Learning Zone
CONTINUING PROFESSIONAL DEVELOPMENT

Aim and intended learning outcomes
The aim of this article is to discuss the psychological aspects of nursing care for patients admitted to hospital for elective surgery. After reading this article you should be able to:

- Outline the changing emphasis of care in surgical nursing.
- State the main psychological themes associated with surgical nursing.
- Describe the psychological interventions that seek to enhance the patient’s experience of elective surgery.

Introduction
Advances in surgical and anaesthetic practice, public demand and increasing healthcare costs have resulted in a considerable reduction in the number of days that patients spend in hospital preparing for, and recovering from, elective surgery. The level of ambulatory surgery being undertaken in the UK has grown from 15% before 1991 to 69% in 2003/04 (Healthcare Commission 2005). This is set to rise further as the current UK government has a target of 75% of all elective surgery to be undertaken on a day case basis by 2010 (Department of Health 2000).

As a direct result of such advances, the broad physical nursing interventions once synonymous with intermediate surgery are becoming increasingly redundant (Mitchell 2000a, 2000b). Some immediate physical...
nursing interventions are still required, although these are brief as the patient is frequently dressed and home within a few hours of surgery (Howat et al 2006). However, the majority of patients remain anxious when entering hospital for day surgery (Mitchell 2005). At present, either little formal psychological nursing intervention is undertaken or such care is marginalised (Pearson et al 2004a).

**Psychoeducational management**

Increased patient anxiety before general anaesthesia and surgery has been recognised as a pertinent issue (McGaw and Hanna 1998). The level of patient anxiety has evolved with the ongoing developments in surgery. For many decades patient anxiety arose from apprehension concerning anaesthesia, the operation, pain, discomfort and unconsciousness (Carr et al 2006). However, studies on day surgery have now revealed the waiting period before surgery is an additional anxiety-provoking aspect (Pearson et al 2004a). Nevertheless, general anaesthesia still arouses the greatest level of apprehension (Carr et al 2005). It has been suggested that such apprehension arises primarily from the thought of having an injection during induction or the belief that a mask will be placed over the face during induction (van den Berg et al 2005).

Patient distraction techniques such as television and music have been used to assist in anxiety management (Clements et al 2004), predominantly because they are quick and easy interventions to use, and leave more time for staff to undertake other tasks. However, such distraction techniques have not demonstrated sufficient improvements in anxiety to warrant their more wide-scale adoption. Some ‘distracting interventions’ are too limited, basic and not all patients find them soothing (Dijkstra et al 2006). While pharmacological treatment for pre-operative anxiety has demonstrated many benefits, more subtle therapeutic interventions are required.

Pre-medication is largely avoided in day surgery because patients (Walker et al 2002):

- May be at risk of delayed discharge when pre-medication is administered as they may not be fit for discharge at the desired time.
- Are required to remember important information on discharge and not feel too drowsy.
- Are required to walk out of the day surgery facility.

Moreover, with such large numbers of anxious patients, it is difficult to determine the level of patient anxiety and distinguish which patients should receive pre-medication.

To help manage patients’ pre-operative anxiety and increase nursing-based knowledge, it has been suggested that surgical nursing should focus on pre-operative psychological management (Rudolfsson et al 2003). Such management should encompass information provision, health locus of control, self-efficacy, therapeutic use of self and environmental considerations.

**Time out 2**

Imagine that you are to go into hospital today for intermediate day surgery. You may have met the surgeon briefly before today, but all the other doctors and nurses are strangers. You must remain nil-by-mouth, dress in a theatre gown, undergo final preparations for surgery and general anaesthesia in an unfamiliar environment. Your relatives may not be encouraged to stay with you and your mobile telephone must be turned off. You have to wait alone, in a strange sterile environment, partially clothed, uncertain of exactly what is to happen and obey fairly inflexible instructions. In addition, you must trust these professional strangers with your life, retain the information they provide and later look after yourself at home with little written information for support.

The majority of day surgery patients are anxious (Mitchell 2000c). What aspects of this situation would cause you to be anxious?

**Information provision**

Patient information provision before surgery is a national and international challenge and has remained so for many years (Pearson et al 2004b). Pai and Nicholl (2005) found that 30% of day surgery patients could not recall being provided with an explanation regarding their surgery and only 40% remembered being told about potential complications. It was therefore suggested that the pre-assessment visit was essential for patient information provision. Forty two per cent of day surgery patients in the UK are currently not offered a pre-assessment visit (Healthcare Commission 2005). However, it is vital that patients are offered suitable information before the day of surgery (Suhonen et al 2005). A study by Mitchell (2000b) found that the majority of day surgery patients would like the information one to three weeks before surgery with no one wanting the information presented to them on the day of surgery.

The main challenges for information provision are the level of information (Stoddard et al 2005), and its suitability to adequately assist with a home recovery (Crook et al 2005). Some patients require less information than others to help manage their anxiety before a stressful event such as day surgery, as too much has the potential to increase anxiety (Royal College of Surgeons of England and Royal College of
Psychiatrists (1997). Conversely, some patients require more information to help manage their anxiety as too little has the potential to increase their anxiety (Castoro et al 2006). In an extensive ongoing study of 670 day surgery patients, 85% of those undergoing general anaesthesia experienced some anxiety. Detailed information was required by 50% of these patients, with further explanations required on the day of surgery to help reduce anxiety. Therefore, patients should ideally be provided with a choice of the level of information at their pre-assessment visit, that is, detailed or standard level (Castoro et al 2006). This preferred level of information should then be continued throughout the patient’s whole day surgery experience (Box 1).

Studies have suggested that patients desire information to aid their recovery, for example, on managing pain, nausea, vomiting and possible sleep disturbance (Ruuth-Setälä et al 2000). A number of studies have also documented patients’ desire to receive information regarding possible post-operative complications and how to recognise such complications so that they are aware of possible coping options (de Jesus et al 1996). Henderson and Zernike (2001) found that some surgical patients were dissatisfied with the discharge information on pain management, practical issues of recovery and wound management, although they said nothing because of the perceived lack of health professionals’ time, the unfamiliar environment and lack of continuity. Henderson and Zernike (2001) concluded that problems that are often perceived to be minor by health professionals are of considerable concern to patients. In a study of day surgery patients’ perceptions by Dewar et al (2004): ‘Patients claimed that they were too groggy or sleepy, had not been feeling well enough to be discharged, and consequently were not able to absorb discharge instructions’.

The information frameworks provided in Boxes 1 and 2 are standard formats only. Greater detail with relevant sub-headings is required, especially concerning information relating to specific operations, anaesthesia and pain management. Such detail has been published elsewhere (Castoro et al 2006, Coll 2006).

**BOX 1**

**Framework for patient admission information**

Provision of information concerning:

- Arrival time, where the unit is situated, arrival reporting.
- Arrangements for relatives and/or friends – remaining with the patient, who to contact, valuables and discharge time.
- Current medications (if any), including the type and dose on the morning of surgery.
- Nil-by-mouth, that is, fasting times, chewing of gum.
- Comfortable clothes for discharge (dependent on site of surgery).
- Procedural information (sequential order of events), behavioural information (actions the patient is required to undertake) and sensory information (bodily sensations likely to be experienced).
- Information relating to surgery – general and specific.
- Information concerning anaesthesia.
- Stages of post-operative recovery – general and specific.
- Post-discharge recovery process – the average length of time to recover.

NB: This is not an exhaustive list

(Adapted from Mitchell 2001, 2005)

**Health locus of control** Health locus of control is primarily concerned with an individual’s desire to be included in the decision-making process. This may be related to their ‘internal’ and ‘external’ health locus of control appraisals (Wallston and Wallston 1982). Health locus of control is based on the assumption that people with an increased personal perception of control (internals) have a greater belief in their ability to shape their own destiny, whereas people with a decreased personal perception of control (externals) feel more influenced by luck, fate and powerful others (Wallston et al 1978).

The surgical environment provides vivid examples of how evaluations of self-control can be easily diminished, for example, brief hospital admission, strange environment, rigid schedules, concordance, signing consent forms, undressing and the administration of drugs. When first entering a day surgery unit, many patients could quickly experience less control than they may have perhaps desired, especially if they deem themselves to have a strong belief in their ability to shape their...
own destiny, that is, a high internal locus of control (Guilbert and Roter 1997). Increasing patients’ perceived level of personal control can help to limit increased anxiety (Sørlie and Sexton 2004) and restrict the impact of the strange, sterile clinical environment (Halfens 1995).

The level of control offered to day surgery patients needs only be minor, for example, a choice of when to undress and prepare for surgery. Other examples include negotiating a possible reduction of when to undress and prepare for surgery. Other patients need only be minor, for example, a choice of

2) Were you content to sit with a stranger or would you have preferred a friend to be near you?

3) What checks of the aircraft’s environment did you make to assure yourself that you would probably be safe and arrive at your destination unharmed?

4) What behaviours did you expect or desire from the flight attendants to help ease any of your apprehensions?

5) Following a possible thump, the aircraft dropping suddenly as a result of air turbulence or another unforeseen/perceived unusual event, did you seek confirmation from the flight attendants that everything was okay?

Now, reconsider the above questions but this time imagine yourself as a day surgery patient who is about to become unconscious, with ensuing total loss of control and placing your life in the hands of strangers.

6) What aspects of nursing intervention, which may have the ability to bestow a perception of patient control and/or choice, do you feel would reduce your anxiety in this situation?

7) How do you think you could implement some of these interventions in your clinical environment to benefit patients?

**Self-efficacy**

Self-efficacy is a belief in one’s ability to cope with a stressful situation or challenging demand (Luszczynska et al 2005). Considerable apprehension can ensue if the perceived ability to accomplish the given task(s) is diminished (Bandura 1982). Positive self-efficacy beliefs can therefore strongly influence an individual’s recovery from surgery (Harnirattisai and Johnson 2005). Day surgery patients remain in the acute hospital setting for a short period. Self-preparation and self-recovery, away from the acute hospital setting, are now the greater part of the surgical experience. In addition to self-preparation, patients need to manage at home on the evening of discharge and the following days having undergone extensive surgery, with little professional assistance. To manage this practical situation effectively patients require buoyant
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self-efficacy beliefs, that is, strong beliefs in their ability to contain the situation and deal effectively with any healthcare problems.

As with health locus of control, the surgical setting may obviate any personal attempt to increase self-efficacy as a result of enforced healthcare practices, that is, brief hospital admission, possible lack of information to aid home recovery, unfamiliar environment, powerful uniformed others determining complex medical events and enforcement of a rigid schedule. As the perceived ability to cope at home following day surgery may be reduced in some patients (Mitchell 2000c), a planned programme by nursing staff to enhance self-efficacy is required (Johansson et al 2005). Surgical nurses should identify aspects of care, which might assist in the enhancement of patient self-efficacy, for example, explaining events, providing the desired level of information, providing a nurse-initiated post-operative telephone call and information conducive to home recovery. Waldrop et al (2001) suggest that self-efficacy can be enhanced in surgical patients by:

- ** Provision of mastery experiences, that is, personal instruction in the necessary skills.
- ** Vicarious learning strategies, that is, modelling or the opportunity to view and copy other patients’ behaviours. This may be direct – viewing other patients’ behaviour, or indirect – viewing a relevant video or DVD presentation.
- ** Verbal persuasion by medical and nursing staff of the patient’s ability to cope well.

**Therapeutic use of self** Therapeutic use of self can have a positive influence on recovery from day surgery (Costa 2001). Therapeutic use of self is defined as the beneficial effects the presence of a nurse can bestow on a patient in the acute healthcare setting. Such an influence will be divided into three aspects:

- ** Social support.
- ** Optimism enhancement.
- ** Provision of cognitive coping strategies.

The availability of social support on the day of surgery can be limited, as many NHS hospitals do not encourage relatives or friends to remain with the patient – sometimes for good clinical reasons. However, having a partner or friend present while waiting would help to ease the patient’s anxiety.

In the absence of a partner or friend remaining with the patient, the presence of a doctor or nurse as an agent of social support has been viewed as highly beneficial (Krohne and Slangen 2005). Their presence has been compared to the reassuring safety that a parent or guardian affords an infant: that is, they feel safer when the parent is close (Teasdale 1995). Therefore, merely being close to and communicating with patients before surgery may confer an impression of increased safety.

Maintaining an optimistic outlook when experiencing a stressful medical event has a positive influence on post-operative recovery (McCarthy et al 2003). Broadbent et al (2003) examined patients’ experiences of a brief hospital stay for hernia repair and highlighted the negative effects of increased pre-operative stress on wound healing. They found that higher reported psychological stress before surgery predicted lower wound repair processes in the early post-operative period (Broadbent et al 2003). Increasing the amount of time nurses spend with each patient while in the day surgery unit is also beneficial for optimism enhancement (Mitra et al 2003). Likewise, additional communication with a nurse via telephone during recovery at home has been viewed as positive (Dewar et al 2003). Patients who experience an increased level of optimism can have a positive effect on carers. During recovery, more optimistic patients have been judged to make the task of caring for them easier (Ruiz et al 2006).

Aiding the expansion of a patient’s repertoire of cognitive coping strategies can also be beneficial. Cognitive coping strategies are defined as the positive thoughts patients can use to help dispel false or unfounded fears during periods of apprehension. Faymonville et al (1997) described cognitive coping strategies as: ‘imaginative transformation of sensation or imaginative intuition’: that is, thinking of other places and situations or purposeful distraction. Such cognitive processes may help to reduce or control ‘catastrophising thoughts’. Catastrophising thoughts can be defined as a tendency to focus on, and to exaggerate, the negative aspects of a noxious situation, and the tendency to feel overwhelmed and unable to cope with a situation or control a situation. For example, in a study by Klopfenstein et al (2000), one group of patients were provided with extra pre-operative information concerning anaesthesia in addition to the opportunity to dispel myths and gain accurate information. This group were significantly less anxious than the group of patients who were not given such an opportunity.

Not all patients may be aware of the scope of coping strategies available as they may have little knowledge of proceedings and therefore be unable to discern the usual from the unusual (Time Out 4). Patients could therefore be advised, for example, that the hospital performs many surgical procedures safely each day or that the anaesthetists, surgeons and nurses are all suitably qualified to undertake their roles. A booklet
produced by the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Northern Ireland (2003) also advises that patients should be informed of the safety and effectiveness of the drugs used during anaesthesia.

Despite evidence, no studies to date have uncovered the most appropriate words or phrases to use during such interactions. Doctors and nurses presumably use words they personally deem to be the most appropriate. Information regarding the most appropriate expressions is vital for a comprehensive pre-operative psychoeducational plan of care. Research is ongoing to uncover the most effective cognitive coping strategies for use in such situations. Initial results from the ongoing study of 673 day surgery patients suggest that supportive statements given in a positive manner appear the most appropriate, for example: ‘The hospital performs many surgical procedures safely’.

Environmental considerations

This aspect concerns the environment and is divided into the behaviour of medical and nursing staff and the physical environment of the day surgery ward and theatre. Few studies have examined these aspects in modern surgery, although the impact of the environment has been identified.

In a comprehensive day surgery study, Kaldenberg and Becker (1999) established that the friendliness of the doctors and nurses, nurses’ concern about patients’ comfort, the information provided and the environment—comfort, waiting room, décor and cleanliness—all gained the highest ratings when exploring satisfaction with care. Moreover, the highest predictor of likelihood to recommend the day surgery unit to others was the perceived level of care provided by nurses. Parsons et al (1993) and Vogelsang (1990) also demonstrated the beneficial effects of the ‘presence’ of the nurse.

The physical environment of the day surgery ward and theatre can also have a considerable impact. Kaldenberg and Becker (1999) stated that: ‘In the absence of direct hygiene or aseptic techniques, the cleanliness of the building serves as a proximal measure. Alternatively, the patient may view the building and the comfort of the patient and waiting rooms as not only reflective of the commitment to the patient but also an indicator of managerial focus on quality. If management doesn’t have a commitment to provide the best building and center possible what kind of commitment do they have to excellence in surgery’.

It has been suggested that windows are essential for adequate sunlight, pleasant odour for impressions of good hygiene, and spatial layout and general ambience for a positive impact on mood (Swan et al 2003). The changes required to improve the general ambience of a clinical environment can be quick, simple and inexpensive to implement, for example, comfortable chairs, softer lighting, pictures on the walls and simple flower arrangements (Ingham and Spencer 1997).

As a result of the rising number of patients undergoing local anaesthesia in day surgery, the ‘awake’ patient in theatre is becoming a focus for investigation (Gnanalingham and Budhoo 1998). In studies of patients undergoing elective caesarean section under regional anaesthesia, helplessness was a strong sensation (Kennedy et al 1992, Chit Ying et al 2001). Being able to talk to a relative or nurse was identified as the most effective support. Faymonville et al (1997) conducted an experimental study with 60 day surgery patients undergoing local anaesthesia for plastic surgery. Instructions on how to breathe deeply and relax significantly reduced intra-operative anxiety in comparison to pre-operative levels. Also, it has been established that having a dedicated person

**Time out 5**

Refer to Time Out 4, where you imagined you were flying to a warm and sunny destination. When an event occurred during the flight that caused you to become anxious, what helped to ease your apprehension?

1) The pilot’s explanation, that is, additional information?
2) The flight attendant’s explanation, that is, additional information?
3) The flight attendant’s non-verbal behaviour?
4) Other passengers’ verbal or non-verbal behaviour?
5) Your partner or friend’s verbal or non-verbal behaviour?
6) All of the above?
7) None of the above. You remained anxious.

Refer to Time Out 4, where you imagined you were flying to a warm and sunny destination. When an event occurred during the flight that caused you to become anxious, what helped to ease your apprehension?

Now, reconsider the above questions and imagine you are a day surgery patient about to become unconscious.

8) If you become apprehensive regarding an aspect of your day surgery experience, what verbal information provision from the nurse or doctor may help you to manage your anxiety more effectively?
9) If you become apprehensive regarding an aspect of your day surgery experience, what non-verbal behaviour exhibited by the nurse or doctor may help you to manage your anxiety more effectively?
10) Think of how you can implement interventions in your clinical environment to relieve patients’ anxiety.
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available to talk to the patient intra-operatively and keep him or her informed of events is reassuring (Stermer et al. 1998).

Conclusion

Modern intermediate surgery is changing rapidly. A shift towards patients spending a reduced amount of time in hospital is taking place, for example, inpatient surgery has been transferred to day surgery and day surgery has been relocated to the outpatient department or health centre. Nursing interventions associated with lengthy hospital admissions for intermediate surgery are no longer pertinent for the modern surgical patient who now only remains in hospital for a matter of hours. Such patients have not undergone minor surgery - extensive surgery is regularly being performed (British Association of Day Surgery 2006). Patients are expected to recover at

References


and environmental considerations should be self-efficacy enhancement, therapeutic use of self and environmental considerations should be further developed before their more formal introduction into surgical care. However, this process will only begin more widely when nurses are made aware of the necessary interventions and such interventions are formally acknowledged.

Home, largely unaided by professional medical or nursing attention. With so little physical care required, psychological interventions, especially information provision, are by necessity becoming a central feature of surgical nursing. Indeed, the majority of day surgery studies discussed in this article have emphasised the need for good patient information provision. Psychoeducational interventions in the form of information provision, health locus of control considerations, self-efficacy enhancement, therapeutic use of self and environmental considerations should be self-efficacy scale: multicultural validation studies. Journal of Personality Psychology. 139, 9, 439-457.


HOW TO USE THIS ASSESSMENT

This self-assessment questionnaire (SAQ) will help you to test your knowledge. Each week you will find ten multiple-choice questions which are broadly linked to the learning zone article.

Note: There is only one correct answer for each question.

Ways to use this assessment

✈ You could test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.

✈ You might like to read the article to update yourself before attempting the questions.

The answers will be published in Nursing Standard two weeks after the article appears.

Prize draw

Each week there is a draw for correct entries. Send your answers on a postcard to: Nursing Standard, The Heights, 59-65 Lowlands Road, Harrow, Middlesex HA1 3AW, or via email to: zena.latcham@rcnpublishing.co.uk

Ensure you include your name and address and the SAQ number. This is SAQ No 386. Entries must be received by 10am on Tuesday April 17 2007.

When you have completed your self-assessment, cut out this page and add it to your professional portfolio. You can record the amount of time it has taken you. Space has been provided for comments and additional reading. You might like to consider writing a practice profile, see page 60.

1. What percentage of elective surgery is targeted to be undertaken as day surgery by 2010?
   a) 15
   b) 67.2
   c) 69.1
   d) 75

2. Which aspect of informal care can become marginalised?
   a) Induction of anaesthesia
   b) Maintenance of anaesthesia
   c) First-stage recovery
   d) Psychological support

3. Which of these arouses the greatest apprehension in day surgery patients?
   a) Possible pain and discomfort
   b) Unconsciousness
   c) General anaesthesia
   d) The operation

4. What percentage of day surgery patients want detailed information?
   a) 20
   b) 30
   c) 40
   d) 50

5. When do most day surgery patients prefer to receive information?
   a) A few hours before surgery
   b) A few days before surgery
   c) One to three weeks before surgery
   d) Five weeks before surgery

6. Procedural information includes the:
   a) Actions a patient needs to take
   b) Order of events
   c) Bodily sensations likely to be experienced
   d) Cognitive strategies to help avoid ‘catastrophising’

7. What factors limit patients’ control over their day surgery?
   a) Strange environment
   b) Rigid schedules
   c) Medication
   d) All of the above

8. A nursing measure that may enhance a patient’s self-efficacy is:
   a) A post-operative telephone call
   b) Not explaining events
   c) Not providing the desired level of information
   d) Coercion

9. Three aspects of therapeutic use of self are:
   a) Control, self-efficacy, cognitive coping strategies
   b) Self-efficacy, cognitive coping strategies, social support
   c) Social support, optimism enhancement, cognitive coping strategies
   d) None of the above

10. Information on which of the following may help to dispel myths about anaesthesia and surgery?
    a) The hospital performs many procedures safely each day
    b) The anaesthetists, surgeons and nurses are all qualified
    c) The drugs used are safe
    d) All of the above

This self-assessment questionnaire was compiled by Mark Mitchell and Lisa Berry

Report back

This activity has taken me ____ hours to complete.

Other comments:

Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent
Good
Satisfactory
Unsatisfactory
Poor

As a result of this I intend to:

Answers
Answers to SAQ no. 384
1. c  2. d  3. a  4. d  5. a
6. d  7. a  8. b  9. a  10. d