What are the information needs of patients receiving procedural sedation in the Emergency Department? A descriptive exploratory study.

A thesis presented in partial fulfilment of the requirements for the degree of

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ABSTRACT

This research addressed the question ‘what information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department setting?’

Providing sedation to perform painful procedures on patients in the hospital Emergency Department (ED) setting has become commonplace in recent years. Best practice guidelines address minimal staffing levels, staff expertise and minimal monitoring and resuscitative equipment but do not cover how patients should receive information about their sedation or what information should be included. Whilst providing patients with additional written information prior to planned procedures is well reported in the literature, no prior studies looked at the effect of giving supplemental written information specifically for procedural sedation in the ED setting.

Method

This was a qualitative, descriptive study involving face-to-face semi-structured interviews with patient participants and two focus groups; one with ED nursing staff and the other with medical staff. Eight patients with recent experience of receiving procedural sedation in a New Zealand regional ED were convenience sampled. Purposive sampling was utilized to recruit five ED nurses and four ED medical staff with experience of monitoring and providing procedural sedation in the same ED.

Results

Inductive thematic analysis was applied to the interview and focus group transcripts and several themes were identified. The overarching need of patient participants was to feel safe and to trust the staff. The information requirements that contributed to meeting this need, recognized by all participant groups, were: competence and efficiency of staff; explanations of progress, delays, procedures and the environment; repetition and clarification of information using a whole team approach; support person presence; and medico-legal discussions including risk versus benefit information. Pharmacology was important to only the doctor participants. Additional written information was not considered to be of value by any of the patient participants.

Conclusion

This research found that adherence to national and international clinical practice guidelines appears to contribute positively to meeting patients’ information needs. Incorporation of these guidelines into a clear local policy that is followed consistently by the whole team effectively provides consistent high quality ED sedation that is deliverable within the local resources. Consistent and repeated information given verbally by multiple members of a cohesive team appears to meet patients’ need to feel safe and to trust the staff without the requirement for additional written information. However, whilst patients in this study rejected the need for additional written information, further research into whether support persons value written information may be beneficial.
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Chapter 1: Introduction

This thesis presents the results of research that was designed to answer the question ‘what information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department setting?’

In the first part of this chapter the subject of providing safe and effective procedural sedation for patients in the Emergency Department (ED) of a regional New Zealand hospital will be introduced and placed in context with reference to clinical practice guidelines, specialty standards and current literature. The importance of providing appropriate information for patients undergoing procedural sedation in ED will be discussed in context of the three stakeholder groups on which the research question focuses. The second half of this chapter will provide an overview of the following chapters.

1.1: Background

It is often necessary to perform painful procedures on patients attending a hospital or to perform investigations/procedures requiring a non-comprehending child to remain still. It has in recent years become common place to provide ‘procedural sedation’ in these situations within the ED setting (O’Connor et al., 2011). Procedural sedation has been known by other terminologies such as ‘conscious sedation’, and has also been used in other settings outside of the operating theatre by non-anaesthesiologists such as dentists. It is acknowledged that sedation and anaesthesia are on a continuum with the level of sedation dependant not just on the choice of agent, but also on the individual patient’s response to it. Therefore, for the sake of clarity, the American College of Emergency Physicians (Godwin et al., 2005) define procedural sedation as “the technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardio-respiratory function” (p. 178).

The safety and efficacy of providing procedural sedation in the ED setting by suitably skilled practitioners following recognised standards of monitoring is well documented in the literature by researchers, key stakeholder collegiate consensus and policy statements (Nejati, Moharari, Ashraf, Labaf, & Golshani, 2011; O’Connor, et al., 2011; Zed, Abu-Laban, Chan, & Harrison, 2007). The suitability of the many choices of sedation agent, including direct comparisons between single agents and/or combinations, is also covered well in the aforementioned literature. The policies and practices in the ED used as the locality for this research also reflect
these standards consistently, and the common choices of sedation agent(s) are in line with those considered favourably in the literature, (Hawkes Bay District Health Board, 2012; Joint Statement on Clinical Principles for Procedural Sedation, 2003). Therefore these aspects of procedural sedation were not the focus of the research question.

Giving hospital patients high quality, comprehendible and consistently accurate information is a requirement of the Health and Disability Commission Act Code of Rights (Health and Disability Commissioner Act, 1994 ). This Code of Rights is recognition of quality healthcare and is an integral step towards achieving legal and ethical partnership between healthcare providers and patients. However, from personal experience, both as a nurse in ED and a recipient of healthcare generally, the researcher is aware that the quality of information provided to patients can vary widely in its delivery, content and usefulness, and that this variability is probably dependant on many factors. Indeed Mills and Sullivan’s (1999) review of information given to newly diagnosed cancer patients cited four reasons for the variability in the quality of this information. These were the extent of the health care professional’s knowledge, the patients’ perceived level of understanding, a lack of appreciation for what the patient actually wanted to know and time pressures. Whilst overall patient satisfaction around procedural sedation in ED has been referred to in the literature (Zed, et al., 2007), factors influencing their satisfaction were not investigated and it must be acknowledged that effective pain relief, success of the procedure or length of ED visit may subsequently improve satisfaction levels when initial information may have been less than adequate.

1.1.1: Purpose of the research

The first aim of the research was to discover patients’ perceived information needs around receiving ED procedural sedation. The second aim of the research was to discover ED nurses’ and ED Medical staff’s beliefs around what information the patient needs to know about ED procedural sedation. The third aim of the research was to determine the best format in which to consistently deliver the key information points to patients in a way that is acceptable to all groups.

1.1.2: Expected significance of the research

Meeting the needs of the patient or healthcare consumer should be the priority of all members of the healthcare team. In order to ensure the information provided to patients fulfils their needs, it is important to elicit patients’ views on the subject. As healthcare providers also have a duty of care and informed consent obligations to the patient, the views
of the staff tasked with providing information are also important. If the addition of information in a written format is thought to be a useful by patients then the information needs voiced by each group may be able to be incorporated into a pamphlet for possible future use and evaluation. The first part of this chapter has presented the rationale for this study into the information needs of patients receiving procedural sedation in ED. The second part of this chapter provides an overview of the subsequent chapters of the thesis.

1.2: Organisation of the thesis

Chapter Two explores the literature currently available around the subject of patient information, sedation and the ED setting. As there appears to be no literature specific to this narrow group of patients, studies that appear to have applicability to the initial question asked are discussed along with their influence on the eventual research question and the choice of research design chosen.

Chapter Three presents the research design as influenced by the literature review discussed in Chapter Two. The method, planning and conduct of the research are then described in detail, including the rationale for how data were gathered, the identification and recruitment of participants and ethical considerations. The chapter then closes with a discussion of how the data were handled and a plan for the data analysis.

Chapter Four presents the findings from the research including a description of the research participants in terms of how representative the sample was to the research population. Findings are analysed and presented as themes within each stakeholder group of participants. Direct quotes from each group of interviews are used to illustrate the findings.

Chapter Five takes the themes identified in Chapter Four and discusses them further to search for relevance and context. Discussion of the findings take place in this chapter, drawing on the literature to establish how these findings sit within current knowledge around patient information needs and procedural sedation, both internationally and within the Australasian setting.

Finally Chapter Six draws conclusions from the research findings presented, focussing on three areas. The quality of the research is discussed in context of its limitations, and recommendations for further research and for future ED nursing practice are postulated.
Chapter 2: Review of Literature

2.1: Introduction

This chapter provides a selected review of the literature surrounding information provided to patients who are about to undergo a procedure requiring sedation. As there was not an abundance of literature directly addressing procedural sedation information for patients in ED, the literature was reviewed under a number of categories in an attempt to draw comparisons between similar situations.

2.2: Search strategy

The literature was reviewed to identify how much is currently known about patients’ information needs around procedural sedation in the ED setting and whether providing written information alongside verbal can improve their experiences. The initial search of the databases with the search terms “patient satisfaction”, “procedural sedation” and “emergency department” returned only articles relating to the well-researched areas mentioned in the previous chapter of safety, efficacy, and agent comparison, with no articles specific to information. Therefore keywords were refined to “patient information”, “patient education”, “written information”, “procedural sedation”, “anaesthesia” and “anxiety”. Databases searched were CINAHL, PubMed, MEDLINE, Google scholar and Cochrane using filters from year 2000 onwards, human studies and English language. The ‘find similar articles’ function was utilised, as was the ‘cited by’ function. Articles that appeared to meet the criteria were retrieved in full, and their reference lists were examined for further articles that appeared to meet the criteria. Journals relating to health education research and patient education and counselling were also searched electronically.

2.3: Overview of the types of studies found

A total of seven studies appeared to address some aspect of the research question around whether giving additional written information to patients prior to sedation or a procedure was beneficial (Galaal, Bryant, Deane, Al-Khaduri, & Lopes, 2011; Johnson & Sandford, 2005; Kastanias, Denny, Robinson, Sabo, & Snaith, 2009; Mathers, Chesson, & McKenzie, 2009; Mauffrey, Prempeh, John, & Vasario, 2008; Samuels-Kalow, Stack, & Porter, 2012; Taylor & Norton, 2000; van Zuuren, Grypdonck, Crevits, Walle, & Defloor, 2006). Only two of these were
set in the ED and neither of these looked at procedural sedation, addressing discharge information only (Johnson & Sandford, 2005; Samuels-Kalow, et al., 2012).

The studies were a mixture of designs: two systematic reviews of randomised controlled trials (RCT) (Galaal, et al., 2011; Johnson & Sandford, 2005); one descriptive review of the literature (Samuels-Kalow, et al., 2012), one quantitative RCT (van Zuuren, et al., 2006); one quantitative prospective randomised study (Mauffrey, et al., 2008); one descriptive quantitative design with quantitative and qualitative data collection methods (Kastanias, et al., 2009); one descriptive exploratory design and a three phase mixed method study (Mathers, et al., 2009). None were undertaken in New Zealand, four being from Britain and the others from Europe, Australia, USA and Canada.

The focus and outcome measures of the studies were also varied, and these shall now be discussed.

### 2.3.1: What interventions reduce patient anxiety prior to a procedure?

In the review by Galaal, et al. (2011) six studies were included from Britain, USA and Canada comparing the efficacy of a variety of interventions that were aimed at reducing anxiety during colposcopic (vaginal microscopic visualisation of the cervix) examination in women in an outpatient clinic setting. Their conclusions found that playing music during the procedure had the most significant positive effect on patient’s anxiety and pain levels using a validated state anxiety tool, while use of information leaflets compared with none showed no effect on anxiety levels. Galaal et al. (2011) concluded that the use of information leaflets did increase patient’s knowledge scores though, and one study showed a reduction in psychosocial dysfunction. The reviewers did comment on the wide variation of techniques employed in clinical practice to reduce patient anxiety during this procedure. They suggested a consensus on one technique should be sought so further research can be done to evaluate the effectiveness of the technique chosen.

### 2.3.2: Providing written information for planned procedures

That said, written information is often sent out to patients prior to them attending for planned investigations, general anaesthesia or procedural sedation (for endoscopy, surgery or diagnostic imaging for example). Some of the studies evaluated the effects of this, choosing a variety of outcome measures (Mathers, et al., 2009; Mauffrey, et al., 2008; van Zuuren, et al., 2006). Mauffrey, et al. (2008) looked at the influence of written information on patient’s recall
of operative risks discussed during the informed consent process for planned spinal surgery. The written information was provided to some patients at the time of their consultation and consent. This occurred two weeks prior to the operation, and risk event recall was tested on their admission for the operation by questionnaire. Whilst the study showed a statistically significant improvement with risk event recall of the group randomised to receive written information, the issue of comprehension was not tested. The focus of this was driven by the medico-legal need to prove informed consent had been given with discussion of risk factors taking place. Written information appears to be a useful addition to the verbal consent process from this standpoint, but whether it would necessarily add value in the emergency setting is not clear from this study, nor was satisfaction with information received or anxiety reduction researched.

2.3.3: Written information, increased knowledge and reduced anxiety

Mathers, et al. (2009) investigated patient’s knowledge of computed tomography (CT) and their views of information provided, and explored the role written information played when patients are referred for diagnostic imaging. In the three phases of this mixed method study, results showed patients had little or vague understanding of CT or of what scan they were expecting. They also revealed levels of anxiety surrounding the scan and its results, and that patients would have liked more information. However patients approved of the information contained in the leaflet provided despite the fact that, post-scan, uncertainty remained over what scan they had received. Patients interviewed did show variable information needs, some ‘skim reading’ the leaflet, some reading it more than once and finding further information elsewhere, some not wanting to read it at all, preferring instead to ‘leave it to the doctor’.

2.3.4: Written information at discharge - ED setting

Johnson and Sandford’s (2005) review hoped to determine the effectiveness of providing written and verbal information at discharge from acute hospital settings, compared with verbal alone. There were only two studies eligible for review by Johnson and Sandford (2005), and while both showed improved satisfaction in the groups receiving written plus verbal information, caution was suggested in generalising the findings. This caution was due to the heterogeneity of the methods in the two trials reviewed, and the need for increasing the range of outcomes to be measured. Neither of these studies included in the review involved procedural sedation, although both were set in ED. The other review that focussed on ED was Samuels-Kalow et al. (2012). A greater number of papers were included in this review, and the purpose was to determine best practice and future research around improving the ED
discharge process. The outcome measures when determining best practice were evidence of increased patient understanding and implementation of discharge instructions. Among interventions found to achieve these outcomes was the provision of additional written information reinforcing key points regarding diagnosis, treatment regimes and follow-up instructions.

2.3.5: How much do patients wish to be told?

The issue of variable information needs was considered during the statistical analysis of results by van Zuuren, et al. (2006). Anxiety and satisfaction levels were measured using validated tools in their RCT. The purpose of the study was to test the potentially beneficial effects of an information brochure on patients undergoing a gastrointestinal endoscopy for the first time. The researchers accounted for bias between the two groups around information seekers and avoiders, plus taking into account patient’s state anxiety levels. They found that all patients receiving the brochure in the experimental group read it and a high proportion found it very helpful. The majority found the information most useful just before the procedure, but also benefitted from receiving it at home. The group who received the written information scored better on all scales. Most benefitted from the information in the time spent waiting for the procedure, and in the moments just before the procedure occurred. They also scored higher in satisfaction questions around preparation for the procedure compared with the group not receiving the brochure.

2.3.6: Who should decide on the content of information required?

If we are to consider the content of the information we give to patients, it cannot be assumed that health care professionals’ opinions will necessarily concur with patients’ views on what they want to know. Kastanias et al. (2009) attempted to ascertain the information that patients regarded as most important related to post-operative pain and pain management. Three themes identified by patients highlighted the need for information to reflect having an analgesic plan to follow. Examples included what to do if it does not work, side effects and how to manage them, and the expectations of the pain experience itself. Many of the other themes that the healthcare professionals questioned in Kastanias et al. (2009) suggested were rated by patients as unimportant or only of mild importance compared with the self-management themes. Taylor and Norton’s (2000) study also acknowledged this disparity between what health professionals think patients need and what patients actually want, in terms of written information to prepare for bowel surgery. They interviewed patients in focus groups following their surgery to discover what issues the patients felt were of most
importance to someone undergoing the same experience. This information led the researchers to alter the content of the written information that was given to patients, with less technical preoperative data and more information around what to expect and how to manage the post discharge recovery phase.

2.3.7: Format and quality of written information pamphlets

On balance, whilst it may be tempting to claim that providing written information is always beneficial for the patient, the literature does not consistently support its use carte blanche. In some circumstances, benefits to patients in comprehension and/or satisfaction and/or anxiety have been shown, but whether any of these benefits would be applicable to the much shorter pre-event phase associated with ED procedural sedation remains to be investigated. Even though this is an untested hypothesis worthy of investigation, emerging themes from the literature around the variability of content, format and readability of patient information resources seemed to be an important first step to address (Coulter, Entwistle, & Gilbert, 1999; Fitzmaurice & Adams, 2000; Fitzsimmons, Michael, Hulley, & Scott, 2010; Lake et al., 2007). A search of other procedural sedation information leaflets provided by other hospitals and dentists, both on the internet and by request from other New Zealand EDs, found that the focus appears to be more on aftercare rather than the sedation itself, and the depth of information was variable (Adult patients discharge following procedural sedation, 2011; Browning, 2008).

2.4: Summary

In this chapter the literature appeared to show that little was clear regarding what information the patients undergoing procedural sedation in the ED environment required. The most appropriate content and format for delivery of this information was also unclear. Therefore, the researcher believes the first step to providing ED patients with accurate, appropriate and consistent procedural sedation information is to discover what information the three key stakeholder groups believe should be included. The second aim would be to ascertain what format this could be delivered in, and specifically whether a written leaflet would be of benefit to patients. The research design and methodology the researcher believes is best suited to answer this question is discussed and described in the next chapter.
Chapter 3: Methods

3.1: Introduction

In this chapter the research design will be described including the rationale for the overall design and for the use of both individual interviews and focus group data collection methods. Methods used to identify and recruit research participants will be outlined, also how the data were gathered and stored. Details of the data analysis are described and the ethical considerations for the research will be explored.

3.2: Research Design

A qualitative research design was adopted to ensure rich data was gathered, and fits best within the ‘descriptive or exploratory’ methodology. Annells (2007) described this in her editorial regarding new forms of qualitative research emerging from the International Council of Nurses conference and since then, as predicted, it has become the most common form of qualitative enquiry (Whitehead, 2013).

3.2.1: Rationale for research design

Qualitative research is not governed by one single approach, but generally adopts a naturalistic inductive and interpretive approach to any occurring phenomenon/situation, without the need of a predetermined hypothesis (Merriam, 2009). This descriptive exploratory approach ensures that attitudes, beliefs, values and opinions of research participants can be explored from their unique perspectives and be based on their experiences regarding the research focus (Whitehead, 2013). Rather than focussing on how often, when, or how effective something is, as is usually the realm of quantitative research, qualitative research design seeks to understand health and nursing care situations. Critical analysis of the healthcare experience from the perspective of patients and staff gives opportunity for any subsequent changes in practice to be informed by the opinions of the end users.

In the case of this research question, data were sought to determine subjects and themes that are of importance and value to all involved in procedural sedation in ED. The aim was to allow each group’s priorities to be known, hopefully leading to enhanced understanding for our patients’ and colleagues’ information needs and values. A disadvantage of this design is that it allows limited ability to generalise findings. Whilst valuable insight may be gained into the experiences of individuals undergoing procedural sedation in ED, each person’s experience and
needs may be vastly different. If the sample groups are not representative of either the patient population undergoing procedural sedation in ED or of the staff regularly providing this service, then the risk is that the results may not be relevant to the majority. The choice of method for gathering the data from the research participants is also important to ensure the participants are provided with a situation that maximises their ability to report their experiences and opinions; otherwise the data may not be rich enough to provide any real depth to what is already known (Lopez & Whitehead, 2013).

Individual interviews were conducted with the patient participants to establish what information they thought, on reflection, was important to know. Focus groups were conducted, one with ED nurses who regularly monitor patients receiving procedural sedation, and one with emergency medicine consultants/registrars who regularly provide procedural sedation, to discover what information they feel is essential for patients to know.

3.2.2: Rationale for individual interview

As identified by Casey (2006) and Borbasi et al. (2005), individual interviews are one of the most common choices for data collection in qualitative research, and can vary in their structure and data collection methods depending on the desired outcomes and logistical considerations. The interviews were audio recorded with some additional field notes added to provide context, then transcribed and de-identified to ensure anonymity of the data. The interviews were semi-structured in format with a selection of broad, open-ended questions to allow participants to talk freely about their experience of their ED attendance while also allowing the interviewer to guide the subject matter, probe for deeper insight, and ask questions to clarify issues. As Lopez and Whitehead (2013) state, the overall benefit of qualitative interviews is their ability to provide a productive, meaningful and supportive medium for successful data gathering. The disadvantages to this format are well documented (Brenner, 2006; Lopez & Whitehead, 2013; Price, 2002) and include being time-consuming and labour-intensive. There is also the possibility that a power imbalance between the researcher and those being interviewed can lead to biased data or data with insufficient depth. These disadvantages can be mitigated and the pitfalls minimised by careful planning and practised execution, and are less about methods and techniques chosen and more about how well the researcher applies these principles in practice. Therefore the questions and interview schedule were proof read and interview techniques practised prior to the research commencing, looking for biased, coercive, emotive, manipulating or unnecessarily leading questions, for example.
Copies of the interview schedule and questions were included in the ethical review proposal and used by the researcher as an aide memoir during the actual interviews [Appendix 10].

3.2.3: Rationale for focus groups

Traditionally focus groups have been utilised as a method of gathering qualitative data in a variety of research domains such as marketing, social sciences, psychiatry and education to name but a few (McLafferty, 2004; Stewart, Shamdasani, & Rook, 2006). Litosseliti (2003) describes focus groups as being useful, when used correctly, for a number of research needs which include the following:

- Discovering new information (e.g. a new product) and consolidating old knowledge (e.g. examining people’s habits)
- Obtaining a number of different perspectives on the same topic in the participant’s own words
- Gaining information on participants’ views attitudes beliefs responses motivations and perspectives on a topic: why people think or feel the way they do
- Examining participants’ shared understanding of everyday life
- Brainstorming and generating ideas, by viewing problems from several different angles thereby possibly finding a solution
- Gaining insight into group dynamics
- Exploring controversial, complex or sensitive topics or issues (Litosseliti, 2003, p. 18)

As the author was intending to gain opinions from two groups of colleagues who were relatively homogenous in terms of their qualification and area of working practice, and who all had similar experiences of the research subject but with the potential for different views, a focus group format appeared to be the most suitable method for gathering data from the non-patient participants (Litosseliti, 2003; McLafferty, 2004). In terms of time and logistics involved, focus groups are also an efficient way of interviewing a group of people (Lopez & Whitehead, 2013). In the case of this research, the focus group participants were colleagues who knew each other, were used to discussing medical issues together and were therefore more likely to be comfortable interacting in a group setting. This made focus groups an obvious choice as a method of data collection. McLafferty (2004) highlights how the purposeful use of group interaction is one of the focus group’s main advantages.
Potential disadvantages of this form of data collection, as described in the literature, include the need for manageable group sizes, and the need for skilled facilitation to ensure equal participation from all group members. If the focus group environment does not allow participants to feel comfortable enough to share insightful or controversial opinions then there is a risk of only bland safe contributions being made (Lopez & Whitehead, 2013; McLafferty, 2004). There is, however, no agreement as to the best group size and it appears to be dependent on many factors such as the topic, the purpose of the research and the skill of the facilitator (McLafferty, 2004). Essentially the group should not be so small that the same information would have been achieved by an individual interview, and not so large that it is too difficult for the facilitator to ensure adequate contribution by most members (Litosseliti, 2003). McLafferty (2004) found, as a novice facilitator, that her practise group of nine was problematic and subsequent smaller groups were easier to moderate and the participants more likely to interact.

To mitigate these potential disadvantages, the researcher planned to engage focus groups of a maximum of six people. Broad topic areas were planned to guide the discussion, with opening questions presented to provoke a ‘brainstorming’, free-form style of interaction. Opportunities were later provided to respond to and generate discussion about some initial findings from the patient interviews that had occurred previously. This is further detailed in the following section.

3.3: Methods

3.3.1: Sample design

Non-probability sampling was utilised to ensure participants were recruited who could provide relevant data (Lopez & Whitehead, 2013). A combination of convenience and purposive sampling was chosen to identify potential participants. Convenience sampling was employed for the patient participants as the research was completed over a fixed time period in a single location. Potential patient participants were recruited from those who attended the ED over a period of one month and who fulfilled the other inclusion criteria. Purposive sampling was used to recruit participants for the staff focus groups. These participants were chosen from a pool of staff who had the required qualifications and experience to provide adequate depth of insight into procedural sedation (Lopez & Whitehead, 2013).

The patient participants had to be 18 years of age or older, to have received procedural sedation in ED, to be well enough to be interviewed within 48 hours of the sedation, and to
have the capacity to consent. These criteria were clearly documented in a flowchart for healthcare team members to easily follow to assist with participant identification and the selection process [Appendix 3].

The inclusion criteria for the medical and nursing staff participants required that they had current experience of providing and/or monitoring procedural sedation in ED.

3.3.2: Identification and selection process for patient interviews

Potential patient participants were identified at the time of their procedural sedation by a member of their healthcare team. If they met the criteria as shown in the flowchart, they were given an information sheet [Appendix 3.1] by a member of the healthcare team at the time of their discharge from ED, after the procedure was complete and the sedation had worn off. This information sheet explained the nature of the research and advised that a researcher would contact them within the next 24-48 hours to invite them to be a participant in the research. Patients who had received the information sheet were identified to the researcher by the staff member by a highlight against the patient’s routine entry in the ‘sedation log’. This log was routinely completed for all patients receiving sedation in ED for audit purposes. The researcher checked the log daily. The identified patients were then contacted by the researcher, by telephone or in person on the ward if they had been admitted, to gain consent and arrange the interview.

During the month in which this process took place, sixteen adult patients attended ED and received procedural sedation. Twelve were identified as having met the inclusion criteria and given information sheets, all of which were contacted within 48 hours of discharge from ED. Of this number, eight agreed to be interviewed.

3.3.3: Identification and selection process for staff focus groups

Potential nursing and medical staff participants were drawn from those who worked in the ED at the regional public hospital that was the site of the research. These potential participants were given information regarding the research by email and via the staff notice board. Some were also aware of the purpose of the research from their involvement in identifying potential patient participants in the previous month. They were then contacted by email and internal mail and invited to participate in focus groups [Appendix 4]. The researcher was not in a position of power over any of these staff and participation occurred on a voluntary basis and outside of their clinical work time.
3.3.4: Gathering and storage of data

The data collection was completed in a sequential manner. The patient interviews were completed first and the data preliminarily analysed. The focus groups were then conducted, allowing this summarised and de-identified information to be brought to the focus groups to generate discussion.

Patient interviews took place at the participants' choice of venue, such as their home, at a non-clinical room at the hospital or on the ward if they were an inpatient at the time of interview. The individual interviews and focus group discussions were all digitally audio recorded. These were transcribed by a professional transcription service and checked by the researcher prior to analysis. The transcriptions were fully de-identified during this process ensuring confidentiality, and the audio files were stored in password protected digital files under coded identification with no patient details attached.

The total numbers of nursing staff credentialled to work in the resuscitation area and therefore be involved in the monitoring of procedural sedation in the department at the time of the research was 38. Allowing for non-participation and the feasibility of finding a mutually acceptable time around roster commitments, the anticipated maximum number for a focus group was estimated at between four to six nurses. In total, five members of the ED nursing staff participated in the focus group. Similarly the total number of senior ED medical staff meeting the inclusion criteria at the time of the research was 15 registrars and consultants. With the same constraints as for the nursing group, the anticipated number for the focus group was between four and six doctors. In total, four ED consultants participated in the focus group.

Light refreshments were provided at each focus group and they were conducted in the privacy of a seminar room with equipment available to manually document the ‘brainstorming’ segment of the discussion alongside the audio recording of the session mentioned earlier.

3.3.5: Data analysis

The method of data analysis was guided by the general inductive approach described by Thomas (2006) whereby the most important themes or categories are identified. This method was in keeping with the objectives of the research which were to identify topics or themes that were of importance to participants so they could be included more consistently in future communication with patients experiencing procedural sedation (Harding & Whitehead, 2013; Thomas, 2006; Whitehead, 2013).
The inductive approach is a data reduction procedure of analysis taking the raw data and moving it into meaningful themes. The primary mode of analysis is the development of categories from the raw data into a framework that captures key ideas judged to be important by the researcher (Thomas, 2006). Table 1 below is a visual representation of this process described by Thomas (2006) who originally adapted and reproduced it from Creswell (2002, pp. 266, Figure 9.4).

Table 1. The Coding Process in Inductive Analysis.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial reading of text data</td>
</tr>
<tr>
<td>2</td>
<td>Identify specific text segments related to objectives</td>
</tr>
<tr>
<td>3</td>
<td>Label the segments of text to create categories</td>
</tr>
<tr>
<td>4</td>
<td>Reduce overlap and redundancy among the categories</td>
</tr>
<tr>
<td>5</td>
<td>Create a model incorporating most important categories</td>
</tr>
</tbody>
</table>

As Harding and Whitehead (2013) state, whilst establishing the trustworthiness of the results of a qualitative study is as important as establishing rigour in a quantitative study, there is not one agreed way of demonstrating this. For the purpose of this study the researcher adopted the position advocated by Rolfe (2006), whereby the criteria applied to establish trustworthiness should be chosen by the researcher and supervisors as the criteria most suitable for the research. Therefore validity of coding and consistency checks were carried out using the criteria of a peer analysis check from the researcher’s nursing and academic supervisors and an audit trail of decision making. As literature postulates, the research findings
will be accepted or rejected by the reader of the report (Harding & Whitehead, 2013; Rolfe, 2006).

3.4: Ethical considerations

Ethics approval from the New Zealand (NZ) Health and Disability Ethics Committee (HDEC) was not required as of 1st July 2012 according to the new process (http://www.ethicsforms.org) and Standard Operating Procedures flow chart [Appendix 1]. Therefore ethical approval for this study was sought and obtained from the Eastern Institute of Technology Research Ethics Approvals Committee [Appendix 2 and 2.1]. Research and locality approval was also sought and granted from the relevant DHB Research Committee [Appendix 7].

The researcher had an ethical responsibility to ensure the research considers and protects the core principles of the United Nations’ Educational, Scientific and Cultural Organisation (UNESCO) Universal Declaration on Bioethics and Human Rights, 19 October 2005 (available at http://www.unesco.org/ethics), which promotes respect for human dignity and protection of human rights and fundamental freedoms (Andorno, 2007; Woods & Schneider, 2013). The process and procedures the researcher adopted to comply with these core principles are discussed here.

3.4.1: Respect for autonomy and individual responsibility (informed consent)

Respect for all potential participants’ autonomy and right to self-determination was demonstrated by allowing them to make choices regarding whether they wished to partake in the study based on receipt of full disclosure of what would be involved and the aims of the study. For patients suitable for individual interviews, information sheets were given to all potential patient participants by a member of staff not involved with the research, with detailed information, which included the intended use of recording equipment and contact details if they wished to ask any questions. Overt statements regarding the voluntary nature of their contribution, including their right to withdraw, were also stated [Appendix 3.1]. They were then given time to read the information in their own time and therefore were prepared for the subsequent contact from the researcher by telephone to ask if they wished to be interviewed. If they declined at this stage their decision was respected and no further attempts were made to recruit them. Individuals could also decline the offer of the information sheet in the first place thereby excluding them from being contacted by the researcher. Individuals without the capacity to consent were identified at the time of the sedation and were not given
an information sheet and therefore not inadvertently contacted by the researcher. Written consent was then gained at the point when the researcher met the patient participant, prior to the interview commencing [Appendix 5].

Similarly, detailed information sheets for staff members suitable for the focus groups were placed in work mail slots and sent as attachments to their work email [Appendices 4, 4.1 and 4.2]. The onus was placed on the staff members choosing to reply indicating their willingness to participate, rather than the researcher contacting them personally. This approach was chosen to reduce the risk of accusation of coercion associated with a power imbalance due to the researcher being a senior colleague to some potential participants. Although consent could be assumed or implied by the action of the staff member attending the arranged focus group, for completeness written consent was obtained from all focus group participants as well [Appendix 6].

3.4.2: Respect for privacy, anonymity and confidentiality

As cited in Woods and Schneider (2013), *The Privacy Act 1993* and the related *Health Information Privacy Code 1994* (Dawson & Peart, 2003) governs how health professionals and organisations must respect an individual’s right to privacy and avoid public knowledge of their private information in New Zealand. To fully ensure privacy, participants should also be afforded anonymity and confidentiality of the information provided for research purposes (Woods & Schneider, 2013).

To ensure participants’ privacy was respected all informed consent documentation containing names was stored in a locked filing cabinet at the researcher’s home, all recordings were filed under a coded ID and stored in a password protected online storage facility. A reputable transcription service with a confidentiality guarantee was employed to transcribe the audio recordings into a de-identified transcript utilising the same password protected online storage facility to transfer the files securely between transcribers and researcher. The patient interviews took place in their own home or on a ward away from ED, so members of the ED team who provided their sedation and gave out the information sheets were unaware of whether or not they had agreed to be part of the study. The staff focus groups were conducted away from the clinical area where the staff normally worked, and in a private seminar room, so other colleagues would be unaware of who was in the focus groups. The researcher ensured that the ground rules iterated to the group included confidentiality [Appendix 10].
3.4.3: Respect for justice, beneficence

The benefit to the patient participants of being involved in the study was largely indirect as any knowledge gained would most likely benefit other patients rather than themselves. Listening to patients’ views and experiences to benefit future patients’ experiences is known to be valued by patients, especially if they can see the potential benefit from their contributions (Aitken, Gallagher, & Madronio, 2003; Murphy et al., 2007). The proposed study will provide increased knowledge of patients information needs. It will provide increased understanding of specific information requirements for the ED procedural sedation setting. It has the potential to help create a consistent way of giving legally appropriate, useful and patient focused information on this subject. All patients and staff fulfilling inclusion criteria were offered the same opportunity to contribute; no judgement was applied as to the potential value of their contribution (Woods & Schneider, 2013).

The study presented no obvious physical risk to the participants, and to minimise the potential for any psychological risk caused by poorly executed interviewing, pilot interviews were completed prior to recruiting research participants. The content of the questions or focus group discussions were not of an especially sensitive or intrusive nature so it was not anticipated that any undue distress would be caused [Appendix 9 and 10]. It was considered that some distress may be caused if the patient had had a negative experience of the procedural sedation. If a patient participant expressed dissatisfaction with their ED visit the researcher would provide them with details of who to address this with at the DHB. If the research interview caused distress then the patient would be offered termination of the interview and an apology. The contact details of the researcher’s supervisors were also on the information sheet. No distress was expressed or evident during any of the interviews or focus groups. Also if the patient sedated in ED was admitted for on-going treatment but was deemed too unwell to cope with interview they were not recruited to minimise any undue burden on the participant.

Potential safety risks to the researcher were considered when going to participants’ homes. These were minimised by ensuring a third party was aware of the researcher’s location during interviews, including anticipated finishing time and cellphone contact was maintained (Endacott & Whitehead, 2013). No dangerous events occurred.
3.4.4: Respect for human vulnerability and personal integrity

All patients in the healthcare environment can be made to feel vulnerable and be at risk of having their personal integrity undermined, either by power imbalances created by insensitive interactions between themselves and their healthcare team, or just merely because of the perceived hierarchical culture of the relationship (Woods & Schneider, 2013). However, some groups of people are more susceptible and efforts must be made to minimise the risk of this occurring, especially as part of research where their vulnerability may be exploited (Woods & Schneider, 2013).

Patients were given the choice to partake in the study in a private and unhurried way as explained earlier. They were also expressly given the choice of where they wished to be interviewed and were offered the presence of a support person. Included in the information sheet and the consent form were the words ‘I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care’ [Appendix 5].

Members of staff may also feel at risk due to a power-base inequality between the researcher and participants, or if the organisational culture appears to undermine the employee’s freedom to participate or not due to unfair influence on their employment (Woods & Schneider, 2013). Staff members were free to choose whether to contact the researcher after they had received the information in a non-intrusive fashion. The researcher was not at the place of work during the research period to avoid subliminal coercion. Included in the consent form were the words ‘I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future employment’ [Appendix 6].

3.4.5: Respect for cultural diversity

There is the added dimension of culture in the context of respecting human integrity, and covers not only ethnicity but may be related to sexual orientation, religious beliefs or employment status, for example (Nairn, Hardy, Harling, Parumal, & Narayanasamy, 2012). The general population of New Zealand is culturally diverse and the research population should attempt to reflect this diversity to ensure relevance. Conducting research within a healthcare setting in New Zealand poses additional ethical concerns and must ensure the Māori population, as tangata whenua, are protected from further exploitation by non-Māori researchers (Hudson & Russell, 2009; Tolich, 2002). As a nurse and researcher, care must be
taken to ensure the researcher’s obligations to cultural safety and the Treaty of Waitangi are honoured (Nursing Council of New Zealand, 2005). Woods and Schneider (2013) advise that consultation is a key component to developing cooperative and ethically sound research practice and outcomes that will provide benefit to Māori, and other culturally diverse groups included in the research.

Demographic data collected for the region by the research DHB regarding ethnicity showed the population as being 24.5% Māori and 3.2% Pacific Island, with the remainder identifying predominantly as NZ/European. Therefore, ideally a similar proportion of research participants would hopefully be Māori in order to reflect the research DHB’s patient demographics. Consultation with the DHB Māori Health Service took place during the research design and proposal stage. Feedback was received and acted on and approval was given prior to the research commencing [Appendix 8].

The actual patient sample contained 25% Māori (n=2) 0% Pacific Island (n=0) 50% NZ/European (n=4) and 25% other European (n=2). From a total of 16 adult sedations during the study timeframe 8 were interviewed, 3 were not competent to consent, 4 declined and 1 was a re-attendance.

3.5: Summary

This chapter has described the aims of this explorative or descriptive study including the choice and rationale of research design and methodology. The data analysis approach was described and the rationale for its choice explained. The core ethical principles were described and applied to the research. The research design, methodology and data analysis approach, underpin the detailed analysis and results of this study, which are presented in the following chapter.
Chapter 4: Results

4.1: Introduction

This chapter presents the results of this descriptive exploratory research in four main sections. First the profile of participants including demographic data and the context of their participation is presented. Secondly, the analysis of the individual patient interview data is presented in themes with supporting text quoted from the interviews. The third and fourth sections present the themes identified from the nurse and doctor focus groups respectively, again with supporting texts from the data collected.

4.2: The study participants

4.2.1: Patient demographic and contextual data

Of the total number of adult sedations (n=16) that took place in ED at the research site hospital during the one month study period, eight (50%) of the patients agreed to participate in the research, four (25%) declined, three (19%) had no capacity to consent and one (6%) was a re-attendance (see Figure 1).

![Figure 1. Eligible Patients’ participation rate](image)

Four (50%) of the participating patients identified as New Zealand European, with two (25%) each identifying as New Zealand Māori and Other European respectively (Figure 2). Demographic data collected for this region by the DHB regarding ethnicity showed 24.5% Māori and 3.2% Pacific Island, with the remainder identifying as New Zealand European.
The mean age of the patient participants was 48 years, however the age groups between 40-59 years were not represented. Their ages ranged from 21 to 82 years (Figure 3). Half of the participants were either married or in a de-facto relationship (n=3 and n=1 respectively); the other half were single. Four were in paid employment, two were retired, one was a student and one was unemployed.
Half the participants required sedation for direct current (DC) cardioversion to revert atrial fibrillation (AF) (n=4) and the other half for manipulation of an injured limb (n=4). Length of time from arrival in ED to the sedation occurring was gathered to see if this affected the patient’s impressions of their experience in ED and their information needs. The shorter times, 0-30 minutes and 31-60 minutes, were for limb injuries, while the delays that occurred for the AF DC cardioversion tended to be due to the range of options for this procedure (Figure 4).

![Figure 4. Patient time from arrival to sedation](image)

**4.2.2: Staff demographic and contextual data**

Of the 38 nurses meeting eligibility criteria, five voluntarily participated in the focus group (Figure 8). All participating nurses had over five years ED experience, and were female. Of the 15 ED registrars and ED consultants meeting eligibility criteria, four voluntarily participated in the focus group (Figure 9). All these participants were ED consultants.

![Figure 5. Participating nurses](image) ![Figure 6. Participating Doctors](image)
4.3: Results from the interviews with patients

The purpose of the research was to find out what information, and in what format, should be provided for patients undergoing procedural sedation in the ED setting. To this end, the eight patients interviewed were asked to recount the circumstances of their presentation to ED to gain the context of their visit. They were then asked to describe for the pre-sedation and post-sedation phases, including discharge, what information they were given and by whom. They were asked to clarify what information they considered helpful or essential, also if any information had been conflicting or unnecessary. Finally they were asked whether they felt a written information sheet would be helpful to someone in a similar situation (Appendix 10).

Whilst the intention was to seek out what specific information might be required by patients in this particular circumstance, what became clear from the data was that, for patients undergoing procedural sedation in the ED setting, specific information about the sedation was not their main focus. All eight patients said they did not feel the need for information in a written format, and identified very few gaps in terms of specific information they needed pertaining to procedural sedation. Instead, they described the whole ED journey as one entity requiring regular information and explanation to update them of their progress, in an empathetic and professional manner. Overall they appeared satisfied with the amount of information they had received, but found it hard to separate the sedation from the whole presentation problem and were more concerned with getting the problem fixed than with the sedation itself.

Patients’ levels of satisfaction with the information they received appeared to come from feeling safe in the ED and being able to trust in the staff. The information they drew on to make this judgement came in a variety of ways. Six main themes emerged from the analysis of the interview transcriptions, all of which relate to a central theme concerning patient safety and trust. These are shown in Figure 7
Each of these themes will be discussed in turn. Direct quotes from the patients are included to demonstrate what this issue meant in terms of the patients experience of receiving procedural sedation.

4.3.1: Competence and efficiency of staff

In order to feel safe, the interviewed patients described ways in which they determined the competence of the staff members providing their care. This was judged by the patients by verbal and non-verbal communication and the patients’ observation of staff behaviours. For example, Patient 2 said of the staff,

And they were very professional; the person in charge of ED was [____]. He built up my confidence and I knew I was with a very professional person...the doctor came in and also the nurse. I would say she was well up in her nursing and yes so both of those gave me the information. Previous times when people were in the room that weren’t as [experienced].....I could tell they hadn’t had this experience before and that made me feel a little anxious that....Perhaps when they are talking in the room it would be good that they didn’t show their inexperience. (Patient 2, p.2, 3 & 6)
Patient 4’s comment was typical:

I don’t think there was anything to concern me I just figured the doctors know what they are doing and they are going to do it. (Patient 4, p.9)

The transparency of the level of care and monitoring being provided around the sedation was how Patient 3 judged the competency of the staff. She appreciated being able to watch the monitors and sensed the fact she was being watched closely without it being intrusive,

But I knew that they were [watching me], which was really reassuring for me that they were watching my pulse rate, my respiration, all those things that, and also I was watching because I could see what was going on up there. (Patient 3, p.8)

Patients also felt safe, and happy with their treatment because of the efficient manner in which they perceived their care to have been administered. For example, Patient 1 had one of the shortest delays from arrival to sedation and this is reflected in her comments,

It was pretty quick. I came, I was only in ED in the chair, like sitting there waiting for about, maybe 10 minutes... and then from then they just took one look at it and said right, we have got to sort it out. So that is when they took me [for sedation] and they [manipulated the ankle], yes. Yes it was really quick actually. (Patient 1, p.1-2)

And Patient 5 also commented positively on a smooth efficient process for his sedation and DC cardioversion,

Yes they just wheeled me in to another cubicle in A and E and went to work on me. (Patient 5, p.4)

Even though some patients described delays occurring for various reasons which are discussed in the next theme, once the sedation occurred patients commented favourably on how efficient they perceived the process to be,

And then, once everyone was back it was just bang, bang, bang, right we are doing this, we are prepping you for that, we are going to do that .....and then that was it I was out to it. (Patient 7, p.3)

Whilst efficiency of the process was valued by patients, two implied that they did not wish to feel rushed, and this is best summed up by Patient 3’s comment,
It is marvellous... I have been so wonderfully cared for. They haven’t made me wait; they have put me in the sort of waiting room where you get your ECG and that sort of thing....because I have always had it done efficiently but in a kindly way and a thoughtful way. (Patient 3, p.2 & 7)

In summary, patients appeared to be looking for clues as to the competency of the team caring for them. The efficiency of the process and the expertise displayed by staff when care was given helped to create a sense of trust when done well, rather than specific information topics.

4.3.2: Explanations of procedures/delay/progress

Most of the verbal communication with the patient was focused around what was going to happen next, what investigations they needed to have done and reasons for any delays. Patients valued this as it enabled them to maintain a sense of control and understanding in a situation in which they could otherwise have felt out of control. Three patients referred to how this steady stream of situational information was helpful in this respect.

I mean they were just telling me what they were doing really. Just again probably that constant reassurance of knowing what is going to happen and how I am going to feel and you know, you are going to talk now or da da da and yes just knowing of the situation I suppose. (Patient 1, p.6)

Before, yes, before they pulled it straight they just pretty much simply just told me what was going to happen then and that they were just straightening it and, and it was going to get put in to a cast sort of thing and that that was all that was going to happen at that stage. (Patient 8, p.6)

And not just the information given directly to the patient was utilised by them;

It was the nurse....she was very helpful, she was, she told me what was happening right from the start. And the other young doctor he was listening in, she was giving him information as well on what to look for and how to set the thing up and... make sure everything was in the right place. So I was listening to that conversation as well. (Patient 6, p.8-9)

Keeping patients constantly informed of their progress meant they were more accepting of delays when they knew and understood the reason for the delay. A number of patients commented on delays, some of which were clinical as in the cases of Patient 6 and Patient 4.
’cause I took a tablet when I woke up in the morning....and they thought that might kick in. So they kept me maybe an hour and a half or sometime like that then decided that they would give me an electric shock treatment. (Patient 6, p.2)

Well probably quite a period of time but I don’t think it was cause they didn’t want to, I just think when he walked in with like the [past history of the] blood clot the doctor needed to get hold of the Anaesthesiologist or somebody to make sure that what they were going to give him [to reduce his dislocated shoulder] wasn’t going to react with the medication that he is on [clarification of what the patient referred to - given by the support person present at the sedation and the interview]. (Patient 4, p.2)

Patient 7 referred to a delay that was not due to a clinical concern, but was due to lack of staff availability to do the procedure safely. While he acknowledged he would have liked it done sooner, he appeared to accept this,

It was, it was a slightly long process, because they had to have the staff available at the time. I came in and they were able to look at me. There were people going on their breaks and things so it was a skeleton crew and that is a bit awkward. (Patient 7, p.3)

One patient experienced one of the longest delays. His delay was initially of a clinical nature but then plans were further delayed by the subsequent arrival of higher priority patients to the department. He described being kept informed and could also clearly see that his planned treatment could not go ahead until those patients were stabilised,

But there was a motor accident and everyone was really busy so I had the amiodarone [anti-arrhythmia medication] by about lunch time and then I didn’t get the shock until about 5pm in the evening. (Patient 2, p.2)

In summary, when patients were given information that allowed them to understand and anticipate the likely course of their treatment, including any changes to that plan, it contributed positively on the patient’s experience. When patients did experience delays, if they had received clear explanations of the reasons and they observed the honesty of these explanations, they were more accepting that the delay was either appropriate or unavoidable. The length of delay did not appear to affect the patient’s overall satisfaction; however their information needs included clear explanations for the reasons for these delays.
4.3.3: Teamwork

All patients identified multiple members of the healthcare team as providing them with information. Despite this, none of the interviewed patients were confused by conflicting information. Instead, they valued the different terminology used, the reiteration of points they may have been uncertain of and the opportunity to ask questions.

*The doctor came in and also the nurse, he talked to me about it too. It was, yes, it was all pretty consistent... Yes, the doctor again and the nurse backed up what she said by reinforcing it a couple of times.* (Patient 2, p. 7 & 10)

*But yes they both gave me information to prepare me for what was happening, what was going to happen and also one of the nurses as well just to make sure that I was at ease and comfortable with what was happening. No it was never conflicting, it was actually really helpful. So it was, it is good to have a couple of different opportunities to think about it and still clearly think do I say yes or do I decline it.* (Patient 7, p.5)

Hearing similar things from multiple people appeared to reinforce the veracity of the information given and demonstrated the cohesion of the team to the patients,

*It was pretty straight forward you know in layman’s terms for me anyway. Everything was explained to me what was going to happen and exactly what did happen. I didn’t wake up and say well you jokers were telling me bloody lies.* (Patient 6, p.12-13)

*They all gave me heaps of information and what was going on and, yes it was all pretty much hassle free so it was good.* (Patient 8, p.17)

*I wasn’t the least bit confused, it was plainly told to me, well it was more than a three way thing because there was a senior doctor and a junior doctor and two nurses and they all just worked as a wonderful team.* (Patient 3, p.7)

Again the concept of patients gathering information from conversations within the healthcare team came up. Patient 4 felt he used these conversations to reinforce points or highlight different aspects of the plan to his benefit and felt included,

*I think it was mainly the doctor but the nurse was kind of talking to him while I was, while she was there, while I could hear you know.* (Patient 4, p.6)
In summary, repetition, clarification and hearing the same information in different ways provided patients with the opportunity to make sense of complex clinical information, and to feel involved in the plan of care. Seeing and hearing open and respectful communication between the team members again contributed to their feelings of safety and trust in the team, and made them feel able to ask questions.

4.3.4: Support person presence

The importance placed by patients on the presence of a support person was evident through all of the interviews. Reliance on them to be present during discussions and the sedation itself helped patients to feel safe. Patient 4 said of his support person,

*She probably remembers way more than me, just because I didn’t really, I wasn’t really with it, I don’t know I was on that gas stuff and it makes you real nutty.* (Patient 4, p.13)

Communication with the support person was also seen as important, with the patients recognising that sometimes they are in a better position to understand the information than the patient themselves.

*Yes they did make a note of letting my partner stay when she was there, and like sort of, you know, aiming the information at her as well as at me so she knew what was going on.* (Patient 8, p.15)

*I think my wife asked a few questions as well and they were quite happy to answer her you know ‘cause she knows a bit more than me.... Yes they explained to me, explained it to my wife, ‘cause she was interested in it.*

(Patient 6, p.8 & 10)

The lack of a support person was brought up by one patient as a real cause for concern and the supportive role of a member of staff who recognised this was appreciated. He said,

*Especially with me being all the way down here by myself and my family is a long way up north, it’s a bit disconcerting when you are all by yourself, you don’t know anyone, you don’t know who you can trust...and they were standing right there supporting me. Like one of the nurses she understood I had nobody ‘cause she was there just making sure I was fine and keeping me comfortable and relaxed.* (Patient 7, p.11 & 17)
This specific information aimed at the support person rather than the patient was recognised as being important by one patient with multiple previous sedations. She was aware that support people have a different experience to the patient as they would be watching a potentially unpleasant procedure while the patient is unaware,

And moreover my husband was present all the time which I appreciated and he did too. The first time he saw it some years ago I think he got a terrible fright.

(Patient 3, p.4)

In summary, the presence of a support person was seen as hugely important by patients. Patients observed the team acknowledging their support person’s needs as well as their own by offering support people the opportunity to stay throughout and involving them in discussions. This transparency and openness during unpleasant and invasive procedures again helped to reassure the patient of their safety and that they could trust in the staff.

4.3.5: Medico-legal discussions

All patients were asked to and gave written consent for the procedural sedation to go ahead and the form they signed contains a list of the pertinent points for the doctor obtaining consent to convey to the patient. However, there appeared to be poor recall of this amongst the patients interviewed. When patients were asked about this part of the communication they were vague as to the risks they had been told about,

[The doctor] explained to me what was involved, how it works, any dangers, you know like, anything that could go wrong, and then I signed a form to say that it was ok. (Patient 6, p.2)

Oh well the length of time that you would be under for, the effects if, in regards to my health, if I am on certain medications that it was going to have an adverse effect which could cause possible problems of some sort. (Patient 7, p.4)

Whether they recalled the risks well or not, they appeared dismissive of them, and sometimes dismissive of the need to even be told about them. There were three patients who, from the description of their clinical presentation, had to carefully consider the safest/best treatment option to receive due to their co-morbidities or potential drug interactions. Interestingly these three patients did not appear to place any more value on the medico-legal or risk/benefit information than any of the other patients with more straightforward clinical presentations.
One of those complex patients summed up his apparently casual attitude to being fully informed and the consent process in the ED setting.

_I think they might have been something to do with another drug or something I don’t know, I just rushed the form and signed it, I didn’t really read it so, yes. But apart from that then obviously you need to know the risks and that is about it. Oh no we did go through the risks, I remember that too now. Another, the other dude actually, the actual one who knocked me out, said something about oh hey well this has got a 5% chance of this can happen blah blah blah and I was just like, oh whatever, you know...... Telling me is probably just going to slow down the whole thing you know.... Doctors should probably, if anything, in my opinion, not really have to tell people and justify to a person. I think it is their judgement and they are a doctor, you know. They have studied for how many years, so it is their job, so they should just get on with it._ (Patient 4, p.11-12)

Patient 4 also went on to bring up a view typical of those expressed by many on the subject of untoward events occurring and the risks explained to them.

_It figured I am in the best place for it if anything did go wrong, you know, I am already in hospital so._ (Patient 4, p.12)

Following on, Patient 3’s comment reiterates this opinion of unquestioning trust in the ability of staff to deal with anything untoward,

_I know that the very first time I was told, somebody said oh you can die under that. And I thought no doctor is going to let me die under a thing like that. ...But after they started the preparation then they pointed out the fact that of things that can happen to you when you have this cardio version, and a consent form was given to me, very thoughtfully and very kindly, and I just signed that._ (Patient 3, p.4 & 12)

In summary, the informed consent process including in-depth discussions about potential risks and adverse events did not seem to be valued by this group of patients. This is despite it being not only a legal requirement but a vital part of providing patients with accurate information so they can adequately assert their right to autonomy. It appeared from the comments made that they felt well enough involved, safe, and they trusted the competence of the team to the extent that their need for risk information was reduced.
4.3.6: Summary of the interviews with patients

In summary, analysis of the patient data revealed what appeared to be an overarching requirement of the patients to feel a sense of safety and trust in the healthcare team. It appeared that if the patient felt this then little importance was placed on the specific details of the information given, including details about potential risks. Analysis of the statements highlighted the relationship between the quality of the interactions surrounding and including the patients and their support persons in ED, and the contributions this communication made to the overarching sense of safety and trust that the patient valued so much. If this state was achieved, then the provision of additional written information held no value to them whatsoever.

4.4: Results from the focus group with nurses

Data was gathered from five nurses in a focus group (FG1) discussion. The aim was to find out from the nurses their views on what information they felt patients needed to know about procedural sedation in ED. The group were firstly asked to brainstorm about what things they generally aimed to tell patients, and these were explored as a group. They were asked who they thought should give what information and when. They were asked what they felt were the main aims when providing sedation in ED, and also whether they felt a standardised written information sheet would be useful. At the same time, the nurses were provided with some feedback of the results derived from the patient interviews and given the opportunity to comment on them (Appendix 11).

Four themes emerged from analysis of the nurse focus group recordings and transcriptions. These are shown in Figure 8. Sedation was clearly seen as a distinct and separate step in the patient’s journey that required equal consideration alongside the patient’s presenting complaint. Direct quotes from the nurse(s) are included to demonstrate the significance of the following themes.
4.4.1: Safety

All the nurses present at the focus group placed great importance on ensuring that patient sedation in the ED was provided safely and followed policy. It was made clear that if they felt sedation was about to go ahead when a part of the necessary preparations had not occurred they would not allow it to commence,

‘Cause they always want you to do it when it is lunch time, [and you have to tell them] no, we can’t give you the nurses to do it I am sorry. No. (FG1, p.18)

The nurses were in agreement as to what constituted an acceptable minimum safety standard to go ahead in terms of staff and environment,

When we do the sedation we have to have a certain environment, in other words the airway [sedation monitoring] nurse, you know, procedure nurse, the doctors, both the [doctors] so it is safe to do. (FG1, p.17).

And that we [are] all set up to cope with it if something goes wrong, that is why we have all of the equipment. (FG1, p.4)

It was seen as important by the nurses to communicate to the patient that having all this monitoring and these people was to ensure their safety,
Yes because the essential [things for the patient] to know is, look, you are safe, we are doing this, this and this for you so, I mean the Doctor is not going to talk much about that is he? (FG1, p.13)

It was recognised amongst the group of nurses that to go ahead with a procedural sedation when the department resources were too stretched to ensure adequate safety and monitoring was ultimately not in the patient’s best interests. One nurse shared with the group how at times it was hard to reconcile the fact that their refusal to compromise on safety had resulted in an individual waiting a long time,

I had a person the other day, this poor Granny, we had three goes [to get the sedation done] and each time we just got [into the resuscitation bay] to attach with the propofol [sedating agent] and the trauma thing [emergency radio from ambulance services] would go off and we just didn’t have time. And then it was 9.00pm at night, [and the on-call consultant said] ‘I am not happy to sedate you’. She would have been fine; you know earlier [when more senior staff are on site]. And then she is still sitting there with a broken arm that, and then it is getting late, and if it is getting late then we are thinking more about the safety aspect [so she was admitted to have the procedure done in theatre]. (FG1, p.18-19)

After learning from the feedback from the patient interviews that the patients did not appear to worry about the sedation part of their care at all, one of the nurses made this observation,

That is a good thing, they don’t have to worry about, ‘is this going to be safe?’ We are worrying about that and they don’t need to worry about it, and maybe they would remember and worry more about the sedation if they hadn’t felt so safe. (FG1, p.31)

In summary, conditions the nurses required for the sedation to proceed included space in the resuscitation room with a designated nurse, a designated senior doctor to sedate, and a separate designated doctor to perform the procedure. Also, appropriate monitoring and resuscitation equipment attached or at the bedside. These stipulations are in alignment with the departmental policy on procedural sedation and the nurses clearly advocated, in terms of patient safety, the importance of adhering to this with no exceptions. The preparation of the area and equipment appeared to be of similar importance to all the nurses to ensure the team was prepared for any untoward events. When faced with the dilemma of perhaps creating
longer delays for some individuals when it was unsafe for ED to undertake the sedation, they agreed that, while personally upsetting, safety had to be paramount. It was these considerations that drove the content and delivery of information they provided to patients.

4.4.2: Explanations and information

A large part of the information given to patients was about letting them know what is happening and why. Some of this crossed over with the safety theme, but most was just around making the patients aware of their surroundings, understanding the process of what was going to happen and the rationale for this,

*Like why are we doing it. So we are doing it to relocate or whatever. What will happen to them. How they might feel. How it is done. Like, yes the set up of making it safe. Why are we using oxygen and why are we giving fluids. And why there is ten of you, and why you are putting five of you in there, you know, doing the procedure. And the de-fib, and the CO$_2$ monitoring, and the noises.*

(FG1, p. 3)

It was recognised by the nurses that there is often repetition for the patient but value was placed on this repetition whether it be from the same or a different member of the healthcare team. It was acknowledged that this was inevitable as patients requiring procedural sedation are often cared for in multiple parts of the department prior to their arrival in the resuscitation bay where the sedation occurs. Not knowing how much or how little the patient had been told did not concern the nurses, as they did not mind starting over,

*Most of the time we tend to have enough time, ’cause the doctors fluff around a bit. Sometimes the cubicle nurse [looking after the patient before they were moved to the resuscitation area] or whatever might fire off a bit of information and we just carry on. Yes and I mean, and if they have eaten, they have got to hang around in any case, so by the time they go for it [the sedation], they have heard bits from everyone.* (FG1, p.9)

*Well I always try and give as much as I can but I don’t assume that people have given information because they may not have.* (FG1, p.10)

Nurses also described re-wording information given by the doctor and checking for comprehension even after consent had been given, which they felt was an important role for the nurse to ensure patients were comprehending what they were agreeing to,
Well they, I feel that the patient needs to know in their language what is going to happen. The doctor talks doctor talk. (FG1, p.15)

I think often the patient goes uh huh and gives the consent and then looks at you and goes what did I just do? (FG1, p.16)

This reiteration of information provided by doctors, whilst being seen as distinct from the doctor’s medico-legal responsibility to practice informed consent, was felt by the nurses to be intrinsically linked to the process by being the patient’s advocate.

‘Cause the doctor is the one that gets the informed consent so they should be the one that should explain about the procedure, can’t get informed consent from someone if you haven’t explained what is happening. But I still think the resus [resuscitation area] nurse should as well because half the time you only hear half of what the Doctor tells you when you are in such a situation, in a stressful situation. (FG1, p.11)

I think with the elderly as well, you know, if you have got a patient with dementia then the recall is difficult sometimes, so you have to explain correctly [repeatedly] to them ‘cause they may not understand. (FG1, p.11)

They also acknowledged it was important for patients to know what to expect and to be prepared for common experiences in the process, such as nausea, or the feel of a plaster cast.

Sometimes I also explain to them that they won’t know what has happened and they have got to be aware that they are going to have a memory loss but that is due to the drugs and that is normal and they have got to know that is normal. (FG1, p.5)

How long it will take, that sometimes afterward they can feel a bit nauseated or, dizzy and drowsy. (FG1, p.7)

Included in this was discussion of ongoing treatments depending on the result of this one, as a way of preparing the patient for different potential outcomes.

What will happen after, why they need to be nil by mouth. Also after the final x-rays or whatever ‘cause [if] that doesn’t work [then they will be] for the [operating] theatre. (FG1, p.4)
[Also explaining the] treatment, yes. Because if they have done the sedation
[for an injured limb manipulation] even [explaining about having] casts and
things ..... you know we go through all of that and the manipulation, going for
an x-ray, come back after, it is not in place you know, so you have to tell them
that there is also the possibility of having it done again. (FG1, p.8)

In summary, the nurses spent a lot of time informing the patients of their progress and
orientating them to their situation. The value of doing this was not underestimated, and they
recognised the importance of advocating for the patient in the informed consent process.
Some of these explanations also had links to the previous theme of safety, and to the following
theme of reassurance and trust.

4.4.3: Reassurance and trust

The nurses perceived that the patients and their support persons may feel anxious or fearful of
the strange environment, and about what was about to happen to them. The nurses therefore
aimed to provide reassurance in a number of ways. One way was verbally, by reiterating
important points, building on the information already given by others and ensuring the
patients were are not being frightened unnecessarily by the process,

    We often tell them there are risks, especially after the doctor has spoken to
    them but, just making sure that they understand that it is minimal. (FG1, p.4)

    Well they need to know.... [and it’s OK to be told information from lots of
different people] as long as the information is congruent from each of them.
    Then that builds trust in the staff as well doesn’t it? They think ah everybody
    seems to be saying the same thing. (FG1, p.14-15)

Clarification was often sought to check that what had been said earlier had been understood
by the patient and that they had opportunities to ask questions,

    And usually I will ask them if they have any more questions even after the
doctors have explained because sometimes they don’t think about it when the
doctor is actually talking to them. (FG1, p.5)

    It is more the reassurance then I think. It is not about how much information
you are giving, it is about how safe, yes, and making them feel comfortable.
(FG1, p.20)
Gaining the patient’s trust in the team’s competence and expertise to perform the procedural sedation were recognised as an important factor in reducing any anxiety for the patient. This did not have to be just about what was said, as two nurses identified,

> And I know I have had people who have said you know, you seem to know what you are doing, and that makes me feel good, like, I don’t need to know more information, you know what you are doing. Yes, I mean, I still give them the information but I think that is quite an important thing to realise is that you feel, you are looking or being confident is actually giving them confidence. (FG1, p.21)

> That is pretty much all you are saying, that they are safe, and reassuring them by looking like we know what we are talking about. (FG1, p.28)

In summary, by acknowledging that the patient may be feeling anxious about an imminent unpleasant procedure and sedation, the nurses used a number of techniques in an attempt to reassure them and gain their trust. These ranged from verbal reassurance of the risks to their health, non-verbal displays of confident behaviours, and giving the patient opportunities to ask questions.

4.4.4: Support person presence

The presence of a support person was a theme of lesser significance to the nurses but was still considered important in that it was identified that these people had different information needs from the patient. The nurses also discussed how support people may not wish to stay with the patient throughout the procedural sedation and they should be supported in that choice, as some procedures can appear unpleasant. One of the nurses acknowledged the need to support the support person,

> Usually talk to the family and just, especially if they want to stay and explain to them what they are going to see. ‘Cause that can be quite scary. (FG1, p.4)

Another nurse highlighted the importance of advocating for the patient, especially if no support person was present to do so,

> So basically even though they can’t remember what we say to them it doesn’t matter, we should still keep doing it and then if they have got no support person they need to know that there is someone looking after them. (FG1, p.27)
In summary, the nurses were very open to support person presence but recognised that they needed to be prepared for the experience as they may not cope well otherwise. If patients were alone, the nurses recognised that the patient may feel quite isolated and vulnerable so attempted to mitigate this by ensuring they felt supported.

4.4.5: Summary of the focus group with nurses

The nurses’ main aims centred around ensuring patients and their support person(s) were well informed about what was going to happen, that they would feel reassured and less anxious or fearful of a stressful event and that the sedation would be performed safely for all concerned. The information they considered necessary to provide to patients reflected these aims.

4.5: Results from the focus group with doctors

Data was gathered from four doctors in a focus group (FG2) discussion. The aim was to find out from the doctors their views on what information they felt patients needed to know about procedural sedation in ED. As in the nurses’ focus group, they were firstly asked to brainstorm about what things they generally aimed to tell patients, and these were explored as a group. They were asked who they thought should give what information and when. They were asked what they felt were the main aims when providing sedation in ED, and also whether they felt a standardised written information sheet would be useful. As with the nurses, the doctors were provided with some feedback of the results derived from the patient interviews and given the opportunity to comment (Appendix 11).

Five themes emerged from analysis of the doctors’ focus group recordings and transcriptions and are shown in Figure 9. Sedation was again clearly seen as a distinct step in the patient’s journey that required equal consideration alongside the patient’s presenting complaint. Also, the responsibility held by the doctor as the sedator came through clearly. Direct quotes from the doctor(s) are included to illustrate the significance of the following themes.
4.5.1: Medico-legal

As alluded to in the nurse focus group, the responsibility to obtain consent based on the patient being adequately informed rests with the doctor. So it was not surprising that the bulk of discourse around information provided by the doctors was around risks and benefits,

*Well the core information with any procedure is giving patients the potential benefits, risks, and alternatives to the procedure.* (FG2, p.1)

*We haven’t outlined necessarily all the risks of things that we talk about but, we go through again the risk benefit type sort of stuff and we focus probably more on the best interest.* (FG2, p.15)

One doctor, in attempting to explain how he adjusted his approach to procedural sedation based on the individual’s risk factors, stated his priorities whilst ensuring he did not breach his duty of care to the patient,

*Mine is safety...yes safety & comfort...yes comfort yes...but not at the risk of safety...I would rather have the patient experience a bit of discomfort than compromise safety, hypotension, or airway compromise.* (FG2, p.20)

As there were doctors with experience of working in other countries, there were also comments made about the differing information needs of patients, personally and legally,
It is interesting coming from [another country] and how [in that country] we have to describe all the benefits but also the multiple risks and all the worst things that can occur. And sometimes you can actually scare the patient bad enough they don’t want it. (FG2, p.3)

The notion of patient choice was discussed and the need to find a balance between being overly paternalistic and expecting too much from the patient to make the sole decision on what option would be best for them,

See I start the information with the choice ‘cause sedation is actually one of the choices for the patients, so, and so it may be that sedation isn’t appropriate for that patient. In that, I give them a choice of that with the sedation, general anaesthetic or local anaesthetic or some other alternative. After throwing out the general terms I get a feeling of which way they want to go, I have a general feeling where I want to go, and then I direct things down the pathway [that fits best]. (FG2, p.1)

And then, you know we sort of have some duty as people who have spent many years in post-graduate training so we need to advise them and, and there is some point where they kind of also need our advice about what we think is best. So I think it is fair and not to paternalistic to advise but also make them aware of the other options. (FG2, p.3)

In summary, the doctors were keen to give as much information regarding the risks and benefits of sedation to allow the patient to make an informed choice when there were options to choose from. However, they also recognised that it was their responsibility to guide the patient towards the best option for their circumstances.

4.5.2: Pharmacological agents

Another major theme that generated a lot of discussion in the doctors’ group was the increased confidence the doctors had in the newer sedative agents and how much more satisfied they felt patients were with the procedural sedation experience now that these agents were available. This was based on their personal experiences of the efficacy in achieving the desired level of pharmacological effect with reduced side effects. Comments from three different doctors follow,
I think ketamine has made life a lot easier. Sometimes with the benzos [benzodiazepines] we didn’t get them right, the fentanyls, the entonoxes… in all procedural sedation with fentanyl and midazolam left a lot to be desired. (FG2, p.5)

[Since the routine use of ketamine & propofol] I would say the vast majority, I can’t think of anyone who woke up and said never frickin doing that again. So my experience is patients are largely really happy. (FG2, p.5)

So if we are talking about the typical agents that we use now, propofol and ketamine … I am under the impression; perhaps your data shows otherwise, that patients are really happy with that service. (FG2, p.6)

They all identified how, compared to when they were using the older pharmacological combinations that were problematic in the past, they are now much more confident of achieving a good outcome for the patient. This is reflected in the way they convey the information regarding choice of sedation to patients, and the following conversation illustrates the group’s opinions on this,

[Before the use of ketamine and propofol I would be thinking that] ‘I can’t promise that I can render you unaware’. In the older style [using benzodiazepines & fentanyl/morphine], the narcotic and anxiolytic combination, or hypnotic would not confer the benefits of the amnesic and the sort of out of body [experience] and their [the patient] perception of any discomfort. There is a huge difference with the new agents. (FG2, p.6)

Some of our older agents where we had to sort of prepare for the risks and benefits, those agents were more likely to cause prolonged sedation or airway issues or blood pressure issues or unfortunately on the other side, inadequate analgesia and amnesia for the event. (FG2, p.6)

Yes overshot or undershot, and it was rarely, rare to find the sweet spot of relaxation, comfort and amnesia. You over shot or under shot too much. (FG2, p.8)

In summary, the increased safety and efficacy of the now commonly used ketamine and propofol has given medical staff increased confidence in the delivery of procedural sedation in ED. As the use of these agents has increased the predictability of both the sedation and the
recovery, the medical staff felt better able to project this confidence to the patients when they were discussing risks.

4.5.3: Explanations and reassurance

As was similar to the nurse focus group, the doctors’ explanations of what was happening around patients and what they could expect next was considered to be important information to communicate to patients. This included explaining who all the different people were in the room, as two of the doctors explained,

*The other thing you have to explain to people is all the stuff you are doing because they are not just laying on the stretcher.* (FG2, p.11)

*Kind of understand who people are and what their roles are, well as a consultant I am always explaining that I am there as a supervisor role and I am usually letting one of the Registrars do the sedation. And whether it is the House Officer or Registrar who does the procedure. Whether it is the defibrillation or the reduction or whatever we are doing, so they are aware of all the different roles people have.* (FG2, p.13)

This information was given in a way to provide reassurance as to why they were setting up a lot of equipment and monitoring, which one of the doctors acknowledged had potential to cause anxiety in the patient,

*You are hooking them up to a monitor, you are putting them on $O_2$, you are putting on a $CO_2$ monitor, you are getting suction out, you are getting all the intubation stuff, so you have to reassure them that we are getting this just in case there are problems but not to scare them at that point cause you are doing a whole lot more than just people laying in bed.* (FG2, p.11)

Another of the doctors shared with the group a strategy observed that a colleague had used to explain the need to set all the equipment and monitoring up, while at the same time reassuring the patient,

*I have noticed [our junior doctors] using the phrase, you know we do this in the resuscitation bay because these side effects we anticipate and are able to manage them in this setting. I don’t know if you guys taught them that or I have noticed some of them say ‘we do this here because this is the place that we can manage any complications’. I thought that was a nice touch. So [the
patients] kind of understand there is a chance [of side effects] and we are prepared to handle that. (FG2, p.4)

This led another of the doctors to describe how he approached the issue of reassuring the patient as to the unlikelihood of needing to use all the airway management equipment they were preparing,

And I may even tell them they I can count on one hand the number of times I have actually needed to support somebody’s breathing and I have never had to intubate anyone. Things of that nature. (FG2, p.4)

In summary, the doctors also provided explanations to the patients of what to expect next. They also acknowledged the fact that patients can become anxious after being told something is relatively safe, but then observing an increased level of monitoring and preparation going on around them, so have developed strategies and phrases to reassure them.

4.5.4: Support person presence

One doctor brought up the importance of including the support person in all the discussions,

I think the other thing is just, is just to speak to the family. So they are aware of what is going on too. ‘Cause they are as important as anybody else. (FG2, p.8)

This led the other doctors to discuss the issue of support person presence. As with the discussion around pharmacological agents, comparisons were made between the current practice of allowing, or even encouraging, support people to stay during the sedation and previous, less inclusive, practices.

I like to think that I have gotten fairly transparent, I let them stay, which is sort of a sporty decision. So we actually, we have an unconscious patient or an unaware patient and, but we have several witnesses sometimes, which is actually new ‘cause we didn’t use to let people stay (FG2, p.8-9)

The doctors also acknowledged that involving the patient’s support person was a situation that required specific consideration that was distinct from the patient’s needs.

Well you occasionally, depending on the agent, if it is ketamine I may explain that it is not unusual, they will look like they are awake, you will see some
funny eye movements, so I sort of prepare the family if they are staying. (FG2, p.10)

[Things] like you can expect to see this for the next five or ten minutes, but within about fifteen minutes they should be right. So giving them sort of, some reassurance and some general guidelines of how long they might appear a bit goofy when you know they are coming back. (FG2, p.14)

In summary, the doctors recognised the importance of involving support persons including changing their practice over the years to allow them to stay throughout the sedation. Support persons need specific guidelines around what to expect to see during the sedation so they are prepared and this was recognised by the doctors as well as previously in the nurses’ group.

4.5.5: Teamwork

As in many healthcare settings, there is often a blurring of roles and responsibilities among teams of healthcare professionals. Whilst some responsibilities mentioned earlier (such as the gaining of informed consent) were clearly identified as belonging to doctors, there was a clear appreciation of the value of utilising the strengths of all team members for the benefit of the patient. One doctor said,

I don’t spend much time actually talking about after and home and stuff. I liken it to a bit like the diabetes stuff, you know, the person telling you most of the diabetes stuff isn’t the Endocrinologist. The diabetes nurses are fantastic, they are excellent nurses, fantastic. The doctors are good but .... I don’t know that we do as good a job sometimes as the nurses do in checking these things. (FG2, p.18)

As these were all consultants, sometimes junior members of the team gave information under supervision as part of their training,

I must admit, like in, I do a lot of letting the [junior doctors] do a lot of the talking about it, and so I do a lot of supervision. (FG2, p.16)

Other benefits espoused by the doctors, of having more than one member of the team giving information, was the opportunity for increased reassurance. It also gave the patient the chance to hear, sometimes complex, information more than once,
But a lot of this repeated discussion about stuff, I let them have that repeated discussion. A lot of nurses are very good at that, they are very good at giving information to patients over and over again and making them feel comfortable and talking about things. So again I don’t necessarily always, I am probably not always as good as I should be about some of the other, some of the stuff but again I think the nurses do such a good job of that reassurance. (FG2, p.16)

One doctor brought up a similar issue to that mentioned by the nurses, of ‘doctor speak’, acknowledging that patients sometimes prefer to hear information differently to how the doctors may deliver it, and that nurses are often more able to engage on a patient level,

Well patients can react with us differently, so they may not ask the doctor and they may feel they want to ask the nurse, if they, very often they don’t have the questions all at once they can then ask questions again later when it comes back up to them. If they have concerns then they can readdress them. And again some people relate better in different ways and again, we don’t realise, sometimes, we say things, we are talking a language that they don’t understand and [with repetition] the breaking down and changing of the words all the time and so [making]a bit more powerful sentence. (FG2, p.17)

Another doctor brought up the issue of how the patient’s fears or level of pain may mean that it takes a whole team approach to effectively communicate with them. He said,

Then again there is competing sort of emotional, shocked, physical pain, and other detractors that it often may take certain several staff members to sort of, re-orientate the person with what is happening, you know what to expect for it to really kind of sink in. (FG2, p.17)

4.5.6: Summary of the focus group with doctors

The doctors’ main aims also centred around ensuring patients and their support person(s) were well informed about what was going to happen, that they would feel reassured and less anxious or fearful of a stressful event. They valued the whole team approach to achieving these aims.

However, a major theme specific to this group concerned pharmacological agents and the doctors’ ability to provide adequate and safe sedation with minimal risk. This in turn had an affect on their ability to fulfil their medico-legal obligations and their duty of care to the
patient. This was a key focus to the information they considered important to convey to the patients they sedated.

4.6: The use of additional written information

The third aim of the research question was to find out if the type of written information given out routinely for other procedures and investigations would be of value in this setting. As no patients independently suggested or discussed wishing to receive information in any format other than verbally, the researcher specifically asked whether the patients would have valued receiving additional information in a written format at any stage. No patients considered the idea of this to be a valuable addition based on their experience and gave various rationales for this.

4.6.1: Patient responses to being asked about the potential use of additional written information

Two patients extolled the benefits that well delivered verbal information can have compared to written,

*It is the way they present the information and their voice, they are not yelling at you or anything, they are just, you know, talking to you like a normal person and just letting you know this is happening and it helps you to start to calm. And you are willing to hear what is going on better than sitting there with a piece of paper.* (Patient 7, p.23-24)

*I don’t think that is what I [would want], I think it is a bit, it lacks sort of, well human warmth, and that is what you want. I think just reading it on a piece of paper isn’t going to console you in a way is it? If they communicate with you they give you that confidence.* (Patient 3, p.14)

Some patients talked about the benefits of verbal over written communication as a more dynamic and interactive way of receiving information, allowing clarification to be sought more easily,

*I like things verbally and I just get a better picture in my mind of what is going to happen. And if someone is telling you, you can ask them. If it is written down on a bit of paper you read it and you think well ok then, [but] if someone is saying to you, you know I can ask questions back at the same time.* (Patient 6, p.23)
No, no I don’t think so I just take it as you get there sort of thing. Otherwise you would probably sit there and be like... Start freaking out about things or something or I don’t know, start over thinking things when you don’t need to or something. (Patient 8, p.16)

Others gave their reasons as being that they felt there was no need to add more information to what they had received verbally. So even if a really good information leaflet was available, for example, they felt the staff did such a good job of verbal explanation that it would not be necessary,

No not really, I don’t think, no. Not as I say, they seem to, yes, they seem to impart their knowledge pretty clearly and they put one at rest. (Patient 5, p.14)

I think just one-on-one and if the person telling you the information, you have confidence in the person if they do it in a professional way, I think that is sufficient. (Patient 2, p. 12)

Patients who identified as being in pain or having received analgesia commented that they were not in the right frame of mind to read anything,

No, not in my situation ‘cause I was just in a whole lot of pain and just wanted it sorted. I didn’t want any, I couldn’t really be bothered reading in that time. (Patient 4, p.10)

But even then, there was just so much going on. I mean I was in too much pain to do anything...but maybe yes, yes if you are knowing you are going to do it maybe but they explain it all pretty well...I don’t know, I wouldn’t really say you would need paperwork. As long as they, yes, as long as they explain everything like they did. (Patient 1, p.11-12)

Overall, for varied reasons patients in this study did not see any value in them receiving standard information about procedural sedation in a written format, based on their ED experience of the same.

4.6.2: Nurse and doctor responses to the patients’ views of using written information

When these findings, regarding the use of written information, were relayed to the nurses and doctors during the focus group interviews, there were mixed feelings. Initially both groups intuitively felt that some patients would place value on receiving written information.
If we give it before and it tells you about after care and things to look out for, like you would for going to day surgery.....I think that it wouldn’t be a bad thing to have sort of like, if you experience this, this and this then you know, you need to see the Doctor or that kind of thing. (FG1, p.33)

However, after hearing that none of the patients interviewed placed any value on it, they re-evaluated their opinion. Some nurses considered the reasons this might be, based on the feedback received from patient interviews,

But they don’t want to know about the sedation...because [the procedure] is what they have come here for, they haven’t come here to be sedated. They have come here to get it fixed...the sedation is just a step to fixing them really. (FG1, p.29)

And they don’t want to show that they don’t understand because [the patient might think] ‘you think I’m thick’ or something. (FG1, p.36)

Some nurses still felt in some circumstances it may be beneficial to receive a written information sheet, interestingly stating that it made her feel better to give them out,

Well I like just, I like giving out pieces of paper to people so....Yes but if something happened then they can look back and go ‘oh what can we do with this?’ ....I would still be giving out information sheets. It would make me feel better. (FG1, p.35 & 37)

While others acknowledged that some patients appeared disinterested in the current written information provided for other ED presentations. Although that is not to say they or their relatives did not read them at home and get some value from them,

You give them those head injury handout and they don’t want to know. No and a lot of the times when I give out the, the pamphlet, the pieces of paper that you had given they were kind of like oh yes, fold it up and sort of like stick it in their bag. (FG1, p.34)

The doctor focus group (FG2) recording was unfortunately stopped due to an interruption and one of the doctors having to leave. However, conversation regarding written information continued between the researcher and the remaining doctors while the focus group was being wrapped up. One doctor acknowledged the patients views for not wanting written information, and personally placed little value on it, preferring to concentrate on providing
quality verbal information guided by the patient’s needs (FG2, verbal communication). However, another doctor stated that, based on his experience of having to care for a relative following discharge from hospital, he had used written information sheets provided to help reassure himself and guide his responses to his relative’s symptoms at home (FG2, verbal communication).

In summary, the staff groups acknowledged, and could understand the rationale for patients not valuing written information in this situation. They could see that it was perhaps more important to focus on providing good verbal explanations that patients could clarify and question in real time. However, the practice of providing written information seemed to satisfy some staff in that it provided a back up to what the patient had been told and guidance on how to seek help after discharge. Comments made by some staff members suggested that perhaps written information may be of more value to the support person responsible for the patient after discharge, especially if they were not present during the procedure.

4.7: Chapter summary

This chapter has presented the results of the descriptive exploratory study. The themes identified from analysis of the data were presented by stakeholder groups and supported by quotes from the participants. The following chapter will discuss the results and their significance in context with the research question and literature.
Chapter 5: Discussion

5.1: Introduction

As stated in earlier chapters, healthcare workers are not only obligated to inform patients about their treatment, but literature supports the notion that patients also wish to be informed. However, based on the identified lack of clarity regarding what exactly patients want to know, specifically around procedural sedation in ED, this research hoped to identify the preferred content and format of that information.

The resulting themes presented in the previous chapter from the participants of the three participant groups, did not in themselves identify a succinct list of bulleted information points that could be easily utilised for informing future patients receiving procedural sedation in ED. Also, the suggested provision of written information was wholeheartedly rejected by the patient group so was subsequently not actively pursued in the staff focus groups.

In this chapter the researcher will discuss the significance of the key themes identified in relation to the research question and current literature on communication within the healthcare environment. The subject of written information will also be discussed in relation to the research findings and current literature.

5.2: Common aims of all participant groups – safety and trust

As stated in the previous chapter, the overarching theme identified from the patients’ interview data was the need to feel safe and to have trust in the staff providing the sedation and procedure. This general patient need is reflected to a greater or lesser extent in other studies (Checkland, Marshall, & Harrison, 2004; Edwards, Staniszewska, & Crichton, 2004; Wright, Holcombe, & Salmon, 2004). All patient participants interviewed appeared to have felt this to some degree despite their individual circumstances being varied as regards age, experiences of delays, pain and previous sedations etcetera.

Reassuringly there was a great deal of commonality between participant group themes in this research, and the nurse and doctor groups both stated their aims were predominantly to provide a safe environment and to provide open and honest communication for patients. This would appear to be in keeping with the patients’ needs; however there were subtle differences in emphasis and style among the three groups’ perceptions of how they approached this, which was reflected in the different choices of theme titles in the results.
chapter. The healthcare team appeared to have a strong culture of safe practice around procedural sedation in the ED where the research took place, which undoubtedly contributed to the satisfaction expressed by these patients.

Broad themes common to all three participant groups can be categorised as the following:

- competence and efficiency of staff
- explanations of progress, delays, procedure and environment
- repetition and clarification of information using a whole team approach
- support person presence
- medico-legal discussions and risk versus benefit information

Similarities and differences between groups within these themes shall be discussed here.

5.2.1. Competence and efficiency of staff

Patients in this research reported that if they considered the healthcare staff to be competent to provide the care needed, it made a positive contribution to how safe they felt. Patients often only have limited opportunity to determine whether this appears to be the case, especially in the unplanned ED presentation. Coupled with this, studies have also indicated that patients feel they do not necessarily have the knowledge to determine the technical competence of the staff caring for them, or their ability to practice safely (Calman, 2006).

Calman (2006) noted that patients did understand the complexity of competence and could identify two components that they see as integral to it. These components are described as ‘competence as seen as technical skill and competence as seen as the caring attributes or personality characteristics’ of the individual (Calman, 2006). As far as technical skill is concerned, patients assume this aspect of competence is monitored primarily by professional and employer safeguards and should not be in question. Therefore they often focus more on surrogate indicators and communication styles to judge whether they should trust those providing their care (Attree, 2001; Cescutti-Butler & Galvin, 2003) and the caring attributes of the staff become more influential.

During the interviews, reference was made to examples of the indicators used by patients to determine staff competence. Participants commented on taking cues from how confident the member of staff seemed, being able to observe them teaching other members of the team and seeing evidence of mutual respect in the interactions between the nurses and doctors. As another example, the way in which staff set up equipment and ensured all the monitoring was in place also contributed to the patient’s opinion of competence and efficiency. Direct
communication with the patient about prior experience of providing and monitoring procedural sedation also contributed, but, as is widely understood in the literature (Epstein, 2006; Jangland, Gunningberg, & Carlsson, 2009; Wright, et al., 2004) patients only truly trusted this information when they could also see this in the practitioner’s body language and actions.

Competence and efficiency were also seen as important attributes that both staff groups knew to project to patients. As stated earlier, there appeared to be a strong safety culture around procedural sedation in the ED of the research so only nursing staff that had been orientated to the resuscitation area were able to care for these patients. (Hawke’s Bay District Health Board, 2012) Also, a credentialing system was in place for doctors working in ED whereby the ED consultants controlled the calibre of ED doctors who were able to sedate patients without direct consultant supervision. (Joint Statement on Clinical Principles for Procedural Sedation, 2003; O’Connor, et al., 2011). Therefore, it is perhaps unsurprising that the patients in this research consistently spoke positively about the competence and experience of the staff providing their sedation, and noted that their sedation was provided with confidence and efficiency.

5.2.2: Explanations of progress, delays, procedure and environment

Being informed of all aspects of their patient journey with courtesy, empathy and respect was identified as an expectation of patients attending ED (Watt, Wertzler, & Brannan, 2005). The findings in this research support the notion that this aspect of care was indeed valued. Engagement with patients and keeping them informed was large part of the procedural sedation experience seen as important by patients in this research. This may be because patients consider themselves to be an active participant when ED staff give them information relevant to their circumstances and about what is going on around them (Frank, Asp, & Dahlberg, 2009). Staff also placed great emphasis on this aspect of the care provided, linking it to providing reassurance and reducing anxiety. Frank et al. (2009) concurred with this viewpoint, stating that patients who are more aware of what will happen create a sense of control for themselves when clear and ongoing explanations are provided.

In this research the focus of the nurses and doctors on safety and building trust was part of an ongoing narrative given to patients as they set up the environment to ensure the provision of sedation was conducted in as safe a manner as was possible. They talked about adherence to local policies and national/international standards, including having adequate numbers and calibre of staff present and the availability of equipment to monitor and manage any adverse events. Both the staff groups identified how they emphasised this preparation and high
standard of safety to the patients to make the patient feel they could trust the staff to look after them properly. This information formed part of the explanations of progress and delays and enabled the patients to have realistic expectations of timeframes and process. This created a shared vision of treatment goals that the patient could feel part of.

5.2.3: Repetition and clarification of information using a whole team approach

As discussed in the preceding paragraph, patients in this research described receiving a constant stream of information coming from multiple members of the cohesive team around them. They described hearing similar information repeatedly either from the same person or from different people and being given time to ask questions. Clarification was provided not only when asked for by the patient, but also as a matter of course by the staff. This style of communication described by patients appears to be an example of a shift from the traditional ‘patient education’ discourse to ‘patient empowerment’ discourse described by Dixon-Woods (2001). Dixon-Woods identified ‘patient education’ discourse provision of information as being derived from the notion of patients as being forgetful, passive and incompetent receivers of medical information, being judged on how well they had understood that information on a set of agendas that were important to staff. In contrast the ‘patient empowerment’ discourse literature judges how effective communication has been by ascertaining how well it has met the needs and priorities of the patient receiving it, with the patient being viewed as an active participant able to engage in shared decision making.

The patients in this research described how the nurses and doctors worked well as a team, with one patient commenting that whilst she knew this should be the norm ‘it isn’t always the case’ (Patient 3). Patient 4 described how after his shoulder was relocated, due to the nurse’s reassessment and discussion with the doctor, the initial decision not to x-ray his wrist was changed and a fracture was discovered. This patient and his support person both positively acknowledged how the mutual respect between the healthcare team was evident, in that everyone was able to challenge and contribute to diagnoses to ensure the best outcome for the patient was achieved. The doctors also voiced the importance of a whole team approach in the provision of information. They acknowledged how this allowed them to concentrate on the responsibilities that were solely theirs, knowing that when the team worked well together other members of the team readily and competently stepped in with repetition or clarification of explanations. While the nurses did not mention teamwork per se, discussions from the nurse focus group showed how the nurses, as well as having specific roles to fulfil, would step in and ‘fill gaps’ they saw in the patient’s care. Two examples of this behaviour were shown in
the way the nurses readily provided repetition and clarification of information as required by the patient, and also by providing the role of support person when the patient had no-one. The nurses in this research appeared to demonstrate a fluidity to their role and responsibilities that contributed to the cohesiveness of the team and provided advocacy for the patient. As the literature around quality and risk in healthcare bears witness to, effective patient care and improved patient safety is dependent on effective teamwork and communication. However, as Salas, Rosen and King (2007) state, teamwork is not achieved simply by placing people together and there is also no requirement that individual team members like each other personally. Salas et al. suggest that teamwork is dependent on team members having a shared goal and cooperating with a view to achieving it. In this research the behaviours that all three participant groups identified as components of effective teamwork have also been identified in the literature as key elements missing when teamwork breaks down and errors occur (Groff & Hoffman, 2003). Namely, respect for others’ clinical assessment, comfort with communication and feeling safe to assert an opinion within the team, flexibility in managing the patient and having a shared plan of care with the patient.

5.2.4: Support person presence

Having a support person present was identified by all three groups of participants as an important aspect of care. This is not surprising as the value of having a support person present when receiving healthcare is not only mentioned in the Health and Disability Commission Act (Health and Disability Commissioner Act 1994) Code of Rights (Right 8, the right to support), but also documented extensively in the literature (Baumhover & Hughes, 2009; Boudreaux, Francis, & Loyacano, 2002; Duran, Oman, Abel, Koziel, & Szymanski, 2007; Frank, et al., 2009; Meyers, Eichhorn, & Guzzetta, 1998; Redley, Botti, & Duke, 2004; Redley, LeVasseur, Peters, & Bethune, 2003). Much of the literature focuses on the presence of family during resuscitation attempts and invasive procedures either within the ED or intensive care setting, and was predominantly shown to be of benefit to both patients and support people. Baumhover and Hughes (2009) listed a number of benefits cited by patients, some of which were that they felt comforted, they felt safer, and they believed their family acted as advocates by providing important information to the health care team. Benefits to the support person identified by Baumhover and Hughes (2009) supported the patients’ views and also included meeting their needs for knowing about and providing comfort to the patient and reducing any guilt, worry, or anxiety about leaving a loved one in crisis. However, there were also gains for members of the healthcare team including promoting holistic patient and family-centred care and encouraging more attention to patient’s dignity, thus reaffirming the nurses’ role as patient
advocate (Baumhover & Hughes, 2009). Concerns from healthcare workers mentioned in the literature (Dougal, Anderson, Reavy, & Shirazi, 2011), regarding allowing the presence of support persons during invasive procedures, include a dislike of being scrutinised, performance anxiety, concern that the family member may not cope with the traumatic nature of what they may witness and fear of litigation. Contrary to this body of literature, none of the participants in this research had objections to the presence of support people. However, as mentioned before, the literature included resuscitation as well as invasive procedures, and the participants did identify that a support person required extra care.

5.2.5: Medico-legal discussions and risk versus benefit information

Focussing on providing the patient with all the choices available to them, while seemingly an example of patient-centred care, may not always be what the patient wants (Epstein, 2006). The information wanted, and the degree of participation in decision making needed by patients, can vary greatly depending on the context of the situation (Epstein, 2006; Jangland, et al., 2009; Wright, et al., 2004). This can vary not only between patients, but also for the same patient at differing points in their presentation, depending on the context. Drawing on personal experience of being a patient in severe pain, Epstein (2006) stated ‘the autonomy being offered seemed like an impossible burden. My cognitive abilities had been so affected by pain that I could not think clearly’ (p.275). This correlates well with findings in this research that appeared to suggest some patients were quite willing to be passive, especially in the acute phase, choosing to ‘leave it to the doctor’(Patient 4). As Wright et al. (2004) found, patients feel there is a difference between being presented with the options, which they valued, and being expected to take responsibility for the final decision. Wright et al. (2004) described the suggestion of expecting the patient to take this responsibility as being likely to undermine the patient’s trust in the doctor, whom the patients expect to decide what the best option is from the ones discussed. Most of the findings from the patient data around discussion of risks and benefits suggested that treatment options were discussed, and sometimes alternatives tried, prior to the decision being made to use sedation. Whilst patient’s perception of the risk of the procedure may influence their need for more information around the risks and benefits associated with gaining consent, this perception may not be a true reflection of actual risk (Graber, Pierre, & Charlton, 2003). The amount of specific risk information and how patients want this to be presented to them is frequently examined in the literature. Lloyd (2001) suggests that patients make decisions on treatment options by using simplistic shortcuts, or heuristics, and prefer qualitative rather than quantitative language to inform their risk perception. Easton et al. (2007) used the example of patients placing a greater value on
discussion of risks for lumbar puncture above the riskier procedural sedation. This viewpoint is congruent with some of the patient’s comments interviewed in this research with statements along the lines of ‘it’s only sedation, it’s not like they are putting me fully under’ (Patient 1, p.12).

Participants in the doctors’ focus group discussed being guided by how much the patient appeared to need or comprehend whilst ensuring they provided the essential facts. If there were multiple options then more discussion was engaged in with guidance provided; whereas if options were limited and/or the need was urgent then discussions were of a more directive nature. Results from the nurses’ focus groups showed that nurses reiterated essential elements of the discussions entered into by the doctors. However, by focussing on clarification, re-wording and offering to answer any questions, their role in this was once again advocating for the patient.

5.3: Themes distinct to individual participant groups

5.3.1: Pharmacology

The original literature review found a plethora of research done by the medical fraternity searching for the perfect combination of sedation agents that were measured against varying outcomes. These measures were commonly patient satisfaction, efficacy, improved recovery times and reduced adverse events (Nejati, et al., 2011; Zed, et al., 2007). It is unsurprising perhaps that the participant group most concerned with this was the doctor focus group, especially as it is their responsibility for achieving predictably effective sedation and procedure outcome.

Similar to patients assuming that the health professionals are competent unless they witness evidence to the contrary, they are likely to take for granted that the agents used to sedate them will be effective and safe. It is also unlikely that patients will have much preference or knowledge of specific agents; therefore it is equally unsurprising that this theme was not mentioned at all by patient participants.

The nurses were also less concerned about different sedation agents, despite obviously having to understand their differences in terms of preparation, administration and adverse effects to monitor and respond to. Perhaps this was because it was seen as the doctor’s role to prescribe the agents, and as long as it was considered an appropriate and safe regime, the nurses just prepared appropriately.
5.4: Use of additional written information

Finally, regarding the third aim of the research; the idea that additional written information should be provided was rejected fairly emphatically by the patient participants. This would appear to be at odds with some of the literature reviewed previously in Chapter Two that describe the benefits of patient information leaflets/pamphlets (Galaal, et al., 2011; Johnson & Sandford, 2005; Mauffrey, et al., 2008; van Zuuren, et al., 2006). However, as discussed in Chapter Two, just two of these studies were in the ED setting and addressed discharge information only, and the others were for planned investigations or procedures.

The reasons given by patients in this research for not valuing information in a written format appear to suggest that the shorter timeframe of events associated with ED procedural sedation does influence their opinion. The urgency of the presentation combined with the temporarily reduced mental capacity of the patient during a stressful event, also featured in their rationales for rejecting the idea of written information. These seem self explanatory and common sense when considering pre-sedation information, however patients in this research also rejected the notion of post-sedation and discharge information in a written format.

Communication aimed specifically at discharge from ED, according to the recent review of the literature (Samuels-Kalow, et al., 2012), consistently supports the use of written information stating that ‘patients need structured content, presented verbally, with written and visual cues to enhance recall’ (p.152). Although much of the reasoning proposed for providing this written information was concerned with the biomedical agendas of increased compliance, reduced re-attendance and recall of key clinical points. Dixon-Woods (2001) describes this ‘patient education’ approach of using purely biomedical goals to guide the content and format of patient information as undervaluing the ‘patient empowerment’ model. The patient participants in this research clearly felt that their information goals had been met verbally as they refuted the need for additional written information, but as acknowledged by staff comments and Patient 4’s support person, written discharge information is sometimes of greater importance to the people responsible for looking after the patient post-discharge.

5.5: Summary

In this chapter the research results were discussed in context with current literature regarding patient information and communication. Resulting themes identified from this research regarding communication within the healthcare environment appeared to find support in the
literature. Medical and nursing staff appeared to communicate well together towards a shared goal and included the patient and their support person in the plan of care. The patients in turn reported satisfaction with the information received from a competent and efficient team. The exception to this congruence with the literature was the patient participants’ rejection that provision of additional written information may be of value. Conclusions will be drawn from this research in the following chapter, along with limitations and recommendations.
Chapter 6: Conclusion

6.1 Introduction

This descriptive exploratory research has provided a rich insight into the information needs of adult patients receiving procedural sedation within the ED setting. The analysis of the results from patient interviews showed an overarching need to feel safe and to trust the staff providing their care. To achieve this, staff competence and efficiency needed to be demonstrated by all individual members, but preferably within a cohesive and effective team environment. Including the patient as an active participant in their plan of care and ensuring that support and advocacy was provided was also considered vital. Specific information in a written format was not found to be valued by patients in this research. Staff participants in this research also focussed predominantly on the importance of providing safe patient care in an open and transparent manner. They demonstrated their commitment to safe practice by consistently adhering to national and international clinical practice guidelines, and conferred this to the patients and their support person in a reassuring and honest manner.

6.2 Limitations

This was research conducted within the confines of one regional NZ ED, on a small population group and sample. This reduces the ability to generalise the results to other EDs or other areas providing procedural sedation. However, many of the findings around the importance of patients to feel safe and trust staff also appear in the literature that explores patient satisfaction. Therefore, there appears to be some merit in the findings.

Patients had difficulty separating out specific sedation information from the overall ED experience, in terms of both what they required and what they were told. Therefore some evidence of less satisfactory sedation information may not have been expressed if the overall experience was successful from the patient’s point of view. This was expressed by the researcher as a phenomenon that she hoped to overcome by focussing only on the sedation information. However as the patients focussed primarily on fixing their presenting complaint, the sedation was seen as merely a means to an end. Therefore perhaps there is little value to healthcare staff in trying to separate understanding of the sedation from the patient’s entire ED experience.
Whilst the research recruited, within a small sample of participants, a good mixture of presenting complaints, ages, ethnicity and lengths of delay, there were no dissatisfied patients among the participants. It is sometimes easier to make recommendations for change based on a poor experience than a positive one, therefore had there been participants who were unhappy with their ED sedation they may have voiced different opinions.

Finally, due to the decision to exclude children from becoming research participants, no parents or carers were recruited. However, participants alluded to the fact that their support people present with the adult patients undergoing procedural sedation appeared to have differing informational needs to those of the patients. As regards the issue of written discharge information, possibly they would be the population who may value this format most. This was indicated in some staff and support person comments.

### 6.3 Recommendations for further research

As stated, it appeared that staff in the ED studied were practicing to a high standard. By doing this, and by following national and international guidelines, they were more than adequately meeting the information needs of patients. Therefore further research may be warranted to see if all DHBs in NZ adhere to the guidelines and the same standards of practice around procedural sedation in ED.

In relation to the provision of additional written information for greater understanding of procedural sedation in the ED setting, the results of this research appeared to contradict the literature on this issue. However, at the same time the research did suggest that the opinions of carers or support persons may be different from the needs of patients themselves. Therefore there may be value in researching the opinions of carers or support persons towards receiving written information. This should attempt to provide more understanding as to who most values this format of information sharing recommended as best practice in the literature.

### 6.4 Recommendations for nursing practice

Despite the limitations described above, the information provided to patient participants in this research and their subsequent satisfaction with the ED experience would suggest that overall these patients’ needs were well met. Nurses and doctors in this ED can feel confident that their adherence to national and international clinical practice guidelines contributes positively to meeting patients’ information needs. Plus, the incorporation of these guidelines into a clear local DHB policy that is followed consistently by the whole team effectively provides consistent high quality ED sedation that is deliverable within the local resources.
Nursing practice can take confidence from the implications of this research that adherence to these guidelines does appear to constitute best practice. Nurses in EDs who are not following these guidelines may find value in reviewing their practice.

Nurses who are providing this level and style of communication as part of a cohesive ED team can be reassured that patients most likely do not need to have further written information provided to them about their sedation, either during the ED experience or on discharge. The importance of all members of the team repeating and clarifying information about the plan of care to patients cannot be underestimated. Neither can the practice of proactively enabling presence of their support person during invasive procedures. Whilst patients do not need to have additional written information, the same cannot be unequivocally said for their support person, however.

6.5 Summary

In summary, the inability to generalise the results of this research because of its size and the single locality may be a drawback. However, in terms of providing examples of what patients’ value with respect to high quality procedural sedation practices and patient-provider communication, the findings are pleasing and may still have applicability to other EDs. This research shows that by focusing on providing patients with ongoing and repeated information relevant to their circumstances, the quality of ED nursing practice is enhanced.


Appendices

Appendix 1: Health and Disability Ethics Committee (HDEC) flow chart
### Applicant details

1. **Name of Applicant(s)**: Suzanne Kay Revell

2. **Position of Applicant(s)**: Master of Nursing candidate

3. **School and Faculty**: Faculty of Health & Sports Science, School of Nursing

4. **Contact Phone**: 021xxxxxxxx

5. **Supervisor(s) (if applicable)**: Dr Shona Thompson

6. **Project Title**: What information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department (ED)setting?

7. **Project Start Date and Duration**: 6/8/12 – 31/3/13

### Research Outline

2.1 **Aims/objectives/hypotheses of project** *(describe in plain language, free from jargon)*

To discover patients’ perceived information needs around ED procedural sedation, discover ED nurses’ and Emergency Medical staff’s beliefs around what information the patient needs to know about ED procedural sedation and to discover the best format to deliver these key points consistently in a way that is acceptable to all groups.
2.2 Participants (include information on the participant population, inclusion and exclusion criteria, number and age range of participants, method of recruitment and any payment or reward offered)

Inclusion: Over 18yrs, English speaking, recipient of procedural sedation in HBDHB ED 24-48hrs prior to interview, emergency medical personnel who are credentialed providers of procedural sedation in ED, emergency nursing personnel credentialed to monitor procedural sedation in ED. I may wish to purposefully select a certain demographic to better reflect the demographic make-up of the population sedated our ED

Exclusion: Does not have capacity to consent, unable to contact within timeframe, critically unwell.

Purposive sample of approximately 6-8 patients, 6-8 nursing and 6-8 medical staff as per criteria above. Potential patient participants will be provided with an information sheet following the procedure at the point of discharge by the ED nurse/doctor explaining that a researcher will call them requesting their consent to being interviewed by the researcher at a place convenient to them. All nursing and medical staff will be made aware of the research aims and objectives, potential nursing & medical participants identified from sedation log and credentialing process contacted by email/letter inviting them to attend focus groups.

Reimbursement of travel expenses for participants interviewed away from their home, light refreshments will be provided at the focus groups, otherwise no cash payments or inducements will be offered.

2.3 Explain the data collection methodology (submit questionnaires, interview / focus group questions, etc, who will actually collect the data, where will data collection actually take place.)

For patient participants, a face to face semi-structured interview will take place either at their home or ED seminar room whichever is their preference. The interview will be audio taped and transcribed by a professional transcriber. For nursing and medical staff participants, focus groups for each professional group will be conducted in the ED seminar room. They will be audio taped and transcribed. The principal researcher will undertake the interviews and conduct the focus groups.

2.4 Data analysis and storage (explain your data analysis procedures and data storage and retention plan)

Data analysed using inductive method and cross checked by supervisors to ensure trustworthiness and robustness. Identification of common themes – to all participant groups & also those unique to some individual groups but not others. Compartmentalize into pre-sedation, peri-sedation and post-sedation (including discharge) information. Identify medico-legally essential information, identify unhelpful or confusing information and identify the format deemed most useful by all groups.

Electronic data storage on password protected computer files, hard copies of consent forms in locked filing cabinet. All transcriptions will be de-identified.

2.5 How will the data be reported, and to whom? (what reports, presentations and/or publications are planned)

Thesis, available in EIT library. Feedback of findings to ED by formal presentation of research findings. Possible publication in peer reviewed College of Emergency Nurses New Zealand(CENNZ)journal and/or presentation at CENNZ conference.
3. **Will the research**

3.1 **Collect confidential, personal or financial information?**

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3.2 **Involve more than minimal risk?**

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3.3 **Involve vulnerable participants?**

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</table>

3.4 **Record research participants on audio or videotape?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>Participants will be informed at the time of consent that they will be audio taped. Transcription will exclude any references to names to ensure de-identification. Audiotapes stored in locked cabinet until research completed, then destroyed.</th>
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</thead>
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<tr>
<td>No</td>
<td></td>
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</tbody>
</table>

3.5 **Involve or impact upon Maori?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>A proportion of research participants should be Maori to reflect our patient and staff demographics. Consultation with the HBDHB Maori Health Service has taken place &amp; been approved regarding appropriateness of the research approach ensuring principals of tikanga are followed especially around invitation to participate and initial contact requesting an interview, and the wording of the questions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>

Signature of the Applicant: [Signature]

Date: 22/7/12

Principal Supervisor Signature: [Signature]

Date: 23/7/12
Appendix 2.1: EIT REAC approval letter

Reference Number 31/12

7 August 2012

Sue Revell
Master of Nursing Student
C/O Faculty of Health Science
EIT Hawke’s Bay

Dear Sue

I am pleased to inform you that your research project “What information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department (ED) setting” was reviewed by the Research Ethics & Approvals Committee at their meeting held on 27 July 2012, and formally approved for two years.

You are reminded that should the proposal change in any significant way, then you must inform the Committee.

Please quote the above reference number on all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely

[Signature]

Jennette Fifield
Secretary - Research Ethics & Approvals Committee

cc: Dr Shona Thompson

Eastern Institute of Technology
Hawke’s Bay Campus 501 Gloucester Street, Napier, New Zealand  P 06 974 8800  F 06 974 8910  E info@eit.ac.nz  www.eit.ac.nz
Postal Private Bag 1201, Hawke’s Bay Mail Centre, Napier, 4142, New Zealand
Tairawhiti Campus 290 Palmerston Road, Gisborne, 4010, New Zealand  P 06 809 08 10  F 06 809 08 29  E info@tairawhiti.ac.nz  www.tairawhiti.ac.nz
Postal PO Box 640, Gisborne, 4010, New Zealand
Regional Learning Centres: Central Hawke’s Bay, Floresmore, Hastings, Marton, Napier, Ruatoria, Tokomaru Bay, Whānau

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Appendix 3: Guidance flow chart (for nursing staff to identify potential participants)

DON’T FORGET....

SUE REVELL is researching the information needs of patients receiving procedural sedation in ED during August & September 2012.

Is this patient a potential participant for Sue’s research?

- Not suitable for the research study.
  - Do not give research information sheet.
  - Do not highlight their entry in the sedation folder log.

- Has the patient received sedation for a procedure in ED?
  - yes
    - Is the patient 18yrs or over and do they have the capacity to consent?
      - yes
        - Is the patient potentially well enough for an interview in the next 48hrs?
          - yes

Suitable participant for the research study.

Please give the sheet titled “Information for research participants” to the patient when they are close to leaving ED.

Please highlight their entry in the sedation folder log.

Sue will contact them the next day and arrange an interview if they are willing.

That is all you need to do.

Start date Monday 13th August. Sue will be checking the sedation folder daily if you have any questions, or you can email her at sueeit@gmail.com

This is not about how much or how little patients were told about their sedation, but what THEY think is important or helpful to be told. Thank you for your help with this piece of work 😊
Appendix 3.1: Information for research participants - patients

Information for Research Participants

You are invited to be part of research being done through the Hospital Emergency Department (ED) that you have just attended. Here is some information for you to read explaining what the research is about and what is involved should you agree to take part.

Research Project: The research is to address the question, ‘What information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department (ED) setting?’

About the researcher: My name is Sue Revell. I am a Registered Nurse at Hawke’s Bay District Health Board (HBDHB) working in the Emergency Department. This research is part of my studies for a Master of Nursing degree from the Eastern Institute of Technology (EIT), Taradale. I am working under the close guidance of my supervisors, Shona Thompson and Denise Bavidge.

What is the research about? The research aims to find out what information patients who receive sedation while in ED feel they need to know about it. It also aims to find out what ED nurses and doctors believe patients need to know about receiving sedation when they are in ED, and to learn what the best way to deliver this information is. You have been invited to be part of the research because you have recently had sedation in ED. Therefore you have valuable insights into what the experience is like as a patient and what information would benefit someone going through a similar event.

What will participating in this research involve? I will contact you by telephone 1 or 2 days after you were at ED. This phone call will be to confirm that you would like to participate in the research and to answer any questions you may have about it. We will also arrange a time to meet so that I can interview you to ask you questions about what information you think is important for patients receiving sedation in ED to know. This interview will take place either at your home or in a private office at ED, whichever is your preference. It is anticipated that this interview will take no more than 30 minutes. No members of the healthcare team involved in your care will be present or aware of your involvement in the research. With your permission the interview will be audio taped and later transcribed. All information that might identify you will be removed from the transcription and the tapes will be destroyed.

What are the benefits and possible risks to you in participating in this research? The information provided by you will benefit future patients undergoing procedural sedation in ED. It will be used to help ensure that the information patients receive in future has been guided by the views of patients like you with experience of the event. I believe there is minimal or no risk. You will be reimbursed for travel costs should you choose to come to the hospital for the interview.
Your rights:

- You do not have to participate in this research if you do not wish to.
- If you are a patient or under the care of students or staff from EIT or HBDHB, you can withdraw from the research at any time and this will not affect your current or future treatment or assessment in any way.
- Once you have completed the interview you have a period of one month within which you can withdraw any information collected from you.
- You are welcome to have a support person present (this may be a member of your family/whānau or other person of your choice)
- You may request a summary of the completed research

Confidentiality: Identifiable information about you will not be made available to any other people without your written consent. All interview transcriptions will be de-identified to ensure anonymity. All audio files will be stored on a password protected file until data analysis is complete and then destroyed.

The researcher will contact you by telephone to participate, but if you wish to know more about this research please feel free to contact:

Contact Person: Sue Revell (Researcher)
EIT School/Section: School of Nursing / Faculty of Health and Sport Sciences
Work phone #: (06)8788109ext2661   Email address: sueeit@gmail.com
Mobile phone #: 021xxxxxxx

Supervisor Name(s): Dr Shona Thompson
Work phone #: (06)9748000ext.6116   Email address: sthompson@eit.ac.nz

Head of School/Manager: Rachael Vernon
Work phone #: (06)9748000ext.5037   Email address: rvernon@eit.ac.nz

For any queries regarding ethical concerns, please contact:

Chair, Research Ethics Approvals Committee, EIT. Ph. 974 8000

This study has been approved by the EIT Research Ethics Approvals Committee on 7th August 2012 Reference # 31/12.
Volunteers Needed...

...to be part of a focus group in September researching the information needs of patients undergoing procedural sedation in the Emergency Department.

If you have experience of providing procedural sedation or monitoring patients receiving procedural sedation I want to hear your views.

Check your email and/or mail slot for detailed information sheets and contact Sue Revell sueeit@gmail.com to volunteer or if you have questions.
Information for Research Participants

You are invited to participate in a research project being undertaken in this Emergency Department (ED) because you have direct experience of providing or monitoring patients undergoing procedural sedation. Below is some information for you to read explaining what the research is about and what would be involved should you agreed to take part.

Research Project: The research seeks to address the question, ‘What information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department (ED) setting?’

About the researcher: My name is Sue Revell. I am a Registered Nurse at Hawkes Bay District Health Board (HBDHB) ED, and this research is part of my studies to complete my Master of Nursing qualification through the Eastern Institute of Technology (EIT), Taradale. I will be working under the close guidance of my supervisors, Shona Thompson and Denise Bavidge, at EIT.

What is the research about? The research aims to find out what information patients who have received sedation for a procedure in ED felt they needed to know. It also aims to discover what information ED nurses and ED doctors believe the patient needs to know about ED procedural sedation, and to understand the best ways to deliver these key points consistently. You have been invited as you have direct experience of monitoring patients undergoing procedural sedation and will therefore have valuable insight into what the experience is like for the patient, and what information would benefit someone going through this procedure.

What will participating in the research involve? If you are kind enough to agree to participate in this research, you will be contacted by internal mail and/or email by the researcher inviting you to attend a focus group discussion. This group will include other ED nursing staff who are regularly involved in monitoring patients undergoing procedural sedation in ED. The aim of the discussion is to find out what information you think is important for patients receiving sedation in ED to know. It will also give you the opportunity to respond to some preliminary findings from interviews with patients who have received procedural sedation in ED.

This focus group will take place in the ED seminar room and will be audio taped and transcribed later, ensuring all identifying information is removed. It is anticipated that this will take no more than 2 hours and refreshments will be provided. Your individual practice is NOT part of the research nor will it be discussed at any time. Participation is on a voluntary basis.

What are the benefits and possible risks to you in participating in this research? The information provided by you will benefit future patients undergoing procedural sedation in ED by ensuring the information they receive has been guided by patients’ views with experience of the event and the experiences of clinicians regularly involved in the event. I believe there is minimal or no risk to yourself in taking part.
Your rights:

- You do not have to participate in this research if you do not wish to.
- If you are a member of staff employed by HBDHB, you can withdraw from the research at any time and this will not affect your current or future employment in any way.
- Once the focus group is completed you have a one month period within which you can withdraw any information collected from you.
- You may request a summary of the completed research.

Confidentiality: Identifiable information about you will not be made available to any other people without your written consent. All focus group transcriptions will be de-identified to ensure anonymity. All audio files will be stored in a password protected file until data analysis is complete and then destroyed.

The researcher will contact you to participate, but if you wish to know more about this research please feel free to contact:

Contact Person: Sue Revell (researcher)
EIT School/Section: School of Nursing / Faculty of Health and Sport Sciences
Work phone #: (06)8788109ext2661  Email address: sueeit@gmail.com
Mobile phone #: 021xxxxxxx

Supervisor Name(s): Dr Shona Thompson
Work phone #: (06)9748000ext.6116  Email address: sthompson@eit.ac.nz

Head of School/Manager: Rachael Vernon
Work phone #: (06)9748000ext.5037  Email address: rvernon@eit.ac.nz

For any queries regarding ethical concerns, please contact:

Chair, Research Approvals Committee, EIT. Ph. 974 8000

This study has been approved by the EIT Research, Ethics Approvals Committee on 7th August 2012 Reference # 31/12.
Appendix 4.2: Information for research participants - medical staff

Information for Research Participants (MEDICAL STAFF)

You are invited to participate in a research project being undertaken in this Emergency Department (ED) because you have direct experience of providing procedural sedation for patients undergoing a procedure in ED. Below is some information for you to read explaining what the research is about and what would be involved should you agree to take part.

Research Project: The research seeks to address the question, ‘What information, and in what format, do patients, nurses and medical staff believe should be provided for patients undergoing procedural sedation in the Emergency Department (ED) setting?’

About the researcher: My name is Sue Revell. I am a Registered Nurse at Hawkes Bay District Health Board (HBDHB) ED, and this research is part of my studies to complete my Master of Nursing qualification through the Eastern Institute of Technology (EIT), Taradale. I will be working under the close guidance of my supervisors, Shona Thompson and Denise Bavidge, at EIT.

What is the research about? The research aims to find out what information patients who have received sedation for a procedure in ED felt they needed to know. It also aims to discover what information ED nurses and ED doctors believe the patient needs to know about ED procedural sedation, and to understand the best ways to deliver these key points consistently. You have been invited as you have direct experience of providing procedural sedation and will therefore have valuable insight into what the experience is like for the patient, and what information would benefit someone going through this procedure.

What will participating in the research involve? If you are kind enough to agree to participate in this research, you will be contacted by internal mail and/or email by the researcher inviting you to attend a focus group discussion. This group will include other ED medical staff who are regularly involved in providing procedural sedation in ED. The aim of the discussion is to find out what information you think is important for patients receiving sedation in ED to know. It will also give you the opportunity to respond to some preliminary findings from interviews with patients who have received procedural sedation in ED.

This focus group will take place in the ED seminar room and will be audio taped and transcribed later, ensuring all identifying information is removed. It is anticipated that this will take no more than 2 hours and refreshments will be provided. Your individual practice is NOT part of the research nor will it be discussed at any time. Participation is on a voluntary basis.

What are the benefits and possible risks to you in participating in this research? The information provided by you will benefit future patients undergoing procedural sedation in ED by ensuring the information they receive has been guided by patients’ views with experience of the event and the experiences of clinicians regularly involved in the event. I believe there is minimal or no risk to yourself in taking part.
Your rights:

- You do not have to participate in this research if you do not wish to.
- If you are a member of staff employed by HBDHB, you can withdraw from the research at any time and this will not affect your current or future employment in any way.
- Once the focus group is completed you have a one month period within which you can withdraw any information collected from you.
- You may request a summary of the completed research.

Confidentiality: Identifiable information about you will not be made available to any other people without your written consent. All focus group transcriptions will be de-identified to ensure anonymity. All audio files will be stored in a password protected file until data analysis is complete and then destroyed.

The researcher will contact you to participate, but if you wish to know more about this research please feel free to contact:

Contact Person: Sue Revell (researcher)

EIT School/Section: School of Nursing / Faculty of Health and Sport Sciences

Work phone #: (06)8788109ext2661 Email address sueeit@gmail.com

Mobile phone #: 021xxxxxx

Supervisor Name(s): Dr Shona Thompson

Work phone #: (06)9748000ext.6116 Email address sthompson@eit.ac.nz

Head of School/Manager: Rachael Vernon

Work phone #: (06)9748000ext.5037 Email address rvernon@eit.ac.nz

For any queries regarding ethical concerns, please contact:

Chair, Research Ethics.Approvals Committee, EIT. Ph. 974 8000

This study has been approved by the EIT Research, Ethics Approvals Committee on 7th August 2012 Reference # 31/12.
Appendix 5: Consent form - patient participants

CONSENT FORM (PATIENTS)

Project Title: What information do patients want prior to procedural sedation in the Emergency Department?

Researcher: Sue Revell

I have read and I understand the Information for Research Participants sheet for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand I am able to withdraw all of my information until one month from the interview.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree to take part in this research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I consent to my interview being audio taped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to allow my data to be used in future research projects providing anonymity and confidentiality are maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wish to receive a summary of the results</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed: _______________________________________________

Name: ________________________________________________
Signature of Research Participant’s Support Person (if applicable)

_________________________________________________

Date: _____________________

Witness: _______________________________________________

I as researcher undertake to maintain the confidentiality of information gathered during the course of this research.

Signed_________________________________________________

Dated______________________

This study has been approved by the EIT Research Ethics Approvals Committee on 7th August, Reference # 31/12.
CONSENT FORM (STAFF)

Project Title: What information do patients need prior to procedural sedation in the Emergency Department?

Researcher: Sue Revell

I have read and I understand the Information for Research Participants sheet for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand I am able to withdraw all of my information up until one month from attending the focus group

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future employment.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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</tbody>
</table>

I agree to take part in this research
I consent to my interview being audio taped
I agree to allow my data to be used in future research projects providing anonymity and confidentiality are maintained
I wish to receive a summary of the results

Signed: _______________________________________________
Name: ________________________________________________

Signature of Research Participant’s Support Person (if applicable)

_________________________________________________

Date:  _____________________

Witness:  _______________________________________________

I as researcher undertake to maintain the confidentiality of information gathered during the course of this research.

Signed_________________________________________________

Dated______________________

This study has been approved by the EIT Research Ethics Approvals Committee on 7th August 2012, Reference #31/12.
Appendix 7: HBDHB Research application approval letter

31 July 2012

Suzanne Revell  
Clinical Nurse Coordinator  
Emergency Department  
Hawke’s Bay District Health Board

Dear Suzanne

RE: Hawke’s Bay District Health Board Research Application - Reference 12/07/114

Thank you for you application to conduct research within the Hawke’s Bay District Health Board and providing the Research Office with the additional information requested to you via email on 25 July 2012.

I am pleased to advise that your application has been successful, subject to:

✓ 1. Obtaining written approval from the EIT Research Committee (as per your RAD Form)

✓ 2. Providing the HBDHB Research Office with a written copy of evidence of your consultation with Maori (it is noted you have identified consultation with the HBDHB Maori Health Service in your RAD form, however, this is not included in your research proposal)

✓ 3. Providing the HBDHB Research Office with an updated / final version of your research proposal.

Your research cannot commence within HBDHB until these above criteria have been provided to the Research Office.

Please find enclosed a signed copy of your application. At the conclusion of your research, HBDHB will require a research report (as outlined in your application).

Should you have any queries during your research, please do not hesitate to contact me during normal working hours.

Regards

[Signature]

Sally Houlston RN, BN, MN  
On behalf of the 
Research Committee
26 June 2012

Sue Revell
Clinical Nurse Coordinator
Emergency Department
Hawke’s Bay Hospital Soldiers Memorial
Omahu Road
Private Bag 9014
Hastings

Tēnā koe Sue

RE: SEDATION RESEARCH FOR MASTERS STUDIES

Thank you for the opportunity to review your proposal for the above.

I support the research you are undertaking here in Hawkes Bay. Māori health services is available to provide support to you and your participants should this be required.

I note that as part of your consent form you use the word whānau. The use of macrons is a te reo Māori standard for Ngāti Kahungunu and should be used in all written material for use within HB DHB.

Any staff member involved in conducting this evaluation should also complete the cultural perspectives training to ensure cultural competence. This can be accessed via Learning & Development.

I wish you well in your research and look forward to receiving a copy of the final report.

Noho ora mai rā

Lewis Ratapu
Kaiwhakahaere

TE WAHANGA HAUORA MĀORI
Corporate Services, Hawke’s Bay District Health Board
Omahu Road, Private Bag 9014, Hastings 4156, New Zealand—Telephone (06) 878 1654 Fax (06) 878 1655
Email: Lewis.Ratapu@hbhib.govt.nz
Appendix 9: Interview structure guide

Interview structure guide

CONTEXT QUESTIONS

I will start by asking them to tell me the circumstances that led to them requiring procedural sedation - Can you tell me about your recent visit to the ED?

From this I specifically wish to understand

- How many times the participant had received sedation for a procedure in the emergency department, - multiple or novice?
- What the participant required the sedation for - was the sedation provided for a potentially painful procedure or were they already in pain or both?
- How much time, roughly, was there between receiving information about the need to be sedated and it happening?

PRIOR TO THE SEDATION & PROCEDURE OCCURRING

What can you recall of the information you were given about what to expect during the sedation?

Can you recall who gave you the information regarding the sedation?

Did more than one member of staff provide you with information about what was going to happen regarding the sedation?

If so can you tell me what profession they appeared to be?

What information, if any, was more helpful to you than others?

What information, if any, was confusing or unhelpful?

Did you feel prepared for what was going to happen and what to expect?

AFTER THE SEDATION & PROCEDURE OCCURRING

Can you recall any information you were given about what to expect immediately after the sedation?

Can you recall any information you were given about what to expect /what to avoid in the following few days after the sedation?

Can you recall who gave you the information regarding the sedation?

Did more than one member of staff provide you with information about what to expect and what to avoid after sedation?
If so can you tell me what profession they appeared to be?

What information, if any, was more helpful to you than others?

What information, if any, was confusing or unhelpful?

Did you feel prepared for what was going to happen and what to expect?

**ON REFLECTION, NOW IT IS OVER**

If you, or someone close to you, was to go through a similar experience what information do you feel would be essential to tell them?

Was there any information that you would have liked to have known about the sedation that you don’t recall being told about?

What ways of presenting this information to patients do you think would be best?

Is there anything else you would like to add?
Appendix 10: Focus group structure guide

Focus group structure guide

Introduction – of myself, the research aims, confidentiality, ground rules, audiotape, transcription and de-identification

Brainstorm ideas from staff about what information they like to give to patients before sedation in ED.

Possibly try to group these visually while they are volunteering info

eg pain, procedures, pre-sedation, post-sedation/discharge, people involved, privacy/dignity, medico-legal.

Get them to discuss who should give what info. Expand on any issues raised. Discuss support person presence and written information.

Maybe then feedback comments from patient interviews and ask them what they thought.