Act (1997, § 7) states nurses are obligated to provide healthcare if necessary. A psychologist and experienced day surgery nurse are available to participants´ through the main study, if support is needed.

10.0 Presentation of Findings

Three phenomena were identified from the interview texts, providing insight to the personal experience of self-care at home after CTS surgery. The first theme centered on a description of pain experienced. The second theme explored the degree of functional disability, while the third encompassed the participants' reflections on variation of given information regarding pre- and post-operative care (training, wound care, pain medication).

The three key themes are explored below using illustrative quotes from the informants formed through text condensation.

10.1 Experience of Pain "The pain felt like someone had put needles in the operation site" (Informant 4)

Through our data collection we were able to gather patients' expressions of pain the first days after surgery. Pain was described as "stabbing, pulling, feeling like needles in the operation site, biting and pounding" (Text condensation). Their descriptions paint a picture of the severity of pain which effected the quality of daily life during their postoperative recovery.

All individuals described pain as being the most challenging on the first day and being the sole cause of sleepless nights. Many found sleeping in the bed difficult and others sat in the chair and slept on and off, whilst trying to hold their hand up high. Most participants got very little sleep or no sleep the first couple of days after surgery, as expressed by informants "the nights were worse due to severe pain, I was in a great deal of pain, I did not sleep all night and I did not do that last night either, when you take the pain killers it works for a while and then it goes out eventually" (Text condensation).

The use of strong painkillers was an absolute necessity to eliminate the pain. Many of the respondents were quite unaware the pain would be so intense as the "pain came on heavily and it was unbearable, I was a little surprised" (Informant 2). Participants did not mention other conservative methods of pain relief rather than taking pain killers that were prescribed to them while some tried to sleep through the pain.

All participants were prescribed analgesia post operatively, and individuals state “Paralgin forte is the least they should give people, the first day and night are the worst due to the intensity of pain. They should especially increase the dose given then, I had used up all 20 tablets of Paralgin forte I had been prescribed, it is not strong enough” (Text condensation). The general impression gained from the interviews was that the pain medication prescribed was not strong enough to tackle the pain that came after the local anesthesia wore off. From the data gathered the informants perceived CTS day surgery as very painful and overwhelming, overshadowing their quality of daily life postoperatively.

10.2 Functional disability “Include in the information leaflet for first timers they will be handicapped” (Informant 6)

Feelings of being handicapped were a constant challenge for all respondents. Their hands were bandaged from the elbow to fingertip, and they were advised to keep their hands held high, if they lowered their arm, it could cause pain and swelling. Whether or not it was their right or left hand or the hand they use the most, the fact is that they only had one hand available to carry out their daily tasks.

All respondents reported they were highly dependent on support from family and friends during the first days after their operation “I just didn't think it would be like this but it is noticeable, so I must have extra help, I had pains” (Text condensation), as they were unable to carry out their activities of daily living. All participants expressed they needed assistance with clothing, tying shoe laces, hygiene, wound care, transportation, cooking and cutting up food.“ I had to stand up here in the morning and fight with the bread when I was going to eat, I don’t know how long I stood there for so I bought ready-made and easily accessible food” (Text condensation). Others needed help with more intimate needs such as getting help from a friend to unbutton their trousers and another needing help from a partner after urinating on the side of the toilet (Informant 4 & 6). Even though some participants had undergone this operation before they were still surprised at how much help they still needed.

It is a prerequisite that those undergoing day surgery have a guardian who can be with them 24hrs after the operation. Our interviews were conducted 3-5 days

postoperatively and those three who were interviewed on the 5th postoperative day still maintained the need for help from either their spouse, children, or friends. The informants´ description of their inability to participate in normal activities, basic ADLs, and intimate care, paints a picture that this surgical intervention is quite disabling as they are unable to function normally.

10.3 Lack of and varied information received "I asked friends who had taken this before" (Informant 2)

The respondents stated they received information from a healthcare professional prior to surgery, some were also given a leaflet informing them how they should prepare for surgery. However, after careful examination of the interviews we noticed that these individuals were given diverse information and some nothing at all in certain areas.

Participants expressed concerns over the lack of information received regarding pain management, and those who received information conveyed its inadequacy. "They could have maybe said it was wise to take a painkiller as soon as you leave the hospital, and they should have been clearer on this, rather than saying I should take the tablets when the local anesthetic wears off" (Text condensation). On the contrary there were some informants who didn't receive any more information regarding administration of pain relief, other than if they were in pain, they should take medication (informant 5).

A consequence of the varied information may have led to poor preparations for the challenges to be met postoperatively. One participant went as far as to consult a friend who was also a medical doctor regarding information on pain medication and the precautions against paracetamol overdose. Due to fear of exceeding the daily recommended dose, this individual made their own checklist to have control. Further stating a "recipe" should be made to make things easier for patients postoperatively (Informant 2).

The need for more information is expressed amongst this patient group regarding timings of administration and safer dosage placing an emphasis on being readily available on the information leaflet.

One respondent who became extremely anxious expressed the need for information regarding anxiety medication, which should be prescribed from the general practitioner, to be made aware on the information leaflet, as they were told they didn't have any medication of this sort and it should have been obtained from the informants´ general practitioner prior to surgery (Informant 5).

These participants could see themselves as functionally disabled after day surgery for CTS as they only had one hand available to use. During the interviews it was expressed that if challenges had been highlighted earlier such as clothing themselves “I would have arranged appropriate clothing in advance without buttons, zips and lace less shoes” (Text condensation**),** these statements were made by participants regardless of previous experience with CTS surgery.

In order to avoid complications with the operated hand, participants revealed they received information leaflets containing simple instructions with training exercises to be carried out postoperatively, however, information was varied amongst these individuals. Some claimed they received verbal warnings from the surgical nurse, that they shouldn't exaggerate the training of the operated hand (Informant 2), whereas others, were not informed and exclaimed “I really didn’t know where to start, after the pain disappears, I will just use my hand as before” (Text condensation). It was claimed by those who had received information on training that they had carried this out and that it had helped with the healing process as there was a reduction of stiffness in their hand.

After gathering all data related to the information given to these patients, after CTS day surgery, we could see there was a clear variation in the type of information given to each individual. Some were given more information and others less. All participants were told they would have to keep the bandage clean and dry. However, some were told “I would have to hold my hand up high and loosen the bandage if it was tight” (Text condensation) and regarding when the bandage should be changed,

some were told to change it after three days, (Informant 2), others were told nothing. Only some respondents were also told to “keep an eye on excess bleeding, and signs of infection, and should contact the hospital if this was the case (Text condensation).

There was also a clear indication that those who were undergoing this CTS operation for the second time were given less information about what to expect postoperatively, it was further stated, “I didn't get information about exercise this time around, because I had been through it once before” (Text condensation).

Nevertheless, many of the informants expressed they most probably received more information about wound care, but this was as soon as they were done with the operation and still reeling from the effects of the anesthetics so they simply “don’t remember” (Text condensation).

11.0 Discussion of Findings

This section discusses the findings from data collection to be able to respond to the thesis´ research question to gain an insight into patient experience and expectations of self-care care after CTS day surgery, the participants' perception from the interview will be presented. Furthermore, we will look at how they have managed to cope with various challenges, and finally discuss whether there is any relationship between what has been said in the interviews, the perception and what is done in practice inspired by Nightingale's Nursing theory.

11.1 Experience of pain

The outcomes from this study shows participants were plagued by pain during the first postoperative days, having a negative impact on their activities of daily living, sleep and nutrition, corresponding to existing literature by Odom-Forren, (2015). Sawhney, Paul, & Alvarado (2010) found pain to be the most common problem following surgery, with Rosén, Bergh, Lundman, & Mårtensson (2011), rating pain being at its peak 48 hours after surgery. The experience of pain amongst CTS patients is more severe than we had initially expected as the few existing literature provides detailed accounts of patients' descriptions of pain.

Nortvedt (2019) stated Nightingale believed that the nurse must firstly understand the patient's world of experience as a basis for good care. As all patients were affected, one might wonder if there is a lack of knowledge between the hospital and the experiences of these individuals in relation to the lack of pain management after CTS day surgery.

It was clearly highlighted by all individuals that their quality of sleep was weak due to the high intensity of pain, many woke up as soon as the pain medication decreased in effect. It has been claimed by Boccara, (2021) that sleep is necessary for the body to function normally, and a lack of sleep is associated with several diseases. In addition, the study by Su & Wang (2014) found sleep was imperative for the maintenance of physical and psychological health and a lack of sleep led to an increased sensitivity to pain in patients postoperatively. Furthermore, Nortvedt (2019) refers to Nightingale who was of the impression that sleep can cause a delay to the

recovery of patients. We can see that pain and sleep go around in a vicious cycle, pain can lead to a lack of sleep and a lack of sleep can lead to pain, causing unnecessary pain, suffering and a delayed healing process for these individuals, therefore more needs to be done to provide adequate pain management to this patient group.

Patients undergoing day surgery for CTS are prescribed pain medication upon discharge, however, there are mutual feelings doubting the effectiveness of the strength of these medications. Many argued the pain was only partially relieved, still affecting their quality of life and that the dosage should be increased. Stulberg et al., (2019) state that physicians often prescribe an average number of pills paying little attention to each individual and their tolerance of pain. The study by Coll, Ameen, & Moseley (2004) recommends an improved pain management approach needs to be implemented as recovery after day surgery can come with challenges which prove to be problematic, these include pain, and tiredness (Dahlberg et al., 2019) which was the case for this patient group.

Nightingale, (1997, p.32) states it is the nurse's role to administer and observe the effect of medication, however, these patients were left to their own devices when it came to administering medication. Judging from the intensity of the pain surrounding their ADLs one may ask were these individuals administering medication in an optimal way, but without the presence of a nurse at hand it would be difficult to observe the effect of the analgesia. The theory of Nightingale, (1997, p.73-75), states nurses must ensure that patients always receive high quality care and consideration needs to be placed about what happens in their absence, as the care is not good enough. So therefore, there is a clear need for healthcare professionals to reevaluate the information given regarding pain management, so the days following surgery are bearable.

Although the majority of patients seems to have relied heavily on pain medication, there were a couple of respondents who were taking less than what was recommended even though they were affected by the severity of pain. A study by Vallerand, Crawley, Pieper, & Templin (2016) found that even though patients experience pain they may not be willing to take pain medication in order to maintain

control over their life, as there is a fear of digesting strong analgesia linking it to unwanted side effects (Gramke, et al., 2007) such as tiredness, constipation and nausea (Sykehusapotekene, 2020).

Garimella & Cellini (2013) state that inadequate pain relief post-surgery is linked to reduced quality of life. However various studies including the study by Horton, Munawar, Corrigan, White, & Cina (2019) have found that patients often take less analgesia than prescribed to them during the postoperative phase which has resulted in excess opioids which can be accessible to others increasing the risk of pill misuse, this could be argued as the reason for limiting medication being prescribed to these individuals. Nightingale believed that nurses must understand the patient's world of experience to carry out good care (Nortvedt, 2019), so therefore we argue that nurses could have supported these individuals in regulating their pain management, so pain can be controlled, and they can carry on with their ADLs. Nightingale further states a nurse could have also contributed to providing knowledge and care to cater for each individual's holistic need (Nortvedt, 2019).

Although it was found that most individuals used up the pain killers (Paralgin forte) prescribed to them, it was also noted that none of the patients were offered advice regarding other forms of pain relief other than medication, i.e., heat and cold therapies. For instance, cooling treatments such as placing an ice pack or a heating pad on the operated area for pain relief is a popular form of treatment which does not involve pharmacological interventions and contributes to the rehabilitation phase (Engelhard, Hofer, & Annaheim, 2019). Furthermore, the study by Aciksoz, Akyuz, & Tunay (2017) found hot and cold treatments improved patients' pain, functional status, and quality of life. Nightingale states it is the nurse's knowledge and empathy that helps encourage the patient during self-care (Nortvedt, 2019). This makes us as researchers as well as surgical nurses, wonder if by making a small alteration in future practice for this patient group, with their management of pain, including both analgesia and conservative treatments, their quality of life could improve significantly after surgery.

After examining patients' experiences of pain we are of the opinion that there is a need for postoperative pain education and the treatments available other than analgesia. This postoperative education should involve informing the patient group of

realistic expectations regarding pain and involving them in their pain management treatment. Furthermore, it would be ideal for nurses to use their professional knowledge to support the patient in their pain management journey, through follow ups of their recovery and giving advice regarding conservative pain management methods to provide what Nightingale describes as “good nursing” (Nortvedt, 2019).

11.2 Functional disability

The general expectation of day surgery is that it is a minor surgical treatment, (Newington, 2019). One of the prerequisites for eligibility as a day surgery patient is to be able to have a guardian present to take care of the patient for the first 24hrs after surgery, painting the wrong picture of how much help is actually needed. The data gathered from the interviews conducted 3-5 days postoperatively with this patient group shows the need for help and support lasting beyond the initial 24hr that was initially stated.

We found all respondents were feeling helpless in relation to clothing themselves, especially regarding buttoning, zipping, and tying shoelaces. Although many of the respondents received help from their partners, others had to resort to asking their spouses, children, and friends to help with clothing themselves. As an adult who is used to being independent it can be hard and humiliating to ask family members or friends for help with intimate assistance. Nightingale (1997, p.124) states that many believe the nurse's role is to help relieve the patient's workload physically, however in fact their actual role is to lighten patients´ worries.

It is natural for one to take their hands for granted, however, when it comes to the point where only one hand is available to undertake ADLs more specifically clothing oneself, feelings of handicapped would naturally be felt. Therefore, it would be beneficial for this patient group to prepare easily accessible clothing prior to the operation, such as jumpers and tops without buttons and trousers with an elastic band which is easy to put on and take off. In addition, it should be recommended that these individuals get themselves shoes that they could possibly slip on and off or perhaps shoes with Velcro straps to decrease their reliance on others.

Physical restrictions such as only having one hand available due to the other one being bandaged carrying out daily tasks such as personal hygiene can be challenging after day surgery (Berg et al., 2013). Individuals from this patient group needed to wait for assistance from family members to carry out basic hygiene needs, where feelings of helplessness were felt in addition to humiliation and shame due to the intimacy related with the hygiene needs. As newly operated patients, it would have proved unfortunate if they had acquired an infection in the surgical site due to poor hygiene. Nightingale (1997, p.51) states there is a need for a healthy and clean home to care for sick people, further stressing the importance of hygiene through her study where she proved unhygienic conditions killed more patients than bullets (Nightingale, 1995, p.15).

Nutrition is regarded as an important factor to achieve optimal wound healing in the postoperative phase and inadequate nutrition has been linked to a risk of higher infection rates (Stechmiller, 2020). It was made clear by the informants that they needed assistance by family members to meet their nutritional needs even after the first 24hrs. Nightingale was the first nurse to make a connection between nutrition and disease and it was the nurse's responsibility to make sure the disease was healed (Sortland, 2001, p. 13). Many respondents relied on help and support from family members who still had an active career, so food had to be prepared for them either before their guardians left for work, or they had to wait for them to come back. Therefore, some of them organized food which was easy to gain access to with one hand, so they would be able to take care of their nutritional needs while family members were away. Nightingale states that one must observe when it's the best time to be able to give the patients food and be punctual so the patient can consume the food without other disturbances present. It could be argued that if this patient group had been admitted to the hospital ward after surgery, they would have received food at regular time intervals (Gill & Gill, 2005).

During the interviews respondents have expressed a need for assistance stretching over several postoperative days. The study by Newington (2019) found cooking, showering, dressing and tying shoelaces was challenging. There was a lack of preparation beforehand for the challenges in the unforeseeable future. It could be argued that as the requirement for day surgery, a guardian present is set to 24hrs,

patients underestimate the need for help and support with many patients feeling they were “handicapped” and in constant need of support. On the other hand, Majholm, et al., (2012) found although family members were satisfied with day -surgery they faced challenges whilst looking after their loved one’s post discharge, burdened with the responsibility of providing care and even having to take time off their own careers to do so. Nightingale (1997, p.191) believed patients who are discharged and return to overburdened homes, and exhausted resources will be unable to meet their need for care, clothing, proper nutrition and comfort and this vulnerable patient group will end up overworking themselves.

Therefore, we as researchers believe that consideration needs to be placed on careers who take on the responsibility of providing care and support to those who have recently undergone day surgery, especially those who are children. Ideally these guardians should be involved during the discharge planning process (Boughton & Halliday, 2009). Even though outpatient surgery has been compared to the success of McDonalds for efficiency, predictability, calculability, and control (Mottram, 2011a) patients and family members in reality are in a vulnerable position during their postoperative phase.

11.3 Lack of and varied information received

A lack of information regarding pain relief, training of the operated hand and wound care in the postoperative phase were all aspects expressed by participants. To achieve self-care successfully, patients were required to constantly assess their physical and psychological state. Therefore, it is advantageous for patients to have an early awareness of what to expect and any adverse reactions they should be wary of (Riegel, Jaarsma & Stromberg, 2012) and through acquaintance with their condition, patients will be able to make informed decisions about their treatment and self-care, (Scott, 2011). However, a lack of information will reinforce the unpredictability of the disease, which in turn will increase the uncertainty around self-care (Bailey & Stewart, 2011, p. 509-513).

Respondents reported receiving limiting and contradictory information regarding pain relief. Some were informed that they would have to take pain relief when the local

anesthesia began to wear off, but were not given a specific time, while others were told the duration range for the anesthesia to wear off was approximately between 2-4hrs of them leaving the hospital. This information can be regarded as vague and rather a large time frame. The pain was described as excruciating as soon as the effects of the local anesthesia faded out. So therefore, we believe that these individuals require a more detailed time frame on when to begin taking their pain medication.

Furthermore, it is a well-known fact by our experience as nurses that in a medication box of Paralgin forte there is an information leaflet with clear warnings stating Paralgin Forte contains Paracetamol. The lack of information can prove to be detrimental to the lives of these individuals, as they may feel the medication they were prescribed after surgery was insufficient so they try to decrease their pain by medicating themselves with analgesia which can be bought without a prescription, and in most cases, this is paracetamol. The dangers associated with the combination of Paracetamol and Paralgin forte should be made aware to patients as there were some uncertainties regarding this and the worst-case scenario could have led to liver failure proving fatal (Spiering & Dietrichs, 2020).

In other instances, regarding the management of pain, respondents were advised to loosen the bandage if it felt tight, despite information regarding elevation of the operated hand was written in the information leaflet (Appendix 6), none of the individuals were told exactly how high they ought to lift the hand, leaving them in a state of confusion. According to Nortvedt (2019) Nightingale believed knowledge and observation of the patient's condition are a necessity for recovery. Continuing education for health care professionals, who are involved with postoperative pain management, is a basis element of successful pain management. Therefore, we as researchers with a background of many years of nursing, believe it would be beneficial to make a medication chart where individuals would be able to write down what time they took their medication, how many of each and could calculate their daily dosage allowing them to regain control over administration of their pain medication.

Participants were requested to carry out simple training exercises postoperatively, to avoid complications with the operated hand, however, some were not informed of the kind of exercises to undertake. This was especially visible in those who had been previously operated, as there may have been an expectation that these individuals remembered what the exercises entailed, regardless of the time frame between each operation. Others were unsure of how much weight they could lift with the operated hand, and some assumed they could begin to lift heavy things when the pain disappeared. This can prove to be dangerous as it may lead to complications during the healing process, further delaying recovery and can lead to early recurrence (Karthik, Nanda, & Stothard, 2012). It is imperative for the respondents to understand the importance of the training exercises which have been recommended, and how much the operated hand can be strained. Nightingale (1997, p. 31-32) emphasizes the role of the nurse as crucial in facilitating the healing of the body. It is imperative patients receive adequate information as if the correct procedure is not followed when the wound is healing, it could cause serious damage. The information leaflet that was provided to some informants illustrated the recommended training exercises as well as a time frame stating when the hand can be strained. An importance must be placed on the respondents understanding of training exercises that have been recommended and how much the operated hand can tolerate to facilitate a successful recovery.

Furthermore, all participants claim being told to keep the bandage clean and dry and an important factor that was expressed in relation to the signs of infection were swelling, redness and discharge. In addition, some informants were told to change their bandage after 48 hours postoperatively, while others were not. Only a few were informed of the risks of postoperative infections concerning hygiene, therefore many participants hadn't changed their beddings, arranged for clean clothing, washed their hair, nor made sure that their houses were ready prior to surgery. We can see that the pre-operative information given to this patient group was limiting. Referring to Nightingale´s ideas of knowledge, it could be argued how patients are to assess what is normal in their recovery (Nortvedt, 2019).

Mitchell (2015), argues nurses are expected to have a more active role and greater responsibility for patient education, discharge, and home recovery. Nursing may need

to broaden its scope to understand the complete patient experience and should be more appropriately tailored to individual needs, as patients have varied coping styles and different requirements. Based on inadequate information provided to the informant about how best to prepare themselves for the post-operative phase, we question whether our healthcare system doesn't provide adequate information in advance for this outpatient group.

Postoperative, cognitive dysfunction has been experienced by individuals after surgery which is a complication caused by anesthetics. It is known to have a significant effect on the patient's quality of life and cause an impairment in memory, daily functioning, and learning after surgery and can have an effect lasting weeks, months or more and a significant factor which increases the risk of cognitive dysfunction is pain (Davis et al., 2014).

Consequently, it is worrying to receive feedback by participants stating they are not provided with adequate pain relief. Nevertheless, our informants started receiving information from the surgeon and the nurse soon after surgery, and many do not remember much due to the lingering effects of anesthesia. We propose detailed written information should be given to these individuals preoperatively and postoperatively, in the form of a leaflet or even a website containing a video of a nurse informing them of the same information which they do postoperatively, during the time the patients are in the local anesthetic phase. This may provide them with quality information which they will be able to fathom.

Although individuals received the telephone number to the day surgery department in case of an emergency none of them had expressed using it, but instead turned to friends and family who had previously operated for CTS for advice. We believe this may be because they do not want to burden the already overburdened healthcare system. Nightingale states it is the nurse's role to make sure patients are followed up and "not be drained of energy" Nightingale (1984, p. 18). Thus, nurses must ensure the patients´ are followed up and given the correct information to provide safe and successful self-care.

The study by Cox & O´Connell (2003) found information provided to patients did not always cater to their needs but was in fact focused on what healthcare providers considered as essential. Moreover, Mitchell (2013) and Mottram (2001a) are of the opinion that due to the high turnover of day surgery patients, time constraints are challenging, therefore a patient centered tailored approach needs to be set in place to facilitate safe and effective holistic care (Berg et al., 2013). These include a customized discharge plan that aims to educate patients on postoperative self-care which will aid in patient satisfaction and reduce the risk of postoperative complications (Gonçalves-Bradley, Lannin, Clemson, Cameron & Shepperd, 2016). Effective dialogue must be established between health professionals and patients to reduce emotional distress, enhance recovery, and patient satisfaction. Nurses are seen as the interceder between patients and the healthcare system and vice versa, so therefore nurses need to provide tailor made information to this patient group for the successful recovery after surgery.

The overall impression by all participants is that they appear to have a positive impression of CTS day surgery by it being a “minor operation” lasting 10-20 minutes (Helse Bergen, 2021), that went “smoothly” and were grateful that the operation was done, even though they faced challenges with their self-care once home. Mottram (2011b) states that day surgery is “marvelous while you are there but the after care is rubbish” which supports the experiences of these individuals. It may be that the positive attitude expressed by these individuals is a form of coping mechanism, as they do not fully understand what is regarded as adequate and safe aftercare. Many expressed the need for extra analgesia, while others noticed the lack of information given and the need for extra support other than the first postoperative day. One participant went further stating that healthcare professionals need to get a full understanding of what it is like to be in the patient's situation, which would be a gold standard for practice. Nevertheless, it was mentioned by all that they were glad to be able to come home after surgery, to their own home and especially their bed, without the disturbance from others, additionally, exclaiming they would have done whatever they had to, to avoid being admitted to the ward. Overall, they felt “well taken care off” and were met by “skilled" and “professional” healthcare workers and were very thankful for the healthcare system in Norway.

12.0 Discussion of Method

We chose to gather data using qualitative interviews with the help of an interview guide. This method is suitable for answering the topic of this thesis. Through qualitative interviews, one can create a relationship with the informants (Polit & Beck, 2017. p. 510), making it possible to accumulate in-depth data from themes raised, allowing an opportunity for follow-up questions to be asked (Polit & Beck, 2017, p. 511- 515). Furthermore, one can clarify any misunderstandings along the way. Six qualitative interviews have been undertaken and text condensation has been achieved. Before the interviews were conducted, a consent form was required to be signed by the participants. By analysis of the data material, the informants have been anonymized so that no ethical challenges would arise Thagaard, 2013, p. 28). Finally, the method has reflected on the validity and reliability by describing how the work selection and methods have taken place (Befring, 2016, p. 56).

A factor for consideration is the language barrier which was faced. We researchers who have English as our primary language may have overseen the mood and the phases expressed by the participants. For instance, one participant in particular made the popular statement “ingen armer, ingen kake” (informant 2), but sensed we did not understand and later went on to say, “I don't know if you guys understand” and began to explain the phrase to us. We are aware language and cultural differences play a part in the validity of the research gathered, however, we made every effort to uncover the meanings of these individuals during this study.

Nevertheless, we are satisfied with the heterogeneous variation of participants in our study. By including men and women in different age groups, retired individuals, individuals with a career, with young children, with older children, married and single individuals, we were able to get a variation of life experiences.

12.1 Reliability

In order to determine whether the research that has been done is rich in quality, reliability and validity are central concepts. To strengthen the reliability, the findings of the thesis have highlighted how the data material has been developed during the research process (Thagaard, 2013, p. 202). Qualitative data is difficult to reproduce, and therefore it has been important to clarify how the data material for this thesis has been developed. This has been done by describing options and procedures in the process accurately so that others can conduct similar studies (Befring, 2016, p. 56).

One potential weakness of this method is that the participants who were interviewed may have wanted to answer what they thought we as researchers wanted to hear, so to avoid this, we explained to the informants that we were not looking for a definitive answer, but rather their thoughts and views. Another possible weakness is that some interviews were conducted on the phone, rather than face to face in person, or via video call, this could have influenced data collected where non-verbal expressions could have gone unobserved. Moreover, another limitation that could be seen is inability to conduct in person interviews due to the COVID-19 situation as we were unable to study the body language and surroundings of the informants.

12.2 Validity

The validity of research is the extent to which the research data measures the elements that are required to be measured (Thagaard, 2013, p. 194). The interviews were conducted where participants were in their homes via telephone and video call, this may increase validity of the interviews being performed in a place they feel safe (McGrath et al., 2019). While we worked on the analysis, it was important for us to be self-critical in our reading and our personal interpretations had to be withheld to avoid jeopardizing the interpretations provided by the informants (Befring, 2016, p. 55). Descriptive validity was presented though data collection which was unique and accurate. The theoretical validity of the thesis has been sought to be strengthened by creating a credible connection between the theory on which the thesis is based on and the data material (Befring, 2016, p. 55).

12.3 Generalization

Polit & Beck (2017, p. 511) states, group samples in this design are usually small, information is studied intensively, and findings cannot be generalized, but contributes to a deeper understanding of this research groups´ self-treatment (Sutton & Austin, 2015).

A total of six participants were interviewed, meaning that are too little informants for the results to be generalized (Kvale & Brinkmann, 2015, p. 289), but anyone can relate to the findings of the study, although it is not possible to speak on behalf of all CTS patients in the country. However, in qualitative research it is not the main purpose to generalize across large groups of people, but rather gain a deeper understanding of individuals' experiences and views. Since this study is part of a larger project where several day surgery procedures are included, findings can be summarized in relation to experiences of self-care.

13.0 Implications for Future Practice

In line with the increase of day surgery, more research needs to be taken regarding the experiences of patient's self-care after CTS day surgery. Although the increase in day surgery has led to a high turnout, it could be asked whether the fast-paced service allows patients to process the procedure even though no individual is the same, further research needs to be undertaken to examine the discrepancies within day surgery.

As mentioned, we are a small project under a larger project regarding patients expectations and experiences of day surgery. By undertaking this study our aim was to contribute to this larger study by providing new knowledge in order to make the self-care process as smooth as possible after discharge.

The research gathered from our study found patients' pain management needs were not adequately met, and it appears that there was a lack of information given to patients as well as extra need for help. We hope our findings can result in a change in the quality of information and sufficient pain management given to individuals carrying out day surgery. We are aware of the consequences that may arise due to a higher dose of analgesic prescribed, however, we hope that patients are offered other forms of pain management such as ice treatment. We also found these individuals were highly dependent on help and support from family members and friends placing them in a vulnerable position. By providing sufficient information regarding pre, peri and post-operative care before the operation patients may be more likely to remember what was being said to them rather than during the fog of anesthetics. We truly believe that individual guidance and information given by a nurse allocated to take care of this patient group can aid in successful self-care and reduce uncertainty as currently nurses have little involvement pre and post operatively in the patients care. Although there are limitations with day surgery we found our patient group to be generally satisfied with this type of surgery as "home is the world's best hospital" (Respondent 4).

14.0 Conclusion

In this thesis, we have answered the problem of patients' experiences with self-care after day surgery treatment with CTS. Data collected shows that the informant has not fully received what they need to achieve optimal self-care postoperatively.

According to the findings in this study CTS patients are experiencing severe pain the first 24 to 48 hours post discharge and the degree of pain overshadows performance of their quality of life. Patients experienced that pain management was not satisfactory, they were more helpless than they had imagined and needed help with daily activities. It also emerged that the information provided did not meet the patients' requirements. Despite this, the informants expressed satisfaction with the day surgery offer.

Studies show there is a need for postoperative nursing for this group of day surgery patients, because they are unable to perform ADLs and pain management to themselves. Since day surgery has come to stay, this challenges the nursing profession to change its focus in terms of how to provide nursing care to patients at home. This may mean that the nursing profession needs to work more on developing information for day surgery patients, creating systems for telephone follow-ups or development of hospital at home models (district nursing)
We believe this study is a contribution to understanding this patient group and providing the nursing profession with knowledge to develop new interventions.

15.0 Reference list

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16.0 Appendix

16.1 Consent form, Appendix 1

Høgskulen på Vestlandet

SAMTYKKE TIL DELTAGELSE I PROSJEKTET; «Pasienters opplevelse og erfaringer med egenbehandling hjemme etter dagkirurgi»

På bakgrunn av den informasjon jeg har fått både muntlig og skriftlig, ønsker jeg å delta i denne undersøkelsen.

Jeg er kjent med at intervjuet vil bli utført av Masterstudenter ved master i klinisk sykepleie som et ledd i et Mastergradsarbeid. Jeg er også kjent med at dette masterarbeidet inngår i en større studie som omhandler mange ulike pasientgrupper som har gjennomgått dagkirurgisk behandling. Studiet er et samarbeid med Høgskulen på Vestlandet og sykehusene i Helse Vest. Jeg er forespurt om dette fordi jeg innehar erfaring, kunnskap og synspunkter som har betydning for studiet. Deltakelsen inkluderer også besvarelse av et spørreskjema som jeg får tildelt av masterstudenten, sammen med frankert konvolutt.

Jeg er informert om at jeg til enhver tid har rett til å trekke meg hvis jeg ønsker det.

Intervjuet vil finne sted hjemme hos meg, eller på et egnet kontor hvis jeg ønsker det. Det vil ikke bli gitt økonomisk godtgjørelse. Jeg er informert om at jeg vil bli kontaktet når jeg har kommet hjem for å finne et passende tidspunkt.

Jeg vet at all informasjon som jeg gir vil bli anonymisert både i forhold til oppbevaring og fremstilling i forskningsarbeidet.

Dato for operasjon: .....

Navn (med blokk bokstaver) .....

Adresse: .....

Telefonnummer .....

Signatur: .....

Samtykke erklæring returneres i vedlagte frankerte konvolutt. Eller tas med til sykehuset når du skal opereres.

Hvis spørsmål, kontakt dagligleder Petrin Eide på telefon: 55 58 56 95 / 91 74 04 35

16.2 Information Leaflet about study, Appendix 2

Høgskulen på Vestlandet

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

PASIENTERS OPPLEVELSER OG ERFARINGER AV EGENBEHANDLING HJEMME ETTER DAGKIRURGI

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å få en bedre forståelse for hvordan det er å være dagkirurgisk pasient og komme hjem etter kirurgi på sykehuset. Siden du har vært gjennom denne type inngrep, ønsker vi å få vite mer om hvordan tiden etter operasjonen har vært, og om du har opplevelser, erfaringer, kommentarer til det å være sin egen behandler.

Formålet med prosjektet

Det overordnede målet med dette prosjektet er å få en økt forståelse for dagkirurgiske pasienters opplevelser og erfaringer med egenbehandling i hjemmet etter dagkirurgisk behandling gjennom kvalitative intervju kombinert med en spørreskjemabasert kartlegging av psykisk helse og livskvalitet.

Hvem er ansvarlig for forskningsprosjektet?

Forskningsprosjektet utgår fra Høgskulen på Vestlandet og forskningsgruppen POPS, ved prosjektleder Venke A. Johansen og dagligleder Petrin Eide, i samarbeid med Dagkirurgiske enheter på sykehus i Helse Vest. Forskningsgruppen POPS (Pasient opplevelser og Pasient sikkerhet) består av forskere med helsefaglig bakgrunn fra Bergen, Førde og Haugesund.

HVA INNEBÆRER DET FOR DEG Å DELTA?

Prosjektet innebærer at du 3-7 dager etter dagkirurgisk behandling vil bli kontaktet og intervjuet av en eller to masterstudenter ved Høgskulen på Vestlandet. Masterstudentene er erfarne sykepleiere som studerer enten anestesi, operasjon eller intensivsykepleie. De vil intervjue deg i forhold til hvordan det har vært å være deg etter det kirurgiske inngrepet, og hvordan du har opplevd rekonvalesenttiden. Selve intervjuet kan foregå hjemme hos deg eller på et egnet kontor hos oss avhengig av hva du føler er best for deg. Her er det du som bestemmer. Intervjuet varer fra 30-60 minutter og vil bli tatt opp på bånd. I tillegg til intervjuet vil vi be om opplysninger om alder, kjønn, hvem du bor sammen med, utdannelse og sivil status.

Du vil få tildelt en spørreskjemapakke etter intervjuet, som er basert på validerte og anerkjente spørreskjema, som vi håper du tar deg tid til å besvare. Hensikten med spørreskjemaet er å få økt kjennskap til den psykiske helsen (angst, depresjon, posttraumatisk stress) hos gruppen dagkirurgiske pasienter. I tillegg inneholder skjemaet spørsmål om mestringsforventning, sosial støtte og livskvalitet. Noen kan oppleve enkelte av spørsmålene som noe nærgående og vanskelig å svare på. Spørreskjemaet tar ofte 20-30 minutter å fylle ut. Det presiseres at spørreskjemaene som benyttes i prosjektet ikke gir grunnlag for diagnostisering av psykiske lidelser hos enkeltpersoner, men benyttes som screeningsverktøy på gruppenivå i forskningssammenheng. Frankert svarkonvolutt er vedlagt. Resultatene basert på skjema vil bli publisert i form av statistiske analyser.

Dersom du føler seg bekymret med tanke på egen helse i etterkant av intervjuet eller i tilknytning til besvarelse av spørreskjema kan du ta kontakt med masterstudenten som intervjuet deg som vil videreformidle til prosjektledelsen.

Dersom spørreskjemabesvarelsen tyder på symptomer (angst, depresjon eller posttraumatisk stress) skal en psykologspesialist vurdere hvorvidt det er behov for å ta kontakt. I så fall gjør vi en henvendelse.

MULIGE FORDELER OG ULEMPER

Det kan oppleves belastende å delta i et intervju og besvare spørreskjema kort tid etter et kirurgisk inngrep. På den annen side kan det også oppleves godt å ha noen utenforstående å dele sine erfaringer med. Det gis ingen kompensasjon for å være med på dette forskningsprosjektet, men vi håper at du med dine erfaringer kan hjelpe oss til å få mer kunnskap om den dagkirurgiske pasienten.

DER ER FRIVILLIG Å DELTA

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få konsekvenser for din videre behandling. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet intervjuet, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte dagligleder Petrin Eide, +47 917 40 435 phe@hvl.no.

DITT PERSONVERN

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelelverket.

Navnet og kontaktopplysningene dine vil bli erstattet med en kode som lagres på eget område på en lukket forskningsserver, der kun prosjektleder har tilgang. Alt datamateriale vil bli behandlet uten navn eller andre direkte gjenkjennende opplysninger.

Prosjektleder har ansvar forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert, og slettes senest fem år etter prosjektslutt. Dato for prosjektslutt 15.11.2023

GODKJENNING

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Høgskulen på Vestlandet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- *Høgskulen på Vestlandet* ved dagligleder Petrin Eide, +47 917 40 435 phe@hvl.no.
- Vårt personvernombud: Trine Anikken Larsen personvernombud@hvl.no
- NSD – Norsk senter for forskningsdata AS, på epost (personvernombudet@nsd.no) eller telefon: 55 58 21 17.

16.3 Interview Guide, Appendix 3

Dagkirurgi og hjemmesituasjon

Prosjekt dagkirurgi; INTERVJUGUIDE

Intervjuguiden er delt opp i tema. Hensikten er at respondenten skal snakke så fritt som mulig. Underpunktene er ment som en støtte for intervjueren.

OBS: Husk å gi informanten kode til intervju og spørreskjema.

Tema 1: Kan du beskrive hvordan du har forberedt deg før operasjonen

- Søkte du etter mer informasjon: internett, venner, behandlingssted
- Andre forberedelser: matinnkjøp, ekstra rengjøring, bytte av sengetøy, organisering av hjelp, ommøblering av hjem

Tema 2: Fortell om det første døgnet

- Hjemreisen
- Ubehag
- Søvn, ernæring
- Stress
- Mulighet til å utføre daglige aktiviteter

Tema 3: Fortell om ditt behov for hjelp og støtte

- Utfordringer
- Uforutsette hendelser/hva som skjedde og hvordan det ble løst
- Hvem har hjulpet deg og hvor mye
- Kontakt med helsevesenet, avdeling, andre

Tema 4: Kan du beskrive hvilken egenbehandling du har blitt anbefalt å utføre, og hvordan du utfører denne

- Administrasjon av smertestillende
- Øvelser/fysioterapi
- Observasjoner av egen helsetilstand
- Sår/bandasje

16.4 Approval from REK, Appendix 4

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Ingvild Haaland	55978498	16.12.2019	31134
			Deres dato: 14.08.2019	

Petrin Hege Eide

31134 Pasienters opplevelser og erfaringer med egenbehandling hjemme etter Dagkirurgi

Forskningsansvarlig: Høgskulen på Vestlandet

Søker: Petrin Hege Eide

Søkers beskrivelse av formål:
Prosjektet har som mål å utvikle forståelse for ulike pasientgruppers opplevelser og erfaringer med egenbehandling hjemme etter dagkirurgisk behandling.
Prosjektets er en deskriptivt- tverrsnitts studie med kombinasjon av kvalitative og kvantitative metoder. Utvalget består av dagkirurgiske pasientgrupper fra alle kirurgisk displiner.
Mål
Få innsikt i:
• generelle og spesielle problemer ved det å være dagkirurgisk pasient
• egenbehandling forståelse og utføres
• behov for hjelp og identifisere hjelpere
• postoperative komplikasjoner, forståelse og håndtering
For å gi en breddeforståelse for pasientenes situasjon benyttes det spørreskjema som måler posttraumatiske stress reaksjoner, mestringsforventning, sosial støtte, livskvalitet og usikkerhet.
Det registreres bakgrunnsvariabler som type kirurgi, ventetid før inngrep, alder, kjønn, boforhold, utdanning, arbeid, avstand til behandlingssted, tidligere dagkirurgi og andre alvorlige livshendelser (jf. Skjema.)

REKs vurdering
Vi viser til mottatt tilbakemelding datert 07.11.2019 for ovennevnte prosjekt. Tilbakemeldingen ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 27.11.2019. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Vurdering
Søknaden ble først behandlet i møtet 11.09.2019.
Komiteen bemerket at prosjektleder ikke har PhD, og må byttes til en som har PhD-grad, for eksempel prosjektmedarbeider Venke A. Johansen. Videre ønsket komiteen en gjennomgang av protokollen og designet av den kvantitative delen med en forbedret redegjørelse av forskningsspørsmål og hypotese. Det ble bemerket at det ikke spørres om

Besøksadresse:
Armauer Hansens Hus (AHH), Tverrfløy Nord, 2 etasje. Rom 281. Haukelandsveien 28.

Telefon: 55978498
E-post: rek-vest@uib.no
Web: http://rekportalen.no

Vi ber om at alle henvendelser sendes inn via vår saksportal eller på e-post. Vennligst oppgi vårt referansenummer i korrespondansen.

deltakerens situasjon før inngrepet, og at slik informasjon kunne ha bidratt til å forstå årsaker til uro etter inngrepet. Komiteen så det som at flere av spørsmålene i spørreskjema var veldig nærgående og ønsker tilbakemelding på om alle spørsmål er relevante og nødvendige for formålet med prosjektet. Komiteen bemerket også at pasienter bør rekrutteres via brev, ikke via telefon. Videre ble det spurt om utvidet beskrivelse av beredskapsplan, også i informasjonsskrivet, med kontaktinformasjon til beredskapsteamet (sykepleier og psykolog). Informasjonsskrivet måtte også beskrive bedre hvilken informasjon som samles inn.

Komiteen ba om tilbakemelding på følgende:
-Informasjon om hvem som skal være ny prosjektleder.
-REK vest ønsker en revidert protokoll med en forbedret redegjørelse av forskningsspørsmål og hypotese. Hvordan henger den kvantitative delen sammen med den kvalitative, og hvordan kan data som innhentes besvare forskningsspørsmålene?
-Hvordan skal de undersøkte variablene i den kvantitative delen knyttes til den tilstand de er operert for? Bør ikke pasientgruppen være mer homogen?
-Komiteen finner ikke at det spørres om deltakerens situasjon før inngrepet. Slik informasjon kunne ha bidratt til å forstå årsaker til uro etter inngrepet. Hvorfor har prosjektet valgt å inkludere en så heterogen deltakergruppe?
-Komiteen finner at flere av spørsmålene i spørreskjemaene er veldig nærgående og ønsker tilbakemelding om alle spørsmål er relevante for formålet med prosjektet?
-Informasjonsskrivet må revideres etter ovennevnte merknader.

Svar fra prosjektleder i tilbakemelding mottatt 07.11.2019:
Ang. prosjektleder skriver prosjektleder:
«Dagkirurgi prosjektet har pr. 30.10.19 to ledere. Førsteamanuensis Venke A. Johansen og Førstelektor Petrin Eide. Petrin Eide vil fungere som daglig leder for prosjektet. Førsteamanuensis Venke A. Johansen er hovedansvarlig for forskning og etikk.»
Komiteen bemerker at prosjektleder må være en person som har PhD-kompetanse eller tilsvarende. Venke A. Johansen settes som prosjektleder.

Ang. revidert protokoll:
Begrunnelse for den kvantitative delen, redegjørelse for forskningsspørsmål, og hvordan dette henger sammen med den kvalitative delen er beskrevet i revidert prosjektplan. Det fremheves at spørreskjema som benyttes er validerte og standardiserte og benyttes for å kunne sammenligne funn med andre studier.
Komiteen bemerker at man savner refleksjon rundt hvordan man skal håndtere inklusjon av ulike typer pasientkategorier, da det kan forventes at de ulike pasientgruppene vil kunne reagere forskjellig på spørreskjema.

Ang. prosedyre for rekruttering av informanter:
Prosjektleder skriver: «Prosjektet har erfaring med å rekruttere informanter fra ulike sykehus i Helse Vest. Vår erfaring er at innkalling av pasienter til behandling gjøres på ulike måter på de ulike sykehusene. Noen sykehus opererer pasienter med samme lidelse i bolker, og alle etterfyller operasjonslistene hvis det er ledig kapasitet. Det blir derfor vanskelig kun å benytte rekruttering pr. post som rekrutteringsmetode. Fordi innkalling skjer pr. telefon ved ledig kapasitet. Taushetsplikten til helseforetaket må opprettholdes og det er kun ansatte i helseforetaket som kan ta den første kontakten med potensielle informanter.»
Komiteen setter som vilkår at deltakerne ikke skal rekrutteres per telefon. Rekrutteringen

må foregå skriftlig eller når de kommer til sykehuset.

Angående beredskap:
Det oppgis at «Alle med-forskerne (masterstudentene) er spesialsykepleiere i enten anestesi, intensiv eller operasjonssykepleie og har minimum 2 års erfaring fra klinisk sykepleie. Med-forskerne skal primært sett ha et forskerperspektiv i en intervjusituasjon, men i en situasjon hvor de intervjuer en nyoperert pasient, har de også ha et faglig perspektiv. De har følgelig god kompetanse i kommunikasjon og vurdering av pasientsituasjonen, totalt sett. De har førstehåndskunnskap i å observere og vurdere kirurgiske tilstander. De har også en handlingsberedskap og en etisk plikt til å gripe inn ved behov.»
Det oppgis videre at man vil følge retningslinjene ved behandlingsstedet når det gjelder beredskap.

Ang. revidering av informasjonsskriv oppgis det at:
· «Informasjonsskrivet er revidert med tanke på navn på personvernombud.
· Det er og tydeliggjort hvilken informasjon som skal samles inn.
· Når det gjelder beredskap ønsker prosjektet å følge retningslinjene til behandlingsstedet.
Men det presiseres at masterstudentene er spesialsykepleiere og at prosjektleder vil ta kontakt hvis en skårer høyt på spørreskjema.»
Komiteen anser beredskapen som tilfredsstillende.

Vedtak
Godkjent med vilkår

REK vest godkjenner prosjektet med følgende vilkår:
Prosjektleder må byttes til person med PhD-kompetanse eller tilsvarende. Venke A. Johansen settes som prosjektleder (dette er avklart med nåværende prosjektleder).
Deltakerne kan ikke rekrutteres per telefon. Rekrutteringen må foregå skriftlig eller når de kommer til sykehuset.

REK vest har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider. Prosjektet godkjennes med hjemmel i helseforskningsloven § 10 på betingelse av at nevnte vilkår tas til følge.

Med vennlig hilsen

Marit Grønning
professor dr. med.
Komiteleder

Ingvild Haaland
rådgiver

Kopi: post@hvl.no

NB! På grunn av tekniske problemer med portalen vil dette vedtaket sendes ut på ny gjennom portalen når problemene er løst. Vedtaket vil imidlertid gjelde fra 16.12.2019.

Sluttmelding
Søker skal sende sluttmelding til REK vest på eget skjema senest seks måneder etter godkjenningsperioden er utløpt, jf. hfl. § 12.

Søknad om å foreta vesentlige endringer
Dersom man ønsker å foreta vesentlige endringer i forhold til formål, metode, tidsløp eller organisering, skal søknad sendes til den regionale komiteen for medisinsk og helsefaglig forskningsetikk som har gitt forhåndsgodkjenning. Søknaden skal beskrive hvilke endringer som ønskes foretatt og begrunnelsen for disse, jf. hfl. § 11.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering.

16.5 Approval from NSD, Appendix 5

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Pasienters opplevelser og erfaringer med egenbehandling hjemme etter dagkirurgi

Referansenummer

298519

Registrert

07.11.2019 av Petrin Hege Eide - Petrin.Hege.Eide@hvl.no

Behandlingsansvarlig institusjon

Høgskulen på Vestlandet / Fakultet for helse- og sosialvitskap / Institutt for helse- og omsorgsvitskap

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Venke A Johansen, <venke.agnes.johansen@helse-bergen.no>, tlf: 91740435

Type prosjekt

Forskerprosjekt

Prosjektperiode

15.11.2019 - 15.11.2023

Status

18.12.2019 - Vurdert

Vurdering (1)

18.12.2019 - Vurdert

BAKGRUNN
Prosjektet er vurdert og godkjent av REK etter helseforskningsloven (hfl.) § 10 (REK sin ref: 31134).

Det er NSD sin vurdering at behandlingen også vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet datert 18.12.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

VURDERING AV BEHOV FOR DPIA
Under intervjuene kan det fremkomme opplysninger om personer som ikke selv deltar i prosjektet (tredjepersoner). Tredjepersoner vil ikke motta informasjon om behandlingen. Vi vurderer likevel at det ikke er snakk om høy risiko for de registrertes friheter og rettigheter, og at det dermed ikke er nødvendig å gjøre en personvernkonsekvensvurdering (DPIA) jf. personvernforordningen art. 35.

Dette er begrunnet i følgende momenter: Det registreres et lite omfang opplysninger, det inngår ikke direkte

identifiserende opplysninger, og fokuset er på deltakerens erfaringer. Behandlingen av personopplysninger er begrenset til det som fremgår som relevant for prosjektet, og opplysningene anonymiseres fortløpende.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:
https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html
Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger om rasemessig eller etnisk opprinnelse, og helseopplysninger, samt alminnelige kategorier av personopplysninger. Prosjektslutt er 15.11.2023, deretter skal data oppbevares av dokumentasjonshensyn frem til 15.11.2028.

LOVLIG GRUNNLAG FOR UTVALGET
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

LOVLIG GRUNNLAG FOR TREDJEPERSONER
Det tas høyde for at datamaterialet vil kunne inneholde opplysninger om identifiserbare tredjepersoner. Tredjepersoner vil være personer som har hjulpet deltakerne etter operasjon, som for eksempel ektefelle, barn, søsken eller venner. Omfanget av opplysninger vil være lite, det vil ikke inngå direkte identifiserende opplysninger, opplysningene skal kun behandles en kort periode, og ingen enkeltpersoner vil gjenkjennes i publikasjoner.

Det er NSD sin vurdering av personvernulempen for potensielle tredjepersoner med dette er lav. Prosjektet har en allmenn interesse gjennom forskningsformål som er veid som høyere enn personvernulempen, gitt tiltakene som er spesifisert over.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være personvernforordningen art. 6 nr. 1 bokstav e), jf. art. 6 nr. 3 bokstav b), jf. personopplysningsloven § 8.

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

UTVALGETS RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

I utgangspunktet har alle som registreres i forskningsprosjektet rett til å få slettet opplysninger som er

registrert om dem. Etter helseforskningsloven § 16 tredje ledd vil imidlertid adgangen til å kreve sletting av sine helseopplysninger ikke gjelde dersom opplysningene allerede er inngått i utførte analyser. Regelen henviser til at sletting i slike situasjoner vil være svært vanskelig og/eller ødeleggende for forskningen, og dermed forhindre at formålet med forskningen oppnås.

Etter personvernforordningen art. 17 nr. 3 d kan man unnta fra retten til sletting dersom behandlingen er nødvendig for formål knyttet til vitenskapelig eller historisk forskning eller for statistiske formål i samsvar med artikkel 89 nr. 1 i den grad sletting sannsynligvis vil gjøre det umulig eller i alvorlig grad vil hindre at målene med nevnte behandling nås.

NSD vurderer dermed at det kan gjøres unntak fra retten til sletting av helseopplysninger etter helseforskningslovens § 16 tredje ledd og personvernforordningen art. 17 nr. 3 d, når materialet er inngått i utførte analyser.

Vi presiserer at helseopplysninger inngår i utførte analyser dersom de er sammenstilt eller koblet med andre opplysninger eller prøvesvar. Vi gjør oppmerksom på at øvrige opplysninger må slettes, og det kan ikke innhentes ytterligere opplysninger fra deltakeren.

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

TREDJEPERSONERS RETTIGHETER
Så lenge tredjepersoner kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13/14), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), protest (art 21).

Det kan unntas fra informasjonsplikt etter art. 14 nr. 5 b), der personopplysninger ikke har blitt samlet inn fra den registrerte da det vil kreve en uforholdsmessig stor innsats for prosjektet.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!

Kontaktperson hos NSD: Lise A. Haveraaen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

16.6 Information leaflet after Day Surgery, Appendix 6

HELSE BERGEN
Haukeland universitetssjukehus

INFORMASJON ETTER OPERASJON AV KARPALTUNNELSYNDROM

Kva er karpaltunnelsyndrom:
Karpaltunnelen er ein trong kanal i handleddet. Denne tunnelen består av handrotbein i botn og sidene, og taket i tunnelen er et sterkt band av bindevev. Gjennom karpaltunnelen går det ni bøyesener og medianus nerven. Det er medianus nerven som forsyner tommel, peke og langfinger samt halve ringfinger. Det er vanleg å kjenne bortdovning og stikking i desse fingrane særleg på natta når ein har karpaltunnelsyndrom. Heving gjer at nerven kjem i klem og den får dermed for lite blodsirkulasjon til å fungere normalt.

Operasjon:
Du har no fått gjennomført ein operasjon som inneber at bindevev- bandet som utgjer taket i karpal tunnelen er spalta for at medianus nerven ikkje lenger er under trykk. Det kan likevel ta opp til 3–6 månader før nerven fungerer normalt igjen. Ein forventar vanlegvis godt resultat etter operasjonen.

Opptrening:
Dei fyrste dagane etter operasjonen er det viktig at du heldt handa høgt og prøver å knytte og strekke fingrane så godt du klarer. Handa skal ikkje verta belasta tungt dei to fyrste vekene etter operasjonen. **Etter 10-14 dager fjerner ein stinga i handa hos eigen fastlege.** Dersom såret nå er grodd kan du bruke handa di normalt. Det er viktig å vere klar over at det kan vera ubehageleg å bruke handa i starten, særskilt kan det å halde gjenstandar mot handflata vera vondt eller ubehageleg. Dette er heilt normalt og du kan ikkje gjere noko gale ved å bruke handa. Du kan trene handa ved å klemme på ein mjuk ball eller liknande. Den beste treninga er å bruke handa i dine daglege aktivitetar og fritidsaktivitetar.

Arrbehandling:
Arret i handflata vert ofte overfølsam etter ein slik operasjon og det er viktig at du veit at dette er heilt normalt og at det einaste som hjelper er å massere og ta mykje på arret. Arret kan masseres når stinga er fjerna og såret er grodd. Bruk gjerne krem/lotion og massar både langs arret og på tvers av arret. Dette bør gjerast minst to gonger dagleg. Du kan med fordel prøve å herde arret ved å stryke over det med ein tannbørste, ein handduk og andre ting som stimulerer. Arret er mest aktivt, det vil vere rødt og hardt fram til det har gått 12 veker etter operasjonen. Deretter vert det gradvis mjukare i opp til to år etter operasjonen. Dersom du har mye ubehag av arret kan du spørje apoteket etter silikonplaster som kan hjelpe. Du må likevel ta plasteret av dagleg og massere i tillegg.

Sjukemelding:
Det er normalt å vere sjukmeldt i tre til seks veker etter operasjon avhengig av kva for yrke ein har. Kontakt fastlegen din dersom du har behov for sjukmelding utover det som vart gitt etter operasjonen.

Ta kontakt dersom du:
- etter 10-14 dager ikkje klarer å bøye fingrane til ein knyttneve eller strekke fingrane heilt ut
- mistenkjer infeksjon i såret (har feber, raudleik, dunkande smerte og heving i handa)
- ikkje klarer å bruke handa i lette daglege gjeremål etter 3-4 veker.

Dersom du har spørsmål eller behov for kontroll,
er du velkomen til å ta kontakt med ergoterapeut ved
Plastikkirurgisk avdeling på tlf. 55 97 28 36.

Helsing Ergoterapeutane