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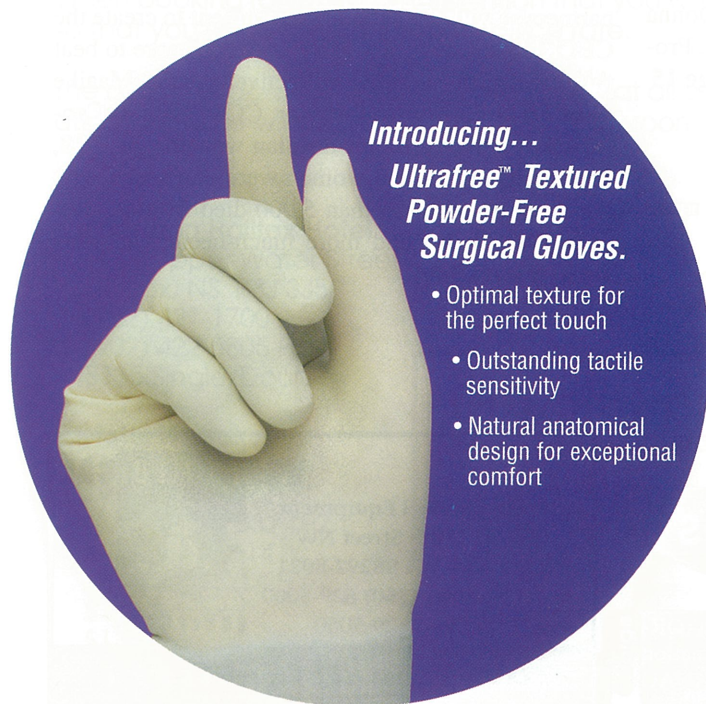

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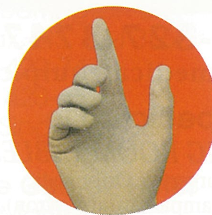

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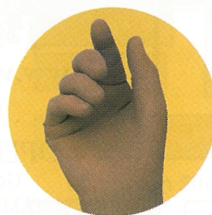

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Intraoperative Progress Reports to Families of Surgical Clients: A Missed Opportunity

By Rose Puopolo, RN, BA, CPN(C), and Julie Cordasco, RN, CPN(C)

Leske (1992) reported that family members feel left out during the intraoperative period. Nurses observe clients, as well as families, exhibiting feelings of fear, tension, irritability, anger, powerlessness, and a sense of timelessness. Ironically, during this time perioperative nurses may have little meaningful contact with the family members as they endlessly wait. Perioperative nurses can effect positive outcomes for the family (and for the health care professional) in a family-centred care environment by providing psychological support in the development of caring, respectful and trusting relationships, and by decreasing physical stress and anxiety through intraoperative communication with the family.

Abstract

The wait while a family member or loved one is undergoing surgery is stressful and anxiety-producing. Perioperative nursing contact during this period can result in positive outcomes of decreased anxiety, increased receptivity to post-operative information, and increased awareness of the professional practice. Perioperative nurses have the skills and the opportunity to provide progress reports to the client's family, at least once during surgery. Characteristics important to this role include motivation and commitment to be informative; caring; sensitivity and perceptivity; sense of humour; and education. Possible barriers to intraoperative communications include various lacks - of time; attention (related to monitoring requirements in the operating room); support from management, peers, and doctors; and therapeutic communication skills to alleviate anxiety. Progress reports to the family can decrease their physical stress and add to their satisfaction with the hospital.

Why

O'Connell (1989) stated two reasons why intraoperative communications by perioperative nurses should be encouraged: hospitalization and surgery are stressful events for the family; and serious illness can precipitate a crisis in the family system. She also found that the parents of children in surgery verbalized the most anxiety. The family systems perspective regards the individual in the context of his or her relationships and environments, and not in isolation (Becvar & Becvar, 1982). Family system theorists have also noted that family members become extremely sensitized to one another's behaviours and that the family system influences the course of chronic illness or conditions (Frederickson, 1989). Thus, the perioperative nurse should examine the family in the context of how coping with the surgery affects each member.

One such effect is a response to stress: the family becomes increasingly anxious. An emotional reaction that occurs in response to stressful situations, anxiety is subjectively characterized as tension, apprehension and nervousness (Donnell, 1989). In addition, anxiety results in increased activity in the autonomic nervous system. The intense feelings of fear

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and flight associated with panic behaviour lead to even higher levels of anxiety, which can be seen physiologically as rapid pulse, usually associated with palpitation, rapid respiration, diaphoresis, dry mouth, dilated pupils and clammy skin (O'Connell, 1989; Atkinson & Kohn, 1986). For many years, in perioperative nursing the concern with stress has been exclusively that in clients: how to identify it, and strategies to alleviate it. Providing information to all family members should be an important goal in all models of nursing, including perioperative nursing.

Involving families in client care by sharing information with them has been found to increase client cooperation and promote client adjustment to illness (Leske 1996). Daley (1984) and Kathol (1984) both found information to be one of the principal needs expressed by families coping with illness, and that it helped alleviate anxiety and stress. She has also noted that after intraoperative communications, families reported that they felt reassured, an increased sense of control, and increased appreciation of the caring they received (Leske 1992).

To reduce a family's anxiety, the perioperative nurse can give information to family members during surgery and prepare them for more positive interactions with the client - for example, a child - during the recovery period. The child is empowered by this assistance and will, in turn, be able to direct more energy toward healing and recovery (O'Connell, 1989). Thus, the nurse is contributing to the family's well-being by being there for their child, which is important because currently, clients are being discharged "sicker and sooner". Reducing anxiety will enable family members to understand instructions and positively affect patient outcomes (Leske, 1992).

Another reason why intraoperative communications should be encouraged among perioperative nursing is that (as the philosophy of nursing at The Hospital for Sick Children states) it is the child's right to expect family-centred care. This reason has two aspects. First, only the family knows the child best and can deliver holistic care; whereas, the nurse must first build a trusting relationship with the child and family.

Second, because of the recent economic restraints, hospitals depend on parents to effectively care for their children. By keeping families well informed through intraoperative communications, nurses are cementing this pivotal, trusting relationship between the family and the health care institution. In the consumer-oriented climate of current health care, perioperative nursing intervention may make a difference in the family's satisfaction with the health care institution.

The third reason why intraoperative communications should be encouraged among perioperative nursing is because of our core values. The Hospital for Sick Children Nursing Mission Statement defines them as caring, collaboration, respect, lifelong learning and advocacy.

Caring involves an interpersonal process in which one values the child's and family's comprehensive needs and diverse perspectives about the perioperative experience by providing a support mechanism for families under stress. Collaboration brings perioperative nurses to new frontiers as they involve families more frequently in caring for their children during the perioperative experience. Perioperative nursing can demonstrate mutual respect with children and their families through effective therapeutic communication during the intraoperative experience. Life-long learning is the foundation for professional and personal growth; it is essential to the improvement of nursing care. Implementing intraoperative communications as a research-based nursing practice contributes to this core value. Advocacy for the perioperative nurse includes the ability to influence health care policy, practice and outcomes by working in partnership with clients' families, other health care professionals, and the health institution in implementing intraoperative communications with families of surgical clients.

By embracing the core values of caring, collaboration respect, life-long learning and advocacy, perioperative nurses highlight their knowledge, skill and judgment in promoting holistic health care for the surgical client and their family. The final reason why intraoperative communications should be encouraged in perioperative nursing is the potential benefits of the personal experience to nurses. McNamara's (1995) study cited self-satisfaction, a sense of collegiality, a sense of developing as a whole person, having their personal philosophy reinforced, making the day enjoyable and fun, and validation of career choice as significant reasons why perioperative nurses embraced intraoperative communications.

Who

When a client is undergoing a surgical procedure, family and friends spend hours wondering, worrying, and imagining the worst. Few hospitals can afford to have surgical nurse liaisons or coordinators take vital information from the operating room to the waiting family; however, it is within the professional role of

the perioperative nurse to embrace the challenges of intraoperative communications.

Perioperative nurses have extensive, specialized technological knowledge of the anatomy and physiology of surgical intervention, which enables them to interpret complex medical terminology into layman's terms. They also have the theory-based critical judgment and intellectual skills to apply a humanistic approach to their responsibilities as client advocates, to offer families health promotion through emotional support in a constantly changing environment.

How

Leske (1992) found intraoperative communications to be an independent perioperative nursing intervention beneficial in reducing anxiety in family members during the perioperative experience. The study demonstrated that family members who received in-person intraoperative communication were significantly less anxious than those receiving no intervention or attention.

If a perioperative nurse cannot leave the operating room for an intraoperative visit to the families, then a telephone call is the next-best alternative. Leske's (1996) later study of the effectiveness of providing information to clients' family members through telephone calls versus in-person visits suggested that family members who receive telephone calls report less anxiety than those who do not receive this nursing intervention.

When

Much evidence supports the premise that contact with the family during a surgery reduces their anxiety; therefore, a brief, simple, and limited nursing intervention of intraoperative communications should be done for every client's family. During long major surgical interventions (longer than 2 hours) or difficult cases, family members should receive intraoperative communications more frequently. With periodic nursing reports from surgery, bad news at the conclusion of the surgery does not arrive completely unexpected. Craig and associates (1986) found that families who have had to prepare themselves for an untoward change of a loved one's condition are better able to hear and understand the surgeon's explanation of the surgery afterwards, and therefore are less stressed.

What

Information-giving consists of a number of interactions between the perioperative nurse and family (O'Connell, 1989). The first takes place when the family and child arrive in the operating room (OR) waiting area. Here, it is extremely important that a trusting relationship commences between the family, child, and perioperative nurse.

Alert the parents that you will visit intraoperatively in the surgical waiting room and the approximate time. When visiting the family, project a positive body language; for example, smile to communicate that something has not gone wrong with surgery. Here is a possible outline of an intraoperative communication:

> *Hi, I was just relieved by another nurse and I thought I would come to let you know that Danielle is fine and surgery is underway. Danielle accepted the mask very well. She was very cooperative while we put on the monitors. She asked very appropriate questions while we were preparing her for the "special sleep", such as when she would see you. I reassured her, as you did, that you will see her in the "wake-up room". I told her she will feel tired and still sleepy after the operation, but that you would be there. She really likes her Elmo doll and fell asleep holding it the whole time. I'll put Elmo on her bed for her to have once she is awake. Overall, I feel it was a positive experience for her. Do you have any questions that I might be able to answer at this time? ....It was nice to have met you.*

Additional information communicated to family members in the surgical waiting area can include the anticipated length of surgery; the approximate time before the child will be transferred from the OR to the post-anaesthesia care unit (PACU); the arrangements that have been made by the surgeon to contact the parents/family; the hospital vicinity, such as where to get a cup of coffee; and the perioperative nurse's plan to update the family on the child's status (O'Connell, 1989).

Characteristics Needed

Perceived nursing behaviour makes a lasting impression, which clients tend to associate with their perioperative experience. The perioperative nurse can reveal self-confidence (or lack of it), regard (or apathy), expertise and authority (or ineptitude). Furthermore, perioperative nursing characteristics must

express motivation and commitment, caring, sensitivity and perception, sense of humour and education, to inspire confidence, trust and honesty in clients and their families.

As a helping profession, nursing's ideal characteristics include motivation and commitment to be informative and sincere in responding to clients having surgical interventions and their families. Perioperative nurses should share intraoperative information for the mutual benefit of clients and their families, since shared information and forewarning can avert problems. By dealing with client's families honestly and factually, control and trust are enhanced by knowledge about their loved one.

The roots of the concept of caring can be traced to nursing's beginnings, and today remain the essence and focus of nursing practice (Killen, 1996). Although caring is the single most important characteristic that nurses are known for, caring can also be painful because it leaves one vulnerable. To insulate themselves against anxiety, suffering or even death, perioperative nurses sometimes lose their ability to intraoperatively interact with clients' families. The perioperative nurse's analysis of her own feelings ensures a more genuine response to the anxious family in the form of understanding, reassurance and support, as communicated by the caring (Watson, 1994).

Another characteristic of perioperative nursing is that they are sensitive and perceptive. Perceptive nurses exhibit a genuine interest and kindness in holistically caring for the surgical client and in looking after them and letting them know that they mean something to them. Perioperative nurses need to extend their sensitivity to anxious families by incorporating intraoperative communications into their everyday role.

Another characteristic of the perioperative nurse is the need for humor. A study done in Toronto (McNamara, 1995) found that perioperative nurses listed having a sense of humor as an important component of illustrating their caring to surgical clients and families.

Education, too, is important for perioperative nurses because a person with quality education approaches challenges creatively and with confidence that solutions to the barriers of intraoperative communications can be found.

Barriers to Communications

In two separate studies, McNamara (1995) and Frederickson (1989) illustrated the concept of caring as being central to perioperative nursing and described how caring has come to be regarded as a science and a philosophy. However, as nursing moves to establish caring as a central activity as well as an attitude of effective and skilled perioperative practice, it is faced with many barriers to implementation of new interventions. This can also be true with intraoperative communications between nursing and families. While some barriers perioperative nurses face today are extrinsic, dominated by the current crisis in health care, other barriers are intrinsic, entrenched in its patriarchal roots.

Extrinsic barriers to intraoperative communications: With the economic restraint predominant in health care today, nursing has been asked to accomplish more, with diminished resources. One extrinsic barrier defined by a study from Johnson and Frank (1995) states that nursing failed to communicate intraoperatively with families because of perceived lack of time, their priority being patient care. Yet the study supported their hypothesis that even a telephone intervention lasting less than 5 minutes (and more often less than a minute) could be as much as 80% effective in reducing the anxiety of family members.

A second extrinsic barrier impeding intraoperative communications between nurses and families is having functional working equipment in the operating room. McNamara's (1995) study discovered that during surgery, nurses were occupied with highly technical machines and participating in technical procedures that required constant assessment and evaluation of their effects on patients. Likewise, Killen (1996) states, "Technology often forces us to focus on the disease rather than on the person with the disease." Therefore, as personnel decreases because of streamlining by institutions, perioperative nurses can become so involved with the technology that the client and family's identities may be overlooked.

The final extrinsic barrier is having management support. Leske (1992) found that current patient-centred intraoperative practices were woven into traditional hospital policies that neither questioned the purpose of isolating family members nor documented any need for it through research. McNamara (1995) also found that one of the barriers to intraoperative communications was lack of support from colleagues and management.

Intrinsic barriers to intraoperative communications: In McNamara's (1995) study, the caring practices of perioperative nursing illustrated that an intrinsic barrier to new interventions included criticism by peers. Having no support from colleagues meant that it was harder for perioperative nurses to assume new responsibilities. In a study by Johnson and Frank (1995), nurses did not see the intervention of communicating with families as part of their role but rather that of someone with greater interpersonal communication skills, such as a clinical nurse specialist.

Another intrinsic barrier to intraoperative communications between nurses and families is physician-nurse conflict. Craig and associates (1986) stated that nurses' desire to communicate with families of surgical cardiac patients intraoperatively met initial reluctance. Doctors were concerned that what nurses said could possibly have consequences later. But after early positive feedback about the communication between nurses and the families, other disciplines besides cardiac surgery asked to be included in the program.

Yet another intrinsic barrier among perioperative nurses is a lack of therapeutic communication skills to help alleviate anxiety. The perioperative nurse has a very limited preoperative period in which to establish a trusting relationship with the client and family. Sometimes, because of the nature or urgency of the surgery, time to establish a caring relationship through communications is restricted. However, Burchiel (1995) challenges perioperative nurses to advertise, articulate and demonstrate their caring actions (intraoperative communications) to the outside world (families of surgical clients) in a way that illustrates the distinct component of nursing work.

Conclusions

The technological advances in the operating room today require us to embrace a new foundation that includes humanistic and holistic approaches to perioperative nursing care. Perioperative nursing should include evidenced-based findings, to validate their practice in these modern times. This may require changing nurses' traditional attitudes about the isolation of family members of surgical clients to include psychological support through the development of caring, respectful, trusting relationships, and by decreasing physical stress and anxiety through communication with the family. In the current consumer-oriented climate of the health care system, doing something distinct may make a difference in market share due to positive outcomes for the family as well as the health care professional in a family-centred care environment. As an independent nursing intervention, progress reports may add to the satisfaction of family-centred care.

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References

Atkinson, L.J., & Kohn M.L. (1986). *Berry and Kohn's Introduction to Operating Room Technique.* U.S., McGraw-Hill Book Company, 3-36.

Becvar, R.J., & Becvar, D.S. (1982). Definitions of systems concepts. In *Systems Theory and Family Therapy: A Primer.* New York, University Press of America, 9-26.

Burchiel, R.N. (1995). Does perioperative nursing include caring? *AORN Journal*, 62, 257-259.

Craig, R., Cioni, D., & Morrison, C. (1986). The forgotten: Families of your surgical patients. *Journal of Post Anesthesia Nursing*, 1(3),170-174.

Daley, L. (1984). The perceived immediate needs of families with relatives in the intensive care setting. *Heart & Lung*, 13, 231-237.

Donnell, S.G. (1989). Coping during the wait: Surgical Nurse Liaison Program aids families. *AORN Journal,* 50(5),1088-1092.

Frederickson, K. (1989). Anxiety transmission in the patient with myocardial infarction. *Heart & Lung*, 18(6), 617-621.

Johnson, M.J., & Frank, D.I. (1995). Effectiveness of a telephone intervention in reducing anxiety of families of patients in an intensive care unit. *Applied Nursing; Research*, 8(1), 42-43.

Kathol, D.K. (1984). Anxiety in surgical patients' families. *AORN Journal*, 40(1),131137.

Killen, A.R. (1996). Caring and competence: Perioperative nurses tell their stories. *Seminars in Perioperative Nursing*, 5(2), 72-76.

Leske, J.S. (1992). Effects of intraoperative progress reports on anxiety of elective surgical patients' family members. *Clinical Nursing Research*, 1(3), 266-277.

Leske, J.S. (1996). Intraoperative progress reports decrease family members' anxiety. *AORN Journal*, 64(3), 424-436.

McNamara, 5. (1995). Perioperative nurses' perceptions of caring practices, *AORN Journal*, 61(2), 377-388.

O'Connell, M. (1989). Anxiety reduction in family members of patients in surgery and post-anesthesia care: A pilot study. *Journal of Post Anesthesia Nursing*, 4(1), 7-16.

Watson, D.S.(1994).Opinion:Technology in the perioperative environment. *AORN Jnl.*, 59(1), 271.

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