

LA COMMUNICATION PÉRIOPÉRATOIRE ET LE NIVEAU D'ANXIÉTÉ ET DE SATISFACTION PERÇU DES MEMBRES DE LA FAMILLE

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Les normes de l'AISOC relatives à cet article figurent dans la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés (9^e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AISOC) de juin 2009, section 1, p. 13; section 1, normes 1.1.6, 1.1.10, 1.1.13, p. 33; section 1, normes 2.3.7, 2.3.8, 2.4.1, p. 37; et section 1, norme 4.5.6, p. 43.

RÉSUMÉ :

L'objectif de cette étude était d'identifier les effets de la communication peropératoire périodique entre les membres de la famille du patient et l'infirmière de la salle d'opération. Les hypothèses sous-tendaient que les mises à jour périodiques pourraient :

- 1) diminuer le niveau d'anxiété perçu lié à l'intervention chirurgicale;
- 2) accroître la satisfaction générale des personnes face à l'expérience périopératoire.

Dans cette étude de commodité, les participants ont été affectés au hasard soit au « groupe témoin » (aucun appel téléphonique périodique) soit au « groupe intervention » (appels téléphoniques peropératoires périodiques toutes les deux heures). Les membres de la famille des participants à l'étude ont rempli des sondages

préopératoires et postopératoires. Cent dix-sept (117) personnes ont rempli les sondages (55 = groupe témoin et 62 = groupe intervention). Les conclusions de cette étude ont démontré que les familles recevant des mises à jour périodiques de l'infirmière en service externe de la salle d'opération éprouvaient un faible niveau d'anxiété ($p = 0,002$), percevaient l'expérience comme une « bonne expérience » ($p < 0,0001$) et étaient plus satisfaites ($p = 0,0002$) que les familles qui ne recevaient aucune mise à jour.

REMERCIEMENTS :

Les auteurs du manuscrit tiennent à remercier leurs collègues de salle d'opération qui ont participé à l'élaboration de cette étude et (ou) à la collecte de données : Kenneth Goodberry, IA, B. Sc. Inf., Terry Breden, IA, B. Sc. Inf., IASO, IPAC, Lora Carver, IA, Paula O'Buckley, IA, B. Sc. Inf., Timothy Epele, IA, B. Sc. Inf et Courtney Smith, IA, B. Sc. Inf. Les auteurs remercient également notre statisticien, Mark Conaway, Ph. D.

Eric Paul Blum, IA, B. Sc. Inf. est décédé le 9 juin 2013. Il a été, durant plus de vingt ans, un infirmier de salle d'opération bien aimé à l'Université de la Virginie, à Charlottesville, en Virginie. Sa gentillesse, son humour et son intelligence, alliés à sa passion pour les soins infirmiers et la pratique fondée sur des preuves, ont fait de lui un leader et une inspiration pour nous tous! Il était très fier de son travail sur la communication avec les membres de la famille, et de sa propre pratique... Eric joignait assurément la parole aux actes. J'ai été personnellement inspirée par son engagement absolu pour faire ce qui convient et par son désir de défendre les membres de la famille qui sont si vulnérables, alors qu'ils attendent anxieusement des nouvelles de leur être cher. Je parle au nom de tous mes collègues de l'Université de la Virginie lorsque je dis que nous nous ennuierons terriblement d'Eric, mais que nous sommes très reconnaissants et fiers que son travail sur la communication familiale soit consulté et intégré à la pratique clinique. Il en aurait été enchanté!

- Suzi Burns

PERIOPERATIVE COMMUNICATION AND FAMILY MEMBERS' PERCEIVED LEVEL OF ANXIETY AND SATISFACTION

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ABSTRACT:

The purpose of this study was to determine the effect of periodic intraoperative communication between patients' waiting family members and the Operating Room (OR) nurse. The hypotheses were that the periodic updates would:

- 1) decrease perceived anxiety levels related to the surgical procedure; and
- 2) increase the overall satisfaction with the perioperative experience.

In this convenience study participants were randomly assigned to either the "control group" (no periodic phone calls) or the "intervention group" (periodic intra-operative phone calls every two hours). Family member study participants completed both pre-operative and post-operative surveys. One hundred and seventeen (117) family member participants completed surveys (55=control group and 62= intervention group). The results of this study demonstrated that families receiving periodic updates from the OR circulating nurse experienced decreased anxiety levels ($p = 0.002$), perceived the experience to have been a "good experience" (p

< 0.0001), and were more satisfied ($p = 0.0002$) than the families that received no updates.

Introduction:

The holistic nature of nursing is evident in the belief that caring for a patient means the inclusion of key family members and significant others in their care. One essential aspect of family support is the provision of information about the patient's status to those who have been identified by the patient to be the appointed recipient of such updates. Literature on communication with family members of critically care patients, and those waiting for word of their loved ones in the perioperative setting, suggest that communication is very important and is linked to anxiety and satisfaction levels.¹⁻⁷

The authors of this study performed a literature review using Ovid Medline from 1990 to 2012 with the search terms family communication, perioperative care, and family information. Combining these terms yielded 19 articles while an additional review of selected articles in the critical care literature on family communication yielded an additional five. The authors

chose to use only those that were most consistent with the focus on communication with family members and the related outcomes. Many of these studies on communication are relatively old but, the authors did not believe this diminished their importance. Three of the selected studies are described below.

Eric Paul Blum RN, BSN passed away on June 9th, 2013. He was a beloved Operating Room nurse, for over 20 years, at the University of Virginia in Charlottesville, Virginia. His kindness, humour, and intelligence, combined with his passion for nursing and evidence-based practice, made him a leader and inspiration to us all! He was very proud of his work on communication with family members, and in his own practice... Eric definitely "walked the walk". I was personally inspired by his absolute commitment to doing the right thing and his advocacy for family members, who are so vulnerable, as they anxiously await news of their loved ones. I speak for all my colleagues at the University of Virginia when I say that we will miss Eric terribly but are so very grateful and pleased that his work on family communication will be read and integrated into clinical practice. He would be delighted!

- Suzi Burns

The holistic nature of nursing is evident in the belief that caring for a patient means the inclusion of key family members and significant others in their care.

Study 1:

Molter, in her seminal work on the needs of family members of critically ill patients, found that a dominant need was the provision of timely information about their loved ones.³ Similar findings by Prachar et al, were noted in a neurological critical care setting where family members were surveyed using Molter's family needs assessment survey.⁴ But, as noted by Bond et al, families report a frustrating lack of adequate and consistent information.⁵ In addition, the authors suggest that information is so important to family members that they are often willing to accept even information that denotes prognostic futility, providing the information is honest.

Study 2:

Leske reported on the anxiety of family members who were waiting for their loved ones in surgery.⁶ Intraoperative progress reports were provided to half the sample (N=50) while control group family members (N=50) received "usual care". The family members' state anxiety level (STAI S-Anxiety Inventory), mean arterial pressure (MAP), and heart rate during the elective surgical procedures were compared between groups. Family members in the experimental group reported lower STAI S-Anxiety scores ($p < .001$), and had significantly lower MAP and heart rates than did the control group ($p < .001$).⁶ Of note, the authors reported that no significant relationship exists between family members' ratings of anxiety and the length of the waiting period.

Study 3:

In another study, Leske describes the effect of intra-operative progress reports on a family members' anxiety.⁷ The participants were placed into 4 study groups. The groups were those who received:

1. no intra-operative phone calls;
2. "in-person" progress reports from perioperative nurses;
3. an "attention" protocol which included a checklist explaining hospital routines and waiting room procedures; and
4. progress reports that were delivered via telephone.

The "in-person" intra-operative progress report group reported lower anxiety scores than the other three groups ($p = 0.001$).⁷ The study results were similar to her previous study (described earlier) with the exception that in the earlier study the majority of the patients were undergoing ambulatory surgical procedures.

Regular updates and information have been shown to decrease the anxiety of anxious waiting family members but this need may not, however, be obvious to the doctors or other staff who are focused on the surgery.

Family members who come to the hospital to support their loved ones requiring surgery experience, according to the above studies, anxiety and their anxiety may be somewhat abated with periodic updates and selected information. Many hospitals do not, unfortunately, routinely provide such information and there may be long periods of time where information about the patient is not forthcoming. Reasons for this are unclear but, as suggested by Dexter and Epstein, "surgical facilities should strive to provide in-person progress reports to family members while their relatives are undergoing surgery. To satisfy HIPAA regulations, the staff and physicians who talk to family members in the waiting room will need to determine first if the patient has agreed to the release of information (e.g., to assure HIPAA compliance)."⁸ Note: HIPAA stands for "Health Insurance Portability and Accountability Act." The HIPAA Privacy Rule provides US Federal protection for personal health information held by covered entities and gives patients an array of rights with respect to that information.⁹

Study Rationale

At the authors' institution a circulating nurse meets with the patient and family preoperatively to complete a pre-operative assessment and provide information about the perioperative routine. The family members have, in addition, the opportunity to discuss the surgery with the surgeon and have often been provided with an estimate of "anticipated surgical time". This anticipated time may be very accurate from the surgeon's perspective but it can, however, differ significantly from the total time the patient is actually in the OR. Regular updates and information have been shown to decrease the anxiety of anxious waiting family members but this need may not, however, be obvious to the doctors or other staff who are focused on the surgery. As a result the update frequency and type of information can vary based on individual surgeon or caregiver practices.

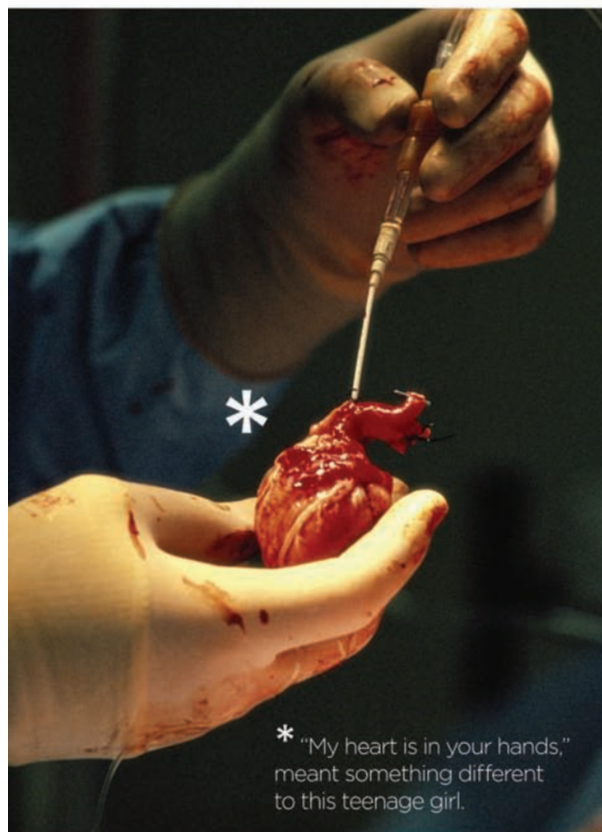
The study investigators' hospital is a 700 bed academic medical center in the mid-Atlantic region of the U.S. An institutional satisfaction survey is used, throughout the hospital, on a yearly basis. The results of this hospital survey, obtained prior to designing the study, suggested that more might be done to improve the satisfaction of family members during the perioperative experience. The specifics of "what might be done" to improve satisfaction were, however, not available. The study team believed that patients and families may not be satisfied with the adequacy of information received during their family member's surgical and recovery periods. The investigators recognized that there was no consistent practice for informing the patient's family about the progression of surgery. Some surgical teams routinely updated the family at prescribed intervals but others, regardless of the length of surgery, did not provide updates. The research team believed that a more standardized approach to communication with family members would be beneficial and should be developed. To that end the study was designed to determine whether or not providing periodic telephone updates to waiting family members would decrease their perceived level of anxiety and increase their overall satisfaction with the perioperative experience. The study hypothesis was that families of patients who are undergoing surgical procedures will, when provided with periodic intraoperative updates about the progression of the surgery, experience decreased levels of anxiety and increased satisfaction in comparison to families who do not receive periodic intraoperative telephone updates.

Study Sample:

The study consisted of a convenience sample of family members (or significant others) of patients undergoing a surgical procedure that was at least two hours in duration. Each family group identified one person who would complete the survey for the family. The participating family member had to be at least 18 years old and be willing and able to complete the study survey. The participants were randomly assigned, by coin toss, to two study groups. One additional group of patients was also included and is described below. The sample was designed to assure that there were 50 participants in each study group for a total of 100 participants. A power analysis revealed that for a power of 0.8 with significance of 0.05 the study required 102 participants to evaluate the two study outcomes (anxiety and satisfaction). The study groups were:

1. **The control group:** family members who did not receive any intraoperative updates and who agreed to complete both the pre- and post-operative questionnaires;
2. **The intervention group:** family members whose loved one would receive regular intraoperative updates. These individuals agreed to be reachable by a reliable method of communication (i.e. willingness to wait for phone calls

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in the surgical waiting lounge or on a cell phone) and were willing to fill out the pre- and post-operative questionnaires; and

3. The third group consisted of family members who were not randomly assigned but, instead, placed in the *intervention group*. This cohort of 10 patients was selected for the *intervention group* because it was known that their surgery was being provided by a select surgical service that always, automatically, provided patient family members with regular periodic updates.

Exclusion criteria included:

- 1) surgery less than two hours;
- 2) inability or unwillingness of family members to complete the pre- and post-operative questionnaires;
- 3) the attending surgeon requesting that periodic intraoperative updates be given (control group only);
- 4) attending surgeon requesting that no updates be given (intervention group only);
- 5) an inability to ensure that reliable method of communication would be available during the intraoperative period (intervention group only); and
- 6) non-English speaking.

The study was approved by the hospital's Institutional Review Board. All members of the "OR Nursing Research Team" completed the institution's required "Citi Training" (www.citiprogram.org/citiinfo.asp).

Materials and Methods:

On the evening before the study at least two members from the OR Nursing Research Team reviewed the next day's surgery schedule to determine which surgeries met the study criteria. On the day of the study the OR research team assigned each case to either the control or the intervention group by flipping a

coin. If the surgery was from one of the services that already provided intraoperative updates then that case was automatically assigned to the intervention group. Once the case had been assigned to either the control group or the intervention group the pre-operative nursing assessment was completed by the assigned nurse.

On the day of surgery either the circulating nurse or a pre-assigned data collection nurse took the family members to a private area, in an adjoining surgical admission suite, to explain the study and obtain verbal consent from both the patient and their family members.

If the surgery had been assigned to the control group the investigator then asked the patient and their family if they would be willing "to participate in a nursing research project that was examining the effects of intraoperative communication". If they gave verbal consent to participate the OR investigators then explained that they would be asked to complete a pre- and post-operative questionnaire and that a data collection nurse would meet with them pre-operatively to answer any questions that they may have and to administer the pre-operative questionnaire. The nurse assigned a random alpha-numeric descriptor to each subject. This descriptor was placed in the top right hand corner of both the pre-operative and post-operative questionnaires.

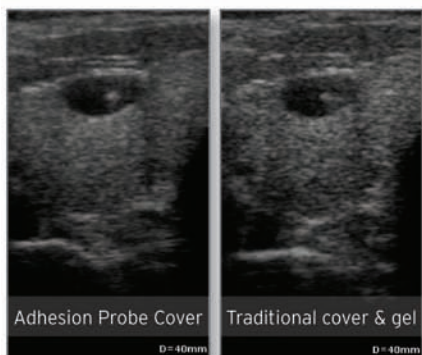
If the surgery had been assigned to the intervention group the same procedure was followed except that the family was informed that they would receive a telephone call, either in the family waiting lounge or at a provided cell phone number, at the beginning of surgery to notify them that surgery had begun and then at approximately two to three hour intervals with updates on the progression of surgery.

The data collection nurse was notified after the pre-operative nursing assessment for both groups was completed and s/he introduced him/herself to the participants, administered the



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COMMUNICATION (cont.)

On the day of the study the OR research team assigned each case to either the control or the intervention group by flipping a coin.

pre-operative questionnaire, and explained that s/he would be the person delivering and collecting the post-operative questionnaire. The anaesthesia care provider then transported the patient to the OR and the patient's family was sent to the family waiting lounge.

Once the surgical incision had been made, and surgery was underway for the intervention group patients, the circulating nurse contacted the waiting family member (in either the family lounge or at the provided cell phone number) to notify them that surgery had begun. At this time they also informed the family member of the approximate times of day that they should expect a call with an update. At the prescribed times (intervals of two to three hours) the family was contacted,

in the same manner, and given an update on the progress of the surgery. All updates were done by phone. None were done in person. Prior to making any update calls the circulating nurse alerted the attending surgeon that it was time to give the family an update and asked if there was any specific information the surgeon wanted conveyed. If there was no specific information to be conveyed then messages such as "surgery is progressing as expected", "surgery is going well" and "Mr. X's surgery is going fine" were given and an approximate time for the next update was established. The content of these messages was designed primarily to provide reassurance and not necessarily to share any specific information. All members of the research team were trained in the use of similar statements

Figure 1: Part 1 question provided pre-surgery to family members.

Please rate your level of anxiety before the surgery began by circling the answer that best describes your anxiety (with 1 being extremely low to 5 being extremely high)

extremely low (1)	somewhat low (2)	not low or high (3)	somewhat high (4)	extremely high (5)
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and limited the statements to these. This procedure was followed for all subsequent update calls until the surgery was complete.

The data collection nurse was contacted by the OR research team member when the surgery was near completion. At that point the data collection nurse returned to the family lounge and located the waiting family to administer the post-operative questionnaire. They told the family the surgery was near completion and the doctor would soon be out to discuss the surgery.

Upon completion of all questionnaires the data collection nurse matched each pre-operative questionnaire with its respective post-operative questionnaire, stapled them together and removed the alpha-numeric descriptor from the upper

right hand corner. After the data was de-identified, the data collector assigned another sequential identifier, i.e. 1C, 2C etc. for a control subject and 1S, 2S, etc. for a study intervention study subject. The questionnaires were then put in an envelope and placed in a locked cabinet until they could be analyzed.

Satisfaction and Anxiety measurement instruments:

This study used a two-part survey (pre- and post-surgery) that was provided to both the control and the intervention group participants. Part one of the survey was given pre-operatively to the patient’s family member and used a self-report Likert 1-5 scale to measure the family members’ level of anxiety before surgery began (see Figure 1).

Figure 2: Part 2 questions provided post-surgery to family members.

1. Did the operating room nurse phone you with updates on the patient during surgery? Please circle the correct answer: yes, no

2. Please rate your level of anxiety after the surgery by circling the answer that best describes your anxiety (with 1 being extremely low to 5 being extremely high)

extremely low (1)	somewhat low (2)	not low or high (3)	somewhat high (4)	extremely high (5)
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3. Please rate your level of satisfaction with your experience today in the perioperative area by circling the answer that best describes your satisfaction (with 1 being extremely unsatisfied to 5 being extremely satisfied)

extremely low (1)	somewhat low (2)	not low or high (3)	somewhat high (4)	extremely high (5)
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Part two of the survey was given post-operatively to the patient's family member. This part asked the participants to score two Likert scale questions (1-5 scale) that assessed the level of the patients' family members' post-operative anxiety and their overall level of satisfaction with their perioperative experience (see Figure 2).

The team members explained the use of the Likert scale to all study participants both in the pre and post surgery intervals.

Analysis and Results:

Summary statistics were used for all variables of interest. Chi-square was used to compare differences between control and intervention group data. 117 surveys were completed, 55 control (no updates) and 62 (intervention-regular updates). No preoperative differences between control and intervention groups were demonstrated between age, relationship of the "family member" to the patient, or pre-operative anxiety. However, differences were demonstrated between groups in the post-operative survey results. They are described below.

Post-operative results:

In contrast to the control group, the family members who received regular updates perceived a lower anxiety level ($p = 0.04$) and greater satisfaction ($p = <0.0002$) than those who did not. (See Tables 1 & 2) Ninety-four percent of the update group noted that the updates decreased their anxiety.

Discussion:

With the current trend in health care towards family-centered care, it makes sense that patients and their families will expect this same standard of care to continue into the perioperative environment. This has not, historically, been routinely addressed. Once all surgical team members have completed their respective pre-operative assessments the family is often sent to a waiting room with the message that the surgeon will contact them at the end of the surgery. The surgeon has, more often than not, also informed the family about the anticipated length of time that the surgery is expected to last. This is often the last communication between the family and the surgical team until the completion of surgery which leaves the family to wait, wonder, and worry. This, however, need not be the case. As noted in this study even brief and periodic updates from a nurse (including information as simple as the timing of the surgical experience) can be effective in decreasing family members' anxiety and increasing their satisfaction. While this simple intervention does not decrease the waiting time, or change the surgical outcome, it certainly was shown, in this study, to decrease the "wondering time" and the related anxiety.

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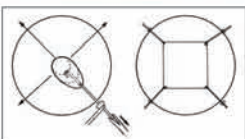


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This study suggests that regular updates provided to family members during the operative waiting period decreases anxiety and improves overall satisfaction with the experience.

Table 1: Post-operative anxiety by study group (updates or no updates)

	Updates	No Updates
1- Low	15 (26%)	8 (15%)
2	19 (33%)	12 (22%)
3	20 (34%)	19 (35%)
4	1 (2%)	10 (19%)
5- High	3 (5%)	5 (9%)
Subtotal	58 (100%)	54 (100%)
Missing	4	1
Total	62	55
chi-square = 0.022		

Study Limitations:

The study was designed to evaluate the effect of periodic phone updates on the satisfaction and anxiety of family members of surgical patients. The research team made every effort to separate the two study groups but this was not entirely feasible. Both the control group and intervention group were in the same waiting room (the hospital had only 2 surgical family waiting rooms – one for the families of thoracic cardiovascular patients and the other for all other families). Both control and intervention study group participants were interviewed privately by the data collection nurse in an adjoining surgical admission suite pre-

operatively (as described earlier). Post-op questionnaires were, however, given to each participant’s family, by the data collection nurse, in the waiting room following the surgery. There is the possibility that the control and intervention may have seen one another’s surveys and, thus, potentially biased the answers. This is, however, unlikely given the fact that surveys were completed and returned them directly to the data collector who was in the waiting room at the time.

Recommendations for future research:

There are, as noted earlier, limited data available to guide perioperative practice related to the information provided to waiting family members. This study, while it adds to the body of information available on the topic, is limited in scope as it tested only the effect of periodic phone communication with family members. The study could be replicated in different perioperative units with studies designed to test the efficacy of face-to-face, versus telephone, communication. Additional studies on other forms of communication, such as text messaging, email, or online computer updates, would also be very useful. It would be interesting to see the results of interactive “real-time” communication with OR staff (ie

Table 2: Report of perception of being “satisfied” with the experience by study group (updates or no updates)

	Updates	No Updates
1- Low	1 (2%)	3 (6%)
2	0 (0%)	1 (2%)
3	2 (3%)	11 (20%)
4	14 (23%)	22 (41%)
5- High	44 (72%)	17 (31%)
chi-square p = 0.0002		

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access to a phone linked to the OR that is designated just for waiting families so the family members could periodically talk to a designated doctor or nurse about their loved one). Regardless of its form there is definitely a need for additional research in the area of perioperative family communication.

Conclusions:

This study suggests that regular updates provided to family members during the operative waiting period decreases anxiety and improves overall satisfaction with the experience. It further determined that the information provided to family members need not be extensive in order to reduce anxiety. Simple statements, such as “the operation is progressing as expected,” provided at regular intervals were shown, in this study, to be sufficient. As suggested by Leske in 1993¹⁰, the application of research findings such as these should be part of the provision of holistic care and will positively change traditions and attitudes related to the family members of surgical patients.

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ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (May 2011) Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (10th edition). Section I, p. 24; Section I, Standard I.1.6, I.1.10, I.1.13, p. 30; Section I, Standard 2.3.7, 2.3.8, 2.4.1, p. 33; and Section I, Standard 4.5.6, p. 39.