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A Journey on Wheels: Patient Experiences and Challenges During In-Hospital Transfers to the Operating Room

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ABSTRACT

Aim: This study aimed to explore surgical patients' experiences, perceived difficulties, and expectations regarding in-hospital transfer via stretcher before, during, and after transfer to and from the operating room.

Methods: A qualitative descriptive study reported according to the Consolidated Criteria for Reporting Qualitative Research guidelines. Seventeen surgical patients hospitalized in the surgical clinics of a state hospital in Central Anatolia, Türkiye, were selected using purposive sampling. Data were collected through face-to-face, audio-recorded, semi-structured interviews and analyzed using inductive content analysis.

Results: Patients' in-hospital transfer experiences were organized into three temporal stages: pre-transfer, during transfer, and post-transfer. Seven themes emerged: (1) Patient Consent and Information Process, (2) Loss of Comfort, (3) Lack of Communication and Information During Transfer, (4) Post-Transfer Lack of Reception, (5) Non-Patient-Oriented Communication Experience, (6) Perceived Continuity of Care, and (7) Expectations and Suggestions for Improvement. Before transfer, patients reported limited involvement in consent procedures, insufficient information about transfer time and destination, and uncertainty about how the transfer would be performed. During transfer, patients described physical discomfort related to stretcher movement, fear of slipping or falling, cold exposure, privacy concerns, emotional distress, and limited communication with staff. After arrival, patients reported insufficient reception, limited orientation to the receiving unit, and communication focused mainly on clinical tasks. Positive experiences were described when nurses welcomed patients, monitored their clinical status, explained the subsequent care process, and remained visibly present. Patients expected clearer information, safer and more comfortable transfer conditions, privacy protection, supportive communication, and continuity of care.

Conclusion: In-hospital transfer was experienced by surgical patients as a multidimensional care process shaped by information, consent, communication, comfort, privacy, emotional support, and care continuity. Improving transfer experiences requires patient-centred practices that address patients' informational, physical, emotional, and safety-related needs throughout the transfer process. Nurses are central to ensuring clear explanations, safe and comfortable movement, privacy-sensitive care, and continuity after arrival.

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1 | Introduction

Patient transfer is a routine procedure involving the movement of patients to internal or external facilities for diagnostic or therapeutic purposes [1, 2]. Although typically undertaken in the patient's best interest, such transfers carry inherent risks [1]. In-hospital transfer refers to the relocation of patients, often under observation or with limited mobility, between hospital units for imaging, diagnosis, or treatment. This process is initiated by a physician's order and conducted by trained healthcare personnel, including nurses and paramedics [3]. Patients are transported using equipment such as stretchers, beds, or wheelchairs [4].

The transfer process is complex and requires the preservation of the patient's clinical stability throughout movement between units [4]. Adverse events during transfer can compromise patient safety and lead to deterioration in clinical status [5]. Such incidents may also prolong hospital stays and increase healthcare costs [6]. Therefore, safe transfer requires careful planning, appropriate equipment, qualified personnel, interprofessional coordination, and effective communication [5, 7–10].

An important example of in-hospital transfer is the transfer of surgical patients to the operating room. This process involves transporting patients scheduled for surgery from the ward to the operating room and, when applicable, returning them to the appropriate ward or unit postoperatively. Unlike many other in-hospital transfers, transfer to the operating room occurs at a clinically and emotionally sensitive stage of the surgical pathway. Evidence indicates that preoperative transfer and waiting may increase anxiety, while the mode of transport and transfer-related safety risks may influence patients' perceptions of control, comfort, privacy, and safety [11–14]. Because the operating room is a restricted clinical area, patient transportation, entry into the unit, and verbal handover must be conducted in accordance with safety, privacy, and communication requirements [9, 15].

In Türkiye, in-hospital transfer to the operating room is generally conducted within institutional procedures that include physician orders, patient preparation, appropriate transfer equipment, staff accompaniment, and handover between units [16]. These procedures provide an operational and safety framework for transfer. However, they do not fully explain how patients experience the process, what difficulties they perceive, or what kind of support they expect. Stretcher transfer is particularly relevant in this context because it may increase patients' physical dependence on staff, restrict movement, heighten vulnerability, and affect perceptions of safety, comfort, and privacy [15, 17].

Existing qualitative studies on patient transfer have focused mainly on healthcare professionals' or transfer teams' experiences [12, 18, 19]. However, surgical patients' experiences of in-hospital transfer before, during, and after the transfer process remain insufficiently explored. This is an important gap because in-hospital transfer in the surgical pathway includes movement to the operating room and, when required, return to the ward or another receiving unit after surgery. Across these stages, patients may need information, communication, physical support, emotional reassurance, privacy protection, and continuity of care. Therefore, this study aimed to explore surgical patients' experiences, perceived difficulties, and expectations regarding in-hospital transfer via stretcher before, during, and after transfer to and from the operating room.

2 | Methods

2.1 | Study Design

This study employed a qualitative descriptive design to explore surgical patients' experiences, perceived difficulties, and expectations regarding in-hospital transfer to and from the operating room [20]. A qualitative descriptive approach was considered appropriate because it enables a comprehensive description of participants' experiences while remaining close to their accounts of the events and processes under investigation [20]. This approach was consistent with the study aim of describing patients' experiences across different stages of in-hospital transfer and identifying the informational, physical, emotional, and care-related issues reflected in their accounts. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [21].

2.2 | Participants

Data were collected in the surgical clinics of a state hospital located in Central Anatolia, Türkiye. The study population consisted of inpatients who were scheduled for surgery and transferred to the operating room via stretcher as part of their treatment. The study setting was selected because surgical patients are routinely transferred to the operating room within the hospital, allowing access to patients who had directly experienced the in-hospital transfer process under investigation.

Participants were selected using purposive sampling. Maximum variation sampling was used to ensure diversity in age, gender, and educational background [22]. Patients were included if they were scheduled for surgery, had experienced in-hospital transfer to the operating room for the first time, had been transferred via stretcher, were conscious and able to communicate verbally, and agreed to participate voluntarily. The focus on stretcher transfer was chosen because this mode of transfer may increase patients' physical dependence, vulnerability, privacy concerns, and need for support. Scheduled surgical patients were included to obtain accounts from patients who experienced transfer within a relatively predictable clinical pathway.

Exclusion criteria were emergency surgical intervention, speech or hearing impairment, psychiatric medication use, and unwillingness to participate. Emergency surgical patients were excluded because emergency transfers may involve clinical instability, time pressure, and different communication conditions. Patients with communication limitations or psychiatric medication use were excluded because the study relied on face-to-face, audio-recorded verbal interviews.

Data collection and preliminary analysis were conducted concurrently. After each interview, the researchers reviewed the

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transcript and noted emerging codes and categories. After the 15th interview, no new codes or categories were identified. Two additional interviews were conducted to confirm data saturation. As these interviews did not generate new analytical insights, data saturation was considered achieved, and the final sample consisted of 17 patients.

2.3 | Data Collection Tools

Data were collected using a semi-structured interview form developed by the researchers based on the relevant literature [11, 12, 16, 17]. The form consisted of two sections. The first section included sociodemographic and clinical questions on age, gender, educational level, reason for hospital admission, postoperative day, and pain intensity assessed using the Visual Analogue Scale. The second section included four main open-ended questions supported by probe questions. The interview form was designed to explore patients' experiences across the temporal stages of in-hospital transfer: before transfer, during transfer, after arrival in the receiving unit, and suggestions for improvement (Table S1). These stages represent the chronological progression of the transfer process and encompass patients' experiences of transportation to the operating room and postoperative transfer to receiving clinical units within a common interview framework. The interview guide was reviewed by three experts with expertise in fundamentals of nursing, surgical nursing, and qualitative research. No changes were required following the expert review. A pilot interview was then conducted to assess the clarity, comprehensibility, and flow of the questions. No changes were made after the pilot interview, and the pilot interview data were excluded from the final analysis.

2.4 | Data Collection

Data were collected by the first author, who has training and experience in qualitative research, through face-to-face in-depth interviews conducted between April 1 and April 30, 2025. Eligible patients were identified in collaboration with clinical nurses. After eligibility was confirmed, the first author approached patients after surgery at a clinically appropriate time when they were stable, willing to talk, and free from pain or discomfort that could interfere with the interview. As the interviews were conducted postoperatively, participants provided retrospective accounts of their experiences across the transfer process. Interviews were conducted in patients' rooms, and privacy and confidentiality were maintained. Before the interviews, the study purpose and procedures were explained, and written and verbal informed consent was obtained. Interviews were audio-recorded with participants' permission, and after the recorder was activated, participants were asked to verbally reconfirm their consent to be recorded. Each interview lasted approximately 20 to 40 min.

2.5 | Data Analysis

The audio recordings were transcribed verbatim. Data were analyzed using inductive content analysis [23]. The analysis involved repeated reading of the transcripts, identification of data segments relevant to the study aim, open coding, grouping of similar codes into categories, and development of subthemes and themes. The analytical structure was developed from participants' accounts rather than from a predetermined coding framework.

The classical paper-and-pencil technique was used because the dataset was manageable in size and this approach supported close, iterative reading, comparison, and refinement of codes across transcripts. First, all transcripts were read several times to gain familiarity with the data. Data segments relevant to patients' in-hospital transfer experiences were then identified and coded. Similar codes were compared and grouped into categories. After the categories had been developed inductively, they were examined in relation to the temporal course of the transfer process and organized for presentation under the pre-transfer, during-transfer, and post-transfer stages. Related categories were then brought together under subthemes and themes.

To address discrepancies in coding, the researchers compared their coding decisions after the initial coding process. Differences in code names, category placement, and theme assignment were discussed in research meetings. Each disagreement was reviewed by returning to the original transcript and participant statements. When necessary, code definitions were refined, similar codes were merged, and categories were reorganized. Final decisions were reached through consensus among the researchers.

2.6 | Rigour

In this study, the four criteria proposed by Lincoln and Guba (1985)—credibility, transferability, dependability, and confirmability—were used to ensure rigour in qualitative research [24].

Credibility was supported through face-to-face in-depth interviews, the use of probe questions, and repeated engagement with the interview transcripts. The semi-structured interview guide was developed based on the relevant literature and reviewed by three experts in fundamentals of nursing, surgical nursing, and qualitative research. A pilot interview was conducted to assess the clarity, comprehensibility, and flow of the questions. During data analysis, coding decisions and emerging categories were discussed among the researchers. The researchers also engaged in reflexive discussions to consider how their professional backgrounds and assumptions might influence interpretation. Participant quotations were used to support the findings and to demonstrate the link between the data and the interpretations.

Transferability was strengthened by providing detailed information about the study setting, participant characteristics, sampling strategy, inclusion and exclusion criteria, and data collection process. Maximum variation sampling was used to include patients with diverse age, gender, and educational backgrounds. Direct quotations were presented under each theme to allow readers to evaluate the relevance and applicability of the findings to similar contexts.

Dependability was ensured by applying the same methodological procedures consistently throughout the study. The same semi-structured interview form was used in all interviews, and probe questions were used when further clarification was needed. The pilot interview helped evaluate the feasibility of the

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interview process; data obtained from the pilot interview were not included in the final analysis. The stages of data collection, transcription, coding, category development, and theme construction were documented systematically.

Confirmability was enhanced by maintaining an audit trail of key methodological and analytical decisions. Coding decisions, category development, and theme construction were reviewed through researcher discussions. When disagreements occurred during coding, category placement, or theme assignment, the researchers returned to the original transcripts and participant statements. When necessary, code definitions were refined, overlapping codes were merged, and categories were reorganized. Final decisions were reached through consensus among the researchers, and the findings were grounded in participants' direct statements.

2.7 | Ethical Statement

This research was approved by the Bayburt University Scientific Research and Publication Ethics Committee (dated 19.02.2025, numbered 22/18). Written informed consent was obtained from the participants before starting the interview. Verbal informed consent was also obtained again at the beginning of the interview. Recordings and transcripts were stored on a password-protected device. The study was conducted according to the Declaration of Helsinki and the ethical standards of the National Research Committee.

3 | Results

The mean age of the patients was 44.4 ± 17.4 years. The mean postoperative day at the time of interview was 2.47 ± 1.2, and the mean postoperative pain level was 3.29 ± 1.7. The interviews lasted between 20 and 40 min. Of the participants, 52.9% were female, and 47% were primary school graduates. Regarding postoperative destination, 14 patients (82.35%) were transferred to a surgical ward, two (11.76%) to an intensive care unit, and one (5.88%) to a post-anesthesia waiting/recovery area (Table 1).

The findings were thematically organized into three temporal stages: pre-transfer, during transfer, and post-transfer. This structure enabled a holistic evaluation of the in-hospital transfer process by allowing patient experiences to be systematically analyzed in accordance with the temporal flow and by identifying the specific needs, problems, and expectations associated with each phase. The themes and subthemes are presented in Table 2.

3.1 | Pre-Transfer

3.1.1 | *Theme 1. Patient Consent and Information Process*

This theme captures patients' experiences related to the provision of information and the consent process before in-hospital transfer. Three subthemes were identified: (1) explicit and informed consent, (2) superficial consent procedures, and (3) transfers carried out without consent. Within this theme, the term 'consent' refers specifically to participants' reported experiences of being informed about, asked for permission regarding, and involved in the in-hospital transfer process.

TABLE 1 | Socio-demographic characteristics of patients' ($n = 17$).

Characteristics	*N* (%)
Gender	
Female	9 (52.94)
Male	8 (47.05)
Education level	
Literate	1 (5.88)
Primary school	8 (47.05)
Secondary school	1 (5.88)
High school	5 (29.41)
Associate degree	1 (5.88)
Undergraduate	1 (5.88)
Postoperative destination	
Surgical ward	14 (82.35)
Intensive care unit	2 (11.76)
Post-anesthesia waiting/ recovery area	1 (5.88)
	Mean ± SD (min. max.)
Age	44.4 ± 17.42 (19–71)
Postoperative day	2.47 ± 1.23 (2–7)
VAS Score	3.29 ± 1.79 (0–5)

Abbreviation: VAS, Visual Analog Scale.

3.1.1.1 | *Subtheme 1.1: Explicit and Informed Consent*

A small number of patients stated that they had received clear information and that their consent had been obtained before transfer. These patients reported that they knew where they would be taken, understood why the transfer was necessary, and accepted the process after receiving an explanation from healthcare staff. Some patients also stated that they were able to ask questions about the transfer and that nurses responded to these questions. For these patients, being informed helped them feel included in the transfer process.

P10: They informed me about it before the transfer and got my consent. There weren't many details, but the nurses were helpful. It was enough for me.

P11: They told me what procedure would be done, and I gave my approval. The healthcare staff were good and guided me.

3.1.1.2 | *Subtheme 1.2: Superficial Consent Procedures*

Most patients described consent as a routine procedure rather than a fully informed process. They stated that they signed forms without fully understanding their content or received short verbal statements instead of detailed explanations. In some cases, patients' compliance with the transfer process appeared to be accepted as consent. Patients also reported limited participation in the decision process and described the transfer information as brief, rushed, and insufficient.

P2: I guess, in their way, yes... they just said, "We're going to move from one place to another."

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TABLE 2 | Themes, subthemes, and categories related to patients' in-hospital transfer experiences.

Process	Themes	Subthemes	Categories
Pre transfer	Patient consent and information process	Explicit and informed consent	• Clear explanation before transfer • Patient knowing the destination before transfer • Patient understanding why the transfer was needed • Patient agreeing to transfer after explanation • Patient having the opportunity to ask questions • Patient feeling included in the transfer process
		Superficial consent procedures	• Consent perceived as a routine procedure • Signing forms without fully understanding their content • Short verbal statements instead of detailed explanation • Patient compliance accepted as consent • Limited patient participation in the decision process • Transfer information given in a rushed manner
		Transfers without consent	• No explicit permission requested before transfer • Transfer started with a brief instruction • Patient informed at the last moment • Transfer initiated without explanation • Emergency or time pressure limiting consent • Patient feeling passive and unprepared
During transfer	Loss of comfort	Physical discomfort	• Stretcher-related discomfort • Shaking or imbalance during movement • Fear of slipping or falling from the stretcher • Pain while moving to or from the stretcher • Discomfort related to IV line or surgical site • Cold exposure during transfer • Inadequate covering with sheets or blankets • High stretcher level • Crowded corridors • Elevator-related physical discomfort
		Emotional discomfort	• Anxiety before reaching the operating room • Fear of the unknown • Loss of control while lying on the stretcher • Feeling vulnerable and exposed • Embarrassment while passing through public corridors • Fear of being taken to the wrong place • Fear of being forgotten while waiting • Loneliness during transfer • Increased stress due to uncertainty
	Lack of communication and information during transfer		• No explanation during movement • Not knowing the route or transfer duration • Not knowing what would happen next • Limited responses to patient questions • Lack of reassurance from staff • Staff silence during transfer

(Continues)

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TABLE 2 | (Continued)

Process	Themes	Subthemes	Categories
			• Task-focused staff behaviour
			• Lack of eye contact
			• Patient feeling transported rather than accompanied
			• Patient hesitating to ask questions
Post transfer	Post-transfer lack of reception		• No clear welcoming in the receiving unit
			• Waiting at the operating room entrance without explanation
			• Being left without orientation after arrival
			• Not knowing where the patient was placed
			• Uncertainty about who would continue care
			• Delayed guidance after arrival
			• Limited support during bed transfer
			• Patient feeling forgotten after transfer
	Non-patient-oriented communication experience		• Short and procedural communication
			• Communication limited to clinical tasks
			• Lack of explanation about monitoring
			• No information about the next care steps
			• Patient not informed about what was being checked
			• Patient feeling left alone after being placed in bed
			• Patient expected to ask for help instead of being proactively guided
			• Care delivered without adequate patient involvement
	Perceived continuity of care		• Nurse welcoming the patient after arrival
			• Identity confirmation in the receiving unit
			• Assistance during transfer from stretcher to bed
			• Vital sign monitoring
			• IV line control
			• Pain assessment
			• Respiratory follow-up
			• Brief explanation about the unit
			• Information about follow-up and care process
			• Staff presence after arrival
			• Patient feeling observed and supported
			• Reduced anxiety through visible care
	Expectations and suggestions for improvement	Need for information	• Information about transfer time
			• Explanation of destination before transfer
			• Information about who would accompany the patient
			• Explanation of how the transfer would be performed
			• Information about waiting time at the operating room entrance
			• Explanation of what would happen after arrival
			• Information about monitoring and care plan after transfer
			• Opportunity to ask questions before and after transfer

(Continues)

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TABLE 2 | (Continued)

Process	Themes	Subthemes	Categories
		Need for comfort	• Safer and more comfortable stretchers • Safety belts or side supports on stretchers • Wider and warmer covers • Slower and more controlled movement • Reducing unnecessary waiting • Attention to pain during transfer • Protection of IV line and surgical site • Privacy protection in corridors • Support while moving to and from the stretcher • Reducing cold exposure
		Need for support and empathy	• Staff talking to the patient during transfer • Asking whether the patient feels well • Using a calm and reassuring tone • Providing emotional reassurance • Not leaving the patient alone while waiting • Making the patient feel noticed • Supportive reception after arrival • Staff showing empathy toward fear and anxiety • Explaining procedures with patience • Maintaining eye contact and respectful communication

P5: They had me sign some papers, but I wasn't sure what I was signing.

P6: I signed it, but it happened so fast—I didn't fully understand.

3.1.1.3 | Subtheme 1.3: Transfers Without Consent

Many patients stated that no explicit permission was requested before transfer. They reported that the transfer often started with a brief instruction and that they were informed at the last moment. In some cases, the transfer was initiated without any explanation, especially when the process was affected by emergency conditions or time pressure. These patients described feeling passive, unprepared, and unable to participate in the transfer process.

P2: The nurses were busy, and everyone was in a rush. It was hard to ask questions. They just said, 'operating room,' but no one mentioned which floor or how long it would take.

P4: They just started moving me... No detailed permission was taken. I only realized where I was going after I was already on the stretcher.

3.2 | During Transfer

3.2.1 | Theme 2: Loss of Comfort

This theme is about the physical and emotional discomfort patients felt while being moved inside the hospital. They reported that the process affected both their physical comfort and mental well-being.

3.2.1.1 | Sub-Theme 2.1: Physical Discomfort

Most patients described physical discomfort during transfer. They reported stretcher-related discomfort, shaking or imbalance during movement, and fear of slipping or falling from the stretcher. Some patients experienced pain while moving to or from the stretcher, particularly due to the IV line or surgical site. Patients also reported cold exposure, inadequate covering with sheets or blankets, discomfort caused by the high stretcher level, and uneasiness while passing through crowded corridors or using the elevator.

P1: I was shaken a lot while being moved on the stretcher. They made sharp turns quickly in the hallway, and it hurt the arm where my IV was. I felt unsafe, like I might fall off.

P8: They put me on the stretcher and rushed me through the hallway. It felt weird passing through the crowds like that. I wasn't uncovered, but still, I felt embarrassed. No one spoke to me; they just left me at the operating room door.

3.2.1.2 | Sub-Theme 2.2: Emotional Discomfort

Most patients described emotional discomfort during transfer. They reported anxiety before reaching the operating room, fear of the unknown, and loss of control while lying on the stretcher. Some patients stated that they felt vulnerable and exposed,

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especially while passing through public corridors. Patients also described embarrassment, fear of being taken to the wrong place, fear of being forgotten while waiting, loneliness during transfer, and increased stress due to uncertainty.

P2: There was no one around me during the transfer. The nurses and staff looked busy. I felt like I was left alone and wondered why no one was checking on me. I felt both abandoned and unsafe.

P7: I was so stressed, my dear. It was my first surgery, and going through those hallways made me feel tight in my chest. I felt ashamed—everyone was looking. You're lying on a stretcher, staring at the ceiling, and since no one explains anything, it just makes you more afraid.

3.2.2 | Theme 3: Lack of Communication and Information During Transfer

Most patients reported a lack of communication and information during transfer. They stated that no explanation was provided during movement, they did not know the route or duration of transfer, and they were unsure about what would happen next. Some patients received limited responses when they asked questions, while others hesitated to ask because the staff seemed busy. Patients also described lack of reassurance, staff silence, task-focused staff behaviour, and limited eye contact. These experiences made patients feel transported rather than accompanied.

P1: One person pushed the stretcher but didn't say a word. No one seemed to check how I was doing. It felt like I was just being moved from one place to another with no concern for how I felt.

P16: They brought me to the surgery area and left me in the hallway. No one explained what I was supposed to do—I was left alone.

3.3 | Post-Transfer

3.3.1 | Theme 4: Post-Transfer Lack of Reception

Most patients reported insufficient reception after transfer. They stated that there was no clear welcoming in the receiving unit, and some patients described waiting at the operating room entrance without explanation. Several patients felt left without orientation after arrival, did not clearly know where they had been placed, and were uncertain about who would continue their care. Some patients also reported delayed guidance after arrival, limited support during bed transfer, and a feeling of being forgotten after transfer.

P1: No information was given. When I was moved to the bed, someone just asked, 'Are you comfortable?' and that was it. A nurse came later and quickly adjusted my IV without saying anything. No one came by during the first half hour.

P7: Honestly, they didn't tell me much. They just said, 'You're in the ward now; rest.' No one explained when I'd eat, when the doctor would come, or when I'd get medicine. I didn't ask either; I didn't have the energy.

3.3.2 | Theme 5: Non-Patient-Oriented Communication Experience

Most patients described post-transfer communication as short and procedural. They stated that communication was often limited to clinical tasks, such as measuring vital signs, checking the IV line, or administering medication. However, patients reported a lack of explanation about monitoring, no clear information about the next care steps, and not being informed about what was being checked. Some patients felt left alone after being placed in bed and stated that they were expected to ask for help rather than being proactively guided.

P2: They only talked to each other. I was left wondering when it would be my turn.

P13: I listened to the nurses talk among themselves, but no one said anything to me. The atmosphere wasn't tense, but they didn't even look at me. I heard their conversations, but they weren't included.

3.3.3 | Theme 6. Perceived Continuity of Care

Some patients described positive post-transfer experiences that contributed to their perception of continuity of care. These patients stated that they were welcomed by nurses after arrival, their identity was confirmed, and they received assistance during transfer from the stretcher to the bed. They also reported vital sign monitoring, IV line control, pain assessment, and respiratory follow-up. Some patients received a brief explanation about the unit and information about the follow-up and care process.

P11: 'When I arrived at the ward, a nurse welcomed me. They confirmed my identity, prepared my bed, and checked my IV line. We had a brief conversation; they asked about my condition and took my measurements.

P17: 'After I arrived at the ward, checks such as blood pressure and pulse were performed. My IV line was checked, and my medications were administered. After a while, the doctor came and summarized my postoperative condition. [...] Later, the nurse came and continued regular follow-up.'

3.3.4 | Theme 7: Expectations and Suggestions for Improvement

Patients' suggestions reflected the difficulties described in the previous themes. Those who experienced uncertainty emphasized the need for clearer information; those who reported physical discomfort focused on safer and more comfortable transfer conditions; and those who felt alone or unnoticed emphasized supportive communication and empathy.

3.3.4.1 | Subtheme 7.1: Need for Information

Most patients expressed a need for clearer information before, during, and after transfer. They wanted to know the transfer time, the destination before transfer, and who would accompany them. Patients also expected an explanation of how the transfer would be performed, how long they might wait at the operating room entrance, and what would happen after arrival. Some

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patients stated that they needed information about monitoring and the care plan after transfer. They also wanted the opportunity to ask questions before and after transfer.

P2: I wish they had explained more. Knowing where I was going, how long it would take, and what would happen would have helped me feel calmer.

P3: They should give more information. Not knowing anything is stressful. Even a bit of reassuring talk during the transfer would help.

P9: No one told me where I was being taken, what would happen there, or how long it would last. Even a short explanation would have eased my mind.

3.3.4.2 | *Subtheme 7.2: Need for Comfort*

Most patients expressed a need for greater comfort during transfer. They suggested safer and more comfortable stretchers, safety belts or side supports, and wider and warmer covers. Patients also emphasized the need for slower and more controlled movement, reduced unnecessary waiting, and greater attention to pain during transfer. Some patients stated that the IV line and surgical site should be protected during movement. They also expected better privacy protection in corridors, more support while moving to and from the stretcher, and measures to reduce cold exposure.

P5: Being alone in the elevator was scary. Having someone there would help. Also, if the stretchers and transport equipment were more comfortable and safer, it would be great.

P8: I was scared my gown would slip open during transport. They should respect our privacy. Also, maybe the stretchers could be made lower.

P15: When everything happens quickly, quietly, and coldly, it makes you feel like a robot. Just a bit of eye contact and a few words of explanation would go a long way.

3.3.4.3 | *Subtheme 7.3: Need for Support and Empathy*

Most patients expressed a need for more support and empathy during and after transfer. They expected staff to talk to them during transfer, ask whether they felt well, and use a calm and reassuring tone. Patients also emphasized the importance of emotional reassurance, not being left alone while waiting, and feeling noticed by healthcare staff. Some patients stated that a supportive reception after arrival, empathy toward their fear and anxiety, patient explanations, eye contact, and respectful communication would make the transfer process less distressing.

P1: The person transporting us should talk to us. We want to know where we are and what's being done. All this uncertainty is stressful.

P2: I think healthcare workers should show more empathy. Instead of being rushed, they should be calm and understanding.

P7: If they cared a bit more about the patient and showed some attention, everything would be easier.

4 | Discussion

This study explored patients' experiences of in-hospital transfer and the challenges encountered from their perspective. The findings show that the transfer process is shaped by the interaction of information, consent, communication, comfort, privacy, emotional support, and continuity of care. By examining the process across three phases—pre-transfer, transfer, and post-transfer—the study identified important deficiencies and areas requiring improvement in patient experience. These findings suggest that in-hospital transfer should be approached as a patient-centred process that integrates procedural safety with the lived experience of being moved between clinical areas.

The results indicate that in the pre-transfer phase, patients are often asked to provide consent without receiving adequate or comprehensive information. This represents a significant ethical concern, as insufficient information undermines the ethical integrity of clinical practice and limits patients' ability to engage meaningfully in decision-making and care processes [25]. Prior studies similarly point to persistent shortcomings in patient education and informed consent procedures [26, 27]. Transfers conducted without explicit consent or sufficient information were frequently described by patients and their families as stressful, abrupt, and disorienting experiences [12]. In a randomized controlled trial, Noroozi et al. (2019) examined the impact of liaison nurses on anxiety levels in patients transferred from the emergency department to the intensive care unit [13]. The study found a significant reduction in anxiety in the intervention group, which was attributed to the liaison nurse's role in conveying accurate and timely information to patients [13]. These findings underscore the critical importance of pre-transfer communication for both patients and their families. Effective information sharing and communication foster a sense of security and preparedness during the transfer process [26]. Consistent with these findings, participants in the present study emphasized that receiving clear information before transfer would alleviate their anxiety. From the patients' perspective, appropriate pre-transfer communication should include timely, clear, and understandable information about the purpose of transfer, the expected process, the destination, and the immediate steps after arrival. Such communication may reduce uncertainty, strengthen patients' sense of control, and support psychological preparedness before transfer. Therefore, it is essential to standardize pre-transfer information and consent procedures, enhance the involvement of patients and their families, and promote transparent communication as a fundamental component of care delivery.

Furthermore, the study revealed that patients experienced both physical and psychological discomfort during the transfer process. Contributing factors included inappropriate stretcher height, rough or unstable transport conditions, inadequate patient positioning, and adverse environmental factors such as cold temperatures, noise, and crowding. These conditions significantly compromised patient comfort. Humphrey et al. reported that orthopedic patients who were given the option to walk to the operating room—when clinically appropriate—often preferred to do so [14]. Dziadzko et al. found that giving patients an appropriate position decreased their anxiety levels [28]. Our study patients reported feelings of fear, anxiety, worry, loneliness, loss of control, embarrassment, and shame—emotions that were further exacerbated by the perceived haste of the process. These findings align with previous literature,

13652753, 2026, 8, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jep.70747 by Bezdi BAL - BOZOK UNIVERSITY-YOZGAT , Wiley Online Library on [15/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

highlighting that the transfer process is not merely a logistical operation but a multifaceted transitional experience with ethical, psychological, and clinical dimensions [12, 17, 29]. A noteworthy point emerging from this study is the role of transfer-related practices, such as hurried movement, inadequate positioning, and limited attention to patient comfort, in shaping negative transfer experiences [17]. Consequently, improving patient comfort and perceived safety during transfer requires attention to transfer practices and staff training, including careful positioning, controlled movement, and patient-centred communication. These practices should be widely integrated into clinical routines and professional development strategies for healthcare personnel. Additionally, the findings highlight the importance of supportive communication during transfer. From the patients' perspective, such support involves respectful interaction, acknowledgement of fear and discomfort, reassurance about safety, and protection of dignity during physically vulnerable moments. Therefore, staff training should address not only technical transfer safety but also patient-centred communication behaviours that reduce anxiety and strengthen perceived safety.

The present study showed that patients often experienced a lack of adequate reception, insufficient information provision, and ineffective communication during the post-transfer phase. These shortcomings contributed to negative emotional responses, including feelings of loneliness, helplessness, loss of control, and worthlessness. Similarly, Bergman et al. found that feeling prepared and safeguarded was central to patients' perceptions of safety during intrahospital transport and highlighted the importance of accurate and timely information [30]. Previous qualitative research has identified inadequate team coordination and communication as potential safety concerns during patient transfers in operating rooms [17]. Furthermore, such experiences can decrease trust in the nurse–patient relationship and weaken confidence in the overall care process. In this context, participants in the current study emphasized the critical importance of being properly received after transfer, receiving clear and understandable explanations regarding their care, and being provided with emotional support. These elements align with the foundational principles of patient-centered care and should be considered essential components of best practice in intra-hospital patient transfer protocols. The identified problems suggest variability in information provision, comfort-related practices, reception after transfer, and emotional support. An evidence-based transfer protocol may therefore be useful because it can define minimum standards for communication, consent, positioning, privacy, handover, reception, and emotional support across all transfer phases. However, a protocol should not be regarded as sufficient on its own. Its implementation should be supported by staff training, interprofessional feedback between ward and operating room teams, and routine evaluation of patient-reported transfer experiences.

5 | Strengths and Limitations

A key strength of this study lies in its qualitative design, which enabled an in-depth exploration of patients' experiences of stretcher-based in-hospital transfer. The inclusion of patients who had experienced this transfer process for the first time allowed the study to capture immediate and direct accounts of the transfer experience. However, several limitations should be noted. The study was conducted in the surgical clinics of a single hospital in northern Türkiye; therefore, the findings may have limited transferability to other clinical settings, regions, or cultural contexts. In addition, the sample included a relatively small number of patients who underwent stretcher-based transfer, which is consistent with the qualitative design but may limit the range of experiences represented. Patients' accounts may also have been shaped by individual and contextual factors, such as age, educational background, previous hospital experiences, anxiety, pain, and emotional state at the time of transfer. These factors should be considered when interpreting the findings. The potential influence of differences between preoperative and postoperative transfers, particularly anesthesia-related effects, postoperative pain, and levels of care in receiving units, on patients' perceptions and recollections was not systematically examined. The use of specific examples in the interview probes may have influenced participants' descriptions of transfer-related concerns. Future studies conducted in different hospitals, clinical units, and patient groups may provide a broader understanding of patient experiences during in-hospital transfer.

6 | Conclusion and Recommendations

This study examined the challenges experienced by patients during the in-hospital transfer process, analyzed across three critical stages: pre-transfer, transfer, and post-transfer. The findings reveal that the pre-transfer phase is often characterized by superficial communication and, in some cases, the absence of informed consent. During the transfer phase, patients reported considerable disruption to both physical and psychological comfort, compounded by a lack of communication and inadequate information. In the post-transfer phase, many patients felt insufficiently welcomed, poorly informed, and deprived of necessary emotional support. Participants articulated various expectations and recommendations aimed at improving the transfer experience. Their suggestions emphasized the importance of clear information and preservation of physical and psychological comfort. These findings underscore that in-hospital transfer should not be viewed solely as a logistical or technical task but rather as a patient-centred care process that requires attention to communication, consent, comfort, privacy, emotional support, and continuity of care. Accordingly, it is recommended that in-hospital transfer processes be restructured in alignment with a patient-centered care model, including strengthening communication practices, ensuring informed consent, and embedding support mechanisms. Future studies could develop and evaluate evidence-based transfer protocols addressing information provision, consent, patient comfort, privacy, handover, reception, and emotional support. The implementation of such protocols could be supported by staff training, interprofessional feedback, and regular evaluation of patient-reported transfer experiences. In future studies, exploring the experiences of not only patients but also nurses, physicians, and other healthcare personnel involved in the transfer process may allow for a more comprehensive and multidimensional evaluation. Comparing transfer practices across different clinical units could help identify unit-specific needs, challenges, and barriers.

Ethics Statement

Bayburt University- Non-Interventional Clinical Research Ethics Committee (dated 19.02.2025, numbered 22/18).

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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