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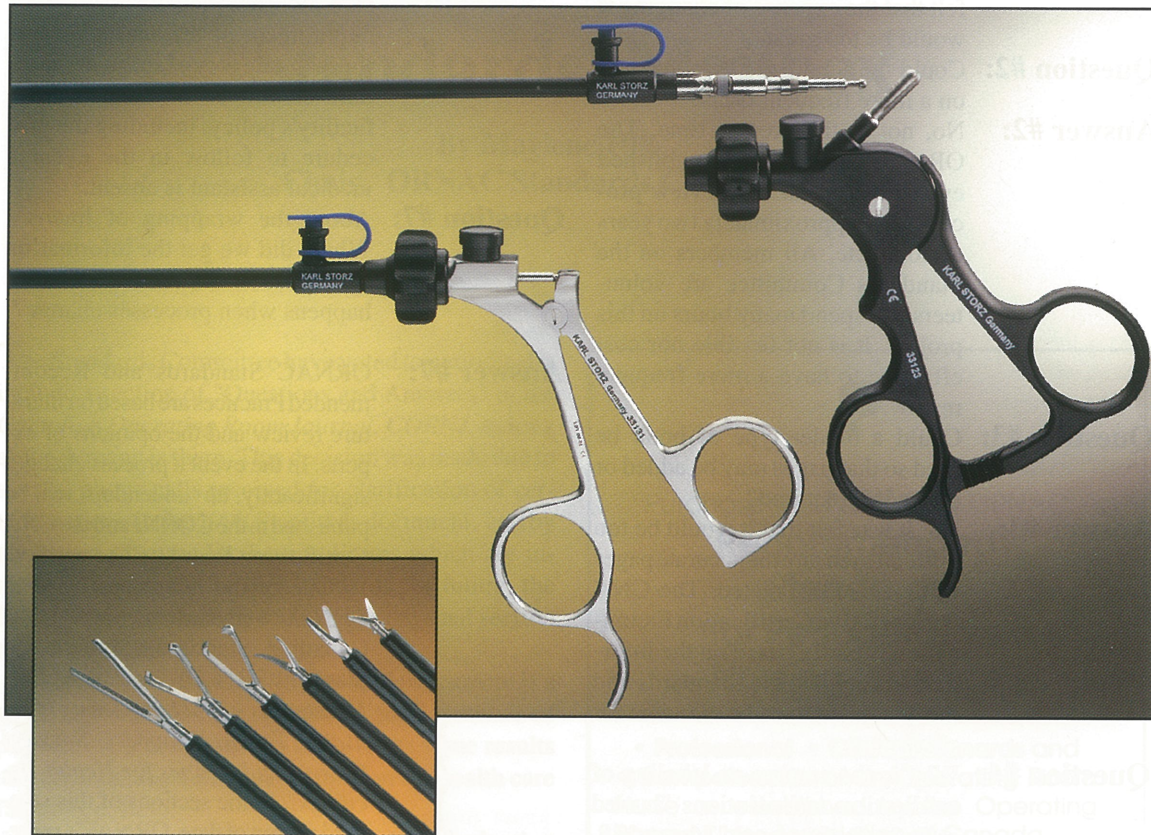

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Parental Presence During Induction: The Role Parents Play Is It Valid ?

By Josephine A. McGann, RN, CPN(C)

Pediatric patients preparing for surgery are exposed to a totally unfamiliar environment. The hospital is a very busy, noisy place. People are continuously coming and going, dressed in unconventional clothing, wearing funny hats and even covering their faces with masks. This creates anxiety and stress for both the pediatric patient and his/her parents. The perioperative nurse has ten to fifteen minutes to assess her patient to determine their stage of development, their emotional and psychological state, their physical needs and lastly their level of anxiety. At the same time she is analyzing how the parent is coping with the fact that their child is headed for surgery and must find some way of reducing their anxiety. Parental presence during induction (PPI) in the operating room can help decrease the stress and anxiety of both the patient and parents. An analysis of the four points mentioned above during the assessment stage, stresses the role parents can play during induction. Is this role a valid one?

A basic understanding of a child's growth and development is necessary to provide care and a safe environment. Noble, Jenks Micheli, Hensley and McKay (1997) define that growth implies changes in size of body as a whole of separate parts. Development describes the differentiation in changes in body function including structural, emotional and social interactions. Personality development is also an added component to the above and seems to be the most widely accepted tool used in pediatric care. Erik Erickson (1950) describes key concepts that an individual strives to master during critical periods of personality development. They are as follows.

Trust versus Mistrust (Birth to one year)

The mother is the primary caregiver and the infant's whole world. As familiarity with mother and other family members strengthens, separation anxiety and stranger anxiety becomes evident and a screaming, clinging infant is usually what a perioperative nurse might expect to encounter (Noble et al, 1997).

Autonomy versus Shame and Doubt (One to three years)

Children are striving to maintain autonomy and increase their ability to control themselves and their environment. Fears of abandonment and separation anxiety are normal. It is important to allow children time to express their concerns and feelings. Parental presence during induction eliminates their fear because there is no separation of parent and child. Instead the parent provides support and encourages co-operation from the child.

Initiative verses Guilt (3 to 5 years)

Children are striving for a sense of independence. Body integrity, with fears of bodily harm and mutilation can become magnified, especially when a child is facing surgery. Information given to the child must be simple, concise and stated in a simple manner.

Industry versus Inferiority (6 to 12 yrs)

Skill acquisition is part of this developmental stage. Making choices is important to this age group.

Author

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The perioperative nurse can allow the child to decide such things as walking or riding to the OR. Children in this stage also need to feel that they can complete tasks and the perioperative nurse can support their need to do well. By allowing the child to participate in their OR experience by helping to take off their EMLA creme for example, gives them control. This reduces stress and anxiety levels.

Identity versus Role Confusion (12 to 18 years)

Adolescents are seeking their identity plus coping with emotional and physical changes. Self-consciousness and modesty are evident as the perioperative nurse interacts with the adolescent. Ensuring their sense of privacy as well as conversing in an easy friendly manner, whether answering questions or providing information, will reduce their anxiety markedly.

Emotional state and anxiety seem to go hand in hand. What type is a child displaying? Are they happy, carefree, or quiet and shy? How do the parents seem? Are they interacting in a calm manner with their child or do they seem anxious and stressed? Children are able to sense whether there is tension or calmness in a parent and will react accordingly. Parents, when they send their children off to the OR with the nurse, must be given reassurance that the nurse will take good care of their child and keep them safe. The child must be reassured in the same manner. She must also emphasize that mommy and daddy will be waiting for them once their surgery is complete. This in most cases satisfies both the child and the parents and allows a smoother transition to the operating room. However, remember one of the greatest fears of children undergoing surgery is separation from their parents (LaRosa-Nash, Murphy, Wade, Clasby, 1995).

Physical needs must also be assessed. The nurse must determine if the patient can walk. Obviously, an infant will have to be carried, but a toddler and older child can be given the choice of either walk or ride. A quick visual head-to-toe assessment of the patient is necessary. Special needs should be addressed accordingly. For example, do they have problems with hearing, sight or movement? Can the child speak English or is an interpreter necessary? Do they have something familiar like a favourite toy or special quilt to bring into the operating room?

Once the perioperative nurse completes her full assessment, her plan of care begins to take shape. Information exchange among the nurse, parent and child is critical to ensure all needs are met. After all, the parents are entrusting the care of their child to a perfect stranger. By allowing a parent to accompany their child to the OR, the fears of both the parent and child could be reduced.

A parent provides love, support, and helps soothe and calm their child's fears. No other person or nurse can substitute. The induction of anesthesia in pediatric patients can be one of the most stressful parts of the surgical experience. An induction that does not go smoothly may result in terrifying memories, (LaRosa-Nash et al 1995). If a parent participates during the induction, the role they assume provides strength and reassurance to their child. At the same time, it allows the parent an opportunity to have an active role in their child's care, thereby decreasing their anxiety.

Research in nursing never stops. Hospitals could survey the community they service to determine if parental presence during induction was a need that was not being met. Developing a questionnaire specific for pediatric patients and their families, listening to parent advisory groups and polling their own operating room staff, would be the first step in implementing a PPI program. However, some staff members may feel uncomfortable offering this service, as change is difficult and they may feel they are being observed too closely and their delivery of service critiqued. These issues will need to be addressed in order for the program to move forward.

When this process is completed and the research determines the need exists, how does a PPI program take shape and who implements it? The nurse manager of the OR would form a committee interested in putting a plan together. This committee would decide on everything, from tools necessary to implement an educational program to the number of people it will take to keep the program going. All costs would have to be considered including the cost of extra staff, to the cost of providing appropriate OR attire for parents to wear. A budget would then have to be submitted to Administration for approval. With funding in place and the educational component complete, approval for such a program must go through the Departments of Surgery and Anesthesia. Staff must be given an opportunity for input and an orientation session must be scheduled. Everyone must clearly understand the importance and the value of a PPI program.

See *"Michael's Surgical Experience"* my personal saga of such a program in the next two pages.

"All he wanted was his mommy. I gave him a big hug and assured him that I was not going anywhere."

Michael's Surgical Experience

One day in March I was enjoying my usual day spending time with my three children. David was almost four, Michael had turned two and Janice was just six months old. Michael was just starting to toilet train but still wore a diaper. During one of these diaper changes I was shocked to see that his scrotum had increased to three times its normal size.

Immediately I called our family doctor and he saw us that day. When we arrived I explained what I had observed and that I was worried it might be something serious. We unpinned the diaper for a look, and his scrotum was back to a normal size. Had I imagined it?

The doctor reassured me that from my description Michael had a hydrocele on the left side and I had several choices: leave it alone; do something about it now; or, wait until he was a little older, as it really posed no threat. None of these choices really appealed. I just wanted the problem to go away.

Following a discussion of the choices with my husband, we both agreed that now was the best time to take care of it.

I wanted to comfort and support him after his surgery

One of the first things I did was call our local hospital. We were living in Sarnia at that time. I wanted to find out what sort of programs they had in place to care for my child. I wanted to stay with Michael over night, post-operatively to comfort and support him after surgery, and I was shocked to discover the hospital did not allow parents to help care for their own child. They made me feel like I was asking for the world. Clearly this was not the place for my son to have surgery, but what was my alternative?

Fortunately, we have a good family friend, a doctor, whom we called for advice. He lives in Hamilton, Ontario, and we lived a two-hour drive away. He sensed I was worried and suggested that the surgery could be done in Hamilton. I asked him to please recommend a doctor to whom he would send his own child. He did, and the consultation appointment was made for two months later.

We were sent to a pediatric urologist who had a calm, easy-going manner and I immediately felt comfortable with him. The diagnosis indeed was correct and if we chose to proceed the surgery would be booked for August. The idea of travelling to Hamilton for a simple surgery seemed ridiculous, but what helped make our decision was the fact that the Health Sciences Centre encouraged parents to care for their child during the surgical experience. By chance I learned that they even allowed parents into the operating room. I was intrigued and thought once I arrived for my son's surgery I could find out a little more about this program.

In those days patients were admitted the night before. On August 12 we arrived at the paediatric surgical floor. A nurse took us to a semi-private room which we could call home for a time. The room was like many hospital rooms, and next to Michael's bed was a cot waiting for me. It was all very stressful and overwhelming but we knew this needed to be done. We had a few hours to relax and unwind before the final pre-op assessment. The staff was extremely helpful and friendly which confirmed that we had made the right decision.

During dinner, both the surgeon and anesthetist arrived to check on Michael and answer any questions I might have. At this point, I mentioned that I had heard parents were allowed into the OR and if this was true could I please go with Michael? Since they were not aware that I was interested in accompanying Michael into the OR, they were not prepared

to support my request, and I was devastated. This was the main reason I had chosen to come to Hamilton and McMaster Health Sciences Centre. I then informed them that I was a perioperative nurse and assured them that I was very familiar with an operating room and knew what to expect. Michael's chart was then flagged indicating that a parent would accompany him. Michael settled down for a quiet night without a care in the world. I had a restless night's sleep.

Michael's surgery was scheduled for 11:00 am. Unfortunately, the OR was running two hours late. My two-year old was starting to get cranky and complained of hunger and I was becoming more anxious. Finally they called for us and Michael was getting his long ride. When we arrived in the OR, the circulating nurse greeted us. She introduced herself and the volunteer that would take care of me. I explained to Michael that I had to get dressed in special clothes to go with him and that I would be right back. When this was done, we were ready.

A Mickey Mouse screen hid the set-up

As we rolled down to the room Michael was starting to become frightened. He did not know where he was going but I reassured him that I was going with. When we arrived in the room the only things really noticeable were the bed, the anesthetic machine and a huge Mickey Mouse screen. Behind the screen, the scrub and one of the circulating nurses were setting up and doing the count. I was very impressed that they were so thoughtful and felt it was a clever way to disguise the purpose of the room. The other circulating nurse was helping me with Michael and introducing me to the anesthetist and the resident, whom I had met the day before. Michael was very co-operative and allowed me to help the nurse place his monitors. All was ready and they then asked me if I was. With the feeling of fight or flight, I helped Michael place the mask over his face and the anesthetist spoke in a very soothing manner. He started to tell Michael a fairy tale. I almost lost my composure. Michael was at the point of fighting the mask and the anesthetist. He clearly did not like this environment and was starting to scream. I reassured him that everything was fine and that I would see him soon. With some help from the nurse, I had to gently restrain him while the anesthetist kept telling his story. Finally, he was asleep. Tears were rolling down my cheeks and I was grateful that I was wearing a mask.

Tears are a release for me when facing an overwhelming situation and this definitely met the criteria. I thanked the anesthetist and told him how much I appreciated his technique. I also thanked the rest of the OR crew and was then escorted by the volunteer. She helped me calm myself and pointed out the PACU entrance, then took me back to the change-room. I had two hours to wait before I could see Michael again.

Michael was screaming !

Two hours could not go by quickly enough. Finally, I was being called into the PACU. Michael was screaming! The nurse quickly introduced herself, assured me all went well and told me she had just given Michael something for pain. All he wanted was his mommy. I gave him a big hug and assured him that I was not going anywhere. The nurse said that I could pick him up and snuggle with him in a big cozy rocking chair placed by his crib. He was immediately quiet, calm and asleep within minutes. It was a wonderful feeling knowing we had overcome the biggest hurdle. Post-op management was on my mind but I decided I would worry about that later. It was quiet in PACU because it was late in the day and the other patients had been sent back to their floors. I settled in for the next hour or more and had a pleasant conversation with the nurse about nursing, what else?

We were back in our room in no time it seemed. Michael had been checked a few times to see if all was well and it was. We put on his own pajamas and spent some quiet time. The doctor came and spoke to me, assuring me that all went well and asked if I had any questions. My only comment was that he seemed to be pain free and that surprised me. He explained that he had given Michael a block before leaving the OR, which had a prolonged effect. I then thanked him and mentioned that our whole experience had been a very positive one. I also stated that allowing parents into the OR, as well as participating in their care was a tremendous privilege. As the evening progressed, Michael still showed no signs of discomfort. I was amazed! It was as though nothing had happened. We settled down to a good night's rest looking forward to going home the next day.

Morning came quickly. A final check was done and Michael and I were free to go. We said our goodbyes and off we went to Sarnia. I could not get on the road fast enough. It had been a stressful three days and I just wanted to get Michael back home and see the rest of my family.

When we arrived, my husband was surprised that Michael was running around as usual and asked me if I was sure he had surgery? "Yes" I said, "I was there."

Parental Presence During Induction

(continued from page 2)

From the moment a child steps through hospital doors, many disciplines are involved with their care. Therefore, an on-going program must be designed to include and explain the roles of all personnel that will be involved. The goal is to educate and prepare the pediatric patient and the family, ensuring their surgical experience will be a positive one.

A hospital tour would create a valuable tool in educating patients and parents. It would also provide an opportunity for staff to assess the best way to help parents and children assume their upcoming roles in the OR. Developing teaching methods such as a videotape, photographs, pamphlets, coloring books etc., will all contribute to educating both the child and parents. A hands-on approach is also encouraged. This provides an opportunity to see and feel what an intravenous needle looks and feels like, what an anesthetic mask looks and feels like, what they will wear and what mommy or daddy will wear. If a child is given the information he or she needs, they feel as though they have some control.

Most parents are eager to participate

Once the surgical date is confirmed the parent and child need to complete their preoperative assessment. A physical examination must be conducted, consent obtained and tests done. Usually this is completed by the child's family physician. A visit to the preoperative assessment clinic is scheduled for a few days prior to surgery. The chart is assembled and checked to ensure all necessary information is included. A team of specialists, determined by the program that is established could be available to speak to the parent and child. This team of individuals may include a perioperative nurse, a pediatric nurse, a child life worker and finally the anesthetist. He/she takes the opportunity at this time to meet the child and parent to explain what type of anesthesia will be provided and answer any questions the child or parent may have. It should emphasized that the parent can touch and talk quietly to their child during induction, which helps to provide encouragement and support, (Zelikovsky, 1996). Questions parents need to have answered are: what to expect as a child progresses through anesthesia, a brief description of the OR equipment, monitors and personnel in the room, and what happens if an emergency situation occurs? (Halverson Carpenter, 1998).

Most parents are eager to participate in their child's surgery. Some however choose not to, as they find it too stressful and perhaps feel their child may not benefit from their presence. At this point, the child and parent will be assessed by the perioperative nurse, as to their suitability as candidates for participation in the PPI program. Not all children or parents for that matter are good candidates for PPI. Children who are overly frightened or anxious, may have difficulty cooperating, even if parents are present. In addition, a child with a tenuous airway or past anaesthetic problem may most likely need pre-operative medication. If this is necessary, an explanation would be given and the appropriate medication administered in the presence of the parent. The parent should appear to cope with their role. If a parent is angry, hostile, or emotionally overwhelmed, they will have difficulty providing support for their child. Some parents may not wish to participate in the induction for reasons such as queasiness, fear of the unknown or feelings of stress. Whatever the decision, the nurse must support the parents' choice, (LaRosa-Nash, Murphy, 1996).

If a child refuses to cooperate, a back-up plan can be used

When the parent and child arrive in the operating room, the personnel present should be introduced and a brief description of the equipment serves as an orientation to the environment. The child is asked to lie down on the bed and given a nice warm blanket. As monitors are positioned, their function should be explained. If the child refuses to cooperate with the placement of the monitors, the anesthetist may delay this step until the patient is asleep. Mask induction is usually the anesthetist's first choice. However, if the child refuses to cooperate, a back-up plan of giving an intramuscular injection, which provides total sedation within two minutes, will be used. The time of initial administration of anesthetic agents to the loss of consciousness is considered the first stage of anesthesia and usually takes less than ten minutes As the child loses consciousness he or she experiences complete amnesia, analgesia, and sedation(LaRosa Nash, Murphy, 1997). The parent may notice changes in the appearance of the child's eyes and involuntary movements of extremities. The perioperative nurse must provide reassurance that this is normal and it may even be necessary to gently restrain their child to prevent injury. At this point, the risks of clinically significant reflex activity such as vomiting, arrythmias, and laryngospasm increase (LaRosa Nash,

Murphy, 1997). A pediatric airway differs from the adult airway because of its size and positioning, causing it to obstruct more easily. If these problems should occur, it would be considered an emergency situation and therefore, the parent would be escorted out of the OR back to the waiting area by a designated person, for example, an OR volunteer. The perioperative nurse must stress that these emergency situations can occur, but will be brought under control immediately.

Numerous hospitals have implemented a PPI program

Numerous hospitals throughout the United States and a few in Canada have implemented a PPI program and have recognized parents as active participants in the care of their child. Researchers have documented that parental presence facilitates smoother anesthesia induction and decreases the use of pre-medication. Questionnaires developed by various hospitals discovered that parents expressed great satisfaction at being present with their children during anesthesia induction and in the PACU. Having clear explanations given to them and their children, experiencing the care and concern of staff members and having interactions with the anesthesia care provider were all reported as positive experiences.

Nursing staff members and physicians also completed evaluations stating that the presence of parents posed no danger and helped with the children during anesthesia induction, (Blesch, Fisher, 1996).

The greatest moment of anxiety for the parent and child is when the child is taken away from the parent, in the OR corridor, (Halverson Carpenter, 1998). Because of pressure from parent groups and special committees, parents have been granted their basic right to provide their children with physical and emotional support, (Zelikovski, 1996). Parental support during a child's hospital stay seems quite natural today. Therefore, perioperative nursing practice must move with the times and face the challenge a PPI program implementation would present. Children rely on their parents for support and guidance. It has been demonstrated that a PPI program eliminates the need for pre-operative medication thereby, shortening the recovery period. The program eliminates separation anxiety, since the parent remains with the child. For the child PPI promotes cooperation, a quiet calm manner and control of their surgical experience. The advantages of PPI are a significant reduction of stress and anxiety and an increase in self confidence. Studies indicate that parents are willing to help their child and cooperate with staff given the appropriate education and tools.

Do parents play a significant role in the operating room? Yes, I was there! ■

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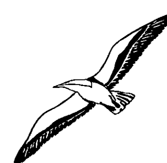

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