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Title	Adult-trained perioperative nurses' practice of family-centered care
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Publication Date	2014-05-08
Publication Information	Hamilton, Grainne, Corlett, Jo, & Dowling, Maura. (2014). Adult-trained perioperative nurses' practice of family-centered care. <i>British Journal of Nursing</i> , 23(9), 477-482. doi: 10.12968/bjon.2014.23.9.477
Publisher	Mark Allen Healthcare
Link to publisher's version	<a href="https://doi.org/10.12968/bjon.2014.23.9.477">https://doi.org/10.12968/bjon.2014.23.9.477</a>
Item record	<a href="http://hdl.handle.net/10379/14731">http://hdl.handle.net/10379/14731</a>
DOI	<a href="http://dx.doi.org/10.12968/bjon.2014.23.9.477">http://dx.doi.org/10.12968/bjon.2014.23.9.477</a>

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Hamilton G, Corlett J, Dowling M (2014) 'Adult trained peri-operative nurses' practice of family-centered care'. *British Journal Of Nursing*, 23 (9):16-21.

### **Abstract**

**Aim:** The aim of this study was to explore adult-trained perioperative nurses' practice of family-centered care (FCC).

**Method:** A qualitative research design using a hermeneutic phenomenological approach was employed. In-depth interviews were conducted with six adult-trained perioperative nurses. Data analysis was guided by Colaizzi's seven-step framework, resulting in a composite description of perioperative nurses' practice of FCC.

**Findings:** While participants supported the principle of family participation in care, they found its implementation in practice difficult and stressful. They reported that families often appeared inadequately prepared for the surgical experience and subsequent poor experiences for families caused feelings of upset and inadequacy for nurses.

**Conclusion:** While some of these findings are similar to previous studies of paediatric nurses' practice of FCC, this is the first known study to examine adult-trained perioperative nurses' practice of FCC. Participants articulated an awareness of what constitutes effective FCC and demonstrated the motivation to accomplish the task of improving family-centered practice in their practice area.

**Key words:** Adult nursing, Family-centered care, Perioperative nursing.

## **Key phrases**

- Family-centered care (FCC) is an approach of caring for children and their families where care is planned around the whole family, not just the individual child.
- Regional hospitals in Ireland provide surgical care for children in operating theatres that cater predominantly for adult patients. Many of the perioperative nurses involved in the care of children are adult-trained and unfamiliar with the concept of FCC.
- This study found that while adult-trained perioperative nurses supported the principle of family participation in care, they found its implementation in practice difficult and stressful.

## **Introduction**

In the mid-twentieth century hospitals were viewed as bleak places for children (Shields et al, 2006). Child psychology studies were reporting that parental separation arising due to hospitalisation was a major contributor to adverse psychological outcomes displayed by some children post hospitalisation (Alsop-Shields and Mohay, 2001). This led to the eventual development of family-centered care (FCC) as a model of care for hospitalised children and their families. FCC involves planning care around the whole family, not just the individual child, and recognises the importance of families to the health and well-being of children (Chorney and Kain, 2010). It is a concept of care that is now widely accepted in paediatric practice as the best method of caring for hospitalised children and their families (Shields, 2007). FCC is also embraced in other settings such as dementia care and intellectual

disability as it acknowledges the important role families and loved ones play in the lives of vulnerable clients (Lopez et al, 2013).

Successful FCC delivery is dependent on positive attitudes from health professionals and parents alike and if FCC is to succeed, understanding, empathetic communication between parents and nurses is vital (Eichner and Johnson, 2012). The role of the parent must be negotiated with healthcare staff. FCC does not mean that parents should undertake all the care for their child. If they want to, then they should be supported to do so, but should not be coerced (Shields, 2010). The communication and negotiation skills required are complex and it is increasingly being reported FCC is a challenging ideal to implement in practice (Murphy and Fealy, 2007; Coyne et al, 2013; Randall et al, 2013).

## **Background**

FCC is particularly important in the strange and frightening environment of the operating theatre and perioperative nurses, with their understanding of holistic care, are ideally placed to provide this care (Shields, 2007). The Family-Centered Perioperative Care Model (Fig. 1) developed by Chorney and Kain (2010) serves as a useful guide to perioperative practice. The model recognises the three phases of perioperative care and identifies important elements of family-centered practice in the perioperative setting. These include recognition of family factors such as anxiety and coping style, adequate preparation of parents and children for the surgical experience, family inclusive decision making in the management of anxiety, parental presence at anaesthesia induction and parental presence in the recovery room.

Regional hospitals in Ireland currently provide perioperative care for children in operating theatres where adult patients are also present (Zgraj et al, 2010). Many of the perioperative nurses involved are likely to be adult-trained and therefore unaware of current philosophies

for the care for hospitalised children and their families. While there is a wealth of literature on many aspects of FCC (Foster et al, 2010; Shields et al, 2012) an extensive search failed to uncover any studies of adult-trained perioperative nurses' practice of FCC.

### **Setting**

The study took place in a mixed adult/child perioperative department encompassing seven operating theatres spread over two floors and staffed by three independent teams of perioperative nurses (n=59). A weekly average of 10 children are scheduled on operating lists alongside adult patients, for ENT, orthopaedic, and general surgeries.

### **Method**

A phenomenological-hermeneutic approach guided by Heideggerian philosophy was chosen for the study. Phenomenological enquiry aims is to understand the meaning of lived experience. This approach therefore enabled descriptions of the reality of practice as lived by perioperative nurses.

Heidegger's philosophy followed on from that of Husserl but rejected Husserl's concept of bracketing, which involves elimination, by the researcher, of pre-conceived ideas about a phenomenon. Heidegger instead used the term "*pre-understanding*" to describe what is already known and argued that pre-understanding cannot be bracketed out because it is already there (Dowling and Cooney, 2012).

Purposeful homogeneous sampling was used to recruit six participants from a sample of thirteen volunteers who expressed an interest in participating in the study (Fig. 2). In order to give as broad a description as possible of the phenomenon being explored, the six participants

were purposefully chosen by the first author to represent varying levels of professional experience and parental status.

Data was collected using semi-structured interviews and analysed using Colaizzi's (1978) seven step framework (Fig. 3). Member checking (returning to the individual participants for their response to the interpretation of the data), resulted in no new data and all the participants stated that the interpreted themes were an accurate reflection of their experiences.

## **Findings**

Following several focused readings of the transcripts and a deconstruction of the data, patterns of meaningful connection were identified. These were reconstructed first into themes, then into subthemes (Fig. 4). Significant statements and phrases were extracted in order to give rich descriptions of perioperative nurses' experiences of family-centered practice. Three main themes were identified; attitudes to FCC; challenges of providing FCC; and resources to support FCC.

### **Theme 1: Attitudes to Family-Centered Care**

#### **Sub-theme: Support and Empathy**

All of the nurses articulated strong support for FCC as the ideal philosophy of care for hospitalised children and their families:

*It's a very important part of the nursing we do. (Rose).*

They acknowledged that undergoing surgery can be stressful and frightening for children and their families and some of the comments highlighted a strong empathy for families:

*It's very hard as a parent to walk away and leave your child with somebody (Rose).*

The respondents all perceived parental presence at induction of anaesthesia and in the recovery room to be beneficial to the child undergoing surgery and this was cited as a factor in their support for family-centered perioperative practice.

*I do think to have a parent there....definitely helps them (children) a lot.....and makes my job easier. (Amanda)*

Despite their support for a family-centered philosophy of care, three respondents expressed a preference for working with older children and one respondent stated that they would rather work with adults than children:

*I would be more comfortable working with adults because I would have possibly spent more time in theatre working with adults. (Amanda)*

### **Sub-theme: Own Parental Status**

Five out of the six nurses who participated in this study offered an opinion on the relevance of their own parental status to their practice of family-centered care. Three nurses who had children of their own felt that being a parent enabled them to show more empathy for families of children undergoing surgery:

*But you know I think when you become a mother you kind of empathise more and you think... oh God love this mother. (Rose)*

Amanda, who was not a parent, felt that this left her at a disadvantage when caring for families and children:

*... so I'm the least knowledgeable person to be asking such questions off..... I suppose I'm at a disadvantage compared to other people here because nearly everyone working here are parents. (Amanda)*

In contrast, Dara, who also wasn't a parent, expressed the opposite view:

*It doesn't make you any better of a nurse because you have children of your own. (Dara)*

Rose used her personal experience of having a child undergo surgery to demonstrate empathy with parents in a similar situation:

*She [names own child] was having a general anaesthetic and even though I knew exactly what they were doing.... exactly what they were giving her, it still was horrible... and you know it's that thing for the parent of walking out the door and leaving your child with somebody that you....you don't know. (Rose)*

## **Theme 2: Challenges**

### **Sub-theme: Lack of Paediatric Experience / Qualification**

When participants were asked how they felt about working with families and children in practice, five of them said that they found it stressful. One participant even went so far as to say:

*Sometimes depending on [child's] age it would engender a...fear (Dara)*

Further probing revealed that reasons given for this stress related mainly to a lack of paediatric qualification and /or experience:

*Not working with children before, not working with them on a regular basis you look at a child and you think .....My God.....difficult to intubate, difficult to get a line in, tears, crying, screaming. (Dara)*

Dara also described how having a parent present prompted feelings of practicing under scrutiny:

*So you are a professional at all times but you feel you are under extra scrutiny when it comes to their cherished child. It does put more pressure on you. You're concentrating on the child, the parent, the anaesthetist and what they want. You've got all those things to take into consideration and you've also got that extra scrutiny. (Dara)*

Amy commented that these feelings of inadequacy usually decreased as professional experience and life experience increased and that these were important factors in building confidence and promoting a positive attitude:

*When I was a younger staff nurse maybe it was harder. I think if we can be confident in ourselves we can reassure the parents. They are still worried and anxious about their child, but if you are capable of reassuring them it makes it easier. And that comes with experience. (Amy)*

### **Sub-theme: Dealing with Anxious Parents**

Despite a self-reported lack of paediatric knowledge and experience, participants appeared ‘tuned in’ to the needs of children and their families, and perceived a direct correlation between parental anxiety and child anxiety. It was acknowledged that dealing with parental anxiety sometimes made the nurses’ job more difficult and affected their ability to provide care to the child undergoing surgery:

*There is the odd time where I feel the parents are very stressed themselves and they maybe don’t handle it very well. In those circumstances you can tell straight away that their anxiety is passed on to the child and can maybe be more of a hindrance because you’re trying to keep things calm and it doesn’t help. (Amy)*

Some participants expressed the view that parents and children were not always fully prepared for their surgical journey and that this sometimes led to less than satisfactory outcomes for all involved. Amy described how a parent fainted after leaving her child in the anaesthetic room:

*A parent fainting out in the corridor..... I think it was the theatre operative who had to lay the woman on the ground. That was her only option ...out on the theatre corridor.....of course she hadn’t had breakfast when we questioned her afterwards. It was a case of having to get a trolley from recovery down into the corridor and get the poor woman on to the trolley. And she made a full recovery in recovery. That was pretty traumatic. (Amy)*

Dara also outlined an experience involving parental and child anxiety:

*Like last week we had a child that was coming to theatre [for] MUA of a fractured limb, and their sister had told them from previous experience that it was going to hurt.....the anaesthetic itself, the mask was going to be painful. She screamed and screamed and her mother was in tears and it was just a terrible, terrible thing (Dara).*

While the primary motivation for recounting these ‘stories’ may have been to illustrate the need to seek better perioperative care for children and their families, it was evident that the perioperative nurses’ involved also found these experiences upsetting and difficult.

### **Theme 3: Resources**

### **Sub-theme: Staffing Levels**

Half of the participants cited inadequate staffing levels and excessive workloads as impediments to the provision of effective FCC;

*Well the first thing is our numbers. You know there are often days that you don't have an extra pair of hands to mind mum or dad. (Rose)*

Participants appropriately recognised that family-centered care involves caring for the whole family and not just the child. The view was expressed that the high-tech perioperative environment can be frightening for parents and children alike and as well as providing specialised clinical care to the child undergoing anaesthesia, the perioperative nurse must provide psychological support to both parent and child:

*But it's stressful for us as well because you also care for the mother or whoever is in the [anaesthetic room]..... two people to care for. (Jean)*

### **Sub-theme: Education for Nurses**

Four of the respondents articulated the view that a lack of knowledge on their part militated against effective family-centered care:

*More education or discussion around the whole area would certainly help.....I hadn't heard of it [FCC] until you mentioned it. (Amanda)*

Participants proposed various formats of education including formal study days, paediatric training and discussion forums. Two participants felt that it was important to reflect on practice, to share experiences with one another and to learn from them:

*Maybe we should take stock every so often have a look at what our procedures are. See is there anything we can improve on. (Amy)*

One participant suggested that staff should be facilitated in obtaining paediatric anaesthesia qualifications and that an anaesthetic nurse practitioner role should be considered in the future, with a view to using this role to lead out on family-centered care education for staff and families alike.

### **Sub-theme: Education for Families**

Participants had already expressed the view that parents and children were not always fully prepared for their surgical journey and that this sometimes led to less than satisfactory outcomes for all involved. Four participants suggested better preparation of parents and children as a means of improving family-centered practice:

*I think that it's before they get to theatre at all they need to be properly prepared, before they even come in to hospital... pre-op preparation of the parents as well as the children. (Amy)*

Suggestions included a Saturday Morning Club where parents and children are invited to tour the surgical facilities prior to admission for surgery. Rose described her previous participation in a similar programme:

*We played games with them entertained them for a while... showed where they were going to go and what was going to happen, but the brothers and the sisters came along as well. So not only were you educating one member of the family you were educating other children. (Rose)*

Other suggestions included issuing questionnaires to parents prior to surgery in order to determine their needs and their child's needs, and pre-operative visits to the ward by perioperative nurses.

### **Sub-theme: Physical Environment**

Participants acknowledged the importance of the hospital environment in promoting effective FCC and recognised that for families of children undergoing surgery the nature of the waiting environment can be important. All participants suggested the establishment of a family waiting area near the operating theatres as this is currently lacking in the facility.

The infrastructure within the operating theatres themselves was also cited by participants as an impediment to effective family-centered care. The lack of adequate space was highlighted.

*Well for a start the environment we work in. Our anaesthetic rooms are small and it's very hard to accommodate a consultant, his junior, a nurse and a member of a family whether it be a mother or father, elder sibling, the patient themselves. (Dara)*

*You can let them [parents] stay inside [recovery room] if you have good space, but if you have 4 or 5 patients in the recovery we can't. (Jean)*

The procurement of more toys for use as distraction aids and child-friendly paintings/murals in the anaesthetic and recovery areas was also suggested.

## **Discussion**

Working with parents and hospitalised children is a complex undertaking that requires health professionals to communicate effectively and negotiate care with families (Shields, 2010). Faced with these challenges it is no surprise that many paediatric health professionals report a preference for working with children than for working with parents (Shields, 2011). In contrast the findings in this study indicate that adult-trained perioperative nurses actively support parental participation in the care of children. However, it appears that this support is derived mainly from the fact these adult-trained perioperative nurses perceive caring for children, particularly anxious or distressed young children, to be a challenging task. Parents can help alleviate any distress the child may have and can assist with, or indeed undertake, distraction therapy. Participants who had no children of their own reported even less confidence in their abilities to provide psychological support for children undergoing surgery. This is supported by Shields (2011) who found that older healthcare staff with children of their own, and who held a specialist qualification in paediatrics gave higher scores for working with both parents and children.

Despite the participants' support for family participation in paediatric perioperative care, all reported that they found working with families and children challenging, and that they

associated paediatric anaesthesia and surgery with feelings of stress. A possible explanation for this dichotomy may be the lack of paediatric training and experience identified by participants as an impediment to their practice. Paediatric anaesthesia is a highly specialised discipline and children undergoing anaesthesia are much more likely than adults to have an adverse event (Mamie et al, 2004). For adult-trained perioperative nurses who work with children on an infrequent basis these events are without doubt frightening and stressful. Some participants expressed a preference for working with older children. Given that the incidence of adverse events decreases with each increasing year of age in children (Mamie et al, 2004) and older children are also less likely to be acutely distressed and more amenable to reasoning, this is not surprising.

The literature identifies a strong correlation between parental anxiety and child anxiety (Kain et al, 2007; Arai et al, 2008) and this was recognised by participants. They expressed the view that parents and children were not always fully prepared for their perioperative journey, resulting in sometimes poor experiences for families and children. Participants reported that they also found such experiences to be distressing and stressful. While the effects of negative hospitalisation experiences on families and children have been well documented (Shields et al, 2012), a search of the literature failed to uncover any studies on how these experiences affect healthcare providers.

There is debate in the literature about the efficacy of parental presence at induction of anaesthesia. A recent review of studies on parental presence found that their presence does not reduce the child's anxiety (Yip et al, 2009). Yip et al (2009) suggest that promising non-pharmacological interventions such as parental acupuncture, clown doctors, hypnotherapy, and hand-held video games be investigated further as means of reducing anxiety. Parents,

however, continually express a preference to be present at their child's induction (Himes et al, 2003; Kain et al, 2003; Anderson et al, 2012). This has resulted in the development of initiatives designed to reduce parental, as well as child, anxiety. Kain et al (2007) demonstrated that family-centered preoperative behavioural intervention not only reduced children's anxiety before surgery but it also reduced the incidence of post-operative delirium, shortened discharge time after surgery and reduced analgesic consumption after surgery. Participants in our study also recognised that better preparation of families and children was crucial to positive patient and parent outcomes. The issue of resources to support effective family-centered practice is a recurrent theme in the literature (Shields, 2010). This is corroborated by the findings reported here where staffing levels, education, infrastructure and physical resources were identified by participants as impediments to effective perioperative FCC. Despite these challenges it was encouraging to find that participants articulated an awareness of what constitutes effective FCC and demonstrated the motivation to accomplish the task of improving family-centered practice.

### **Study Limitations**

The study findings are limited by the small number of interviews conducted and by the collection of data in one setting only. While the findings cannot be generalised across settings, they do provide an interesting insight into the unexplored area of family-centered practice among adult-trained perioperative nurses, and have the potential to act as a vehicle for improvements in family-centered practice.

### **Conclusion**

FCC is an important component of perioperative nursing and perioperative nurses, as accountable practitioners, have a responsibility to meet the needs of both patient and family (Shields, 2007). However, improvements in practice and changes in the care setting cannot be achieved without organisational and managerial support (Murphy and Fealy, 2007). Continuing education and workshops focusing on the development of skills necessary for constructive communication with families must be facilitated if perioperative nurses are to practice effectively. There is also a need to include FCC in induction programmes for adult-trained nurses who are expected to care for children in mixed adult/child perioperative settings. Above all, it is vital that organisations recognise that FCC involves providing care for the child *and* for the family and staffing levels must reflect this reality.

The development of a family-centered preparation programme for children undergoing surgery and their families requires serious consideration. A multi-disciplinary approach that includes input from interested families and other healthcare professionals would lead to the development of a robust preparation programme.

Finally, adult-trained perioperative nurses' practice of FCC remains largely unexplored and further research is needed in order to identify learning needs and support practice changes.

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