

**MASTER OF NURSING
(BY RESEARCH)**

**THE 48 HOUR PATIENT – WHO
REAPS THE REWARDS?**

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DECLARATION

I, **ROSEMARIE CROZIER**, declare that the Master of Nursing by Research thesis entitled “THE 48 HOUR PATIENT – WHO REAPS THE REWARDS’ is no more than 60,000 words in length, exclusive of table, figure, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the ward of any other degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signed:

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Rosemarie Crozier

Date:

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ABSTRACT

The purpose of this evaluative case study was to evaluate the effectiveness of a 48 hour Medical Unit in relation to Patient Satisfaction, Patient Care, Nursing Staff Job Satisfaction and the Average Length of Stay for Patients' Pre and Post a Rapid Assessment Medical Unit's (RAMU) inception. The study used a combination of Patient Satisfaction Survey's, Interviews, and data of the average length of stay of patients pre and post RAMU. This report aims to provide a comprehensive description of the research process and the results obtained from the collection of data throughout this research project.

An evaluative case study using Yin (2003), as a framework of this study was deemed appropriate, as no research to date had been conducted on 48 hours Medical Wards, because of their uniqueness. A case study allowed for "multiple sources of evidence gathering", thus ensuring that the findings to this study are more likely to be accurate if based on several different sources of information.

Despite the study's limitations, the results to this study were surprisingly supportive and positive of those patients who had participated in this research project. Nursing Staff on both wards that participate in the interviews had a positive attitude in relation to how well RAMU is functioning.

The findings indicate there are a few minor changes that are required and further research is recommended, however the hospital and staff have managed to find a formula that works extremely well in providing patient satisfaction, patient care and job satisfaction in a short period of time.

PROLOGUE

AN EVENTFUL RESEARCH PROJECT

In April 2001 a RAMU was opened at a hospital with the goal to alleviate the pressure of increased presentations and admissions, and bed blockages placed on the Accident and Emergency Department (A&E), mainly during the winter months. This unit was devised as a quick turn over unit with patients only staying for a period of 48 hours or less before being either discharged home or admitted to an appropriate medical ward. Due to the researcher's involvement at the time of the opening of RAMU it seemed appropriate that a research project should be conducted on such a ward to evaluate the desired outcomes.

At the commencement of this research project, the aim was to collect quantitative data on approximately 100 participants using patient satisfaction surveys, with a projected return of approximately 50 per cent. This did not seem unachievable at the commencement of the research project due to the high turnover of patients that pass through RAMU during a weekly period. From this return, it was hoped that 10 participants would agree to a follow up one-on-one interview about their experience on RAMU.

However things did not go to plan. During the data collection process, the hospital commenced its own patient satisfaction survey and participants were reluctant to take part in two patient satisfaction surveys. Many of the long-term chronically ill patients would be readmitted to hospital following a short period of discharge home, particularly in the winter period. They were not asked to participate in the research project if they had already agreed to do so to ensure that repetitious answers were not given, thus aiding to produce a non bias outcome.

After nearly eight months of data collection only 30 participants had returned their patient satisfaction survey, five of who agreed to participate in the interview stage. However, upon contacting these participants only one agreed to participate in the interview. Three stated their intention of no longer wanting to participate and the other participant had passed away. The only participant who wished to participate was an elderly widow, who throughout the course of the interview wanted to only 'please' the interviewer.

As a result this section had to be omitted from the original research project, much to the disappointment of the researcher, as this was seen as a major contributing factor to the research project. The aim was to follow up with the participants, some of their answers to the satisfaction survey for further clarification and it was also hoped that they could contribute by adding to any changes that may be need help RAMU function more effectively.

It must be stressed that the majority of patients that pass through RAMU are elderly with the over 70's age group contributing to 90 percent of patients. Most of these patients have chronic long-term medical conditions comprising of more than one medical condition such as, Chronic Obstructive Airways Disease combined with heart problems and diabetes for example, which are often exacerbated over winter, hence the rebound rate of such patients is extremely high.

After months of data sorting, gathering and analysing the research project has finally been completed, with an unexpected result.

Chapter 1:

INTRODUCTION AND BACKGROUND

INTRODUCTION

Title

The title of the study is:

“THE 48 HOUR PATIENT – WHO REAPS THE REWARDS”?

As the title suggests, “who does reap the rewards?” Patients, families, medical staff, hospitals, or government in outcomes for patients admitted to a 48 hour medical unit. Four main areas form the basis of this evaluative research study, these being, patient satisfaction, patient care, nursing staff job satisfaction, and average length of patient stay post and pre admission to a RAMU. Each of these four areas will be extensively evaluated throughout this thesis, using an evaluative research method, incorporating quantitative and qualitative methods.

BACKGROUND TO THE RESEARCH

As the Australian population lives longer, with the over 65 years making up 12.1% of the population, (Australian Bureau of Statistics 1997, cited in George and Davis, 1998, p.282), chronic medical complications and illnesses also increases. By the age of 75 years 65% of the population will suffer from one or more chronic illness such as Chronic Obstructive Airways Disease (COAD), Acute Myocardial Infarction and Diabetes, of which two thirds will require hospitalisation, thereby generating a higher proportion of bed demand within hospitals (George et al, 1998, p.283).

Winter and seasonal changes bring an increased number of patients with exacerbation of chronic medical conditions into hospitals. This influx of patients over the winter months increases the number of hours that patients have to wait to receive medical treatment, thereby creating a ‘flow on’ effect throughout the rest of the hospital. It adds increased pressure on A&E staff trying to meet the medical and physical needs of those patients waiting for treatment. It creates bed shortages or ‘bed blocks’ within the hospital, as there is not enough beds to deal with the increased volume of patients requiring hospitalisation, hence patients may have to wait anywhere up to 12 hours or more for a hospital bed. This practise results in Government fines being imposed on the hospitals for not meeting the required patient stay in A&E of less than 12 hours to obtain a bed.

With A& E Departments overflowing with patients awaiting hospital admission, hospitals cannot receive patients admitted via ambulance (except in extreme emergencies), this results in ambulance by-passes. Therefore, patients will be transported to a hospital, not necessarily the closest available hospital. This again imposes Government fines on the hospital for such practice.

Purpose

With the focus today on hospitals being able to 'fast track' patients to help alleviate the pressures on A&E, and with higher expectation of better delivery of quality health care, new means of providing faster health care are being trialled and implemented. Faster approaches to delivering health care without compromising the quality of care provided is through the introduction of Short Stay Wards, Acute Medical Wards. Patients that require admission into hospital stay for a maximum of 23 hours or less, and receive the same standard of care of those who may need a longer stay in hospital.

The purpose therefore of this study was to evaluate the introduction of RAMU to a hospital and the overall impact that such units have on patient care within a 48 hour time frame.

Aims and Objectives

There are four main **aims** which were the focus points of this study:

1. the average length of stay of patients pre and post RAMU,
2. patient satisfaction, of their stay and treatment whilst in hospital,
3. patient's own evaluation of their care, whilst on RAMU and on a Medical Ward, and
4. nursing staff job satisfaction on both RAMU and a Medical Ward.

Specific study **objectives** were to:

- a) Evaluate the average length of stay for patients in hospital;
 - i) prior to the opening of RAMU, and
 - ii) after the opening of RAMU.
- b) Present an in-depth understanding of patient's views, opinions and expectations of RAMU,
- c) Identify any problems, issues or concerns that patients have encountered during their stay on RAMU,

- d) Investigate any issues, problems or concerns that Nursing Staff on RAMU and other Medical Wards have in relation to patient care, and patient outcomes since RAMUs,
- e) Uncover any concerns that nurses of other Medical Wards have in relation to job satisfaction since RAMUs' operation,
- f) Make recommendations, based on data collected, for possible future RAMUs.

Emergence of a Rapid Assessment Medical Unit - RAMU

A way of combating the escalating number of patients presenting to an A&E was the inception of a 20 bed, 48 hour RAMU. It began operation on the 26 April 2000.

RAMU is unique in its design, as it is derived from many concepts of similar units/wards that currently exist. The structure of RAMU comprises of a twenty-bed ward, which is located within the main structure of the hospital and is unlike, other 'observation units' that operate within the same parameters as an A&E.

Essentially RAMU is designed to meet the needs of patients with acute/chronic medical conditions (those requiring non-surgical intervention). However, when and where necessary, a patient who may require any form of surgical, neurological or cardiac intervention will be admitted to this unit when there are normally no beds available within the hospital. Inevitably, there will be times when 'bed blocks' occur within the hospital and patients cannot be transferred to their 'parent ward' within the allotted 48-hour period. In these situations patients remain at RAMU until a bed within the hospital becomes available or they are discharged home.

Model of Health Care Guidelines for RAMU

The main goals of RAMU is to provide medical patients admitted to the Hospital (via A&E) with a model of health care that provides:

- a) Prompt clinical management and organisation of discharge plans prior to a patients transfer to 'parent wards' and/or discharge to home within a 48-hour period,
- b) To deliver:
 - i) Rapid diagnostic evaluation;
 - ii) Risk assessments;
 - iii) Symptom relief; and
 - iv) Patient management plans.

(Thus providing a valuable link between Medical Staff and Allied Health Professionals in formulating plans and guideline within the set item frame of 48 hours, for patients, relatives and/or carers),

- c) Improved access through A&E for medical patients,
- d) Improved patient outcomes and therefore shortened lengths of hospital stays,
- e) Reduced re-admission, and
- f) Reduced bed blocks.

(Hospital Proposal Implementation of RAMU, March 2000).

Essentially the ultimate aim of RAMU is to develop and a deliver a health care system that is capable of 'fast tracking' medical patients, helping to elevate the burden placed on hospitals, in particular A&Es, whilst still being able to provide care that the patient is satisfied with.

Delivery of Health Care on RAMU

When a general medical patient is admitted into hospital via A&E, they are assigned to one of two medical units. This unit will treat the patient until they are discharged home or place of residency such as a nursing home or hostel. The two Medical Units each comprise of a Medical Consultant, Medical Registrar, and Interns. Upon arrival to RAMU, the patient is greeted by a mixed multi-disciplinary team of Clinical Nurse Specialists, Clinical Co-ordinators and Registered Nurses Divisions 1 & 2 and Allied Health Professionals who closely monitor acutely ill patients, initiate any ECGs, pathology requirements, x-ray and physiotherapy.

Essentially, all diagnostic requirements and investigations, Allied Health Services/interventions are initiated and organised prior to the patient being transferred to their 'parent ward' or discharged home within 48 hours. The nursing staff organise expected dates of discharge for patients and the implementation of any services required by the patient prior to discharge such as Meals on Wheels and the Royal District Nursing Service. They organise any services the patient may be ordered whilst in hospital such as physiotherapy, a dietitian, speech pathology and social workers with the allied health team.

SIGNIFICANCE OF RESEARCH

This study of a 48 hour unit will allow patients, carers, and nursing staff the opportunity to express their experiences, views, concerns, and any changes that they feel may be of benefit to RAMU and the delivery of better health care. The research also aims to compare and evaluate if there are any changes in the average length of stay of hospital stays for patients, pre RAMU and post RAMU.

The inspiration to research and evaluate this “new mode of health care” came from having the opportunity to work in the RAMU since its inception in April 2000. From this nursing experience many questions and issues were raised by families, and nursing staff. Given the opportunity to evaluate RAMU in depth, it is hoped that the many questions raised can be answered and recommendations viewed and challenged.

THE THESIS

This thesis is an evaluative case study containing seven chapters in which descriptions of each of the structures of the study are presented. A summary of the remaining chapters is as follows:

Chapter 2: Literature Review

The purpose of this study is to use an evaluative case study approach to evaluate patients'/carers/and nursing staffs' perceptions, understanding and opinions, on the quality of patient care, patient satisfaction and nursing staff job satisfaction since the inception of a RAMU. Therefore the following literature will be reviewed:

- Short Stay Wards and RAMU,
- Patient/Nursing Care,
- Patient Satisfaction,
- Job Satisfaction,
- Evaluative Research Methods, and
- Average Length of Hospital Stays - The older person.

The first section of the literature review provides an overview of the objectives of “Short Stay Wards/Medical Acute Wards” how they function and the benefits. It will also clarify the function of a RAMU any similarities/benefits that exist between Short Stay Wards and RAMUs. The second section will present literature that is related to what is ‘patient care’ and provide the definition of ‘care’ in today’s health system the history of ‘nursing and today’s perceptions of nursing care. The third section will address ‘patient satisfaction’ how it is defined and how it is measured. The fourth part will examine ‘job satisfaction’. How is it defined and does it have an effect on staff morale, patient recovery time, and is there added stress in the work place, the average length of hospital stays. The fifth part will determine what is the average length of stay of patients and how is it measured and the impact the ageing society has on our health care system. Finally, the fifth part will review methodologies of an evaluative case study.

Chapter 3: Method of Research

Chapter 3 provides a detailed and systematic account of the methods, concepts and procedures involved in this research project. The literature review covers the various types of evaluation methodologies in the previous chapter.

The first part of Chapter 3 focuses on Patton's method of utilisation-focused evaluation and combines Wadsworth (1997) approach to evaluation. The remaining sections of Chapter 3 focus on describing the process and tools in both the qualitative and quantitative phases of the research.

Chapter 4: Quantitative Results and Findings

Two sets of quantitative data were collected during this study. This chapter reports on the first set of data collected, retrospective survey sampling. The data collected determined the average length of stay of patients both post and pre RAMU's inception. The results are present in a pie graph with the respective findings.

This chapter also presents the findings of the patient satisfaction survey results of this research in the form of bar graphs. It covers the patient's progress through hospital from the time they arrive in the A&E until the time they are either discharged home or transferred to another ward.

Chapter 5: Discussion – Quantitative Findings

This chapter presents the results of the patient satisfaction survey that was conducted and aims to present these findings in relation to patient care and satisfaction.

Chapter 6: Interpretation of the Qualitative Findings

This chapter presents the interpretation of findings of the qualitative data collected. The first section -patient interviews, looks at the problems encountered whilst trying to organise and conduct these interviews and the only patient interview that eventually occurred. The second section – focused group interviews, pertains to interviews conducted with nursing staff on both RAMU and a Medical Ward. It is divided into three different sections focusing on three main topics, patient care, patient satisfaction and job satisfaction.

Chapter 7: Conclusion

The final chapter of the thesis describes the outcomes of the research study which evaluated the effect that RAMU has on patient care, patient satisfaction, job satisfaction, and the average length of stay of patient pre and post RAMU's inception.

This chapter is presented in the following way: methodology, limitations to the study, problems encountered, future research, recommendations and conclusion.

CONCLUSION

This chapter provides a background into the aim, design and reason for conducting this study. Presented in the next chapter is a literature review of the areas to be addressed and evaluated in this study.

Chapter 2:

LITERATURE REVIEW

INTRODUCTION

As previously stated, the purpose of this evaluative case study is to examine and evaluate in depth the ramifications that a RAMU produces. Literature examined during the course of this study was sourced through a variety of research and nursing books, Nursing and Medical Journals, the internet, Government Health Departments and knowledge and experience whilst working on a RAMU, with the emphasis of obtaining data from 1990-2006, where possible. Due to the unique function of a RAMU literature that is available only focuses on Short Stay Wards or Wards that patients only stay for a maximum of 23 hours.

OBSERVATION UNITS OVERSEAS

To date there has been no research conducted on a 48-hour medical unit, as it is new in concept and design and has only been operating since April 2000. Research to date only focuses on Acute Medical Wards, Short Stay Wards or 23 hour or less wards.

Throughout the United States of America and the United Kingdom for the past twenty years, A&Es have been dealing with overcrowding with the introduction of 'observation units'. Today a variety of terms are used to describe 'observation units' including terms such as 'rapid treatment units', 'short stay observation wards', 'emergency department observation units' and 'medical acute units'. However, they are similar in concept, design, benefit and projected patient outcomes and can be broken down into the following categories:

United Kingdom: Medical Acute Units

In the United Kingdom, Medical Acute Units or MAUs have been operating since the mid 1980's to tackle the increasing pressure faced by A&Es, due to the escalating numbers of patients presenting with increasing emergency admissions and the reduced number of acute medical inpatient beds available. (Jervis, 2000, p. 42-43). At Stoke-On-Trent in the United Kingdom, a Medical Acute Unit was developed and operates along side the A&E. This unit treats patients with chronic and acute medical complications that have been referred by their local General Practitioner or from the A&E. Patients are not nursed on beds, but rather, on stretcher trolleys. The average stay of a patient in this unit is generally less than three hours but no more than four hours, before they are either discharged

home or transferred to a ward for ongoing treatment. (Jervis, 2000, p. 44). The principle function of a MAU according to Wood (2000, p.44) is to “triage medical patients rapidly – and admit those who require hospital care”.

United States of America: Observation Patients/23 Hour Patients

In America, specialised observation beds or services were implemented as far back as 1960. They were staffed with full time emergency physicians. These observation beds were designed to evaluate and observe patients to determine whether a hospital admission was necessary. Generally patients were observed for a short period of time then discharged (Carlson, Shahinnpour & Zonsius, 1995, p.24).

Over time, observation beds/services have progressed and have now evolved into what is termed as '23 hour patients' or 'observation patients'. These patients are not 'admitted' into hospital, but however are monitored in observation units for a period of no more that 23 hours. This enables doctors and hospitals to determine those patients who could ideally benefit from a hospitalisation verses those who are able to receive treatment within the observation unit and then return home. (Carlson et al, 1995, p. 24).

Observation beds allow for patients to receive diagnostic evaluative workups relevant to their medical condition. This is medical treatment that requires close monitoring but without the high intensity services required as an inpatient. Therefore, allowing the patient to be discharged from hospital with a time frame of 23 hours or less. Dunkle & Windsor, 1999, 38-42), addresses the benefits of rapid treatment units, stating it allows for, rapid diagnosis and treatment before, or in lieu of inpatients admission. It is used when the patient's condition is expected to respond quickly to interventions, thus eliminating any reason for admission. Hence, the expected outcome is to be achieved with 24 hours or less (p. 38-42).

United Sates of America: Holding Areas/Closed Patient Units

Two hospitals located in Texas and on Rhode Island in America use 'holding areas' and or 'closed inpatient units'. Essentially these are used for stable patients, that is, those who don't require monitoring or active treatment during their wait for an inpatient bed to either a surgical or medical ward. These patients wait for approximately 5-23 hours before being admitted to the appropriate ward. 'In-patient' care for these patients is on going and it addresses their needs ranging from dietary intake to wound dressing changes and is inductive to inpatient routine. This allows for the patient to be familiar with the ward routine that he/she will be transferred to. Thereby reducing the patient's anxiety level and allowing for an easy transition into the hospital environment. (Zimmerman, 1996, p.307-310).

Brisbane Australia: Holding Areas

Since 1981, the Royal Brisbane Hospital has had a similar concept of 'holding areas' within A&E, however it is entirely separate from the accident and emergency. The holding area is used only for treating patients in a stable condition, or who are waiting for admission into hospital. Conditions treated within this area are of non-critical

conditions such as minor injuries, those waiting scans and asthma treatments. The length of stay is less than 24 hours. However, if patients require an inpatient bed, they are cared for, by the unit's medical staff, to which they will be admitted. (Zimmerman, 1996, p. 307).

BENEFITS

In all the literature available to date, one major theme emerges as the main driving force for the implementation of such 'Observation Units', and that is, the monetary gains and benefits to the hospital, governments and the administrators. Carlson et al (1995), states that, cost containment has become the main driving force behind health care systems. The use of observation beds is increasingly appealing and prudent to hospitals to help in such cost containment. Observation beds, enables the doctors and hospitals to determine those patients that may require hospitalisation and those who can receive treatment in a short period of time and return home (p.23-24). Roberts and Graff (2001) remark that the, "overall effects of observation units are cost saving as it avoids the costs associated with hospital admissions thus dramatically reducing the costs to the healthcare system and reducing the expenditures per patient treated"(p.20). There is improved patient quality of care and patient satisfaction, which in turn is linked back to the monetary benefits and gains to the patient. They further go on to state that, observation units improve the quality of patient care by identifying patients whose diagnosis may have been missed after an A&E evaluation.

NEGATIVITY OF OBSERVATION UNITS

A study conducted by Sinclair & Green, (1998), on patients admitted to an inpatients ward and patients who could have benefited from an observation unit admission instead, found that; observation units reduces hospital costs, as fewer support services are required, fewer diagnostic tests and investigations are carried out and doctors discharge on an hourly rate rather than on a daily rate. They also argue against observation units because they do not improve patients quality of care as that without strict admission and discharge policies, continuity of care is poor, subsequently increasing hospital admission rates and that observation units simply delay the decision making process (p. 670-674).

NURSING CARE

Defining Care

Care according to the English Collins Dictionary means, “to look after or provide for” (2001, p.8). To be able to clearly define what ‘nursing care’ is we must look back at the evolution of nursing through the influence Florence Nightingale had on health care of individuals and those who have influenced nursing today through their theoretical perceptions of nursing. This chapter will provide a brief insight into the evolution of the concept of ‘nursing care’ from Florence Nightingale in the 1880’s to renowned nursing theorists from the 1950s, 1960s and 1990s who have advocated what nursing care is or should be.

The Beginning of Nursing

Florence Nightingale in 1860, believed that nursing practice reflected the changing needs of society and wrote, “the role of nursing as having charge of somebody’s health based on the knowledge of how to put the body in such a state to be free of disease or recover from disease”. (Potter & Perry, 1993, p.8).

Florence Nightingale in 1853 brought major reforms to the care that soldiers received at the Barracks Hospital in Scutari, Turkey. She introduced basic nursing care such as hygiene, sanitation and nursing practice and thus reduced the mortality rate from 42.7% to 2.2% in a six-month period. (Potter & Perry, 1993, p.8). These early factors in improving ‘human basic needs’ implemented by Nightingale could be argued that it laid down the foundation of the beginning of what is termed today as ‘nursing care’.

Theorists Perspectives

Throughout the history of nursing, there have been many theorists that have contributed to the notion of ‘models of nursing practice’. It is important to know what each patient places on their individual aspect of care, failing to understand what patient expectations of care are may in fact impede attempts to improve better patient outcomes.

In 1952 Peplaus, for example focuses on the individual, nurse and the interactive process, with the result being the nurse/client relationship. The goal of the nurse is to educate the client/family and help the individual achieve a ‘mature personal development’ therefore, the nurse “becomes” a resource person, counselor or surrogacy role model. As the relationship develops, the nurse helps the individual to identify problems and potential solutions. (Potter & Perry, 1993, p.10)

In 1968 Johnson, focuses on how the individual adapts to their illness and how actual and potential stressors affect the individual health and their ability to adapt. Therefore the goal of nurses is to reduce stress so the client can move easily through the recovery process. (Potter & Perry, 1993, p.12).

What is Nursing Care Today?

In the past the principle role of the nurse was to provide care and comfort for individuals. Today nurses' roles have expanded to include being health promoter, caregiver, decision maker, client advocate, manager, rehabilitator, comforter, communicator and teacher. (Potter & Perry, 1993, p.23-24). With so many 'roles' that nurses have to undertake today in nursing, it is often difficult to deliver care that patients and their families expect. It is often therefore difficult to deliver nursing care in a fast revolving hospital environment.

According to Larrabee and Bolden, 2002, nursing care comprises of five major themes in the nurse/patient relationship:

1. **Providing for my needs** including taking care of me, monitoring my progress, responding to my requests, providing pain relief or comfort, giving accurate information and providing a pleasant environment (p.36).
2. **Treating me pleasantly.** Treating me with respect, having a positive attitude towards patients, treating me the way you would like to be treated (p.37).
3. **Caring about me.** Being concerned about the well being of patients, being there for me, getting to know me, spending time with me and being supportive (p.38).
4. **Being competent for me.** Knowing when and how to perform and process accurate knowledge and skills in providing me with the optimum level of care (p.39).
5. **Providing for prompt care for me.** Being prompt and punctual, responding, answering when I call (p.40).

Research conducted by Young (1996), cited in Dunkle and Windsor (p.15), on the comparison of patient and nurse perceptions on patient care found gaps between patients' actual values and what health professionals perceives as patients' values. Family and patients want health care professionals to be attentive and responsive to their needs. They do not want to feel that, "nobody cares or that no one is listening to me"(p.20). Patients expect responsiveness, accessibility and value for their money and when these three components are removed, patients feel they are not getting value for their money (Cunningham, 1991, cited in Larrabee & Bolden, p.47-49).

To be able to address and capture the perspectives of both the nurse and the patient is important in ongoing nursing care. The perspective of the patient how care should be provided to be consistent with their expectations, while the perspective of the nurse addresses the way care is provided (Lynn, & McMillen, 1999, p.66). Without a doubt, nursing care doesn't happen by accident. It results in careful planning and attention to detail, it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives (Potter and Perry, 1993, p.69).

Conclusion

The delivery of health care is influenced by political decisions and factors. All levels of government have an impact on the affect of how health care is delivered and who pays for it. Ultimately, it is the consumer who must adjust to changes with in the health care system.

In the past care was measured by a patient's perception and individual experience on such things as empathy, compassion, trust and communication, now the emphasis is placed on cost containment, and maximum utilisation of resources. Nurses will be pushed to the limit to redesign and implement a care delivery system that increases productivity and produces more effective clinical outcomes for patients (Messner and Lewis, 1996, p.22).

SATISFACTION

Definition of Satisfaction

While the healthcare system constantly changes at an accelerating rate, the basic concepts of caring, compassion, competence, and patient satisfaction assumes a greater significance to all those involved within the health care system. Above all, the delivery of "patient satisfaction" is each health care person's primary focus and responsibility at all levels of provision, as the patient is the end user who experiences the health care systems first hand (O'Malley 1996, cited in Larrabee & Bolden, p.5-7).

Satisfaction means, 'the pleasure obtained from the fulfillment of desire. Something that brings fulfillment'. (Collins English Dictionary, 2000, p.690). Within a health care setting, satisfaction maybe perceived by a patient as, the degree of ideal care and the perceptions of actual care received. (Messner & Lewis, 1996, p.2). It is according to O'Malley, (1996, p.216) a personal perception held by an individual patient, independent of other patient's, about your caring, care, attitude and service towards them.

Nurses Role in Patient Satisfaction

Patient satisfaction is a combination of diverse reasons. A variety of 'little things'; but to the patient a 'little thing' can be 'big things'. Having patience and finding time to be with a patient in the every changing array of the health care system is a hard thing to achieve. But we must not forget patients are our work, not an interruption to our work. Success = quality and pride. We cannot have one without the other. We would not have nurses if we did not have patients. (Messner & Lewis, 1996, p.212).

Patient satisfaction comes down to the 'ordinary' human virtues of communication, sensitivity, respect, dependability, trust and personalised service (Messner & Lewis 1996, p.3). If you know what patients want then you are better able to adjust to those expectations and increase the likelihood of 'patient satisfaction'.

Nurses have the most critical role to play within the healthcare setting, as they are the largest workforce and the most visible of the healthcare professionals the public sees. Nurses play a key role and have the greatest influence on patient outcomes, as they are the ones who spend the most time and contact with patients and are in a position to change the care that they render and promote a more satisfying patient experience. (Houlster, 1999, p.43-50).

Hence the public tends to judge 'satisfaction' with the care that nurses provide at the time of admission to hospital.

If patients are dissatisfied with the care they receive in a particular hospital, they may neglect follow up care, choose to go to another hospital, and pass on their negative experiences to other family members and friends. Houlster (1999), goes on to say, that negative perceptions may have an impact on the economic stability of a hospital and this may in fact effect services offered to patients as well as employment conditions. (1999, p.45). Therefore, it is fair to argue that nurses have the greatest influence on patient outcomes. They alone are in a position to change the care rendered to patients, promote and encourage a more satisfying patient experience, and promote positive patient perceptions of a hospital and its staff.

Defining "Patient Satisfaction"

Much research has been conducted on what patients believe as being 'satisfactory care' delivered to them during their stay in hospital. Constant themes emerge from research conducted (Houlster, 1999).

- a) **Communication:** Listening to the patient's concerns, issues and questions is one way nurses can learn a lot about the patient. It demonstrates genuine concern and allows for a one-on-one relationship with the patient. Better communication also leads to improved clinical outcomes (p.43).
- b) **Education:** Allowing the patient to actively participate in their treatment, gives the patient more control and produces a more positive outcome. Giving the patient and families easy to read information and instruction on their treatment helps to ease the stress of their stay in hospital. Allowing the patient and family time to ask questions and providing education increases the likelihood that patients will adopt any recommendations suggested to them by health professionals (p.45).
- c) **Presence:** Being there for your patients. The acceptance of people as individuals communicates volumes about how much we value them. Acting as a patient advocate in times of need, responding to a call bell quickly, spending a minute to hold a hand and give comfort when needed. These are what patients' value the most (p.46).
- d) **Autonomy & Respect:** What nurse's say to a patient is as important as what they do for them. The best nurses are the ones who view the patient as an individual. Patients are dissatisfied with 'one size fits all' health care that really doesn't fit anyone's needs. Above all respect and common courtesy are the most important any relationship. Respect is the core of every relationship (p.47).

- e) **Professional Knowledge and Skill:** Patients expect direct and immediate answers to any question they ask. They don't want untrained nurses operating equipment or conducting procedures on them. Patients want to be nursed by those who are 'up-to-date' with the latest technology and are well informed (p.49).

Nurses today play a key role in the healthcare picture and have a major impact on an individual's health outcome whilst in hospital. As nurses are the most numerous visible group of the healthcare profession, the public tends to equate satisfaction with care that nurses provide. (Houlster, 1999, p.50).

Conclusion

As a result of the ever-changing healthcare systems, hospitals and their employees continually face many challenges while trying to achieve their primary goal, of providing the highest quality of care, with the best possible outcome to all patients. (Dunkle & Windsor, 1999, p.38). Health care will no longer be quantified by strict, biophysical parameters such as how a body system responds to treatment. Rather, it will also be assessed by individuals with regards to the process and product of healthcare in improving their overall quality of life. (Messner & Lewis, 1996, p.21).

NURSING: SATISFYING PROFESSION?

Being a nurse in today's fast-paced, demanding impatient settings is grueling, physically exhausting, mentally and intellectually draining. As the role of nursing rapidly changes to meet these increasing demands placed on hospitals to improve patient outcomes, does the art of caring for patients simply become a chore, or is it still for the 'love of the job'? Does 'fast tracking patients' and having all diagnostic procedures performed by one medical unit place added stress on nurses of that ward? Are nurses from other wards missing out on performing essential nursing skills and are therefore left to perform "basic nursing care" of patients? Does job satisfaction exist in such climates, but more importantly, is there a standard of care and satisfaction for patients and their families?

Job satisfaction, according to Neubauer, 1996, (p.7) means, "enjoyment in one's job, ability to do quality work, adequate time to meet task requirements, and adequate ability to identify task requirements. Job satisfaction usually includes a sense of pride and a sense of accomplishment".

Job satisfaction in nursing emanates from a wide range of issues, implementing nursing care with, having the appropriate and up to date equipment. Nurses being recognised for their achievements, independent thinking and decision-making, the atmosphere of the working environment i.e. the communication between allied health professionals. The care and support from their working colleagues and managers, flexibility in working hours and the opportunity for ongoing education, on the job training, and more importantly from feedback from patients and family members. (Huey-Ming, & Ketefian, 2000 p.40-42).

Aiken & Patrician (2000) was prompted by inpatient hospital nursing and its affect on patient care in hospital to conducted research on the characteristics of professional nursing practice environments. The work environments affects nurse satisfaction and turn over, which in turn influences the organisation cost of replacing nurses, thus establishing a link between satisfied nurses, satisfied patients, and better patient care. Aiken & Patrician (2000), go on further to say that nursing-patient outcomes are affected by the environment in which care is delivered. When nurses are given authority in line with their responsibility, autonomy, and control over patient care resources, they are in a better position to establish positive relationships. Hence these factors influence better patient-nurse outcomes.

Nurses appear to regularly carry out tasks which are more appropriate to be carried out by domestics, social workers and doctors. This is not only irritating to the nursing staff; the time spent is detracted from patient/nurse time. It means less time to spend with patients and the added stress of carrying out duties of others. So it is not surprising that many nurses feel their skills and talents are being under-used. Similarly, nurses have to carry out so many and such a range of tasks which are not central to nursing care, may produce real difficulties in maintaining standards of patient care. In simple terms understaffing leads to the deskilling of nursing (Mackay, 1989, p.65).

Beaudion & Edgar (1994, p.107), re-enforces Mackay argument by stating that nurses face many daily 'hassles' that affect their work tasks that are not officially related to nursing duties. These problems included such topics as working conditions, staffing skill mix, managerial/administrative and operational tasks and the environment. These problems are often representative functional tasks necessary to delivering patient care but often are not tasks that are officially assigned to nursing.

Nursing is a difficult and stressful job at the best of times. Stress according to Mackay, (1989, p.65-71), comprises of numerous components. These include staff shortages, the level of responsibility, dealing with death and the dying, patient's relatives, coping with unpredictable patients, and being responsible for patient's well-being. Staff attrition creates additional operational costs in the recruitment and orientation of new staff. In addition to cost consideration, staff vacancies impact on the morale of senior staff who are asked to work short or extra shifts, and to train newly hired staff. Staff burnout is often the result.

A nurse's job satisfaction is increasingly being shaped by their position within an organisation. As a result, pressure and stress is often associated with; new roles, role conflict, lack of job security, 'tight' resources, using new technology, a perceived lowering of standards of patient care, coping with increased amounts of paperwork and the experience of working in a rapidly and constantly changing environment. Thus nurses must now perform a balancing act of having to deal with increased internal conflicts, responsibility for providing an effective, optimal staffing establishment at the lowest possible cost, accountability for care and its documentation and bureaucratic pressure to assess and effect a faster turnover of patients, prior to earlier discharge. (Tovey & Adams 1999, p.150).

Patient outcomes are measured by the effectiveness of hospital care, but more importantly, are the effects of hospitals on the staff they employ. High levels of stress, staff dissatisfaction and patient dissatisfaction associate

with hospitals having a high turn over of nursing staff. Ultimately, you will never have patient satisfaction without employee satisfaction. (Costello, 2001, p.8)

AVERAGE LENGTH OF STAY (ALOS)

ALOS – The Ageing Population

The ALOS is the most common quantitative performance indicator to measure the effectiveness of discharge planning. However, as the population ages the rise in the percentage of older people requiring treatment and care increases. At present patients over 70 years of age use more than 46 per cent of all multi-day stays. Policies designed to shorten lengths of stay in hospital and to maximise throughput in hospital beds can have adverse consequences for older patients, who on average take longer to recover from surgery or illness and who often present to hospital with co-morbidity medical problems. (Victorian Government of Human Services, 2003, p.x).

As people get older, changes to their physical and sometimes mental condition mean that they access and use health care services more frequently and for longer periods. Older people are more likely to have a number co-morbidities resulting in more complex care requirements. Department of Human Services state, that 63 per cent of people over the age of 70 years admitted to hospital have four or more diagnoses and often require multi-day stays in hospital. Where there is no intermediate care available to aid recuperation and rehabilitation outside the hospital, older patients, especially those living alone can be at risk and as a result often rebound upon discharge from hospital (Victorian Government of Human Services, 2003, p.2.).

The disadvantage for older people is evident when efforts are made to measure the cost-effectiveness of particular treatments in order to make an informed decision about the allocation of resources to particular services. Health economists in the United Kingdom use measures called QALYs (Quality Adjusted Life Years) to assess the changes in length or quality of life for patients brought about as a result of particular interventions. In terms of quality of life gained, for example, an operation to remove a cataract, older people will not enjoy the benefit of the operation for as many years as a younger people will. These differentially rates of health gain are then used to justify allocating fewer resources to health services for older people, on the grounds of cost effectiveness (Robinson cited in Fredman and Spencer 2003, p.108).

The Average Length of Hospital Stay – What is it?

As the ageing population steadily increases, older people i.e. those 65 years and over are the significant users of Health Care Services due to their greater medical complexity and care requirements. As a result, this group of people who have multi-complex medical needs often require frequent admission into hospital and when admitted into

hospital often remain in hospital beyond what is termed by hospitals as the “ALOS”. Commonwealth Department of Health and Aged Care, 2000, p.58)

The ALOS is the time that a patient will require hospitalisation according to their Diagnosis Related Group (DRG) or reason for a hospital admission. The ALOS that a patient spends in hospital can be effected by what is called Clinical Factors and Non Clinical Factors. Clinical Factors may include: age of the individual, severity of illness (acute/chronic), and the presence of co-morbidities, mode of treatment required. Non-clinical factors may include; bed occupancy levels, patient’s social situation, resources for outside ongoing care, discharge planning arrangements and staffing arrangements. (Commonwealth Department of Health and Aged Care, 2000, p.59)

Understanding Diagnosis Related Groups - (DRGs)

A case-mix describes the type of patients treated by a hospital. Under the Case-mix system hospitals are paid for each admitted episode. A DRG is given to each patient that is admitted. This puts patients into groups based on clinical similarities and resources used. A DRG is ascertained through a coding process where codes are given to each diagnosis and each procedure relevant to that episode of care. Other factors that contribute to DRG’s are the patients age, sex, transfer to another hospital, discharge home and admission weight for each patient aged 65 and over. Each DRG has an average length of stay and has a high and a low boundary point which describes the minimum and maximum amount of days a patient would usually stay in hospital for that particular DRG. (Commonwealth Department of Health and Aged Care, 2000, p.59)

Reducing ALOS of the Elderly

Patients who are admitted to their correct speciality ward/unit on admission are more than likely to have their care requirements planned in a consistent manner. Patients not admitted to their correct wards often have issues that arise in the management of care these include: multidisciplinary staff may not have clinical expertise to plan the patient’s care, doctors are not easily accessible to discuss issues and plan care with multidisciplinary team members, multidisciplinary team discharge planning meetings are not represented by all the team members responsible for the patient’s care because they are located in other ward areas, patients are last to be reviewed in regular ward rounds (NDHP-2, 1999, p.15). Therefore it is essential that these patients be admitted to their correct ward, and not moved from one ward to another.

According to the Victorian Government of Human Services (2003, p.xi) if patients are required to move from one care setting to another i.e. from ward to ward, it is important that care is provided in an integrated way that meets the needs of the person and the carers. Care settings need to be designed and managed so that the appropriate physical, social and environmental features relating to the needs of the older patient are provided and meet accordingly e.g. the use of an appropriate “physical environment” is essential for making hospitals stays for the older patient safe, smooth, less stressful, and their ALOS shorter. It must be enforced that older people may have a visual deficit, hearing deficit and/or mobility problems. The appropriate use of handrails, non-slip floors, appropriate

signage, and areas where they can navigate easily are essentially for the recovery of these patients (Hegarty & Griffiths, 2002, cited in DHS, 2003, p.29).

Discharge Home

Aged care assessment teams are a must in discharge planning for older patients. Other groups of patients that are appropriate to refer to the aged care assessment team include patients with, an extensive history of re-admission to hospital, patients with potentially long length of stay in hospital, patients with complex needs. (The NDHP-2, 1999, p.49).

Involving the family, where possible, is essential for an older person to be discharged home appropriately. According to Dash et al, discharge planning is vital as it helps the patient and their family find solutions to health care problems, ensuring that the patients, “1) receive the most appropriate level of care, 2) remains in hospital for the shortest length of time, 3) receive the highest level of care and are not hospitalised unnecessarily and 4) have a planned post hospitalisation programme to meet continuing needs with the least restrictive options”. (1996, p.13). Allowing the patient and their family to be involved in the care and discharge planning aids the balance between dependency and independency for the older person. It also facilitates better understanding by the family of the aged person’s needs. (Dash et al, 1996, p.14).

IMPACT THE AGEING POPULATION HAS ON HOSPITALS

As the aged are the major consumers of hospital services, admission rates and the ALOS tend to increase with age. According to the latest data available the Australian population continues to have one of the highest life expectancies in the world. Those born in 2001, the life expectancy was 80.1 years of age and with this the mortality rates in Australia has decreased substantially over the last 30 years. (National Health Performance Committee 2003, 2004, p.26). Hence as the population ages and lives longer, the demand for hospital services will grow.

Not only does extended life expectancy have an impact on hospitals and beds available, the advancement with medical technology and intervention also impacts on hospital capacity. The older patient is now being offered operations and treatment that were not available 10 years ago. They are now able to undergo lengthy procedures that were previously denied to them. Advances in medicine are raising the expectations of patients together with consumer expectations. As a result, there will be a further increase on the pressure of hospital resources in the ensuing years. (Trends in Hospital Activity Aust 1991-92 to 2000-01, p.64, 2003). The burden and resources on hospitals will steadily increase throughout the next decade. New strategies need to be implemented and old strategies such as discharge planning updated in order for the health care system in the future to operate effectively to deal with the increasing influx of those ‘older patients’ requiring medical intervention.

EVALUATIVE RESEARCH

There are many different types of evaluation methodologies used in evaluation research and depending on what is being studied and by who will determine which theorist's method of evaluation will be used.

Patton (1997, p.298) and Wadsworth (1997, p.12), evaluation methodology is based on six fundamental framework evaluation questions, the 'what' (objectivity), 'whom' (key players), 'why' (rational), 'when' (timing), 'where' (information gathering) and 'how' (results findings). Their evaluation method was deemed appropriate for this research project and their application to this study is examined in the next chapter.

Posavac et al (1997), list four main goals for a achieving a good evaluation study. These being:

1. **Need:** The need to seek, identify and measure the level of unmet needs of a community or organisation. Through working closely with participants, evaluators can determine which aspects of a program are useful and which are not (p.7).
2. **Process:** Once the program has begun evaluators commence documenting the degree to which the program operates and if it meets the needs of the participants (p.8).
3. **Outcomes:** Assess, are participants performing well?, are all services accessible to the participants? Was the program a failure or did it meet the entire needs of all those using its services? (p.9).
4. **Efficiency:** Deals with viability. Was the program cost effective? Can it be financially supported? Were all the outcomes achieved? (p.10).

Wholey, (1983) cited in Posavac et al, (1997 p.10) states, that there is a logical sequence to the four general types of evaluation. "Without need, planning cannot be rational, without effective implementation, good outcomes cannot be expected and without achieving good outcomes, there is no reason to worry about efficiency". The purpose of this study is to contribute to the quality of the services being provided by providing feedback to those who can make the changes. Without feedback the services which are being delivered cannot be carried out effectively.

EVALUATION = ACCREDITATION FOR HOSPITALS

In order for hospitals to obtain ongoing accreditation, hospitals and health care facilities must demonstrate the high quality care is being provided and improvements are being meet (Posavac & Carey, 1997, p.12). It is important that evaluation in health care settings continue and that the findings of the evaluations are widely available. Comparisons of what works and what do not work are essential for improving practice. (Baum, 1998, p.495). Evaluators are

interested in theories that may provide the best possible outcome for both the organisation and the participant with the least amount of disruption to all involved. Evaluation contributes to quality service by providing feedback from those using the system and without feedback; human service programs cannot be conducted efficiently. (Posavac et al, 1997, p.13-14).

Finally, an evaluative study allows for the determination of not only whether care is adequate but also which method of care is best under certain conditions. Studies can be used to determine whether a particular type of nursing care is cost effective, that is, that the care not only does what it is intended to do by that it also does it at less or equivalent cost. In an era of health care reform and cost containment for health expenditures, it has become increasingly important to evaluate the relative costs and benefits of new programs of care. (Beanland et al, 1999, p.213).

CONCLUSION

There are considerable gaps in literature available about RAMUs and therefore this chapter has reviewed the literature relating to the various similar short stay medical units that are currently operational today. The literature review started with health care in Australia and how it is delivered today. It then proceeded to introduce the concept of Rapid Assessment Medical Units and fast tracking Medical Units that exist overseas.

The literature further explored to identify what patients deem as 'good patient care' and 'satisfaction' whilst in hospital today. It was also explored what nurses see as the 'delivery of patient care' and 'satisfaction', whilst also taking into account their own job satisfaction. It also explores the relationship between the average length of stay and the effects the ageing population will have on the lengths of stays.

Finally, this chapter concludes with Research Evaluation and the various ways Evaluation can be explored, depending on the type of research to be undertaken. Chapter 3 will examine in further detail the use of an evaluation research for this research project and the justification for its appropriateness to this project. These combined literature reviews summaries the key components of the literature relating to this research study.

Chapter 3:

METHOD OF RESEARCH

EVALUATIVE RESEARCH

As previously stated in Chapter 2 this research was conducted using an evaluative research case study method. This type of study allowed for the ability to address the situation in which the boundaries between phenomenon and context are not clearly evident, thus allowing for the use of multi-sources for evidence gathering. (Yin, 2003, p.135). Further more, an evaluative study allows for flexibility, and diversity, and takes into account the potential for overlapping of other research designs. It also offers both combined and complementary strengths and weaknesses (Hakim, 1987, p.63). Essentially, an evaluative case study will allow for the testing of the relationship between processes and outcomes. (Yin, 2003, p.xi). It is the process of securing valid, reliable and applicable information about programs, program structures, processes, outcomes and impacts, to permit managers to make decisions for improvement and fulfil their responsibility for public accountability. (Franklin & Thrasher, 1976, p.319).

This evaluative case study incorporated the essentially usage of the method using triangulation. Triangulation allowed for the researcher to use “multiple perceptions to clarify meaning, verify the repeatability of an observation or interpretation, and served to clarify meaning by identifying different ways a phenomenon can be seen”. (Denzin, 2000, p. 289). Yin (2003, p.97), further enforces this use of triangulation by stating that “a major strength of case study data collection is the opportunity to use many difference sources of evidence. The need to use multiple sources of evidence far exceeds that in other research strategies”. The most important advantage by using multiple sources of evidence is covering all lines of inquiry and that any finding or conclusion in a case study is more likely to be convincing and accurate if it is based on several different sources of information.

UTILISATION-FOCUSED EVALUATION

Evaluation research assesses program effectiveness i.e. delineates the degree to which program goals and intervention promises are achieved. Evaluation research is undertaken to influence the policy making process of social intervention. Utilised Focused Evaluation deals with several basic concerns, these being, “What is the purpose of the evaluation? How will the information be used? What will we know after the evaluation that we don’t know now? What actions will be able to take based on evaluation findings?” (Patton, 1997, p. 189).

Rossi and Wright (1977) indicated, the definition and operationalisation of the program, its goals, and proposed impact are not provided by the researcher but by the policy makers. Franklin & Thrasher (1976), p.319 suggests

evaluation study is the process of securing valid, reliable and applicable information about programs, program structures, processes, outcomes and impacts, to permit managers to make decisions for improvement and fulfil their responsibility for public accountability. Whereas according to Patton (1997, p.23) utilisation focused evaluation gathers information that is needed and wanted by the primary intended users and uses it to improve programmes and decision-making. Essentially, evaluation research is limited to the research setting of the intervention program. (p.317)

SIX EVALUATION RESEARCH QUESTIONS

Data analysis of this research evaluation methodology, will use the fundamental framework questions that Patton (1997, p.298) and Wadsworth (1997, p.12), identified. These being; 'what', 'who', 'why', 'when', 'where' and 'how' is this research for.

The What? (Objectivity)

Identification of the 'object' to be investigated and the findings, answers the 'what' of evaluation research. Utilisation of evaluation research allows methods and procedures to evaluate a program, treatment and practice to analytically document the worth of any activity or object. (Beanland et al, 2001, p.212-213).

The Whom? (Key players)

The "whom" question will clearly identify who the key stake holders/players are in this evaluative case study. (Wadsworth, 1997, p.12).

The Why? (Rational for an evaluation)

Allows for relationship testing between process and outcome (de Vaus, 2001, p.247) It, also address the situation in which the boundaries between phenomenon and context are not clearly evident thus allowing for the use of multi-sources for evidence gathering. (Yin, 2003, p.23).

The When? (Timing of an evaluation)

Identification of the appropriate time to implement the study answers the "when " question. The selection of an appropriate evaluation approach is influenced by when the evaluation is to be conducted in relation to the commencement and duration of the program being introduced/developed. (Beanland et al, 2001, p.213)

The Where? (Gathering of information)

Information will be gathered using a variety of research collection methods in the form of, questionnaires, interviews, prospective/retrospective data gathering and focused group interviews in order to produce the final result of an evaluative case study. Data collected will be used to determine which care is adequate and which method of care is best under certain conditions. (Beanland et al, 2001, p.214).

The How? (How will results be used)

The 'how' will be used to implement and refine further rapid medical units or modify such units to suit the patient not the stakeholders. Cost containment for health expenditure has become increasingly important, as is the need to evaluate the relative costs and benefits of new programmes of care. (Beanland et al, 2001, p.212-213).

STUDY DESIGN

This case study was designed using a mixed evaluation method design. Stage One of this research was using a quantitative method involving two phases. Phase one involved the use of a retrospective survey sampling of approximately two hundred randomly selected patients with the ALOS in hospital totalling 1500 days to help determine the ALOS of patient's pre and post RAMU. Phase two used a technique of prospective questionnaire surveys of one hundred randomly selected patients on RAMU. (Cohen et al, 2000, p.174).

Stage Two involved the use of qualitative research. It was to be used to gather subjective data from patients that had agreed to participate in one-on-one in depth audiotaped interviews following their admission and discharge from hospital. Chapter 8 discusses problems and issues in collecting this data.

Stage Three again used qualitative research to gather subjective data from Focused Group Interviews of staff from both RAMU and an associated Medical Ward. It allowed for individuals to expand on their own personal experiences, taking into account their attitudes, perceptions, views and feelings about RAMU.

Stage One – Quantitative Research

DATA ANALYSIS: PHASE ONE – RETROSPECTIVE SURVEY SAMPLING

Phase One used a retrospective survey sample using four hundred randomly selected medical patients' with a total of approximately 1500 days stay in hospital, regardless of their age, medical diagnosis sex and other vital statistics to help determine the ALOS of medical patients of the Hospital. This group was then subdivided into two further groups. Group A being two hundred patients who were admitted prior to the implementation of RAMU and the ALOS determined. The second group, Group B being two hundred patients admitted to RAMU after it was opened and the ALOS was determined.

The sample time frame for both the pre and post surveys were from the period of April to September. This is when the number of patients requiring medical attention in A&E increases and when it is at its peak during winter months.

It was deemed that a sampling of one hundred randomly selected medical patients was too small to work out the ALOS of patients both pre and post RAMU. 25-30 patients could be admitted into hospital on any given day with approximately the same amount of patients discharged daily the number was deemed to small to work with.

Therefore the number was extended to fifteen hundred patients both pre and post RAMU's inception and from this number the ALOS was established.

DATA ANALYSIS: PHASE TWO – PROSPECTIVE SURVEY

Phase Two used a prospective survey questionnaire of one hundred randomly selected patients who were admitted to RAMU and met the selection criteria for this research project. Questionnaires were sent to patients whom consented to participate in the research project after they had left hospital. This allowed patients to answer freely and candidly without being placed under any due pressure and allowed patients the time to reflect on their recent admission into hospital. (Beanland et al, 1999, p.305).

Questionnaires used a combination of dichotomous questions (closed questions), multi choice questions, rating scale question/responses, and four open-ended questions. The questionnaires followed the patient through the transition from the A&E, RAMU and until they were discharged home from hospital. Questionnaires were a way of simplifying patient's responses and allowing for objective research material to be gathered. (Beanland et al, 1999, p.305).

Stage Two – Qualitative Research

THEMATIC ANALYSIS: GROUP ONE – PATIENT INTERVIEWS

“Interview is a qualitative data-gathering technique during which information is shared. This method of data collection permits an exploration of a person's feeling, ideas, attitudes and thoughts in the words of the individual and not in the words of the researcher”. (Beanland et al, 1999, p.294).

A qualitative method of using one-on-one in-depth taped interviews with ten consenting patients was going to be conducted following their completion of the questionnaires and discharge from hospital. The aim of the interview was to “explore a person's feelings, ideas, attitudes and thoughts in the words of the individual”. (Beanland, et al, 1999, p. 294). It was hoped that those patients participating in the interviews would expand on their own personnel experience of RAMU and that the information gathered from these interviews to be used to help further develop better management of patients on such fast paced high turn over wards. However, this did not eventuate for various reasons. Only one patient agreed to participate in the interview. Chapter 6 discuss the problems faced whilst trying to organise and conduct this interview.

THEMATIC ANALYSIS: GROUP TWO – FOCUSED GROUP INTERVIEWS

Focused Group Interviews were conducted for Nursing Staff working both on RAMU and other General Medical ward, with permission of Unit Managers. They were conducted at separate times and locations. Focused Group Interviews was considered the most appropriate method to collect qualitative information as it allowed for staff to express freely their opinion, perceptions, experience, attitudes, and gain new insight into problems encountered by themselves and patients. It also allowed the researcher to gain a clear view of the thinking, language and reality of the participants' environment and examine the relationships in the field and also explore the amount of variation, diversity or consensus on a RAMU (Minichiello et al, 1999, p. 420).

STUDY PROCEDURES

Selection Criteria – Patients

Due to the high volume of patients that pass through RAMU, a stringent selection criteria was needed in order to select the most appropriate patients for this research project. A set of guidelines was devised by the researcher, based on the knowledge of having worked on RAMU. As one of the requirements by the University Ethics Committee was that the researcher was not allowed to approach patients to participate in this research project, it was facilitated by the Ward Clerk to ask on my behalf if they wished to participate in this research project.

Patients approached by the ward clerk and meeting the following criteria were asked to sign a consent form and at a later date upon discharge a questionnaire was despatched to them.

Patients selected for the questionnaire surveys were required to meet the following selection criteria:

1. Have a mailing address.
2. Reside within either a home environment, hostel or retirement village.
3. Be able to talk, read, write and understand English. (English not necessarily their first language).
4. Not be cognitively impaired i.e. suffering from dementia.
5. Reside within a 20km radius of Western Hospital.
6. Not have been admitted to hospital with ethanol or drug abuse.
7. Not have been admitted to hospital with any psychiatric condition.
8. Not admitted to hospital with a terminal illness.

Selection Criteria – Nursing Staff

The selection criteria for nursing staff employed at the hospital was as follows:

- a) Be employed on a Medical Ward and/or RAMU,

- b) Be employed by the Hospital on a contract basis for a period of three months or more i.e. full-time/part-time, employed on Nurse Bank at the Hospital and
- c) Be either currently registered as a, Registered Nurse Division 1 or a Registered Nurse Division 2.

Recruitment of Patients

PATIENT SATISFACTION SURVEYS

When patients arrived at RAMU, those that meet the selection criteria, were asked whether or not they wished to participate in a research project about their stay on RAMU and stay in the hospital. If they agreed to participate, the RAMU ward clerk who was given permission to participate in the research project gave patients a letter detailing the nature of the research project and a consent form. Patients were advised that they were under no obligation to participate (Appendix 1, page 88).

Once patients who had consented to participate in the research project (Appendix 2, page 89) and were discharged home, a patient satisfaction survey package was despatched to them (Appendix 3, page 90). It contained the patient satisfaction survey, a self-stamped returned addressed envelope. Also in the package contained a consent form to participate in a one-on-one audio taped interview (Appendix 4, page 99).

During the course of data collection, the hospital was conducting its own Patient Satisfaction Surveys and as a result some patients declined to participate in my research project, as they only wanted to complete one patient satisfaction survey. This led to a further delay in being able to complete my data collection within the set time frame allocated and also reduced the number of patients wanting to participate.

PATIENT INTERVIEWS

As previously stated, when the patient satisfaction package was despatched to the agreed participants, it also contained a consent form to participate in a one-on-one audio taped interview. Participants were advised that they are under no obligation to participate in an interview. If, however they did wish to participate in an interview, patient confidentiality would be adhered to at all times and they can stop the interview at any time.

It was hoped to that ten patients would participate in this interview. However, only one agreed to participate when telephoned to organise a time, place and date that best suited them. Chapter 6 discusses the problems encountered whilst trying to organise patient interviews.

Recruitment of Nursing Staff

FOCUSED GROUP INTERVIEWS

A courtesy telephone call was made to the Nurse Unit Managers of RAMU and the Medial ward requesting permission to organise a time and date to discuss the research project and ask permission to conduct staff focused group interviews. A courtesy letter was also despatched to the Nurse Unit Managers (Appendix 6, page 101).

Once permission was granted, letters were despatched to the Nursing staff of both participating wards informing them of the research project and requesting volunteers to participate in the Focused Group Interviews. Staff were informed that they were not obliged to participate if they did not want to (Appendix 7, page 102). The focused group interviews were conducted on separate days and on the weekends when the nursing staff are at their least busy i.e. nursing staff are not dealing with a high rate of discharges, also Allied Health professionals only attend in emergency cases and doctors ward rounds are limited. Volunteer staff participants on both wards, were asked to complete a consent form (Appendix 8, page 103) and a short survey (Appendix 10, page 105).

ETHICAL CLEARANCE

At the commencement of this research project, The Hospital did not have an established Ethical Committee for dealing with such a research project. As a result, verbal approval was given by both the Chief Executive Officer (CEO) and by the Director of Nursing (DON) of the hospital on the provision that clearance was granted by the University Ethics Committee.

PILOT STUDY

Using the principle function that pilot questionnaires are used to increase the reliability, validity and practicability of the surveys (Cohen, Manion, & Morrision, 2000, p.260), A Patient Satisfaction Survey along with a letter of explanation (Appendix 9, page 104) about the research project were distributed to ten randomly selected consenting adults who had no affiliation with any medical expertise, worked within the medical industry or who had had relatives or friends admitted to Hospital in particular RAMU at the time of the distribution of the pilot surveys. Prior to the Patient Satisfaction Surveys being distributed, both the CEO and the DON of the Hospital, requested to view the Pilot Questionnaires prior to the distribution to patients. Both were satisfied with the Pilot Questionnaires and distribution of the surveys commenced in July 2003.

The Patient Satisfaction Survey's sort information about the patient, how old they were, how many admissions had they had to hospital, was this their first experience on a RAMU ward, did they encounter any problems during their stay, and were they transferred to a different ward after they arrived on RAMU. Only a few minor changes were recommended, these being punctuation and a repetition of one particular question that appeared in two different sections. Responses from the Pilot surveys were not included in the final data analysis.

STUDY TOOLS

To date as there has been no research conducted on 48 hour Medical Units, the Patient Satisfaction Questionnaire was devised by the researcher with some adaptations from a similar questionnaire by TQA research Pty Ltd- State Government Victoria on Patient Satisfaction. However the majority of the questions were devised by the researchers knowledge of having worked on RAMU.

Patient Information Letter – Questionnaire

An information letter along with a consent form was given to participants that wished to participate in the research project. It provided the participant with the following information:

- A brief but comprehensive statement out the purpose of the research study,
- Details about patient confidentiality,
- Obligation to participate in the research project, and
- Patients care whilst in hospital.

Patient Consent Form – Questionnaire

As per Victoria University guidelines for participants to participate in a research project, the consent form was devised using their approved consent form protocol and approved by the University Ethics Committee. It include the following information:

- The purpose of the project i.e. concerns about treatment and care,
- Freedom to withdraw from the research project,
- Confidentiality of information provided including medical history,
- Information provided would not affect participant's care,
- Ability to contact the Researcher at any time for follow up questions/concerns,
- A questionnaire will dispatched upon discharge from hospital,
- Consent to participate in an interview at a later date, and
- Over 18 years of age.

Patient Information Letter – Taped Interview

Once patients were discharged from home, a letter and package was dispatched to them regarding their acceptance to participate in the Research Project. The Research package contained the Patient Satisfaction Questionnaire (Appendix 3 page 90) and a Consent Form to participate in a taped interview, (Appendix 4 page 99), if they so desired. The Patient Information Letter regarding the taped interview included a no obligation clause to participate in the interview and stated that the patient could withdraw at any stage from the project. Any withdrawal from the project would not jeopardise them in any way.

The aim of the taped interview was to allow the patients the opportunity to:

- a) Clarify answers,
- b) Express opinions or concerns about their stay on RAMU, and
- c) Make recommendation about improving hospital care.

Confidentiality – Taped Interview

A confidentiality clause was added to the consent form for taped interviews. It's main purpose was to express to the patient that patient confidentiality would be adhered to at all times and any identifiable name would not be used throughout the course of the interview and that all information collected throughout the course of the research project would be stored where needed and destroyed according to University Protocol. (Cohen et al, 2000, p.279).

Patient Consent Form – Interview

Again as per Victoria University guidelines for participants to participate in a research project, the consent form was devised using their approved consent form protocol and approved by the University Ethics Committee. It include the following information:

- Aim of the research project identifying patient's requirements, understanding and concerns about treatment and care, on a Rapid Assessment Medical Unit,
- Opportunity to discuss some answers from the questionnaire,
- Opportunity to have any questions answered.
- Availability to be contacted to organised an interview,
- Ability to withdrawal from the interview at any time,
- Information provided will remain strictly confidential,
- Ability to contact the researcher at any time, and
- Over 18 years of age.

Reminder Letter to Patients

A reminder letter was despatched to patients who had not responded to the original research package. The reminder letter was despatched approximately four weeks after the Research Package was sent out. It was first established before they were sent the reminder letter that they had not been re-admitted into hospital or anywhere else (Appendix 5, page 100).

Focused Group Interview – Nurse Unit Managers

Even though permission had been granted for the research project to be conducted by the Hospital, courtesy letters were despatched to the appropriate Nurse Unit Managers for Focused Group Interviews to be conducted on their wards. The letters stated why the project was being undertaken and that a date and time would be agreed upon that best suited nursing staff.

Focused Group Interview – Invitation to Attend

A letter was dispatched to nursing staff of both RAMU and a General Medical Ward asking for volunteers to attend a Focused Group Interview. The letter outlined the topic to be discussed and gave specific guidelines that the researcher deemed appropriate for the interview to be conducted.

The safety guidelines included:

- i. Confidentiality of comments made during the interview,
- ii. Identifiable names participating in the interview would not be used,
- iii. Judgments would not be made about other staff member's contributions,
- iv. Supervisors and researchers had access to tapes only, and
- v. Destruction of all correspondence at the end of the research project according to University Protocol.

Focused Group Interview – Consent Form

As per Victoria University guidelines for participants in a research project, the consent form was devised using their approved consent form protocol and approved by the University Ethics Committee. It includes the following information:

- Comprehensive explanation as to the nature of this research project, and any risks involved;
- Consent for interview being taped;
- Ability to withdrawal at any time;
- Confidentiality of all information at all times, including patient confidentiality;
- Be non judgemental;
- Employed by a metropolitan hospital as a Registered Nurse;
- Over 18 years of age; and

- Voluntary consent.

DATA MANAGEMENT

Patient – Satisfaction Surveys

Whilst in hospital, patients were 'tracked' using their patient hospital identification number, by the researcher on a fortnightly basis. This allowed the researcher to follow their progress to ensure that surveys were only despatched once they were discharged home. By using the patient's hospital identification number it also allowed the researcher to access how many times the patient may have been admitted into hospital during the data collection period.

Patient hospital identification numbers were also used when patients had not responded to reminder letters about their surveys. This again allowed the researcher to see if the patient had been readmitted into hospital during the period of despatching the surveys and the reminder letters. The tracking of patients during their hospital stay was vital as it also avoided any unnecessary embarrassment or distress to patients or their families if anything happen to them whilst they are in hospital, such as if they passed away unexpectedly or were admitted to another health care facility.

Patient – Interviews

As previously stated on page 27, there were various reasons why patient's interviews did not go according to plan. Chapter 6 discusses the problems encountered on this part on the research project.

Focused Group Interview – Nursing Staff

Once permission had been granted from the Unit Managers of both RAMU and the General Medical Ward a time, date and place was set in order to conduct the Focused Group Interviews. Staff that participated in the interviews had to sign a confidentiality consent form and were advised identifiable names of either patients, relatives and staff members participating in the interview would not be used, judgments would not be made about any other staff member's contributions, and that only the researcher and supervisors would have access to the tapes. Chapter 6 goes into further details and discusses the results of the Focused Group Interviews.

Average Length of Stay

With the assistance of Medical Records staff at the Hospital, an average length of stay of medical patient's pre and post RAMU was conducted. Chapter 4 discusses this in further detail.

CONCLUSION

Chapter 3 provides an account of the structures and processes involved in this research project. The first part of Chapter 3 focuses on evaluative research incorporating the combined concepts used by Patton, (1997), Yin (2003) and Wadsworth (1997); who is the evaluation for, who will benefit and what is the purpose of this study. Thus providing justification for its appropriateness as a framework for this research project.

The second part of the chapter outlines the stages of the research design: Stage one – quantitative research incorporating both retrospective survey sampling and a prospective survey; Stage two – qualitative research incorporating patient interviews and focused group interviews. The remaining sections describe the procedures used, the study tools required and analyses of the research project.

Chapter 4 will present the results and findings on the quantitative data and will explore in depth further responses of patients and explore nursing perceptions.

Chapter 4:

QUANTITATIVE RESULTS

STAGE ONE

Introduction

Chapter 4 presents the results and findings of the quantitative data. The first section, stage one, phase one retrospective survey sampling, determine the ALOS of patients post and pre RAMU over a 1500 day stay in hospital. The findings of this data is presented under the following heading:

Retrospective Survey Analysis – ALOS

Phase two of quantitative results and finding, Prospective Survey Sampling – Patient Satisfaction is also presented in this chapter. Two sets of quantitative data were collected during the course of this study. This chapter presents the second data collection prospective survey sampling, the patient satisfaction survey that was conducted. This chapter records the researchers second and third aim of the research project to discuss patient satisfaction and care in a short time fast paced hospital environment.

PHASE ONE – RETROSPECTIVE SURVEY ANALYSIS - ALOS

Phase one used a retrospective survey sample using four hundred randomly selected medical patients with a total of approximately 1500 days stay in hospital, regardless of their age, medical diagnosis and sex, to help determine the ALOS of medical patients at the Hospital. This group was then subdivided into two further groups. Group A being two hundred patients who were admitted prior to the implementation of RAMU and the ALOS was calculated. The second group, Group B being two hundred patients admitted to RAMU after it was opened and the ALOS was also calculated.

The sample time frame for both the pre and post surveys were from the period of April to September 1999 and 2001. This is when the number of patients requiring medical attention in A&E increases and when it is at its peak during winter months. The sample of patients was divided in to two sub groups, these being Group A patients admitted prior to RAMUs opening and Group B after RAMU's inception. The sample time frame for both the pre and post surveys was from the period April to September. This is when the number of patients requiring medical attention in A&E increases and when it is at its peak during autumn/winter months.

Retrospective Survey Findings - ALOS

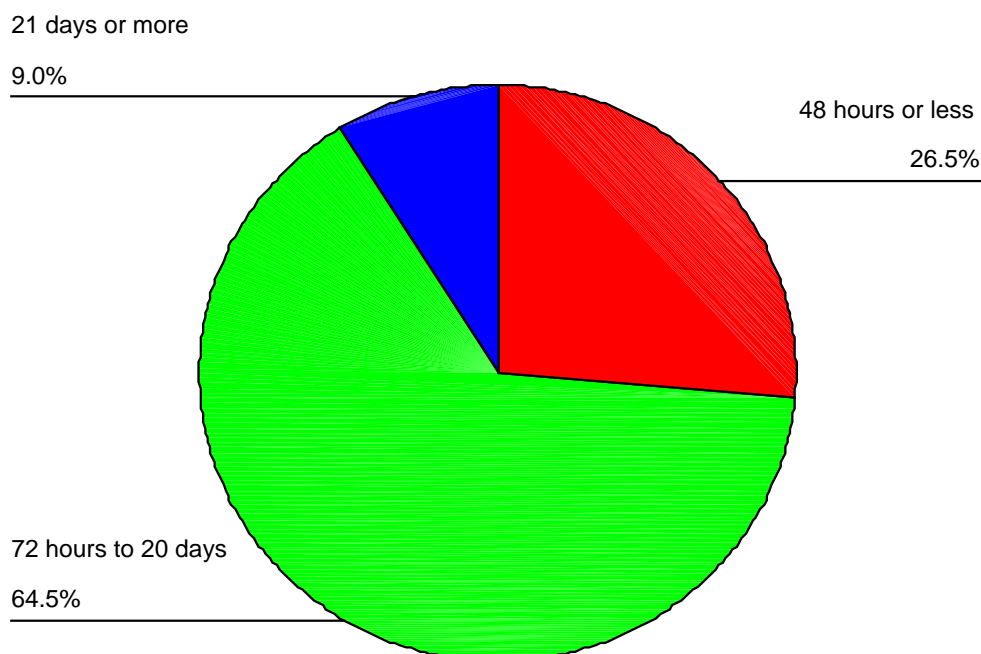
A quantitative retrospective survey sample was used to randomly select medical patients' records, regardless of their age, medical diagnosis and sex, to help determine the ALOS of medical patients at the Hospital. Four Hundred patients pre and post RAMU were found with a total amount of admission days of 1494 and 1478 respectively to determine the ALOS.

Group A – Pre RAMU (April 1999 – September 1999)

Using a sample size of 200 medical patients with the total number of days equalling 1494 days (with the over 65 years of age making up 90 percent of all admissions), in relation to each patient's DRG an average length of stay during the period April 1999 to September 1999 was determined at 7.47 days.

During the period April 1999 – September 1999 a sample size of two hundred medical patients admitted to hospital with the total number of days equalling 1494 days and using each patient's allocated ALOS during this period April 1999 to September 1999 was determined at 7.47 days (Graph 1).

Graph 1: Average Length of Stay (April 1999 - September 1999)



Sample size = 200

Total days = 1494

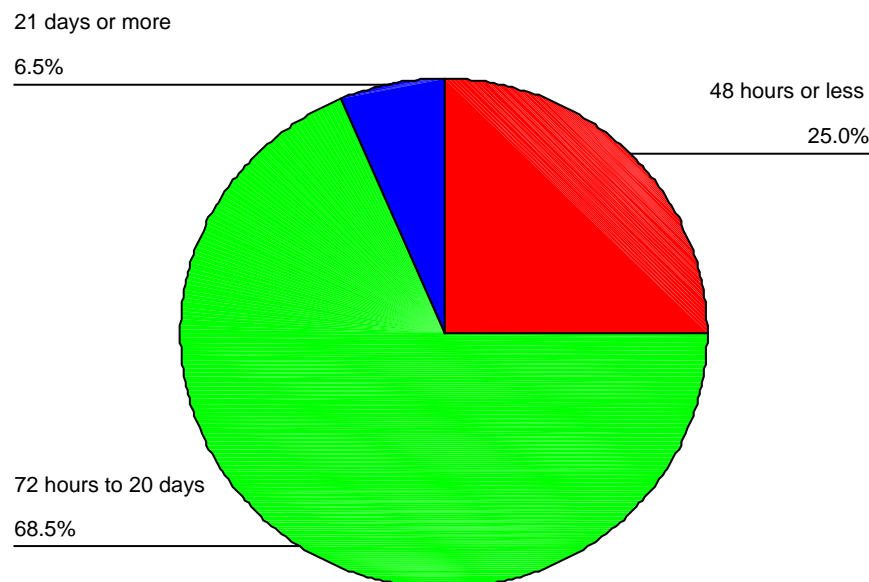
Average Length of Stay = 7.47 days

Group B – Post RAMU (April 2001 – September 2001)

Again using the sample size of 200 medical patient with the total number of days equalling 1478 days, (with the over 65 years of age making up 90 percent of all admission to RAMU), the ALOS during the same period of April 2001 to September 2001, 12 months after RAMU had opened was 7.39 days.

Again using the sample size of two hundred medical patients admitted to the hospital over the period of April 2001 – September 2001 with the total number of days equalling 1478 days, and using the in patient’s Diagnostic Related Group (DRG), an average length of stay during the 12 months after RAMU had opened was 7.39 days (Graph 2).

Graph 2: Average Length of Stay (April 2001 – September 2001)



Sample size = 200

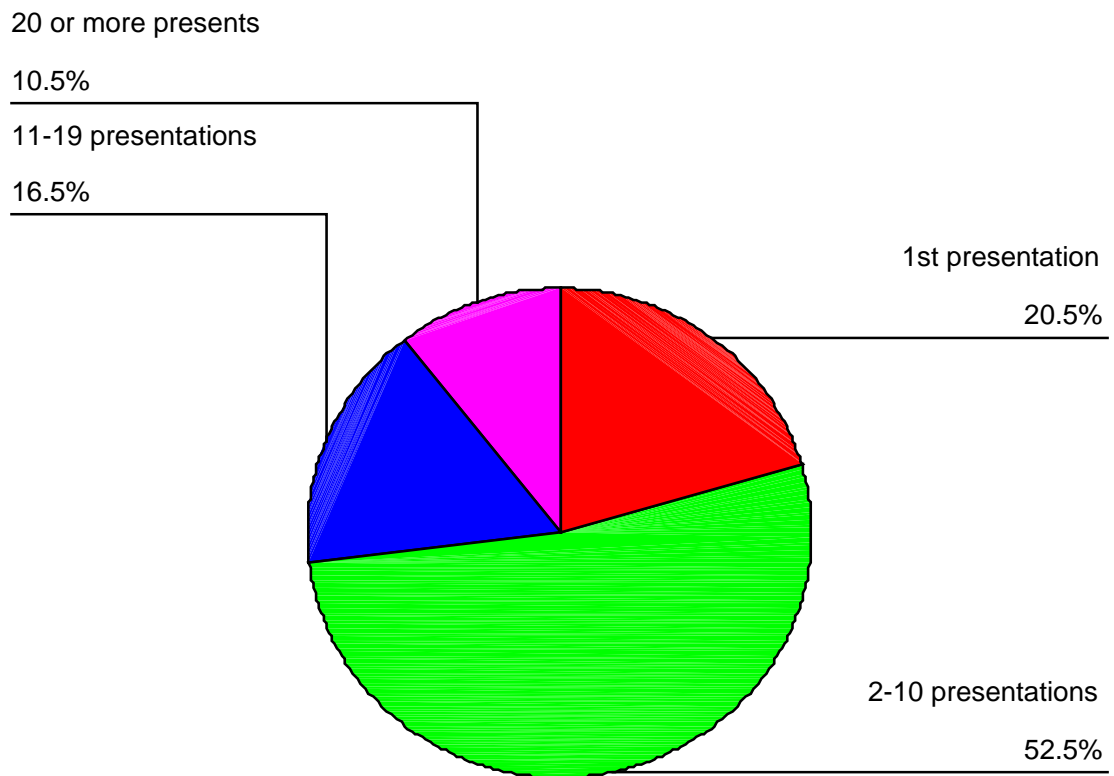
Total days = 1478

Average Length of Stay = 7.39 days

Using the original 200 patients admitted to RAMU both pre and post its inception, the amount of presentation by patients can be broken down in the following way.

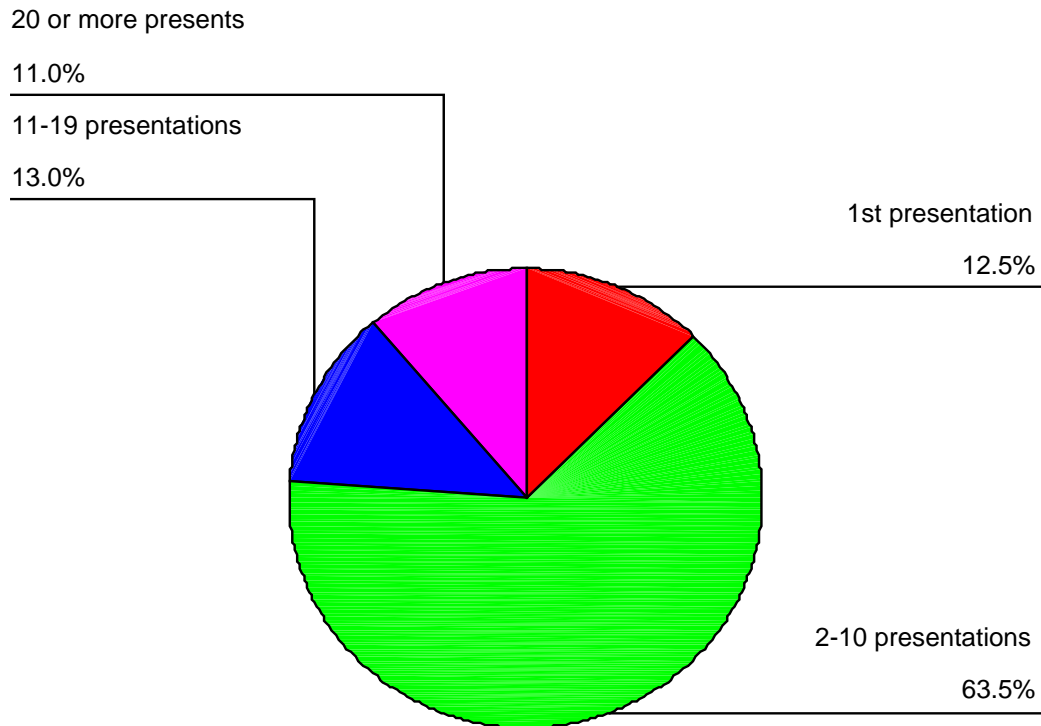
Presentations: Pre RAMU (April 1999 – September 1999)

Graph 3: Number of Presentation Pre RMAU (April 1999-September 1999)



Presentation: Post RAMU (April 2001 – September 2001)

Graph 4: Number of Presentation Post RMAU (April 2001-September 2001)



PHASE TWO - PROSPECTIVE SURVEY ANALYSIS – PATIENT SATISFACTION

Phase two used a prospective survey questionnaire and was aimed to gather information from one hundred randomly selected patients who were admitted to RAMU and met the selection criteria for this research project , fifty surveys were dispatched with a return rate of 60% . The patient satisfaction survey was divided into eight different sections. Though patients did not have to complete all the sections and could exit from the survey depending on when they were discharged from hospital i.e. discharged to home from RAMU within the specified 48 hours, or transferred to another ward before being discharged home. The following graphs represent the patients' findings.

Section One – About You!

Figure 1: Age

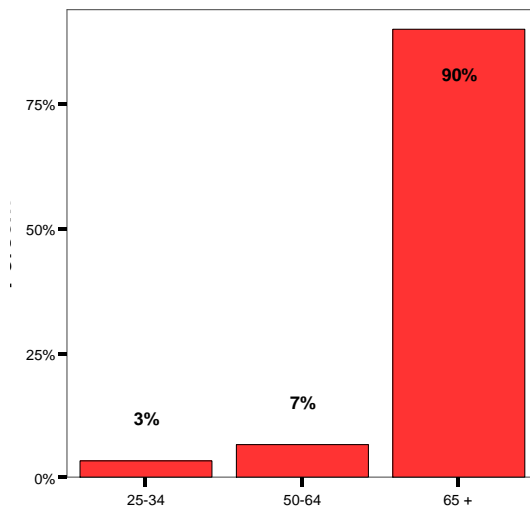


Figure 1 relates to the age of the participant and clearly shows that 90% of those that participated were over the age of 65 years plus, while at the other end of the scale 3% were aged between 25-34 years of age. Of the age group of 35-49, 0% presented to RAMU during the course of this research project.

Figure 2: Gender

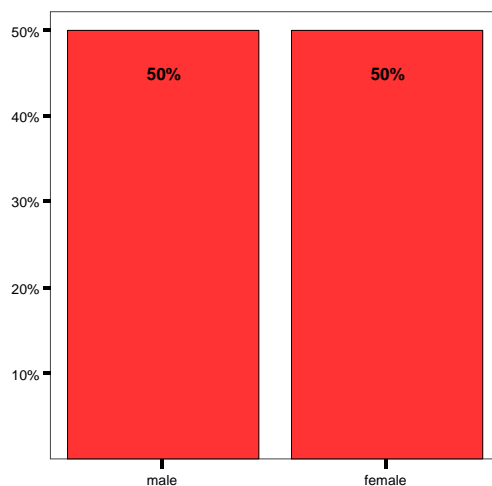


Figure 2 shows the gender of those participants who completed the surveys. It has to be noted that these patients were randomly selected and therefore the equal distribution of the patients of male and female is coincidental and does not reflect the overall distribution of patients that RAMU see.

Figure 3: Language

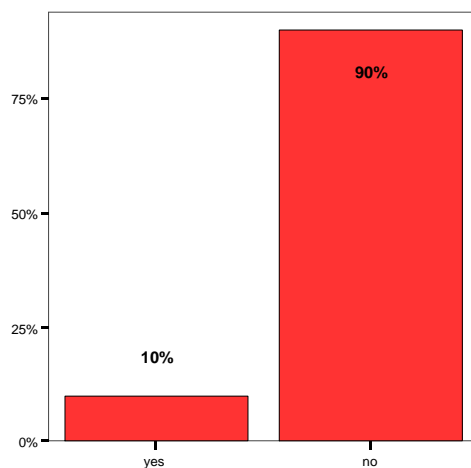


Figure 3 aimed to find if English was the only language that was spoken within the home environment and if not what was the main language spoken within the home environment. 10% of those that completed the survey stated that they spoke another language at home however, failed to state what language they spoke at home and if it was their first or second language.

Hospital Admissions

Figures 4, 5, 6 referred to the patient's admission to hospital within the last 12 months. Of those that completed the survey 33% stated that it was their first admission into hospital in the last 12 months with 7% who had been admitted seven or more times. However, these multiple admissions may have also include other non-medical interventions such as surgical and cardiac admissions. Only 3% of those had been admitted to hospital were admitted for 24 hours. An equal distribution on 33% for those admitted from 3-6 days and 33% admitted for longer than 7 days. Of this 60% believed that their stay was deemed 'adequate', 33% felt their stay was 'just enough' and 7% felt their stay was 'too long'.

Figure 4: Admission Into Hospital In Last 12 Months **Figure 5: Length of Stay in Hospital**

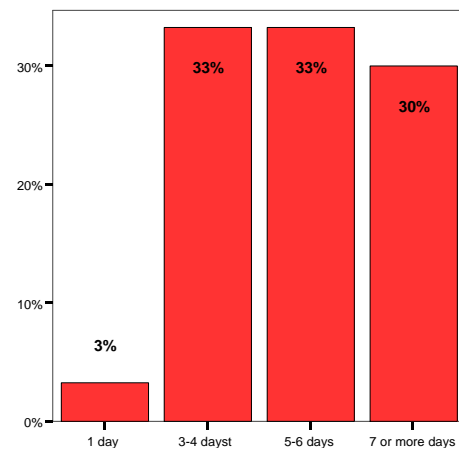
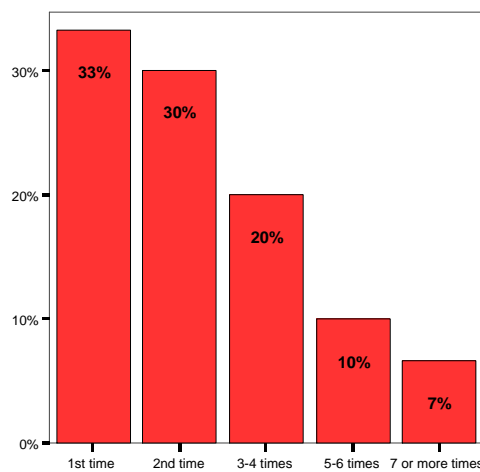
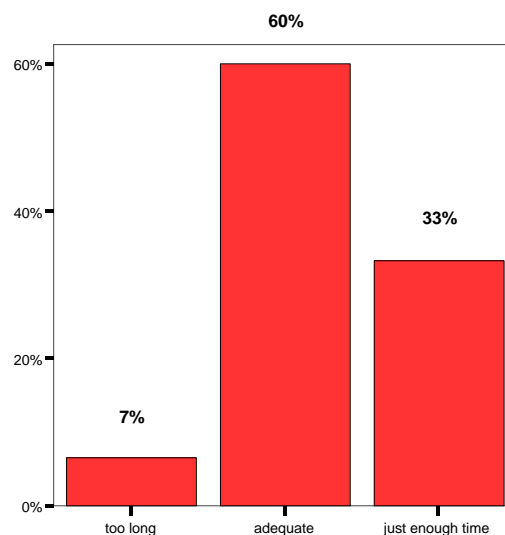


Figure 6: Length of stay last admission



Completion of Survey

Figure 7: Completion of Survey

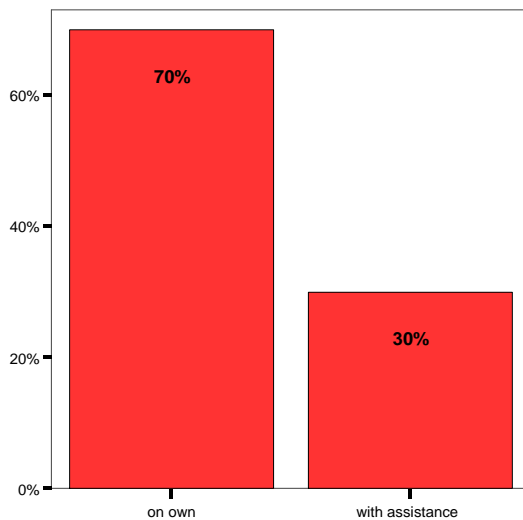


Figure 7 represents how patients were able to complete the survey. However, the results show no reflection on whether or not another language was spoken within the home environment. Thus it cannot be determined if the 30% that had assistance with completing the survey had difficulty because of language or of another unspecified reason.

Participants Findings – About RAMU – Sections 2, 3, & 4

Sections 2, 3 and 4 of the patient satisfaction survey aimed to discover how the patient felt about their stay on RAMU. It also included the A&E's involvement of notification of patients being admitted to RAMU, time of arrival and their level of patient care and satisfaction with staff on RAMU. The following results are shown:

SECTION 2 – ADMISSIONS TO RAMU

Section 2 reviews the amount of admissions that patients have had to RAMU and also includes some information about being informed by A&E staff about RAMU.

Figures 8 and 9 looks at how many admissions patients had to RAMU within the last 12 months. 73% stated that it was their first admission to RAMU and 27% stated that they had had a previous admission to RAMU. Of this 27% who had had previous admissions to RAMU, 10% stated that they had had 3-4 previous admissions and 7% stated that they had had 5-6 admissions to RAMU within the last 12 months and 13% had not had any previous admission to RAMU.

Figure 8: First admission to RAMU

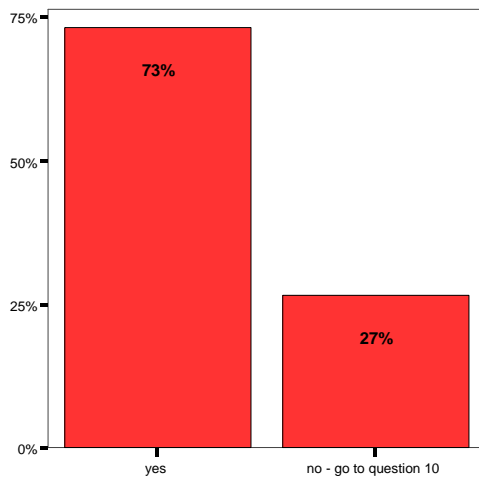
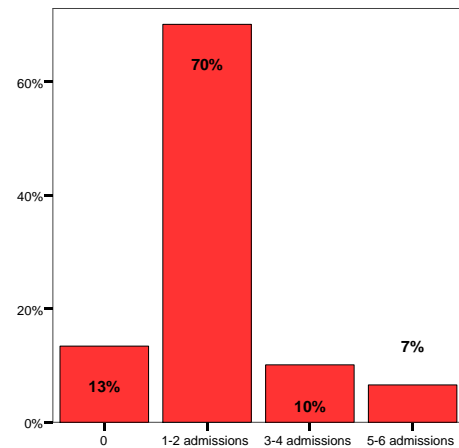


Figure 9: Admissions to RAMU in the last 12 months



Figures 10 and 11 reflect the verbal communication barrier that may exist between A&E staff and patients in relation to their understanding of the concept of RAMU. This is reflected in the following figures. 80% of patients stated that they were not given an explanation by A&E staff about RAMU compared to 20% who stated that an explanation was given. 73% stated that neither themselves nor their family were made aware of the length of time they would be spending on RAMU, compared to 27% who stated that they were given an explanation about their length of time to be spent on RAMU.

Figure 10: Explanation given by A&E staff before arriving on RAMU

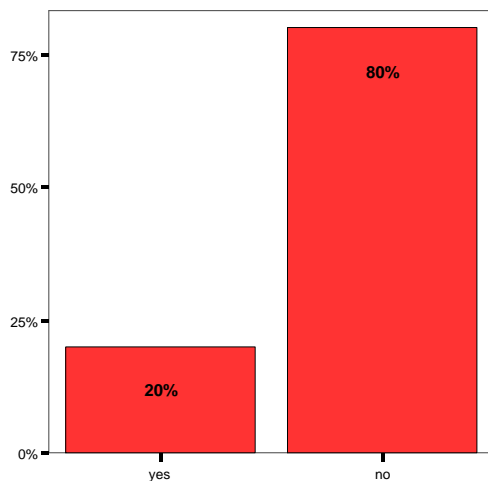
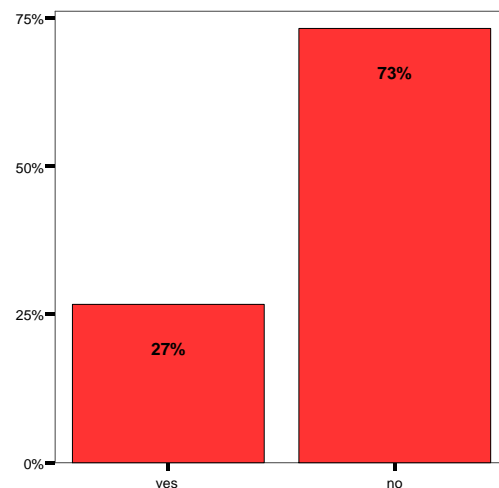


Figure 11: Did A&E staff explain to you/your family your length of stay on RAMU



These figures do not represent those patients who had had previous admission to RAMU and who were already aware of RAMU and the length of time they would be spending there. They do not represent whether the nurse assigned to the patient was an agency nurse or was employed by the hospital. Therefore if it was an agency nurse they may not themselves be aware of what RAMU is and how long patients and expect to be on the ward for. However, if it was a nurse employed by the hospital, then he/she should be aware of the objectives of RAMU and

should have explained to the patient the concept of RAMU. Communication may be an issue between nursing staff within A&E in the absence of explanations to patients about RAMU.

SECTION 3 – ARRIVAL TO RAMU

Section 3 of the patient satisfaction survey related to when the patient had arrived on RAMU and the relevant information they should have received about their stay whilst in hospital and on RAMU. The following five graphs pertain to the participant's arrival at RAMU.

Figure 12: On arrival at RAMU did staff introduce themselves

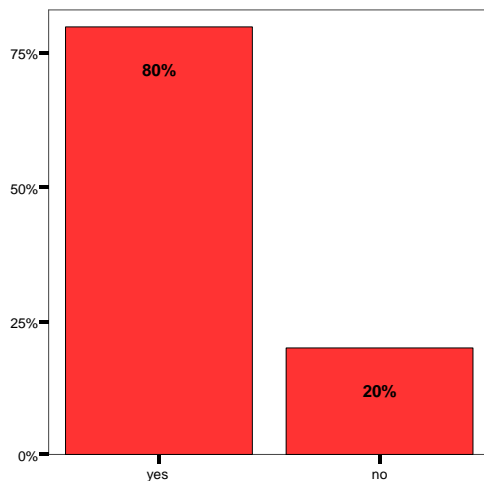


Figure 12 asked the question did nursing staff introduce themselves to you when you arrived on RAMU. 80% of those survey said yes and 20% said no.

Figure 13: When did you arrive at RAMU...

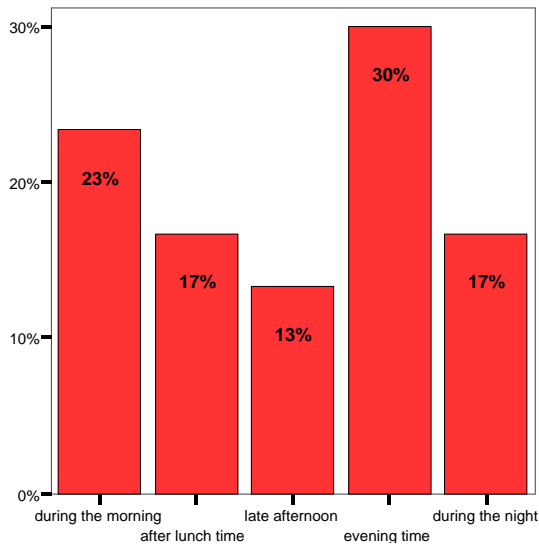


Figure 13 presents the time patients arrived on RAMU. The highest being 30% that arrived in the evening. It is interesting to note that patients were being admitted to the ward overnight with 17% stating that they arrived during the night. However 23% of patients were still admitted to RAMU of a morning.

Figure 14: Time of arrival on RAMU was an explanation given about LOS

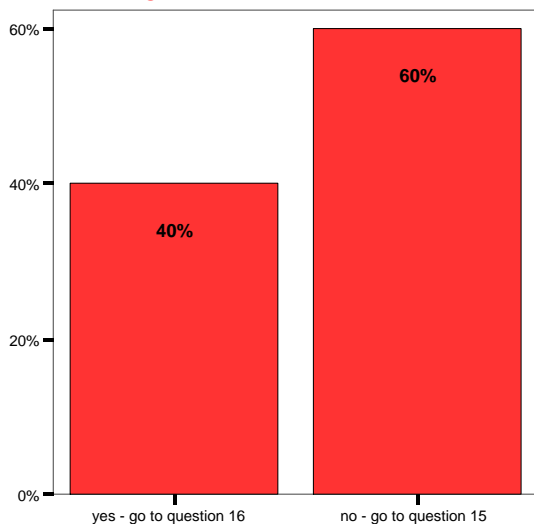


Figure 14 asked the question, "Given the time you arrived on RAMU was an explanation given to you about the length of stay on RAMU"? 60% stated they were not given any explanation and 40% were given an explanation. This may be the result of the patients' actual arrival time on RAMU.

Figure 15 asked patients at any stage during your stay on RAMU was an explanation given about your length of stay. 23% stated they received an explanation during the course of their stay and 77% stated that they had not received any explanation. Of those who had received an explanation Figure 16 shows that there was a varied range of how the information was received by patients. 27% stated that the information given to them was very informative, 10% stated that they received no explanation at all, 7% stated that they did not understand the information given to them. Of those that did not understand the information, further investigation needs to be assessed as to why they did not understand such as language barrier and information overload.

Figure 15: At any stage during your stay was an explanation given...

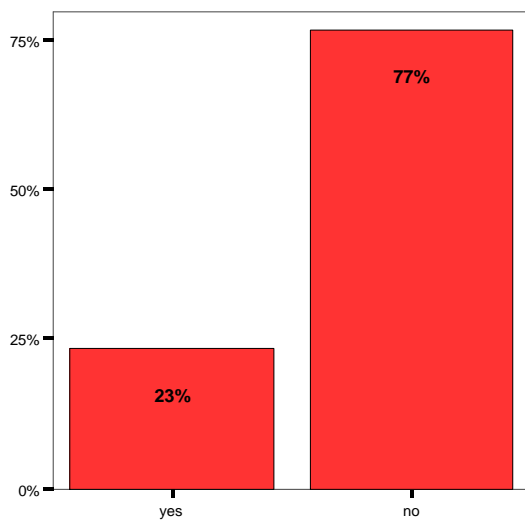
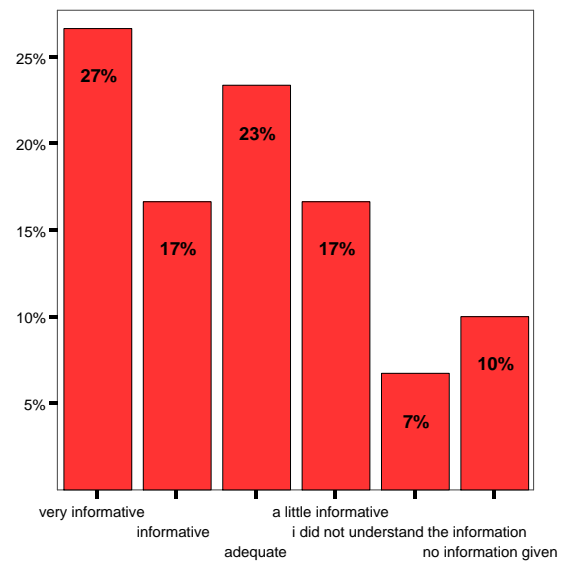


Figure 16: How would you rate the explanation...



SECTION 4 - DURING YOUR STAY ON RAMU

Section 4 of the survey aimed to discover how the patient felt they were treated on RAMU and whether they were satisfied with their overall care and treatment. Remembering that patient satisfaction is a combination of a whole lot of 'little things'; but to the patient a 'little thing' maybe a 'big thing' to them.

Whilst on RAMU, referrals by nursing staff were initiated to other allied health professionals including physiotherapists and dietitians for patients who may benefit from their visits.

Figures 17 and 18 asked, did allied health professionals introduce themselves to you and did they explain their role to you. For both questions the response was an equal 80% said yes, 7% said no and 13% required no referrals to other health professionals.

Figure 17: Did Allied health staff introduce themselves

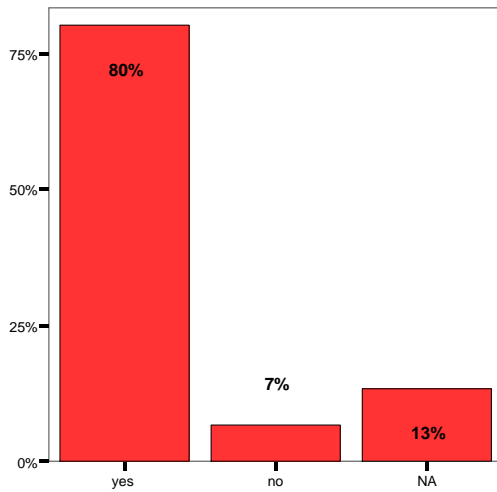


Figure 18: Did they explain their role

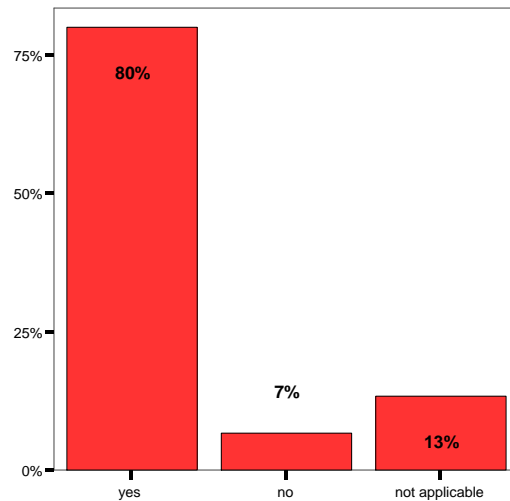
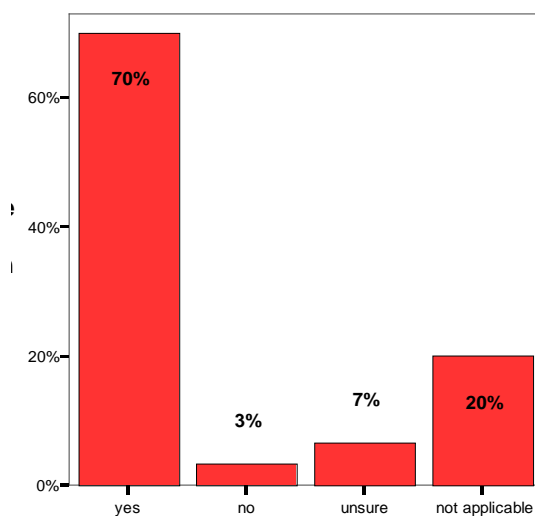


Figure 19: Did you benefit from their visits



Of those patients who were referred to an allied health staff member, figure 19 shows that 70% stated that they had benefited from the referral 3% stated no and 7% stated they were unsure if they had benefited from their treatment.

Figures 20 to 28 explore on a basic level the concept of patient satisfaction and patient care. Patients were asked to “rate” using the following expressing: excellent, very good, good, fair or poor about their treatment and care on RAMU. In figures 20 to 26 and in figure 28, 3% of patients failed to indicate an answer for this question nor gave a reason for not answering this question.

Figure 20: Courtesy of doctors and nurses

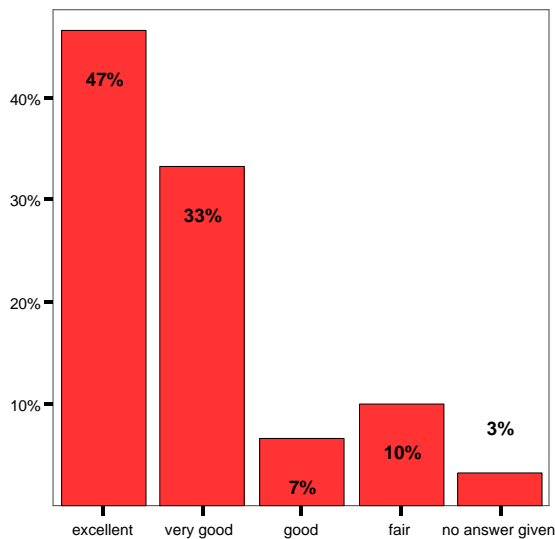


Figure 21: Treatment explained by doctors/nurses on RAMU

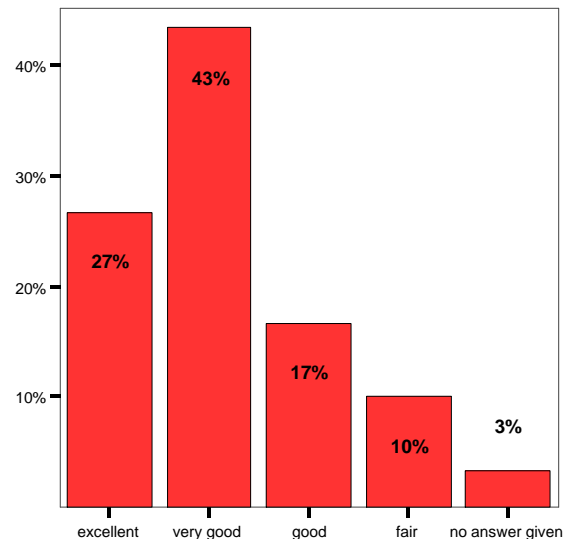


Figure 22: Length of time to answer call bell

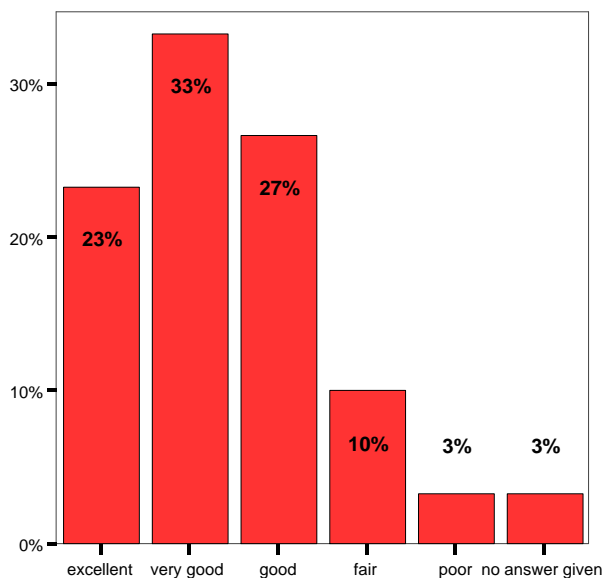


Figure 23: Respect for privacy

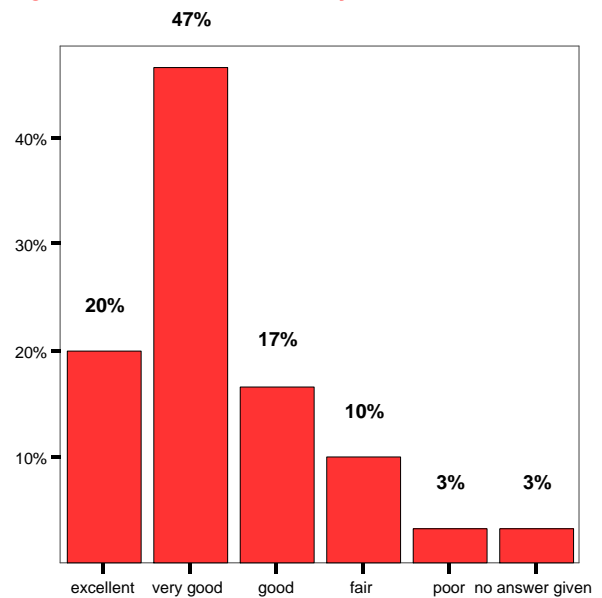


Figure 24: The way information about your condition was explained

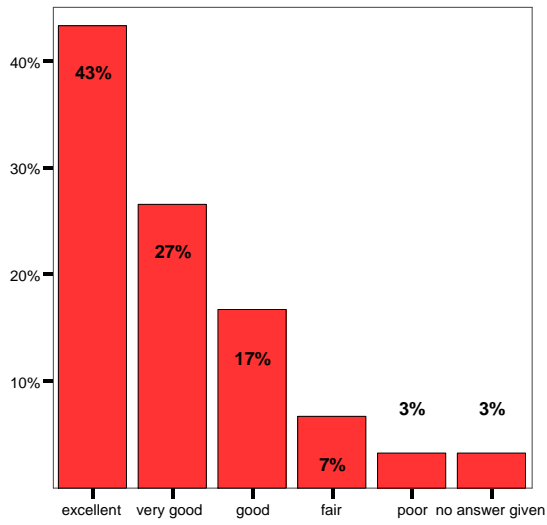


Figure 25: Treated with respect

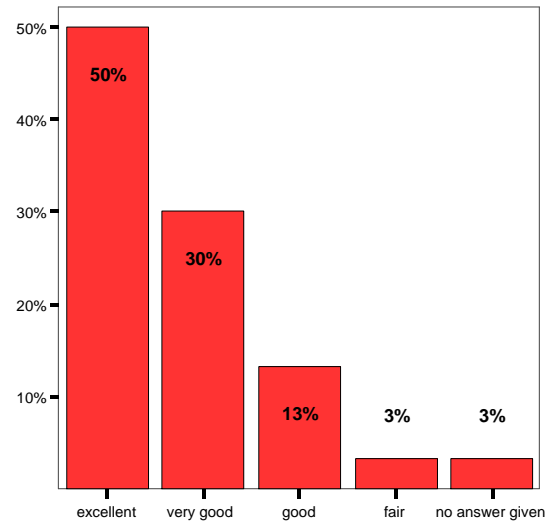


Figure 26: Opportunities to ask questions

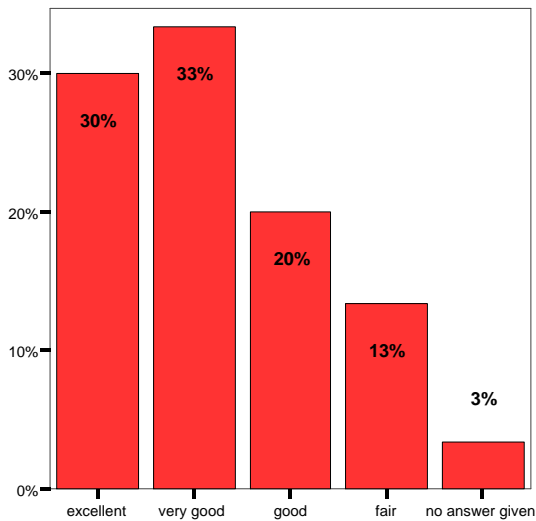


Figure 27: Explanation of medication

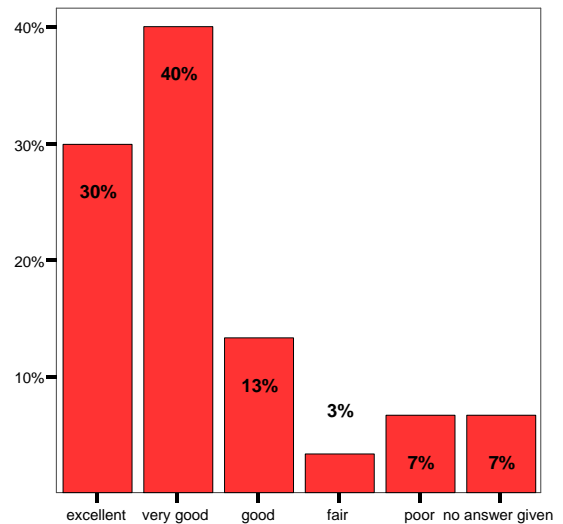
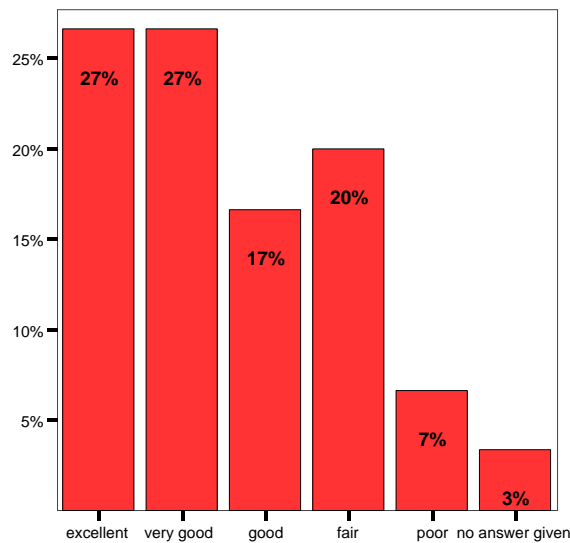


Figure 28: Involvement of family in your treatment



SECTION 5 - DISCHARGE PLANNING

Section 5 focused on when the patient was notified about their discharge from hospital and where they were discharged from i.e. RAMU or were they transferred to another ward before being discharged. Also when notification of their discharge was given, how long did they have to wait.

Figure 29 asked the question, whilst on RAMU was an expected discharge date discussed. 52% stated yes and 48% stated no. Figure 30 asks was it too early to be planning discharge. 73% said no and 23% stated yes.

Figure 29: Expected date of discharged discussed with you or you family

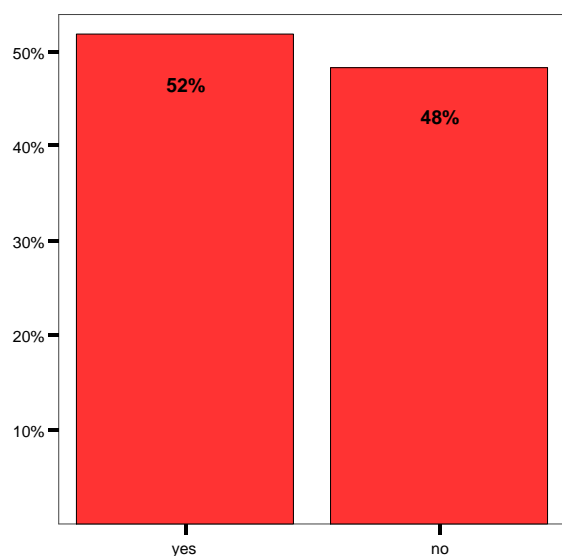


Figure 30: Early discharge planning

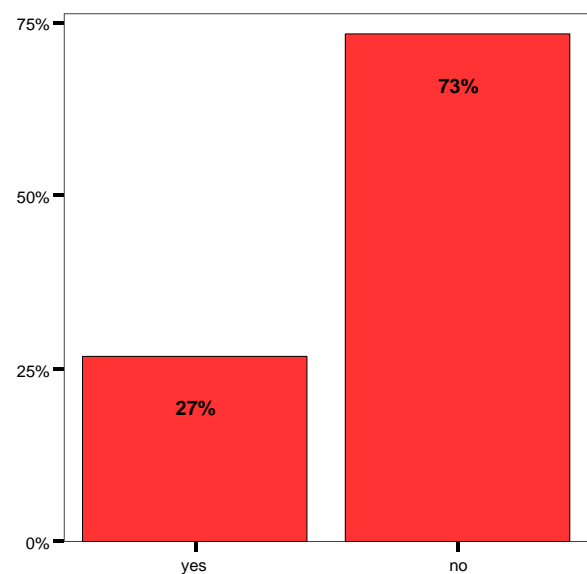


Figure 31: When was your discharge date discussed

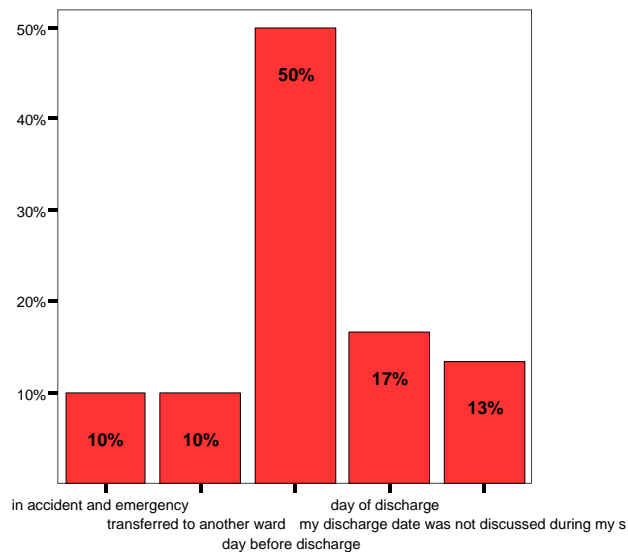


Figure 31 shows the response from patients who were asked, when during the course of your stay in hospital was your discharge date discussed. 10% stated in emergency, 10% when transferred to another ward, 50% stated the day before their discharge, 17% stated on day of discharge and 13% stated that no discharge date was discussed at all.

Figure 32: Where were you discharged from

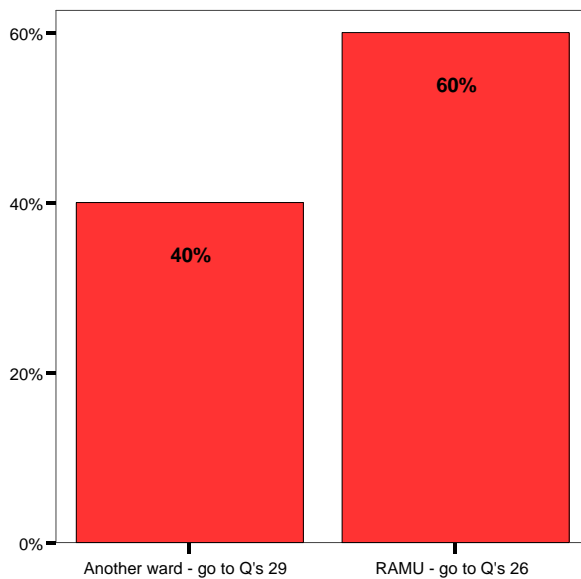


Figure 32 shows 60% of those discharged were discharged from RAMU and 40% were transferred to another ward for ongoing treatment.

Figure 33: How much notice were you given regarding your discharge

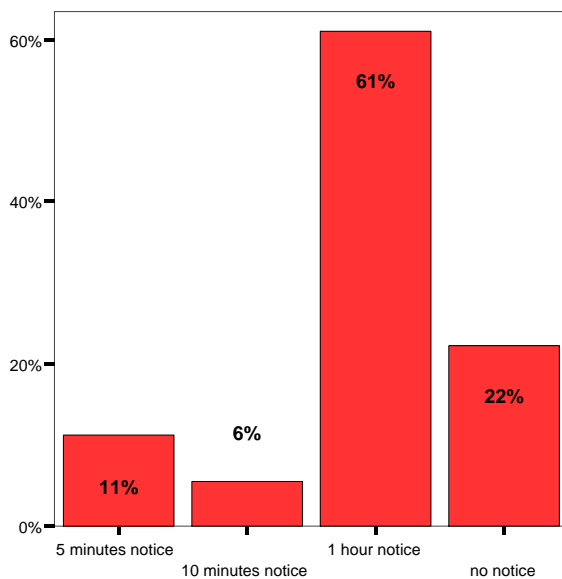


Figure 33 shows that of those patients that were discharged from RAMU, 61% stated that they were given only one hours notice, 22% stated that they were given no notice, 11% five minutes notice and 6% ten minutes notice.

Figure 34: RAMU staff prepared everything for discharge

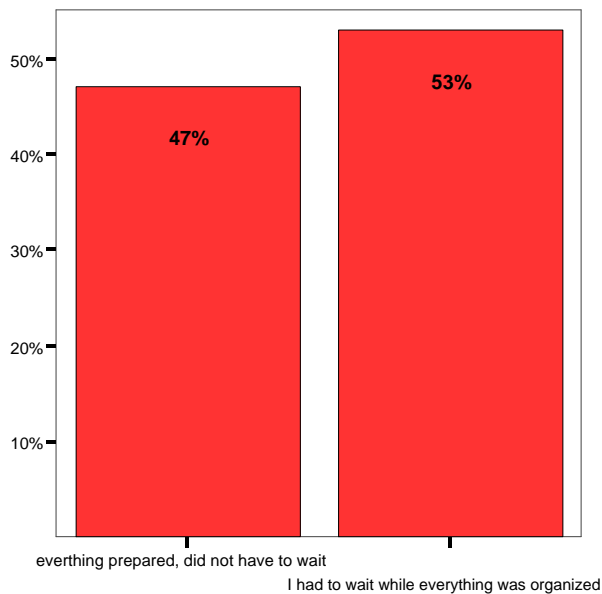
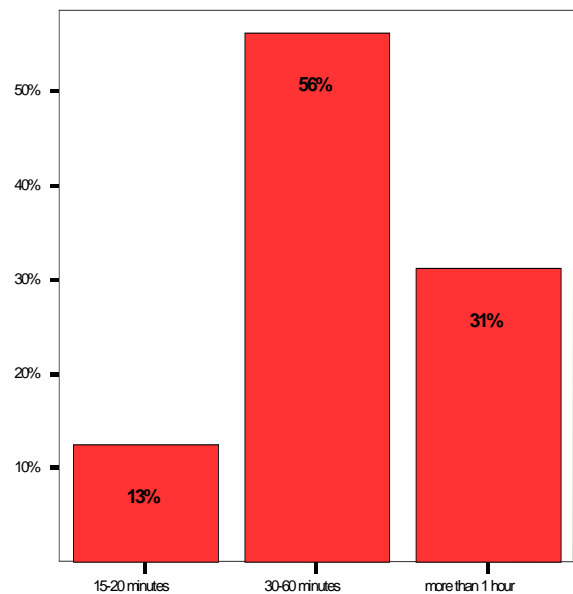


Figure 35: How long was your wait



Figures 34 and 35 examined if patients were discharged home from RAMU had staff prepared everything for them and if they had to wait, how long was their wait? 47% stated that everything was prepared for them however 53% stated that they had to wait for things to be organised for them. Of those that had to wait 56% stated at they waited between 30-60 minutes, 31% stated that they had to wait one hour or more and 13% stated that had to wait 15-30 minutes.

SECTION 6 – TRANSFERRING TO ANOTHER WARD

The next series of questions were for patients that were being transferred to another ward, after their allocated 23-48 hours were deemed up in RAMU. It also included questions about why patients were not happy about transferring to another ward.

Figures 36 and 37 focused on whether or not the patient was notified about being transferred to another ward and how much notice they were given. Of those that were transferring to another ward 54% stated they were aware they would be transferring after 24-48 hours and 46% stated they were unaware of the transfer. 43% stated they were only given 20-30 minutes notice 7% 40-60 minutes notice, 29% one hour notice and 21% only 5-10 minutes notice of their transfer.

Figure 36: Were you advised of being transferred to another ward

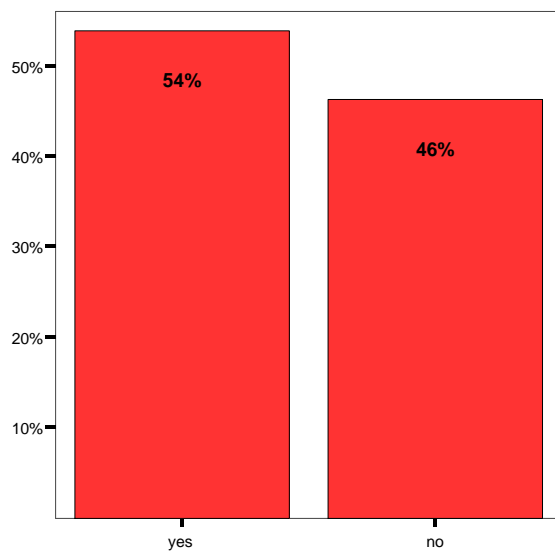


Figure 37: Notice of transfer to another ward

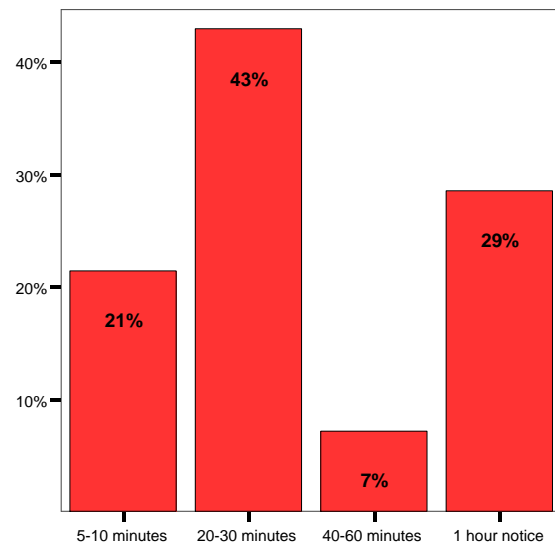


Figure 38 shows that 71% were informed of which ward that they were to be transferred to and 29% unaware of the ward they were going to. However Figure 39 shows, there is an equal distribution of 50% of yes and no about family being informed of the transfer.

Figure 38: Were you informed about which ward you transferring too

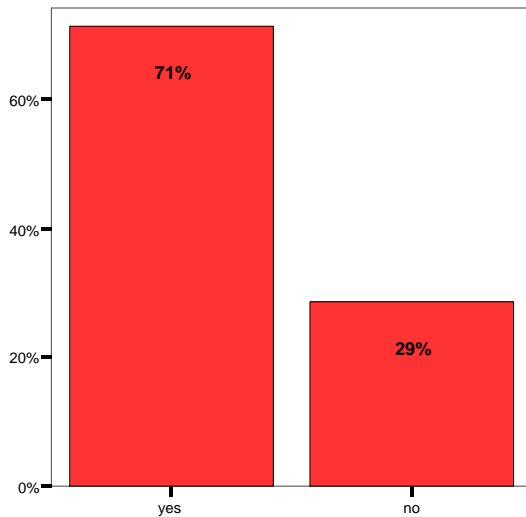
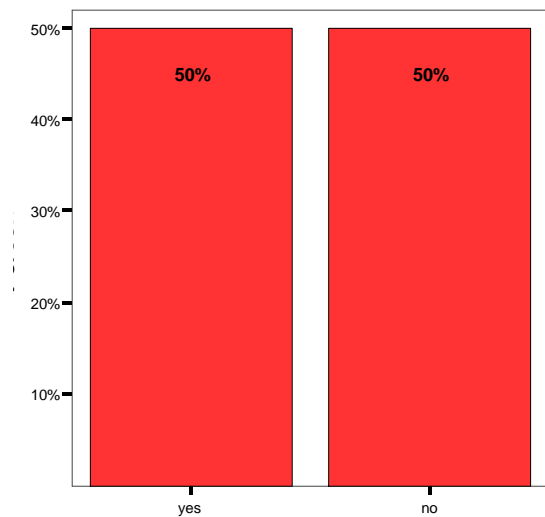


Figure 39: Were your family informed of transfer to another ward



Figures 40 and 41 asked the question in relation to family members being able to locate their relative after the transfer and if they were happy about the transfer. Figure 41 shows that 46% of relatives were not happy with the transfer whereas 54% were happy with the transfer. 93% of relatives stated that they could find their relative after being transferred and only 7% stated that they had difficulty locating their relative.

Figure 40: Could your family easily located you after your transfer

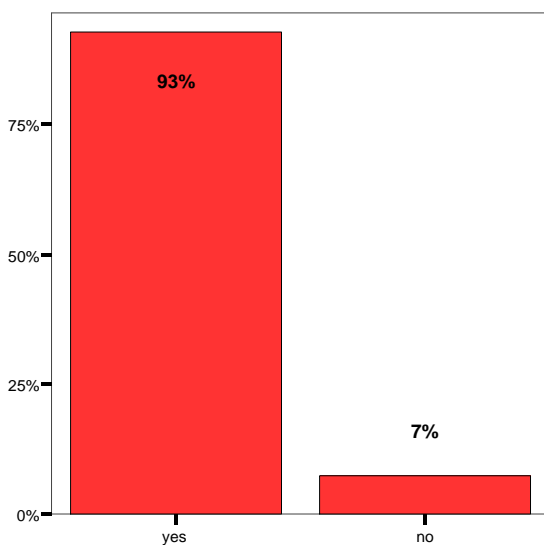
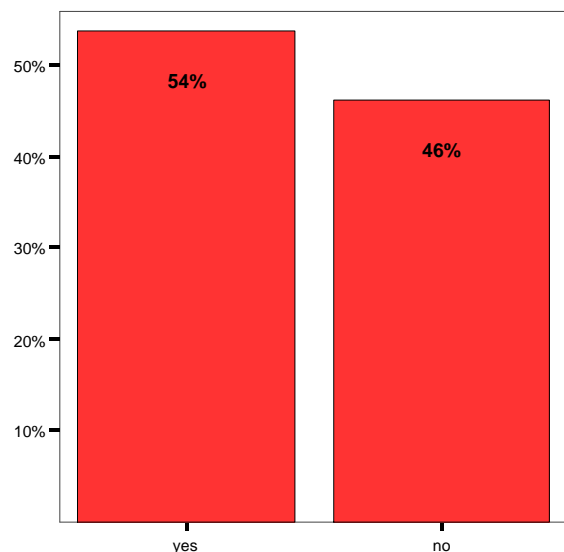


Figure 41: Were you/family happy with the transfer



Figures 42-46 in this section asked those that were being transferred to another ward to annotate by ticking the most appropriate box about why they were unhappy about their transfer to another ward. Patients could annotate more than one box. The question asked was “why were you not happy with transferring from RAMU to another ward because.....”

Figure 42: Familiar with surroundings

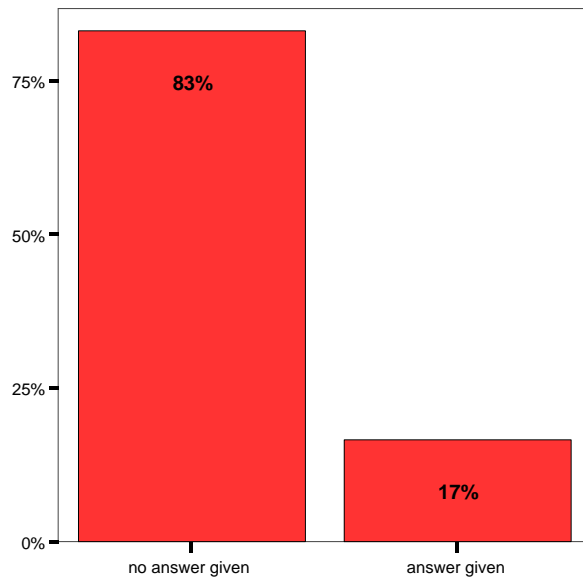


Figure 43: Familiar with staff and routine

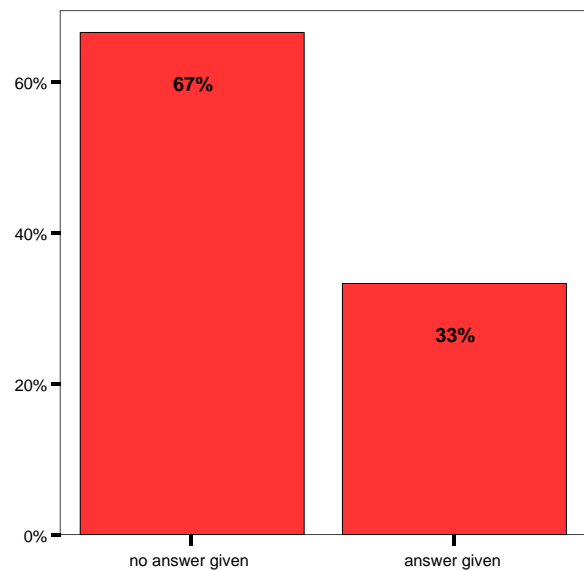


Figure 44: Liked where you were

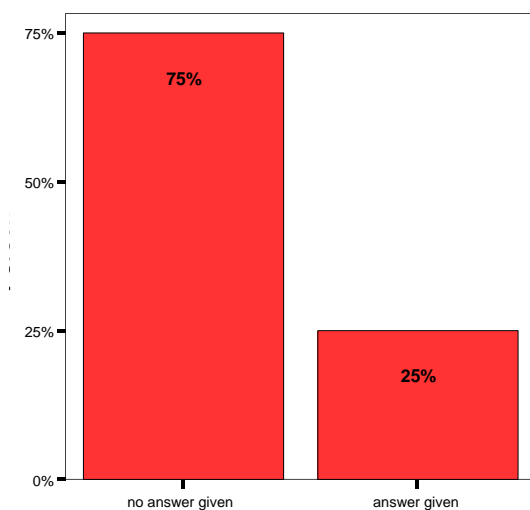


Figure 45: Not happy about transferring because

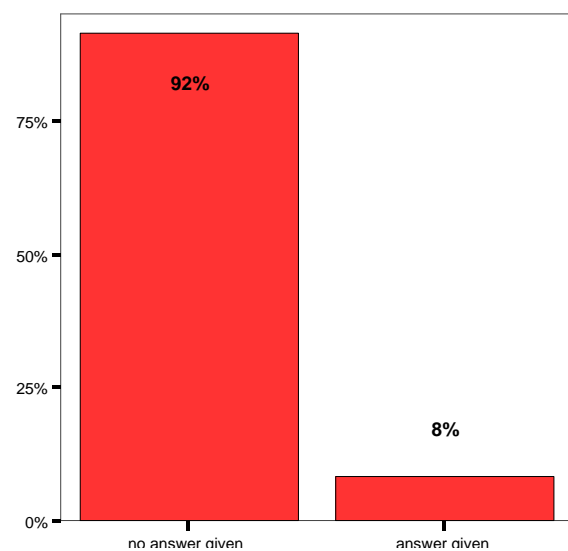
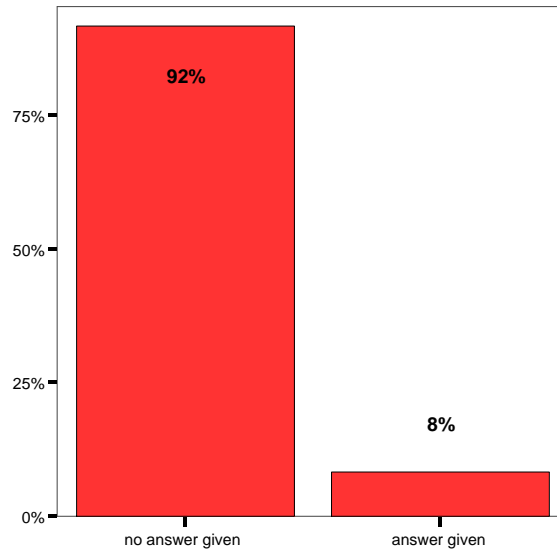


Figure 46: Family and friends could not locate you



SECTION 7 – ARRIVAL AT YOUR NEW WARD

Figure 47: Which ward were you transferred to

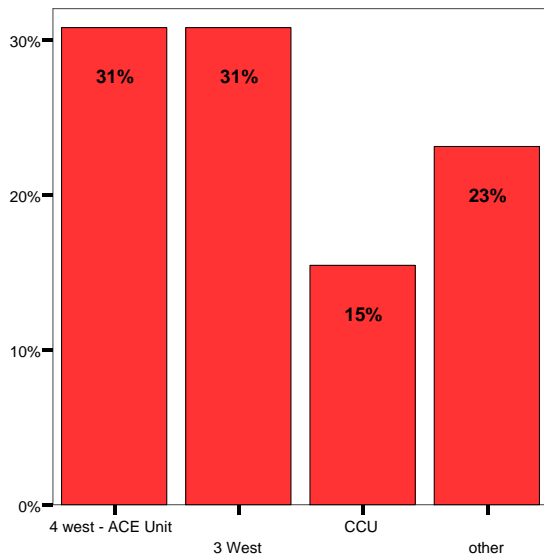


Figure 47 looks at which wards patients were transferred to. An equal number of patients were divided between two Medical Wards depending on the care required and the availability of beds. These being 31% each to Medical Ward 3 West and 4 West ACE (Aged Care Evaluation Unit). 15% went to the Coronary Care Unit and 23% were placed in other Wards throughout the hospital.

Figure 48: Family able to locate you easily after transfer

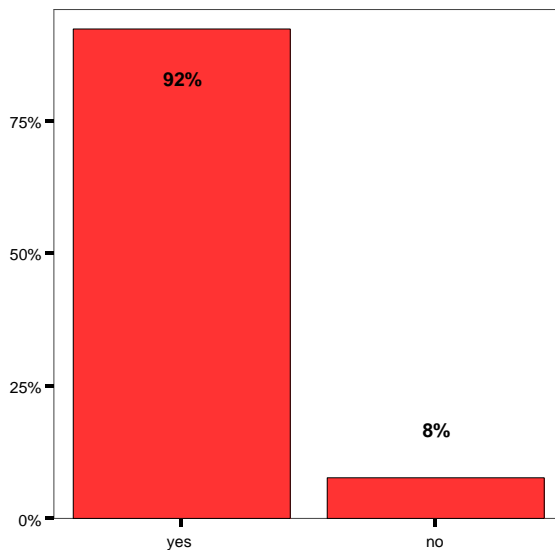
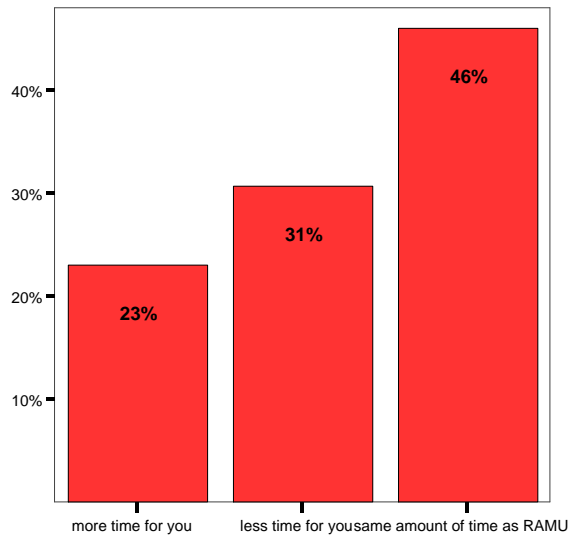


Figure 48 shows that 92% of relatives stated that they could find their loved one once they had been transferred to one of the above wards, however 8% stated they had difficulty locating them.

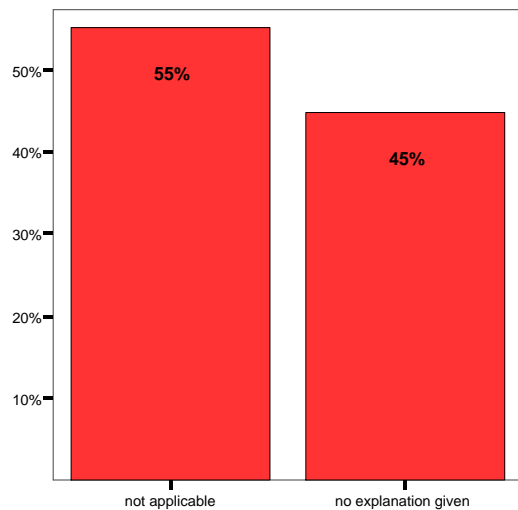
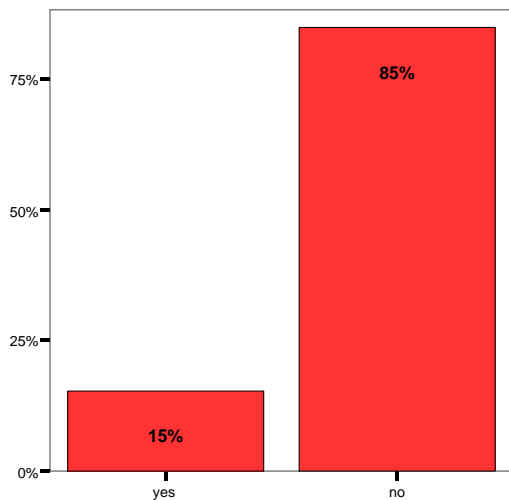
Figure 49: Nursing staff on new ward had time



In figure 49, the patient was asked whether or not they thought nursing staff on their new ward had more or less time for them compared to staff on RAMU. 23% thought they had more time for them, 31% stated less time for them, and 46% stated they had the same amount of time to spend with them as what staff on RAMU had.

Figure 50 asked the question whether they thought being transferred to another ward affected their recovery. 85% stated no it did not affect their recovery however 15% stated yes. Figure 51 shows that when asked that patients give a reason as to why they thought it had affected their recovery, no one gave any explanation.

Figure 50: Transferring to another ward affected your recovery **Figure 51: What way was your recovery affected**



SECTION 8 – SUMMARY SECTION

The summary section asked five questions in relation to how patients thought their stay and progression through hospital was. Participants were asked to give a brief explanation about their transition through hospital and answer four questions. However, a few gave inappropriate answers i.e. “I had a bad heart”, “the doctors knew me and should not have to ask me questions”, others failed to give any explanation. The following four questions were asked.

Figure 52: Proceed to RAMU first or go straight to a ward

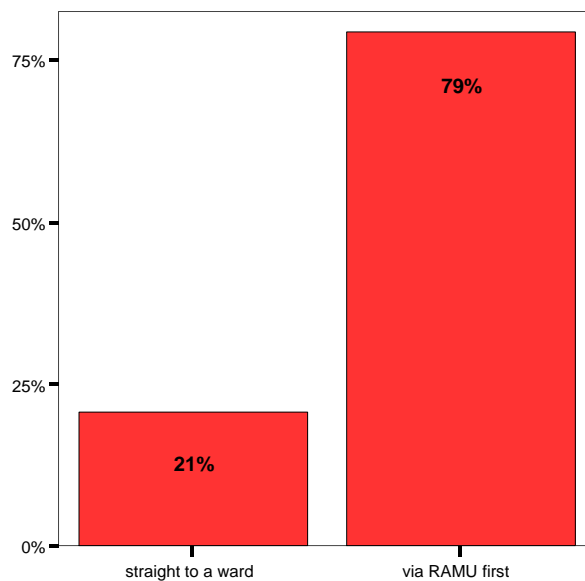
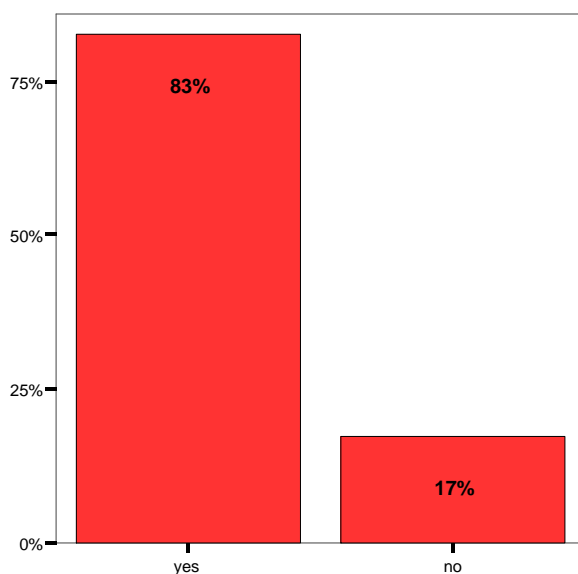


Figure 52 – would you prefer to proceed to RAMU first or go straight to an allocated ward. 79% stated that they would prefer to go via RAMU first and 21% stated they would prefer to go straight to an allocated medical ward.

Figure 53: Do you feel you should be admitted to RAMU first on any further admission



Should you be admitted to RAMU first on any further admissions to hospital. 83% stated yes and 17% stated no.

Figure 54: RAMU provided smooth transition though hospital

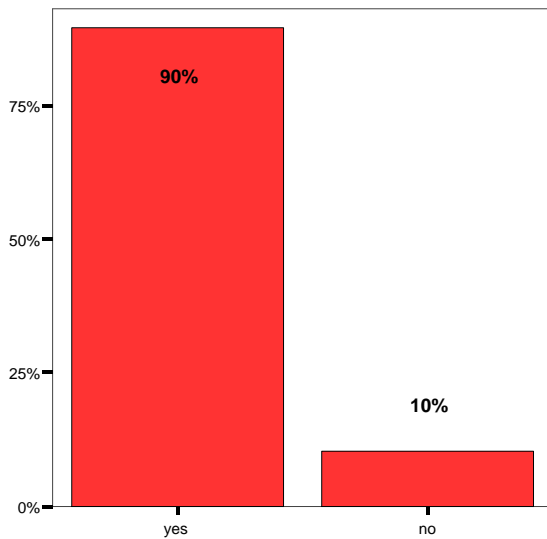
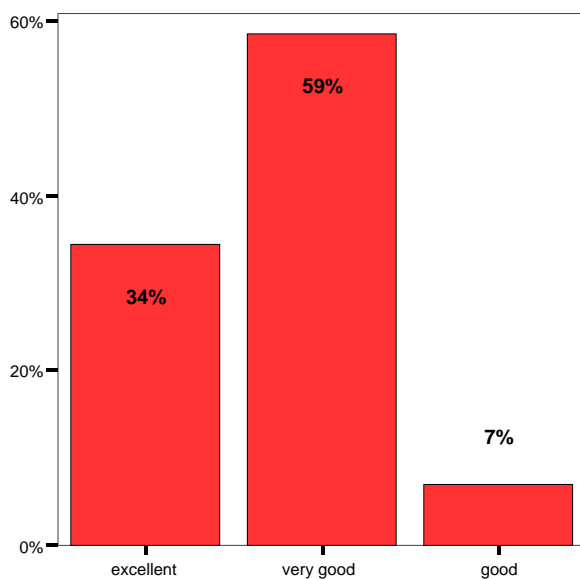


Figure 54 shows that 90% believed that RAMU provided a smooth transition through hospital during their stay.

Figure 55: Overall treatment



Overall 55% stated that their treatment on RAMU was very good, 34% stated it was excellent and 7% stated it was good.

CONCLUSION

This chapter focused on the data gathered and the results of both the retrospective and prospective survey. Chapter 5 presents the findings of the results of both data and examines closely the patients' perspective, understanding and thoughts about RAMU.

Chapter 5:

DISCUSSION – QUANTITATIVE FINDINGS

INTRODUCTION

Chapter 4 presents the results of the patient satisfaction survey that was conducted on thirty randomly selected patients who agreed to participate in this research project. This chapter aims to discuss the findings of the survey of patient satisfaction and patient care in relation to the literature.

PATIENT CARE

Chapter 2 reviewed what constitutes patient care and patient satisfaction in today's hospital environment. It proceeded to explore what patient's expectations were in relation to what they want and what type of care they should received whilst in hospital.

POSITIVE OUTCOMES

From the results received, it appears that patients and their families are extremely positive and happy about being admitted to RAMU first and have a positive attitude to the way that their hospital admission had progressed. 59% stated that their treatment was very good on RAMU, 90% stated that it had provided a smooth transition through hospital, 79% stated that they would prefer to proceed to RAMU first and 83% stated that they should be admitted to RAMU first on any further admissions.

“Ratings”

Section four of the patient satisfaction survey asked patients to “rate” their stay in hospital as excellent through to poor. These included areas such as courtesy of nurses and doctors, explanation of treatment, bell response time, being treated with respect, involvement of family in treatment opportunities to ask questions. (Larrabee & Bolden, 2002, p.36-40 & Houlster, 1999, p.45). From the results of the patient survey, patients were happy about their treatment on RAMU in respect to privacy, courtesy, response time to call bell, the opportunities to ask questions and involve family members.

Three percent stated 'poor' for privacy, answering call bell and information explained about their condition to you/your family (Figures 22, 23 & 24). However, privacy issues may relate to having to share a room with one or more patients (maximum of 4 per room), language barrier for explanation of treatment and condition of patients, if English is not a first language. Call bell times may have been the result of the nurses' capacity in handling the simultaneous workload of caring for more than one patient or caring for numerous patients. The morning shift is generally the busiest with medication rounds, dressings, and showers of patients to be carried out, discharge of patients to be organised to either home or transferring to another ward.

Positive Transfer

Section six of the survey focused on those patients that were transferred to another ward. Surprisingly 54% stated they were happy to be transferred to another ward compared to 48% who were not happy.

Question 34 asked the patient to choose one or more from a series of five short statements as to why the patient was **not** happy about transferring to another ward. Of those that gave a response to this question about not wanting to transfer 17% stated they were familiar with their surrounding (Figure 42), 33% stated they were familiar with staff and routine, (Figure 43), 25% stated they basically like where they were (Figure 44), 8% stated they were discharged the next day and believed it was inappropriate to be moved and 8% of family/friends had difficulty locating them (Figure 45).

Overall the response by patients about being transferred to another ward for ongoing treatment was very positive. 83% stated that on any further admissions they should be admitted to RAMU first and 79% of patients surveyed stated that they would prefer to proceed to RAMU first rather than going straight to an allocated ward. Also it was interesting to note that patients were asked whether or not nursing staff on their new ward had more time, less time, or the same amount of time as nursing staff on RAMU had. Considering the turnover of patients that RAMU may see within a 24 hour period 23% stated that the nurses had more time for them on their new ward, 31% stated they had less time for them and 48% stated that they had the same amount of time for them as RAMU nurses did.

This may contradict the findings made by Flinders Medical Centre where, patients are admitted to their correct ward/unit on admission or with 24 hours are more likely to have their care requirements planned in a consistent manner. Patients not admitted to their correct ward encounter management issues i.e. patients are last to be reviewed in regular ward rounds, discharge planning meetings are not represented by all team members responsible for the patients care (NDHP-2, 1999, p. 15). Of those patients that were transferred to another ward for further treatment, 85% stated that it had not affected their recovery in any way with 15% stating they felt it had, however of these 15% no one stated why they felt their recovery was affected.

NEGATIVE OUTCOMES

Communication

Communication appears to be the biggest issue that was apparent in the results of the patient satisfaction survey. Section two of the survey, “About RAMU”, Question 10 & 11 focused on patients been given an explanation about RAMU by A&E staff. Of this 80% and 73% respectively received no information about RAMU and about their length of stay. This may have been the result of, Agency Nursing Staff being employed on that shift, and they themselves not being aware of what RAMU is about, shift change over occurring at the time the patient was due for transfer, language barrier - patient/family not understanding the concept of RAMU, family stressed and anxious due to sudden acute illness of family member that is requiring to be admitted and having ‘information overload’.

However, nursing staff on RAMU also failed to give the patient or their family any explanation about RAMU or their expected length of stay. Section Three – Arrival to RAMU focused on when the patient arrived on RAMU. Of those surveyed 60% and 77% respectively answered they were given no explanation about RAMU or their Length of stay at all during their stay on RAMU. Of those that received any information about RAMU 27% said that the information given to them was “very informative”, 23% stated that it was “adequate”. However, it is interesting to note that 80% of RAMU nursing staff introduced themselves to their patients and their family, however they failed to give the patient any explanation about their stay on RAMU (Figure 12).

Discharge

Section five of the patient satisfaction survey focused on discharge planning. This is an area that is lacking in communication between patient, family and health care providers but is an essential necessity for careers, to be given a date of discharge. 52% of patients surveyed stated that they have been notified of their discharge date whilst on RAMU with 48% stating that they had not been given a discharge date. Of those that had had their discharge date discussed 73% stated that they did not consider it too early to be discussing a discharge date. 10% retrospectively had had their discharge date discussed in A&E or when transferring to another ward. 50% stated that it was the day before they were actually discharged home. 17% stated it was on the day of their discharge and 13% stated that a discharge date was not discussed with them at all.

However, 60% of all patients were discharged home from RAMU (with 40% being discharged after they were transferred to another ward). Of this 61% stated that they were given one hours notice of discharge, 11% stated five minutes notice, 6% ten minutes notice and 22% stated they were given no notice of discharge. However, even though patients were given such short notices of discharge they still had to wait for RAMU staff to prepare their discharge including medications from pharmacy and referral letters. 56% stated they had to wait 30-63 minutes 31% an hour or more and 13% 15-30 minutes.

Transferring to another ward

There was an improvement of communication between staff and patients in relation to the patient being transferred to another ward. Of the 40% that were transferred to another ward 54% stated they were advised of the possibility of being transferred to another ward and 46% stated they were not advised. 71% were informed of the ward they were being transferred to, compared to 29% who were not advised. However there was a 50/50% answer for family being advised of their relative being transferred to another ward.

Of those transferred to another ward, 43% were advised 20-30 minutes before the ward transfer was activated, 21% stated they were only given 5-10 minutes notice, 7% 40-60 minutes notice and 29% one hour or more notice. The short notice of transfer for patients to another ward is dependant on pending discharges and or discharges of patients from other wards. RAMU patients are allocated a particular ward and a bed number to where a patient is transferred (Figure 37).

CONCLUSION

This chapter's main focus was to establish if patients felt they were receiving satisfactory care whilst in RAMU and throughout their hospital admission. There appears to be a major consensus that patients feel that their needs are being met and are satisfied that they are receiving good quality care whilst in hospital especially whilst in RAMU. With the majority stating that they would prefer to be admitted to hospital via RAMU in the first instance.

Chapter 6: INTERPRETATION OF THE QUALITATIVE FINDINGS

INTRODUCTION

Chapter 6 presents findings from the qualitative data that was collected through conducting patient interviews and nursing staff interviews. The patient interviews were to be conducted using one-on-one in-depth taped interviews with ten consenting patients following their completion of the questionnaires and discharge from hospital.

The Focused Group Interviews (Nursing Staff interviews) were conducted on RAMU and a Medical Ward where patients are transferred to after their allocated 48 hours on RAMU. The interviews were conducted utilising a focused group interview, allowing nurses to freely express their thoughts, opinions and concerns (Beanland et al, 1999, p .294). This chapter is presented in the following way:

PATIENT INTERVIEW

- Aim of patient interviews
- Problems encountered with patient interviews
- One and only patient interview
- Summary of interview

NURSING STAFF INTERVIEWS

- Purpose of Focused Group Interviews
- Participants' Credentials

FOCUS GROUP INTERVIEW - FINDINGS

- Patient Care
 - RAMU – Defining Nursing Care
 - Medical Ward – Defining Nursing Care
- Patient Satisfaction
 - RAMU – Defining Patient Satisfaction
 - Medical Ward – Defining Patient Satisfaction
 - Summary

JOB SATISFACTION

- RAMU – Findings
- Medical Ward – Findings

CONCLUSION

Qualitative Data and Findings – Patient Interviews

AIM OF PATIENT INTERVIEWS

The aim of the patient interviews was to allow for patients participating in the interviews to expand on their answers that they had given from their patient satisfaction survey. It was also hoped that the patient would expand on their own personal experience of RAMU, and that the information gathered from these interviews to be used to help further develop better patient management of patients on such fast-paced high turnover wards.

The researcher had hoped to be able to interview ten participants; five from those that had discharged from RAMU straight to home and five that had been transferred from RAMU to another ward. From this selected group of patients, the researcher was also hoping to interview those patients that were not happy with their recent hospital admission and find out why and how things could be improved. However this did not eventuate.

PROBLEMS ENCOUNTERED WITH PATIENT INTERVIEWS

Time

Due to the longevity of obtaining those patients that met the criteria to participate in the patient satisfaction survey, the time frame from when some patients agreed to participate in the interviews a period of 6 months or more had elapsed and patients no longer wanted to be interviewed.

Rebounding Patients

During the course of collecting data some patients that had agreed to the interview when conducted had rebounded back into hospital and their hospital experiences were different second time round i.e. they had not gone directly to RAMU but however had gone straight to another ward, some were discharge straight home within 24 hours of admission to hospital and therefore their initial patient satisfaction survey that they completed was not appropriate.

Other Issues Encountered

Of those that had initially agreed to participate in the patient interviews, five in total, one had passed away, one had gone to a nursing home, two were no longer interested in participating as they were going away on holidays and only one agreed to do the interview.

ONE AND ONLY PATIENT INTERVIEW

There was only one patient that agreed to be interviewed in relation to their patient satisfaction survey. However this interview was not successful for a number of reasons. Firstly, he never had any previous admissions into hospital through out his lifetime and therefore could be classed as a minority, and secondly he only wanted to talk about his wife's experience in hospital.

To set the scene, this was an elderly widow gentleman who lived on his own. He had spent the last 5 years looking after his wife who had died of cancer and who was treated at the Palliative Unit at the same hospital he was admitted to.

The researcher asked the participant about his recent admission to Hospital. He stated that:

"it was his first admission into Hospital as a patient and was in fact his first admission to hospital in his life time. However he had been there numerous times visiting his late wife".

The researcher asked the participant about being informed about his length of stay on RAMU. He stated:

"that he had not been informed about how long he would be there or when he would likely to be discharged home". He went on to say, "that he did not like being in hospital as it reminded him to much of when his wife was in hospital and just wanted to get home as soon as possible"

This patient was in the majority of those who completed the patient satisfaction survey that stated that they had no knowledge of how long they would be on RAMU for or if they would be transferred to another ward or discharged how with in a given time.

The participant was transferred to another ward and was subsequently discharged home with 72 hours of his admission to hospital. The researcher asked the participant about how he felt about being transferred to another ward then discharge the next day. He stated:

"that he did not like the ward he went to as he had to share it with three other gentlemen (on RAMU he shared a room with one other gentleman) and that there was no television in the room that he went to. The room was old and there was no ensuite and he had to share a communal bathroom with other patients on the ward. He also felt that he should have stayed where he was as he was being discharged the next day.

He further went on to say that:

“that the nursing staff on both wards were wonderful and could not fault his care. He further went on to state that the care his wife had received was also fantastic and they were very supportive to him”.

The researcher asked if he would like to add anything or make any suggestions in relationship to his recent admission on RAMU. He stated, *“No, the care was great”*. Though the interview was only short, throughout the course of the interview, the participant wanted to ‘please’ the researcher and give the answers he felt the researcher wanted to hear. He also kept reminiscing about experience that his recently deceased wife had had whilst in the hospital and how good the staff was in giving treatment to her. He did not want to elaborate on his own recent experience in hospital. The interview was then terminated.

SUMMARY OF PATIENT INTERVIEW

As previously stated the aim of the patient interviews as to obtain further information: in relation to, attitudes, feelings and expectations about the participants experience on RAMU. To the researcher, these interviews would have helped gain further information about the responses to the participants patient satisfaction surveys, (Chapter 4, Phase Two), thus establishing improvements that may be facilitate patients transition from the A&E via RAMU to other wards. The time between patients having completed the surveys and returning them, to contacting the participants may have been too long and should have been completed sooner.

FOCUS GROUP INTERVIEWS – NURSING STAFF

Purpose of Focused Group Interviews

The purpose of conducting focus group interviews on both RAMU and a Medical ward was to try and clarify if there were any issues or concerns that may have arisen pertaining to patient satisfaction or patient care that staff may have had about the introduction of a Rapid Assessment Medical Unit. It also aimed to ascertain if staff, are happy to be working in a fast paced high turnover work environment. And if staff on Medical wards felt that they were being ‘short changed’ in only receiving patients that were no longer acutely ill.

Staff interviews were conducted approximately two years after RAMU had been operational.

Participants Credentials

Volunteer staff participants on both wards, were asked to complete a consent form (Appendix 8, page 103) and a short survey (Appendix 10, page 105) which indicated their age, gender, years of nursing experience, nursing and employment status. If the staff member was currently employed on RAMU, it was established for what period of time. RAMU staff were initially interviewed and one week later staff from a Medical Ward were interviewed.

Four RAMU nursing staff participated in the interviews and these consisted of the following status:

DESCRIPTION	RESPONSES
Gender:	4 Females
Nursing status:	4 -RN DIV 1
Age:	1 = 40 years plus of age 1 = 36-40 years of age 1 = 31-35 years of age 1 = 26-30 years of age
Employment status:	2 = Full time 2 = Part time
Nursing Experience:	2 = 1-2 years nursing experience 1 = 8-10 years nursing experience 1 = 3-5 years nursing experience
Time Nursing on RAMU:	2 = 6-12 months 2 = 3-5 years

Four Nursing Staff again agreed to be interviewed from the Medical Ward. Their credentials are as follows:

DESCRIPTION	RESPONSES
Gender:	3 Females 1 Male
Nursing status:	4 –RN DIV 1
Age:	1 = 40 years plus of age 1 = 31-35 years of age 2 = 26-30 years of age
Employment status:	2 = Full time 2 = Part time
Nursing Experience:	1 = 3-5 years nursing experience 2 = 5-8 years nursing experience 1= 10 plus years nursing experience
Time Nursing on RAMU:	4 = 0 time spent on RAMU

FOCUSED GROUP INTERVIEWS – FINDINGS

The focus group interviews were to focus on four main topics; patient satisfaction, patient care, job satisfaction and recommendations for improvements. Nurses on both wards were asked to identify what they thought patient care and patient satisfaction involved. According to Potter & Perry, (1993, p.21), in the past the principle role of the nurse was to provide care and comfort for individuals. The following are the findings of the Focused Group Interviews that were conducted:

Patient Care

RAMU - DEFINING NURSING CARE

When the question was put to RAMU staff what they thought patient care involved and remembering the five major themes which are, providing for my needs, treating me pleasantly, caring about me, being competent for me, and providing form prompt care for me, (Larrabee et al, 2002, p.37-39), the following answers were given:

“patient care starts from the time they come into hospital and it is attending to their every day basic needs whilst in hospital”..... “just giving my best care”

This nurse states that it begins at the very moment that they enter hospital and providing them with the best care they can give to the patient. This response looks at patient care, dealing with and 'providing for my needs' looking after and taking care of me. (Larrabee and Bolden, 2002, p.36).

"dealing with their emotional needs" "addressing issues at home and putting in the appropriate paper work to deal with these issues".

Having to deal with a patient's emotional needs is often as demanding or more as well as looking after their physical and medical needs whilst in hospital. This statement is best suited to come under the heading of Patient Satisfaction. Houlster 1999, (p.46-47) equates this to as "Presence", spending a minute to hold a hand and give comfort when needed", "Communication", listening to a patients concern, and "Autonomy & Respect", what a nurse says to a patient is as important as what they do for them.

MEDICAL WARD – DEFINING NURSING CARE

When the question was asked of nursing staff on the medical ward the following answers were given.

"meeting patients needs and getting them back home and making their hospital stay as smooth as possible"

This response deals with, according to Larrabee and Bolden, (2002,p. 36): Providing for my needs including; taking care of me, monitoring my progress, responding to my requests, providing pain relief or comfort, giving accurate information and providing a pleasant environment.

"looking after a patient and supporting their emotional, spiritual, and physical needs as well taking on a holistic approach to their care".

This response comes under the heading of: Caring about me. Being concerned about the well being of patients, being there for me, getting to know me, spending time with me and being supportive (Larrabee and Bolden, 2002, p.38).

"dealing with social issues".

This response may take on a variety of issues for a patient. Though the nurse that made this statement did not clarify what they meant by 'social issues'. It may include such things as: the patients ability to cope at home, do they live alone or with an elderly relative, do they require extra additional services i.e. for the council to help maintain their independence at home, or do they require assessment for placement in supported accommodation Such as a Nursing Hostel or Nursing Home.

Today, the roles of nurses have expanded to include being health promoters, caregivers, decision makers, client advocate, managers, rehabilitators, comforters, communicators and teachers (Tovey & Adams, 1999, p151). It would therefore seem that neither nursing staff on RAMU or nursing staff on the Medical ward are unable to clearly

identify the five major themes of what nursing care is. If nurses cannot define and identify what nursing care is, how can they delivery to their patients the care that they expect to receive? (Potter & Perry, 1993, p. 23-24).

Patient Satisfaction

Much research has been conducted on what patients believe as being 'satisfactory care' delivered to them during their stay in hospital. Constant themes emerge, and these are Communication, Education, Presence, Autonomy and Respect, and Professional Knowledge and Skill; (Houlster, 1999, p.43-50). When nursing staff from both wards were asked to define what constitutes "patient satisfaction" the following various interpretation were given by staff:

RAMU - DEFINING PATIENT SATISFACTION

When nursing staff on RAMU were asked what they thought constituted patient satisfaction the following responses were given:

"staff are friendly to the patients and are very approachable"

This shows that the nurse is willing to listen to the patients, is able to communicate with patients by listening to their concerns, issues and questions:

"we work well as a team and it what patients like to see"

Showing the respect and common courtesy not only to the patients but each other. Teamwork being the ultimate ingredient on RAMU that allows it to function well

"the ward is always clean and looks brand new"

This response is of partial importance however, it is often the Personal Service Attendant (Cleaner) that ensures that the ward is cleaned.

"we answer our buzzer on time"

This answer reflects both patient care and satisfaction i.e. providing for prompt care for me. Being prompt and punctual, responding, answering when I call and Presence: Being there for your patients, responding to a call bell quickly.

MEDICAL WARD – DEFINING PATIENT SATISFACTION

"patients don't have any complaints about their stay in hospital"

"good service provided"

These two responses are very broad in terms of what is said. The nurses that said these statements' feel that the patients' needs are being met whilst in hospital and that good patient care and patient satisfaction is being provided

on their ward. However, if the patient was unhappy with their treatment, would they in-fact make a complaint about their hospital treatment or stay? Cunningham (1991, p.63) states that, it is one thing for patient to have a complaint, but it is quite something else for the patient to take the initiative to express this concern”.

“their expectation and what they expect from us is being met”

This statement is dependant on what the individual patient expectations were. According to Cunningham (1991, p.68), patients come to hospital with definite expectations. Whether these expectations are realistic or not depends on the trouble the health care provider has taken to discuss the care and treatment regime. Satisfaction is linked to ensuring that patients and family members have realistic expectations and have easy access to someone who can resolve any complaints that may arise.

Summary

Nurses today play a key role in the healthcare picture and have a major impact on an individual's health outcome whilst in hospital. Nurses are the largest and most visible group of the healthcare profession and are the most visible force in hospital. The public tends to equate satisfaction with the provision of care by nurses. (Houlster, 1999, p. 43).

However, it would appear that nurses have forgotten the basic nursing fundamentals of what constitutes patient care and patient satisfaction in today's environment. This is demonstrated by the lack of perception as revealed by the interviews of some of the nursing staff, with only some staff able to identify some of the five themes i.e. communication and respect, that comprise nursing care according to Larrabee and Bolden, (2002 p.36-40) and no-one able to identify any of the themes which are communication, education, presence, autonomy and respect and professional knowledge and skill, that constitute patient care. Nurses on both wards feel that they are providing good nursing care to their patients and that their patients and their families are happy with the care that they are receiving whilst in hospital.

However, though nursing staff were able to identify only some of the basic themes that constitute patient care and patient satisfaction, the results of the patient satisfaction survey that was conducted for this research project, identified that the patients and their families were happy with the care and treatment that they were receiving whilst in hospital, with the majority stating that they would prefer to go via RAMU first.

Job Satisfaction

Nurses' job satisfaction is increasingly being shaped by their position within an organisation. As a result, pressure and stress is often associated with; new roles, role conflict, lack of job security, 'tight' resources, using new technology, a perceived lowering of standards of patient care, coping with increased amounts of paperwork and the experience of working in a rapidly and constantly changing environment. Nurses must now perform a balancing act of having to deal with increased internal conflicts, responsibility for providing an effective, optimal staffing

establishment at the lowest possible cost, accountability for care and its documentation and bureaucratic pressure to assess and effect a faster turnover of patients, prior to earlier discharge. (Tovey & Adams, 1999, p.45).

Being a nurse in today's fast-paced, demanding patient settings is gruelling, physically exhausting, and mentally and intellectually draining. As the role of nursing rapidly changes to meet these increasing demands placed on hospitals to improve patient outcomes, does the art of caring for patients simply become a chore, or is it still for the 'love of the job'? Does 'fast tracking patients' and having all diagnostic procedures performed by one medical unit place added stress on nurses of that ward? Are nurses from other wards missing out on performing essential nursing skills and are therefore left to perform "basic nursing care" of patients? Does job satisfaction exist in such climates, but more importantly, is there a standard of care and satisfaction for patients and their families?

Findings

Nurses from both wards were asked, "What is job satisfaction"? For each nurse there was a different response to what they considered job satisfaction to be.

RAMU – NURSING STAFF

"People you work with, and that you all get along". "Good team work and share work load". "Getting together to talk things over... helps reduce stress". "Not having the same patient everyday, especially if you have a difficult patient last shift".

Teamwork for nursing staff on RAMU is important and essential due to the high turn over of patients. It appears to be the main ingredient that allows such a fast paced ward to function so efficiently. The ability for the nurses on RAMU to work well together and function as a whole unit is reflected in the response given in the patient satisfaction survey that showed the majority of patients preferred to go via RAMU first.

"Assessment skills become quicker on patients and you are able to recognise things sooner and make suggestions to improve patient care"... "Getting all my work done properly, my patients are looked after and cared for and at the end of the day I am happy that I have completed all my duties and my patients are well". "Nature of the ward, fast paced, dealing with acutely ill patients and doing things for them".

It would appear for those nurse interviewed that they are happy in their current jobs and are able to meet the demands placed on them in such a busy environment.

When asked was there anything negative about their job the following responses were given:

"Need more equipment" "Need a waiting room for families with a TV in there for them, the room where in doctors use it to discuss to families their relatives diagnosis/prognosis which is inappropriate".

The nurses did not specify what equipment they needed more of; they emphasised the need for a family/relative room for doctors to be able to discuss treatment of patients to their relatives. This is an issue that needs to be further investigated and raised with management.

“too many dementia patients”...

Unfortunately with the increasing population of the elderly comes an increase with old age related medical problems for which patients may need hospitalisation. Their treatment should be no different to the generalised population requiring hospitalisation. However, is this ward adequately set up for patients with dementia that may wander and become disorientated? Should they be admitted to one particular ward and stay there for their duration to limit the amount of confusion and over stimulation that they may experience and thus allow for the patient to become ‘familiar with that ward’?

“too much paper work; our paper work has to be completed in 24 hours of admission of a patient including their discharge”

This is an issue that needs to be discussed with management in producing more comprehensive paper work. It is one of the issues that is raised by Tovey & Adams, (1999, p.150), the increase in the amounts of paper work, and the effect that fast turnover has on patients prior to their discharge.

“patients refusing to be transferred to another ward”.

Communication issues between patient/family and nursing staff arises from patients refusing to transfer to another ward. It was one of the major issues that arose from the patient satisfaction survey with 46% of patients stating that they were not advised they were being transferred to another ward (Figure 36).

RAMU – Focused Group Interview Conclusion

Those nurses from RAMU that participated in the interviews enjoyed where they worked and the type of patients that moved through RAMU. Not one nurse stated that they did not like working on RAMU. Therefore, it may be apt in quoting from Hinsaw, Smeltzer, & Atwood, 1987, (cited in Neubauer, 1996, p.7) job satisfaction means’

“enjoyment in one’s job, ability to do quality work, adequate time to meet task requirements, and adequate ability to identify task requirements. Job satisfaction usually includes a sense of pride and a sense of accomplishment”.

MEDICAL WARD – NURSING STAFF

In contrast, nurses from the Medical ward had a very different opinion on what job satisfaction is. Staff were more concerned with the impact that RAMU has on patients and their families in relation to their care and their overall

outcomes. Aiken & Patrician (2000, 49-3,p.146-153) states that, “nursing-patient outcomes are affected by the environment in which it is delivered”.

Issues that were raised by the nurses on the medical ward were:

“A lot of patients complain when they arrive here. They’re anxious and very agitated. Why am I here? Where’s the television, why’s the toilet so far?” “We get angry people, we’ve got to explain things continuously why someone’s been moved to our ward and why this is done, and then they say well on the other ward this happened and that happened and we have to re-educate them all over again”.

“Older elderly patients don’t cope well with change”.

Change of Environment: Patients are transferred from a new ward to an old ward where there are no personalised televisions, patients have to share rooms with three other patients and there are no ensuites. Beaudion & Edgar (1994, p.107), states nurses face many daily ‘hassles’ that affect their work tasks, these problems included such things as working conditions, staffing skill mix, and the environment.

“Patients don’t know that RAMU is a short stay ward. They need to be educated perhaps given a pamphlet about their stay on RAMU”..... “When transferring a patient who has been on the ward a couple of days there maybe family or social issues and nothing is documented and families say, ‘I’ve already explained all this to the last lot of nurses”..... “families have the opinion that because their family member has move to another ward their condition has deteriorated, something has changed in their condition that they had to be move to another ward”.

Continuity of Care and Communication: Nursing staff on the Medical Ward seem to feel that there is a lack of continuity of care and communication between the two wards when patients are transferred, especially in relation to discharge and discharge planning and transferring to other wards. Of those patients surveyed, 54% stated that they were aware that they would be transferred to another ward. In relation to discharge, 52% stated that an expected date of discharge was discussed on RAMU of those, 40% were transferred to another ward for ongoing treatment. Cunningham (1991, p.85), states, that continuity of care and continuity of communication among health care teams is critical to overall patient satisfaction.

Nurses employed on the Medical Ward appeared to enjoy their work as they nursed both a mixture of general medical patients and surgical patients on their ward. However their concerns were for patients that were transferred from RAMU to their ward, especially those that had some difficulty coping with change. They believed that RAMU worked well for patients that only need admitting for 24-48 hours and who could be discharged home afterwards, and those that need ongoing hospital admission should be admitted directly to a medical ward.

CONCLUSION

This chapter focused on what patient care is, patient satisfaction and job satisfaction.

With so many 'roles' that nurses have to undertake today in nursing, it is often difficult to deliver the care that patients and their families expect. It is often difficult to deliver nursing care in a high patient turnover hospital environment. Much emphasis in today's hospital is placed on being able to get the patient home as soon as possible, are nurses for-going the basic fundamentals of patient care and satisfaction or have they simply forgotten what care and satisfaction is about?

It would appear that nurses have forgotten some of the basic fundamentals requirements for what constitutes patient care and patient satisfaction, with the answers from the Focus Group Interviews showing that nurses today are unable to define the difference between patient care and satisfaction. In saying this, nurses from both wards feel that they are capable of delivering satisfactory care to their patients without patient complaints and this is emphasised with the response to the Patient Satisfaction Surveys which showed that 83% stated that they should go via RAMU in the first instance, 85% stated that being transferred to another ward did not effect their recovery and 46% stated that the nursing staff on both wards had equal amount of time to spend with them.

Job satisfaction does not appear to be an issue for those nurses interviewed, as they all seem to enjoy where they work and the types of patients that they nurse on a day-to- day basis.

Chapter 7: CONCLUSION

INTRODUCTION

The final chapter of this thesis summarises the outcomes of the study which examined and evaluated the effects that a RAMU has on patient satisfaction, patient care, job satisfaction, impact of our ageing society and the average length of stay for patients post and pre RAMU. It also discusses the problems that were encountered during the course of this research project and the need for further research to be conducted on RAMUs. This chapter is presented in the following way:

- Methodology
- Limitations to the study
- Problems encountered
- Future research
- Recommendations
- Conclusion

METHODOLOGY

As there were no previous studies identified that investigated function and operation of an RAMU, it was deemed that the best research approach would be to use an evaluative research case method. An evaluative research method allowed for the use of multi-sources for evidence gathering and took into account the potential for overlapping of other research designs. According to Beanland et al (1999, p.213), an evaluative study allows for the determination of not only whether care is adequate but also which method of care is best under certain conditions. Studies can be used to determine whether a particular type of nursing care is cost effective, that is, the outcome is positive and optimum for the patient at a calculated fiscal cost to the health care unit. In an era of health care reform and cost containment for health expenditures, it has become increasingly important to evaluate the relative costs and benefits of new programs of care. By incorporating the use of both qualitative and quantitative research techniques a multitude of research data can be gathered for interpretation and to address the aims and objectives of the research project.

The use of quantitative research for both prospective and retrospective data collection in phase one of the research was apt. However, for future data collection at a retrospective level, a larger number of patients i.e. one thousand,

with a break down of their admission diagnosis, may change the outcome of the ALOS for patients. On the prospective side of data collection, vetting the correct patients that met the criteria to participate should have been at the discretion of the researcher, rather than the ward clerk, thus reducing the time it took to collect data.

The use of qualitative research to gather subjective data from patients post-discharge from hospital was very limited due to one interview participant. It was hoped that the information gathered from the interviews would identify any problems or issues that patients may have had during their stay in hospital. The qualitative method using focus group interviews with nursing staff allowed for subjective data to be collected, allowing for the participants to express concerns or issues they may have about their current working environment or those voiced by patients or relatives.

The study has demonstrated that the design of using an evaluative research method incorporating the use of mixed methods has attempted to capture the effect that fast tracking medical wards have on the standard of patient care and patient satisfaction. It has also attempted to capture the feelings that nurses have towards this method of nurse practice on wards and the impact it has on their ability to nurse patients and their relatives in such environments. The use of a mix method case study would be of useful benefit for future evaluation of such wards, but the limitations of the study and other operational issues within the hospital would need to be adequately addressed.

LIMITATIONS TO THE STUDY

Although this case study was aimed at evaluating the ALOS of patients pre and post RAMU, patient satisfaction, patient care and nursing staff job satisfaction through the use of qualitative and quantitative data, using a combination of questionnaires and interviews, there were limitations to this study.

Sourcing Appropriate Participants

Though RAMU has a high turn over of patients per 48-hour period than any other hospital ward, the availability to source appropriate patients became an issue. It was left to the ward clerks to source the appropriate patients that conformed with the requirements of this research project as laid down in Chapter 3 of this research project. Thus it took longer than expected to obtain consent from appropriate participants of this project. Also it was deemed inappropriate to expect patients to participate if they had already or agreed to or declined to in their previous admissions.

Validity and Reliability of Patient Responses

Fifty patients agreed to participate in the Patient Satisfaction Questionnaire. Of those fifty questionnaires that were distributed only thirty were eventually returned. This was after follow-up reminder letters being posted and telephone calls made. The validity of postal questionnaires according to Cohen et al (2000, p. 128) can be seen in two ways.

Firstly whether respondents who complete them do so accurately, honestly or correctly and secondly, whether those who failed to do so, would their questionnaires have given the same distribution of answers as did the returnees.

Questionnaires have an advantage over interviews in that it is anonymous, encourages honesty and is more economical in terms of time and money. However this is counter balanced with low returns, incomplete questions especially if the participants don't understand the questions. Overall the one main issue considering the reliability and validity of questionnaire surveys is that of sampling i.e. an unrepresentative, skewed sample that is too small or too large can easily distort the data. (Cohen et al, 2000, p.129). It was therefore hoped that data collection from patient interviews would add further information about patients and families concerns or issues they may have and also add as a secondary source of data analysis to validate responses that patients had given on the patient satisfaction survey.

PROBLEMS ENCOUNTERED

A variety of problems were encountered along the way in the course of this research project. These problems included:

1. Lack of literature material available

At the beginning of this research project (2001) no literature material had been available that focused on what a RAMU (Rapid Assessment Medical Unit) was, how it functioned, how it operated and who benefited from such wards. A new medical era in treating patients within a 48hour time frame had been created. A medical unit, where patients are admitted from the A&E to a ward. Here the patient's medical condition is assessed, ongoing treatment provided and the patient is either discharged home within 48 hours or transferred to another ward.

Literature that was available pertained to 24-hour short stay wards or observation wards that are similar in concept, but operate along side A&Es as discussed in Chapter 2 – Literature Review. A parallel had to be drawn between the literature available on short stay wards and the concept of what RAMU was.

2. Ethics Committee Dilemma

As this research project was based within a hospital environment, using patients and staff, approval for this project was sought through the CEO of the hospital, as at the time the hospital did not have an Ethics Committee. Therefore approval was sought in conjunction with the University Ethics Committee and the hospital CEO.

3. Sourcing Patients

One of the criteria that were stipulated by the Ethics Committee stated participants for the surveys had to be sourced by a third party. Therefore it was left to the ward clerks on RAMU to help find the most appropriate participants. However, due to their workload, and with set guidelines that participants had to meet in order to participate in the research project, often several weeks would pass before the appropriate types of participants were asked to participate. As a result it took approximately 8 months to distribute 50 patient satisfaction surveys of which 30 persons agreed to complete.

This added to the problem of obtaining participants to take part in patient interviews; the length of time between completing the survey and agreeing to participate had been too long. They had been re-admitted to hospital during the intervening period from agreeing to participate to when the actual interviews were to occur. They were no longer available i.e. going on holidays, moved into a nursing hostel/home, or passed away.

During the course of distributing the patient satisfaction surveys, the hospital was also conducting their own patient satisfaction survey. Thus patients did not want to complete two satisfaction surveys.

4. Patient Interview

Of the initial five that agreed to participate in the patient interviews only one was ultimately interviewed. However, this interview was deemed inappropriate as it became obvious to the researcher that the participant wanted nothing more than to “please” the researcher and reminisce about the experience and the care that his deceased wife had had whilst being treated in hospital. As a result, patient interviews did not eventuate. Which was unfortunate, as it would have provided valuable information into how patients felt about RAMU and would have validated necessary change to procedure and or routines in patient transition to other hospital units.

RECOMMENDATIONS

The following recommendations in relation to this thesis are as follows:

1. Conversing with Potential Participants

Due to the length of time it took to obtain an adequate amount of participants for this research, it would be recommended for future research that the researcher be allowed to vet participants and obtain consent from them as well as involving several others i.e. nurses to help in this process. This may also help eliminate the time taken to conduct interviews and avoid the possibility of participants renegeing of interviews.

2. Education

Education of staff members, patients and their relatives about the role of RAMU would help eliminate the unnecessary anxiety and stress that relatives may have about being transferred to another ward within the allocated time frame of 48hours. This may be in the form of a pamphlet (written in several languages) handed to patient and relatives in either A&E or on arrival to RAMU. Also, an information sheet present on the walls of each patient's room, again stating the role of RAMU.

3. Patient Satisfaction Surveys

Patient satisfaction surveys to be divided into two separate surveys. One for patient's that are discharged home from RAMU, and another for patients that are discharged from other wards. This may lessen the confusion for patients completing the surveys. In this research survey both areas were incorporated together.

4. Rebounding Chronic Patients

Those patients who have chronic medical conditions with multiple admissions and who require more than 48 hours in hospital, should be admitted directly to an allocated ward, to lessen the stress and burden on the patient and the family. Patients who are admitted to their correct speciality ward/unit on admission are more than likely to have their care requirements planned in a consistent manner. (NDHP-2, 1999, p.15).

5. Discharge Planning

Discharge Planning is an area that was of concern in relation to the data that was collected. Though patients agreed that it was not too early to be discussing discharge when admitted into hospital, 48% stated that a discharge date was not discussed with them at any stage during their stay in hospital. 61% stated that they were only given one hours notice of discharge, 22% stated they were given no notice. An improved implementation of informing patients of their pending date of discharge and an expected time needs to be devised, especially for patients that have to organise someone to pick them up or to arrange transport.

FUTURE RESEARCH

Further research needs to be conducted in the following areas:

1. ALOS

Though RAMU has reduced the average length of stay marginally, further investigations into the types of medical conditions that patients are presenting with is needed. Researching their ALOS and devising a care plan may reduce the length of stay in hospital and prevent these patients from "rebounding".

2. Fast Tracking Patient

Implementation of a rigorous Patient Satisfaction Survey to be conducted every four months, for patients that are being 'fast tracked' with chronic medical problems and complications, to ensure that the constant moving of patients from ward to ward Does not add undue stress and worsen their medical condition, and increase bureaucracy, cost and workload/stress.

3. Ageing Population

As the population ages and the need for medical services and interventions increases, further research needs to be conducted on the impact that the ageing population will have on the health care system within the next 10 years. Will 'hospital care' for those with chronic morbid medical conditions be 'outsourced' to other medical teams to treat these patients in the community to alleviate the pressure on hospital beds?

4. Staying Healthy

With the steady increase in the ageing population and the expected burden it will place on the health care system, increased education needs to be conducted by GPs, governments and hospitals through media advertising to encourage society to take a "healthy living approach" to prevent those approaching 65+ age from developing morbid chronic medical conditions. The effectiveness of such campaigns will need to be evaluated.

5. RAMU, why it works

Why has RAMU worked where others have failed? What causes this unit to be unique and operate so well?

6. Nursing Staff

Assess the coping strategies used by staff on RAMU to prevent stress, burn out and high turnover of staff.

CONCLUSION

This research was undertaken to evaluate four main areas since the introduction of a RAMU. The two areas of most concern were patient satisfaction and patient care. Can effective medical and nursing care be given to patients within a 48-hour time frame? Are patients happy with this type of medical practice? The other two areas were job satisfaction of both staff on RAMU and a Medical Ward. Were those employed on a Medical ward being "short changed" in relation to dealing with acutely ill patients? Were nurses happy to practice in such a "fast tracking" medical environment? Finally does a RAMU reduce the average length of stays of a patient'?

The introduction of RAMU has only reduced the total over all average length of patients marginally from 7.47 to 7.39 days. Through data gathered, patients were happy with being admitted to hospital via RAMU, and with the patients ongoing care and needs being assessed on RAMU before either discharge home or transfer to another ward the average length of stay for patients in realistic terms has not changed.

From the data gathered from this evaluation study, patient care and patient satisfaction can be answered in one paragraph. It would appear that when it comes to patient satisfaction and patient care, patients and their families who are admitted to hospital are happy with the treatment they received whilst on RAMU and whilst in hospital. As previously stated, 90% believed that RAMU provided a smooth transition through hospital, 83% stated that they would prefer to be admitted to RAMU first on any further admissions into hospital. With the main focus on the health care system today to increase productivity and reduce the average length of stay for patients, it would appear that with the introduction of a RAMU, patient care and satisfaction is not compromised and can be achieved in a short period of time.

From information gathered from the Focused Group Interviews, job satisfaction or lack thereof does not appear to be an issue with staff on both RAMU and the Medical Ward. RAMU nurses appear to enjoy the structure of the ward and the workload in relation to the high turnover of patients, with a mix of acute and chronic medical patients and do not believe that patient care is compromised in any way, whereas, staff on the Medical Ward have a variety of mixed surgical/medical patients. They feel that the transferred patients should be better informed on their arrival in the Medical ward. They feel that they are not being deskilled in relation to dealing with acutely ill patients. The only issue that nurses from the Medical Ward have is the lack of patient education and information that patients receive in relation to their stay on RAMU. Costello, (2001, p.8), sums up by saying "You will never have patient satisfaction without employee satisfaction".

Finally, the delivery of health care is an ongoing issue for Governments and Health Departments. New ways of delivering and dealing with the increasing number of people that require access to today's health care system is a challenge for any hospital. This hospital and its staff have developed a formula that appears to work well for them with the introduction of a Rapid Assessment Medical Unit and has managed to find the ultimate balance of providing patient satisfaction and staff job satisfaction, whilst being able to efficiently and effectively deliver 'fast track' medical care within a period of 48 hours.

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APPENDICES

APPENDIX 1: INVITATION TO PARTICIPATE IN RESEARCH STUDY

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus

Ballarat Road, Footscray

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

Dear Sir/Madam,

My name is Rosemarie Crozier and I am a Registered Nurse currently undertaking a research project as part of a Masters of Nursing at Victoria University of Technology – St Albans Campus.

Aim of Research Project

As an in-patient on RAMU (Rapid Assessment Medical Unit), I am inviting you to participate in a survey questionnaire about your recent admission and stay in hospital. The aim of this research project is to help gauge the effect and impact RAMU has on patient care, patient satisfaction, and most of all, what opinions yourself and others have about RAMU.

No Obligation

I must stress, that you are under no obligation to participate in this study and is in no way connected to any future care you may seek. If you do choose to participate in this research project, please complete the attached consent form and then a survey will be mailed to you after you are discharged from hospital.

Patient Confidentiality

Patient confidentiality is of the utmost importance, and patient confidentiality will be adhered to at all times with only my research supervisor, Dr H. Baker and myself having access to your personal details and any responses to your questionnaire.

Contact Details

If you have any questions concerning this research project do not hesitate to contact myself on (03) 9741 7115 or my research supervisor Dr. H. Baker on (03) 9365 2830 or alternatively the University Human Research Ethics Committee on (03) 9688 4710.

Thank you for your assistance and time and hope that your stay in hospital was pleasant and brief.

I look forward to hearing from you.

Kind Regards,

Rosemarie Crozier

Please retain this information sheet for any further enquires you may have.

APPENDIX 2: CONSENT FORM TO PARTICIPATE IN A RESEARCH QUESTIONNAIRE

Victoria University
PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road, Footscray

CONSENT FORM TO PARTICIPATE IN A RESEARCH QUESTIONNAIRE

I

OfPhone No:.....

Certify that I freely give my voluntary consent to participate in the research project,

“The 48 hour Patient – Who Reaps the Rewards?”

being conducted at Victoria University of Technology – St Albans Campus by Rosemarie Crozier.

Thank you for participating in this research project.

Participants Consent:

Signed: Dated:

Witness, other than the researcher:

Signed: Dated:

Any queries about your participation in the study may be directed to the researcher, Rosemarie Crozier on: (03) 9741 7115 or to my supervisor Dr. Helen Baker on (03) 9365 2830. Alternatively, if you have any queries or complaints about the way you have been treated, you can contact the University Human Research Ethics Committee, Victorian University of Technology, PO Box 14428 MCMC Melbourne 8001 or Telephone: (03) 9688 4710.

APPENDIX 3: RAPID ASSESSMENT MEDICAL UNIT – PATIENT SATISFACTION SURVEY

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000

Facsimile:
(03) 9689 4069



Footscray Park Campus

Ballarat Road, Footscray
Dear Sir/Madam,

How are you? I hope that you are feeling better and that your stay in hospital was short and uneventful. I would like to re-introduce myself. My name is Rosemarie Crozier and I am a Registered Nurse, undertaking a Masters in Nursing.

Stage One - Research Questionnaire

Whilst admitted to hospital recently, you kindly agreed to participate in a Research Project that I am undertaking in relation to your stay on RAMU (Rapid Assessment Medical Unit). If you are still willing to participate, please complete the questionnaire and return it in the pre-paid envelope provided.

Stage Two – Taped Interview

I would also like to take is opportunity to ask whether you may be interested in participating in Stage Two of this project, and that is an audio taped interview.

The aim of this audio taped interview will allow you the opportunity to:

- (a) clarify any of your answers to the survey,
- (b) express any opinions or concerns that you may have about your stay on RAMU,
- (c) make any recommendation about improving your care whilst in hospital, and
- (d) answer any questions about RAMU that you may have.

This audio taped interview would be conducted at a time and place that suits you.

Confidentiality

It is important to stress that patient confidentiality will be adhered to at all times and any identifiable names will not be used throughout the course of the interview. Only my supervisor and my self will have access to these tapes and they will be kept in a secured container. All information collected throughout the course of this research project will be destroyed accordingly to University Protocol.

No Obligation

You are under no obligation to participate in this audio taped interview and you may withdraw from it at any stage. Withdrawal from this project will not jeopardize you in any way.

If however you would like to participate in an interview, please complete the “Interview” form attached and return it along with your questionnaire.

Contact Numbers

If you have any concerns or questions in relation to either your questionnaire or the interview please do not hesitate to contact my supervisor Dr H. Baker on (03) 9365 2830, myself (03) 9741 7115 or the University Human Research Ethics Committee on (03) 9688 4710.

Thank you for your time in completing the questionnaire and returning it.

Kind Regards,
Rosemarie Crozier

Please retain this information sheet for any further enquires you may have.

Official Use Only

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RAPID ASSESSMENT MEDICAL UNIT -
PATIENT SATISFACTION SURVEY

(Adapted from TQA Research Pty Ltd- State Government Victoria)

The following questions are about your recent admission to RAMU.

Please **TICK** the answer that applies to you.



About You!!!

Q1. What is your current age group?

- 18-24 (1)
- 25-34 (2)
- 35-49 (3)
- 50-64 (4)
- 65 years and over (5)

4

Q2. Gender

- Male (1)
- Female (2)

5

Q3. Do you speak a language other than English at home?

- Yes (1)
- No (2)
- Specify (3)

6

Q4. How long was your last stay in hospital?

- 1 day (1)
- 2 days (2)
- 3-4 days (3)
- 5-6 days (4)
- 7 days or more (5)

7

Q5. Did you complete this survey ...

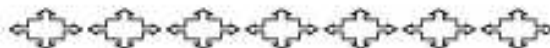
- On your own. (1)
- With assistance. (2)

8

Q6. Including your most recent admission into hospital how many times have you been admitted to Western Hospital in the last 12 months?

- 1st time (1)
- 2nd time (2)
- 3-4 times (3)
- 5 times or more (4)
- None (5)

9



Official Use Only

- Q7. Do you feel that your length of stay on your last admission was
- Too long (1)
 - Adequate (2)
 - Too short (3)
 - Just enough time (4)

10



About RAMU???

- Q8. Was this your first admission to RAMU?
- Yes (1)
 - No - go to Question 10 (2)

11

- Q9. Approximately how many admissions have you had to RAMU in the last 12 months?
- 1-2 admissions (1)
 - 3-4 admissions (2)
 - 5-6 admissions (3)
 - 7-8 admissions (4)
 - 9 or more admissions (5)

12

- Q10. **Before** your arrival to RAMU from the Accident and Emergency Department, was any explanation given to you or your family About the RAMU?
- Yes (1)
 - No (2)

13

- Q11. Did any staff member in Accident and Emergency explain to you or your family how long you would be staying on RAMU?
- Yes (1)
 - No (2)

14





Arrival On RAMU

Official Use Only

Q12. When you arrived on RAMU, did nursing staff introduce themselves to you or your family?

- Yes (1)
- No (2)

15

Q13. When you arrived on RAMU – did you arrive

- During the morning (1)
- After lunch time (2)
- Late afternoon (3)
- Evening time (4)
- During the night (5)

16

Q14. Given the time of your arrival to RAMU, were you or your family given any explanation about RAMU or how long you would be staying?

- Yes – go to Question 16 (1)
- No – go to Question 15 (2)

17

Q15. At any stage during your stay on RAMU were you or your family given an explanation to how long you would be staying on RAMU for?

- Yes (1)
- No (2)

18

Q16. How would you rate the explanation you were given about RAMU

- Very Informative (1)
- Informative (2)
- Adequate (3)
- A little informative (4)
- I did not understand the information (5)

19





During Your Stay On RAMU

Official Use Only

Q17. During your stay on RAMU, you may have been exposed to a wide range of people from different health professionals, e.g. physiotherapists, diabetic educators, pharmacist, etc. Did they introduce themselves to you?

- Yes (1)
- No (2)
- Not Applicable (3)

20

Q18. Did they explain their role to you?

- Yes (1)
- No (2)

21

Q19. Do you feel that you benefited from their visits?

- Yes (1)
- No (2)
- Unsure (3)
- Not Applicable (4)

22

Q20. How would you rate the following statements about your stay on RAMU:

Please tick the correct response	Excel- lent	Very Good	Good	Fair	Poor
a. the courtesy of nurses & doctors on RAMU					
b. the way your treatment was explained to you by doctors and nurses on RAMU.					
c. length of time it took staff to respond to your call bell.					
d. respect for your privacy					
e. the way information about your condition was explained to you and your family					
f. being treated with respect					
g. opportunity to ask questions about your treatment whilst on RAMU					
h. purpose of your medication being explained to you, including side-effects					
i. involvement of your family in your treatment and care whilst on RAMU.					

23a

23b

23c

23d

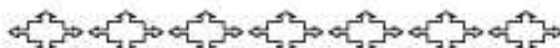
23e

23f

23g

23h

23i





Discharge Planning

Official Use Only

Q21. Whilst on RAMU was your expected date of discharge discussed with you or your family?

- Yes (1)
 No (2)

24

Q22. Do you think that it was too early to being planning your discharge home?

- Yes (1)
 No (2)

25

Q23. When during the course of your stay in hospital was your discharge date discussed?

- When you were in Accident and Emergency (1)
 When you were transferred to another ward (2)
 The day before your discharge (3)
 The day of your discharge (4)
 Discharge date was not discussed during my stay (5)

26

Q24. Were you discharged home from

- RAMU – go to Question 26 (1)
 Ward - go to Question 29 (2)

27

Q25. If you were discharged straight to home, how much notice was given in relation to your discharge?

- 5 minutes notice (1)
 10 minutes notice (2)
 30 minutes notice (3)
 1 hours notice (4)
 No notice (5)

28

Q26. Had staff on RAMU prepared everything for your discharge ie. medications, follow up appointments **OR** did you have to wait?

- Everything was prepared for me, I did not have to wait (1)
 I had to wait while everything was organised –

(2)

29

Q27. If you had to wait, how long was your wait?

- 5-10 minutes (1)
 15-20 minutes (2)
 30-60 minutes (3)
 more that 1 hour (4)

30



Official Use Only

If you were discharge direct to home DO NOT complete the following questions. Instead, proceed to the SUMMARY SECTION at the back of the Questionnaire.



Transferring To Another Ward

Q28. On RAMU was it explained to you or your family that you would be transferred to another ward within 24-48 hours?
 Yes (1)
 No (2)

31

Q29. How much notice were you given that you would be transferred to another ward?
 5-10 minutes notice (1)
 20-30 minutes notice (2)
 40-60 minutes notice (3)
 1 hour or more notice (4)
 No notice was given (5)

32

Q30. Were you informed to which ward you were being transferred to?
 Yes (1)
 No (2)

33

Q31. Was your family informed of your transfer to another ward?
 Yes (1)
 No (2)

34

Q32. Could your family locate you easily after your transfer?
 Yes (1)
 No (2)

35

Q33. Were you and your family happy about the transfer to another ward?
 Yes (1)
 No – go to question 35 (2)

36



Official Use Only

Q34. Why were you **not** happy with transferring from RAMU to another ward? **Tick** the most appropriate response – (you may have more than one response to this Question).

a. you were familiar with your surroundings	
b. you were familiar with staff and the routine	
c. you like where you were	
d. you were due for discharge the next day and believed that it was inappropriate to be move to another ward	
e. your family and friends could not locate you, once you had moved to another ward.	

37a
37b
37c
37d
37e



Arrival At Your New Ward

Q35. What ward were you transferred to?

- 4 West – Age Care Evaluation Unit (ACE) (1)
- 3 West (2)
- CCU (Coronary Care Unit) (3)

38

Q36. Was your family able to locate you easily once you were transferred?

- Yes (1)
- No (2)

39

Q37. Do you feel that the nursing staff on the ward you were transferred to had (tick **one** response only)

- more time (1)
- less time (2)
- no time (3)
- same time (4)

40

to spend with you and explain your progress than staff on RAMU had.

Q38. Do you think that being transferred to another ward, affected your recovery in any way?

- Yes (1)
- No (2)

41



Official Use Only

Q39. In what way do you think your recovery was affected?

.....
.....
.....

42



SUMMARY SECTION

Q40. Following your recent admission into Hospital would you have preferred to proceed straight to a ward or go via RAMU first?

- Go straight to a ward
- Go via RAMU

43

Q41. In your opinion, do you feel that you should be admitted to RAMU first on **any further** admissions into hospital?

- Yes
- No

44

Q42. Please give a brief explanation to your answer on either yes or no

.....
.....
.....

45

Q43. Do you think that your admission to RAMU provided a smooth Transition throughout your stay in hospital?

- Yes
- No

Q44. Over all do you think your treatment on RAMU was

- Excellent (1)
- Very Good (2)
- Good (3)
- Fair (4)
- Poor (5)

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**Thank you for your time and participation.
Don't forget to mail the survey in the envelope provided.**



APPENDIX 4: CONSENT FORM TO PARTICIPATE IN AN AUDIO TAPED INTERVIEW

Victoria University
PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road, Footscray

CONSENT FORM TO PARTICIPATE IN AN AUDIO TAPED INTERVIEW

I

Of Phone No.....

Certify that I give my voluntary consent to participate in Stage Two of the research project:
“The 48 hour Patient – Who Reaps the Rewards?”
being conducted at Victoria University of Technology – St Albans campus by Rosemarie Crozier.

I acknowledge, understand and have been appropriately informed that:

- *the aim of this research project is to identify patients requirements, understanding and concerns about treatment and care of patient, like myself, on a Rapid Assessment Medical Unit,
- *information given by myself, will help identify any concerns/issues that patients have about a Rapid Assessment Medical Unit,
- *the audio taped interview will discuss some of my answers from my questionnaire,
- *I have the opportunity to have any questions answered.
- *the researcher will contact me to organize a date, time and location that suits myself for the interview.
- *this will be an audio taped interview and consent to such,
- *I can withdraw from the interview at any time and withdrawal will not jeopardize me in anyway.
- *information provided will remain strictly confidential, be kept in a secure container and will be destroyed accordingly at the completion of the research project,
- *I can contact the researcher at any time if I have any concerns regarding the audio taped interview,
- *I am over 18 years of age,
- *My medical history and identity will be safeguarded at all times.

Thank you for participating in this research project.

Participants Consent: Signed: Dated:

Witness other than the researcher: Signed: Dated:

Any queries about your participation in the study may be directed to the researcher, Rosemarie Crozier on: (03) 9 741 7115, or to my supervisor Dr. Helen Baker on (03) 9365 2830, or alternatively if you have any queries or complaints about the way you have been treated, you can contact the University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC Melbourne 8001 or Telephone: (03) 9688 4710.

APPENDIX 5: REMINDER LETTER – PATIENT SATISFACTION SURVEY

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road, Footscray

Dear Sir/Madam,

RAPID ASSESSMENT MEDICAL UNIT – PATIENT SATISFACTION SURVEY

Hi, it's me again, Rosemarie Crozier. This is just a short note to remind you about a Research Questionnaire I recently sent to you, regarding your recent admission into hospital and your stay on RAMU (Rapid Assessment Medical Unit).

If you have already completed the questionnaire and sent it to me, just ignore this letter. If you are yet to complete the questionnaire or having trouble understanding any of the questions please do not hesitate to telephone myself on (03) 9741 7115 or alternatively my supervisor Dr H. Baker on (03) 9365 2830.

I hope that you are feeling much better and on the road to a complete and healthy recovery. I look forward to hearing from you soon.

Thank you for your time.

Regards

Rosemarie Crozier

APPENDIX 6: RESEARCH STUDY – FOCUSED GROUP INTERVIEW PARTICIPANTS

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road. Footscray

RESEARCH STUDY

FOCUSED GROUP INTERVIEW PARTICIPATION

For:

3 West (NUM)
RAMU (NUM)

Dear Nurse Unit Managers,

My name is Rosemarie Crozier. I am a Registered Nurse undertaking a Research Project as part on my Masters of Nursing at Victoria University of Technology – St Albans Campus.

I am currently undertaking a research project examining the role of RAMU. I am looking at various issues and concerns that have been raised since its inception. Some of these issues/concerns include; patient satisfaction, patient care and nursing staff job satisfaction.

I would like your permission to conduct an audio taped Focused Group Interview with some of your Nursing Staff at a date and time that is best suited for your staff.

I would be pleased to discuss any concerns or issues that you may have and can be contacted on Home: 9741 7115 or alternatively, you may contact my supervisor Dr Helen Baker at VUT St Albans Campus on (03) 9365 2830.

Thank you for your co-operation.

Rosemarie Crozier

APPENDIX 7: INVITATION TO ATTEND A FOCUSED GROUP INTERVIEW

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road, Footscray

INVITATION TO ATTEND A – “FOCUSED GROUP INTERVIEW”

Dear Colleagues,

My name is Rosemarie Crozier and I am a Registered Nurse currently undertaking a Masters in Nursing.

I am seeking volunteers who have been employed on this ward for a period of three months or more to attend a taped Focused Group Interview, (at a time and date to be decided, and with afternoon tea provided), interested ?

The topic of discussion will be, the impact if at all, that RAMU has had on, patient satisfaction, patient care, and Nursing Staff Job satisfaction. Your views, issues and concerns are of importance to this Research Project and your attendance would be greatly appreciated.

It is important to stress that all comments made during the audio taped interview will not be discussed outside the interview. Judgments will not be made about other staff members' contributions and only my supervisor and myself will discuss what is said on the tapes.

If you have any concerns regarding this Interview please do not hesitate to contact me on (03) 9741 7115 or my supervisor Dr. H. Baker (03) 9365 2830.

Still interested?????? Stay tuned for a date and time.

Regards

Rosemarie Crozier

APPENDIX 8: FOCUSED GROUP INTERVIEW CONSENT FORM

Victoria University
PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000
Facsimile:
(03) 9689 4069



Footscray Park Campus
Ballarat Road, Footscray

FOCUSED GROUP INTERVIEW CONSENT FORM

I

Certify that I freely give my voluntary consent to participate in an audio taped interview, for the purpose of a research project:

“The 48 Hour Patient – Who Reaps the Rewards?”

conducted at Victoria University of Technology – St Albans Campus by Rosemarie Crozier.

I understand and acknowledge that:

- * I have been given a full and comprehensive explanation as to the nature of this research project, any risks involved and why this research project is being conducted;
- * I consent to this interview being audio taped;
- * I have the opportunities to have any questions answered;
- * I can withdraw from this interview at any time, and this withdrawal will not jeopardise me in any way;
- * I have been advised that any information provided will remain confidential, be kept in a secured locked container and will be destroyed accordingly at the completion of this research project;
- * I will not compromise patient confidentiality;
- * I will not make judgements about other staff members' contributions;
- * I will not discuss/disclose what is said during this audio taped interview to other staff members, patients, relatives or friends;
- * I am employed by Western Hospital as a Registered Nurse;
- * I am over 18 years of age; and
- * This consent was made voluntary.

Thank you for participating in this research project.

Participants Consent: Signed: Dated:

Witness other than the Researcher: Signed: Dated:

Any queries about your participation in the study may be directed to the researcher, Rosemarie Crozier on: (03) 9741 7115 or to my Supervisor Dr. H. Baker (03) 9365 2830. Alternatively, if you have any queries or complaints in the way you have been treated you can contact the University of Human Research Ethics Committee, Victoria University of Technology, PO Box, 14428MCMC, Melbourne 8001 or Telephone: (03) 96884710.

APPENDIX 9: PILOT SURVEY REQUEST LETTER

Victoria University

PO Box 14428
MELBOURNE CITY MC VIC 8001
Australia

Telephone:
(03) 9688 4000

Facsimile:
(03) 9689 4069



Footscray Park Campus

Ballarat Road, Footscray

Dear Participant,

My name is Rosemarie Crozier, and I am a student at Victoria University of Technology currently studying for a Masters in Research – Nursing. I am currently researching a new method of medical care that is currently undertaken at Western Hospital – Footscray, called a Rapid Assessment Medical Unit or RAMU.

The aim of RAMU is to help alleviate the overcrowding that occurs within their Emergency Department, by providing patient care within a time frame of 48 hours. The basic concept of RAMU is patients arrive at the Emergency Department are admitted to hospital, if needed, then transferred to RAMU where all investigations and procedures are conducted, these may include, discharge planning, x-rays, physiotherapy etc which is organized before the patient is transferred to the appropriate Medical Ward or discharged home within 48 hours.

Since RAMU's inception, patients, families and Medical Staff have raised concerns and issues in relation to patient satisfaction; patient care and staff job satisfaction. The aim of my research project titled "The 48 Hour Patient – Who Reaps the Rewards?" is to explore and investigate these issues. Part of this investigation is to distribute "Patient Satisfaction Surveys" to patients that are admitted to RAMU.

Before the surveys can be distributed to patients, it is part of the University Guidelines that Pilot Surveys be distributed to agreed participants who have no vested interest in this research project or who are not connected to the Hospital.

Please find enclosed a Pilot Survey – Rapid Assessment Medical Unit – Patient Satisfaction Survey for your vetting. Please feel free to add any comments to the survey. If you have any questions regarding the survey or RAMU please do not hesitate to contact me on Ph: 97417115.

Yours sincerely

Rosemarie Crozier

APPENDIX 10: FOCUSED GROUP PARTICIPANTS GENERAL INFORMATION

Focused Group Participants General Information



Please complete the following information about you, by placing a tick next to the appropriate response.

GENDER:

- Female
- Male

NURSING STATUS:

- RN DIV1
- RN DIV 2
- Graduate Nurse

AGE:

- 20-25 years
- 26-30 years
- 31-35 years
- 36-40 years
- 40 plus years

EMPLOYMENT STATUS:

- Full time
- Part time
- Nurse Bank

NURSING EXPERIENCE:

- Graduate Nurse
- 1-2 yrs nursing
- 3-5 yrs nursing
- 5-8 yrs nursing
- 8-10 yrs nursing
- 10 yrs plus nursing

TIME NURSING ON RAMU:

- 1-6 months
- 6-12 months
- 1-3 years
- 3-5 years
- Graduate Rotation

Thank you for completing this information.

