What Patients Want To Be Told Prior To Going To A Surgical Intensive Care Unit

by

Glenna Clemens

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APPROVED:

[redacted]

Marie Berger, M. S., Assistant Professor of Nursing
Field Study Advisor

[redacted]

Virginia Cory, M.S.N., Assistant Professor of Medical and Surgical Nursing
First Reader

[redacted]

Sandra Stone, M.S., Assistant Professor of Medical and Surgical Nursing
Sedond Reader

[redacted]

John M. Brookhart, Ph.D., Chairman, Graduate Council

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CHAPTER I

INTRODUCTION

The literature in the last few years has been filled with different aspects of preoperative teaching. The purpose, the effectiveness, and the patients' reaction to the teaching have all been reviewed carefully. In all this literature, however, there is little or no mention of involving the patient in defining goals of the teaching program. Physicians and nurses decide what needs to be taught and proceed from there in their teaching.

Teaching as an element of the nursing function has long been recognized as an important aspect of patient care. The National League of Nursing Education recognizing the importance of preparing nurses for teaching, in 1918 stated, "Another limitation of the ordinary training is that it deals only or mainly with disease, neglecting almost entirely the preventive and educational factors which are such an essential element..."[24] The 1937 curriculum guide stated, "the nurse is essentially a teacher and an agent of health in whatever field she may be working..."[22] In 1950, teaching principles of learning, and teaching skills were advocated as a factor relative to all nursing curricula.[23]

Teaching by nurses has been done on both a formal and informal basis. Classes taught by nurses in a group setting cover a wide range of topics from pre-natal instruction to teaching of the preoperative patient.[21,27] Informal teaching is done by nurses daily

while care is given to hospitalized patients and by follow-up instruction to patients in a doctor's office or clinic.

Preparation of patients preoperatively by physicians and nurses for intensive care unit range from formal to informal teaching. The instruction the patient receives depends on the particular hospital and its personnel. Hospitals with a formalized teaching program present what the personnel think is important for the patient to know.

Research on teaching of the intensive care patient centered around his needs is limited. Much research has been directed toward the open heart patient and his preparation for the intensive care area. Although there is much similarity between the care of the open heart patient and the care of other major surgical patients in an intensive care unit, nurses cannot be sure that the patients want or need the same type of information prior to going to the unit.* The questions which arise are: "How do nurses know what information is needed or wanted?" and "Will finding out what patients need help a nurse toward more productive and satisfying contact with patients?"[27]

> It is generally believed that adequate psychological preparation plays a significant role in aiding patients to adapt to illness and treatment with the least emotional expense. Recently we have begun to see evidence of attempts by members of the surgical team to prepare their patients psychologically as well as physically for the surgical experience. Unfortunately, it has been our experience that most of these attempts are ineffective. We believe their ineffectiveness is due to a discrepency between what is offered by the staff members and what the patient actually needs and can utilize.[9]

"But what information do patients consider essential? What do they think is most meaningful? What do they perceive as helpful but not important, or not helpful at all?"[28] What do patients going to a surgical intensive care unit want to be taught seems a logical question in preparation of a teaching plan for these patients.

Review of the Literature

Preoperative preparation of surgical patients has long been a task of physicians and nurses alike. The literature as far back as 1941 mentions the importance of preparing patients for their surgical experience.

Many reasons are presented in the literature for giving preoperative instruction to the surgical patient. Although the reduction of anxiety and having a more cooperative patient postoperatively is cited in the literature as a goal of preoperative teaching, no specific study has shown a direct relationship. Meyers found that less tension was created when the patient was given specific information upon which he could structure the event of impending stress. She concluded that to tell the patient exactly what would happen to him was most desirable, decreased tension, and could make the patient more comfortable during stressful events.[20] Levine and Fiedler reported that upon evaluation of their preoperative program after one year's use they found their patients more accepting of procedures used in their care and received more patient and family cooperation. A definition of "cooperation" was not given.[15]

The purpose of preoperative teaching is twofold: briefly, it consists of giving the patient some information as to what he may expect, and correcting the misconceptions which he may have about his coming ordeal.[4] Abdellah and Levine found that patients want an explanation of their care. They want to know what to expect and what is expected of them. When a patient enters the hospital he

enters a strange and new environment. Coupled with the anxiety of this new environment is the unknown aspect of his care.[1] "Fear of pain, of the unknown, and being suddenly dependent is common in almost every preoperative patient. The greatest fear appears to be that of the unknown."[15]

The results of preoperative teaching on the course of patients postoperatively has been a goal of a number of studies. Dumas's study, "The Effect of Nursing on the Incidence of Postoperative Vomiting", indicated that the patients who received teaching and counseling prior to surgery had a significantly lower (p.01) rate of postoperative vomiting than did similar patients who received the usual preoperative preparation from the hospital staff.[10]

In a study by Egbert, patients were judged best prepared for surgery with both administration of pentobarbital sodium and preoperative explanatory visit by the anesthesist, but better prepared with the visit alone than with the pentobarbital sodium alone.[12]

In another study patients receiving preoperative and postoperative instruction about postoperative pain requested significantly less (p.01) narcotic after the immediate postoperative period than did those without such instructions. The instructed patients were discharged on an average 2.7 days earlier than the control group even though the surgeons did not know who had or had not received instruction.[11]

Dealing with the principle that respiratory and circulatory complications are the most common postoperative complications, Lindeman studied the effect of preoperative teaching on length of

hospital stay, pain medication required in the first seventy-two hours postoperative and ventillatory function test. The results indicated that nursing intervention with structured preoperative teaching reduced length of hospitalization and improved ventillatory function, but did not lower the need for postoperative pain medication.[16]

Healy's study involving 321 surgical patients indicated that those patients receiving preoperative instruction were discharged earlier, needed less pain medication and started oral pain medication earlier than those patients without preoperative instruction. Families of the patients receiving preoperative instruction were thought to be less apprehensive because they did not spend the night with the patients. For example, of the 181 patients instructed, 176 had families who did not spend the night while of the 141 control patients, 96 had some family member available at the hospital all night.[13]

Preoperative instruction by nurses has traditionally been done by general duty nurses on the surgical floor. In the last few years nurses from other areas of the hospital have started to play a role in the preoperative preparation of surgical patients. Studies have been done to determine the effectiveness of visits by operating room nurses.[8, 17, 26] Cardiac recovery room nurses have been very active in the preparation of open heart patients. Thus it is not unusual for the intensive care nurse to play a role in the preoperative preparation of surgical pateints.

Lisboa has written an article on the "Role of the Special Unit Nurse in a Preoperative Teaching Program".[19] She indicated that the intensive care unit nurse does have a role in preparing

patients for the intensive care unit experience. The article describes the preoperative teaching plan being carried out at Good Samaritan Hospital in Phoenix, Arizona.

> Based on seven years of use it is felt that the intensive care nurse does have a specific role in the team effort to prepare patient and family for the postoperative phase of his illness. It is essential that during the preoperative interview with the patient and his family the SCU nurse establish a rapport of trust and confidence. The interview should be informative to the patient and his family and the nurse should collect data pertinent to the patient's care.[19]

The teaching plan at Good Samaritan Hospital provides for specific information to be given by the nurse but also allows for individual differences among the patients. Information that is given to the patient includes a general description of environment after surgery, explanation of a change in routine of nursing care, explanation of any nursing care specific to the patient's condition and a communication system to be used if the patient should have a tracheostomy or be on a respirator.[19]

DeMeyer in studying the environment of the intensive care unit concluded that how the patient sees and reacts to the intensive care unit can be altered by preparation for the experience. "Only when the professional nurse ascertains the patients concept of himself and shares and uses this knowledge can really effective nursing care be provided in the intensive care unit."[6]

The process of interviewing patients who have just undergone a certain experience or procedure to determine what they feel would be most helpful in preparing future patients for the same experience

has been used to study the needs of cardiac patients and those having diagnostic studies. The results of these studies have been useful in detecting areas of patient concern that beforehand had been overlooked by nurses.[2,5,28]

A study was done by Brambilla to investigate questions patients have before and after cardiac surgery.

> In general, patients' questions as elicited by this study could be classified into two major groups. First were those questions related to facts about the surgical experience which nurses have generally included in their teaching plans: preparation for surgery, the incision, prosthesis, oxygen therapy, intravenous infusions, chest tubes, and monitors. The second group of questions, however, related to topics which have not been included in the teaching plans reported in the literature: activities following discharge, detailed inquiries about equipment used during surgery and its effect on the body and many questions about individual problems.[5]

The main idea which emerged from the study by Brambilla "is that of a teaching plan which not only includes material that nurses think patients should know, but also one which considers what the patients say they want to know."[5]

Sister Cashel Weiler used a questionnaire type interview with postoperative heart patients to determine what information given preoperatively was most beneficial to the patient. Eighty-four out of a hundred patients interviewed stated they would add other information to the instructions given preoperatively. Information the patients indicated they would like added tended to fall into the categories of psychologic responses; pain; progressive patient care; and deep breathing and coughing exercises. She found that the most

important areas of instruction were deep breathing and coughing; information about pain, oxygen and chest tubes, description of intensive care; information regarding seeing a minister, rabbi or priest; visiting hours; and communication of information to relatives.[28]

Although many of the studies revealed that what patients wanted to know dealt with individual problems that cannot be considered relevant for all patients, a study on structured vs. unstructured preoperative teaching clearly substantiated the value of structured preoperative teaching. Both the effectiveness of structured preoperative teaching and the value of it in terms of patients welfare were evident by the decreased length of hospital stay and the higher scores on the tests of ventillatory function.[16] Preparing patients for intensive care units cannot consist of only a counseling or telling situation. There should be a definite plan where teaching is carried out. In patients that have a high anxiety level which could interfere with their learning, it has been shown that the use of Rogerian interviewing technique along with a definite teaching plan provide up to 94.25% retention rate as measured in the postoperative period.[3]

A recent study by Dodge shows that while nurses and patients agree on some of the information that should be given to patients, there are also areas of disagreement. Patients were highly concerned about knowing how serious their situations were in relation to recovery, recurrence and results of treatments. None of this information was rated as highly important by nurses. Nurses were more concerned with patients having a clear idea of what to expect in relation to hospital routine, care, diet, and treatments while patients ranked these relatively low in importance. A major trend seen in Dodge's

study is that while nurses stressed preparing patients for coming events, patients did not see that as important as having information about their condition.[7]

Preparatory teaching for the intensive care unit must take into account the fact that each patient is an individual with different backgrounds and needs. Only when nurses understand what patients want and need to be told preoperatively will their teaching be effective.

Statement of Problem

The need for intensive care units has become well recognized in recent years. The advantages provided are obvious. It is also known that an intensive care unit can cause patients and family to manifest signs of anxiety and fear. Many times this fear and anxiety is a result of the unknown. By giving the patient certain information about what is going to happen to him, his fears and anxiety about his intended intensive care experience will decrease. Thus, knowing what kinds of information patients wanted would serve to greatly improve patient teaching.

Patients who have never been to an intensive care unit may not know what questions to ask of the nurse or physician and, therefore, are dependent upon hospital personnel for their knowledge. On the other hand, patients who have recently been in an intensive care unit are more likely to know what information they would like to have had included in preoperative teaching. If nursing personnel teach what patients think is important, then the tendency to assume knowledge of patients needs for information will be reduced.

Purpose of Study

The purpose of the study is to determine the type of information patients scheduled for a surgical intensive care unit want to be told prior to going to the specialized unit.

Limitations

1. Limited to surgical patients in the intensive care unit excluding open heart patients.
2. No controls were set regarding surgeons or medical personnel caring for the subjects.

CHAPTER II

METHODOLOGY

Setting

The study was conducted in a 400 bed private hospital located in a city of approximately 325,000 people. Specifically, the data was collected on the surgical floors of the selected hospital.

Subjects

Subjects for the study were selected on the basis of having been in a surgical intensive care unit. The sample used for this study were those patients, 17 years or older, discharged from the surgical intensive care unit during the period of data collection.

The population was comprised of fifteen post intensive care unit patients, twelve men and three women, who were convalescing on a surgical floor in the selected hospital. The average length of stay in the intensive care unit for the fiteen patients was 2.1 days. The subjects were interviewed on the average of 3.3 days after their discharge from the intensive care unit. Table 1 shows the preoperative diagnosis of the fifteen subjects, their length of stay in the intensive care unit and postoperative day during which they were interviewed.

Table 1. Preoperative Diagnosis of Fifteen Patients, Their Length of Stay in the Intensive Care Unit, and Postoperative Day Interviewed.

PREOPERATIVE DIAGNOSIS	DAYS STAYED IN ICU	POSTOPERATIVE DAY INTERVIEWED
(R) Carotid Endarterectomy.	2	4th
(R) Carotid Endarterectomy.	1	2nd
(R) Carotid Endarterectomy.	2	4th
(L) Carotid Endarterectomy.	2	6th
(L) Carotid Endarterectomy. with saphenous vein patch graft.....	1	3rd
(L) Carotid Endarterectomy.	2	9th
(L) Superficial Femoral-Popliteal embolectomy..	1	5th
Femoral Embolectomy.....	5	9th
Abdominal Aneurysm Repair...	5	9th
Exploration for Aortic Aneurysm.....	1	2nd
Thorocotomy.....	2	6th
Choledochotomy and Choledocholithotomy.....	1	5th
Repair Lacerated Liver.....	4	5th
Mediastinal Exploration and Placement of Irrigation Catheters.....	2	8th
(L) Hip Prosthesis.....	1	5th

Data Collecting Tool

The questionnaire used in the present study was originally developed and used by Sister Cashel Weiler in her study of open heart patients.[28] Permission was received from Sister Weiler to use the questionnaire in the present study. No deletions or additions were made of the original questionnaire consisting of thirty-one statements and one open-ended question. The statements could be answered by indicating whether the information in the statement was: "very important", "somewhat important", "helpful", or "not

helpful" to know prior to going to a surgical intensive care unit. The introductory page of the questionnaire was modified to conform with the objectives of this study. The patient questionnaire is located in Appendix A.

The questionnaire, although developed for use with open heart patients, meets the requirements for content validity in relation to needs of the surgical intensive care unit patient. Both open heart critical care unit and the surgical intensive care unit are equivalent in their care of critically ill patients. Both groups of patients undergo the specialized and individual treatment common to all critically ill patients.

The questionnaire covers common areas of preoperative teaching as reported in the review of the literature. The open-ended statement allows patients the opportunity to add any information they feel is important. Comments to the open-ended statement made by the hundred subjects in Sister Weiler's study were reviewed for additional areas of concern and none were judged pertinent for addition to the original questionnaire.

Procedure

Written permission was received to conduct this study at the selected hospital. Data collection was carried out in the following manner. Names of patients discharged from the surgical intensive care unit were obtained from the intensive care unit census book. This selection was then coordinated with the Surgical Unit Director. Each patient who met the sample criteria was approached after his discharge

from the surgical intensive care unit. An explanation of the study was given and they were asked to participate. Participation was voluntary and assurance given that anonymity would be maintained. All patients indicated a willingness to participate. Instructions were read to each subject by the researcher (see Appendix B). The patients were encouraged to answer all the questions and it was emphasized that there were no right or wrong answers. The researcher then read each statement and asked the subject to respond with the appropriate answer: very important, somewhat important, helpful and, not helpful. After each statement had been answered the questionnaire was then given to the patient for him to complete the open-ended question. Data was collected over a period of three weeks until fifteen subjects had completed the questionnaire.

The answers to the questionnaire were tabulated and arranged in a frequency distribution and rank-ordered. Due to lack of randomization and the small sample size, no attempt at statistical inference was made. The findings of the study is significant only to the population utilized in the study.

CHAPTER III

REPORT OF THE STUDY

Introduction

This study was undertaken for the purpose of identifying the type of information fifteen patients felt necessary to know prior to going to an intensive care unit.

Findings

Item One asked if the patient had received instruction prior to going to the intensive care unit. Four subjects reported they had instructions prior to going to the intensive care unit, ten had not received instructions and one subject was unsure. The number of patients' responses regarding prior preoperative preparation is shown in Table 2.

Table 2. Distribution of Subjects Who Had and Did Not Have Preoperative Instruction.

Instructions Prior to Going to Intensive Care Unit		
YES	NO	NOT SURE
4	10	1

Item One section B asked the question, "I received the most helpful instructions from", and the choice of answers were: doctor;

nurse; other patients or patient and; relative of another patient. Three subjects indicated they received the most helpful information from the doctor, while four subjects indicated they received the most helpful instructions from the nurse. Patients responses can be found in Table 3.

Table 3. Determination of Who Gave the Most Helpful Preoperative Instructions.

Person Giving Instructions	Number of Responses
Doctor.....	3
Nurse.....	4
Other patients or patient....	0
Relative of another patient..	0
Doctor and Nurse.....	1
Total.....	8

Part Two of the questionnaire listed information commonly used in giving preoperative instruction. Subjects were asked to rate the components as: 4 - Very important; 3 - Somewhat important; 2 - Helpful; and 1 - Not helpful. These answers were arranged in a frequency distribution and ranked from highest to lowest. The results are shown in Appendix C.

Subjects indicated a preference for explanation or information about treatments rather than the specific reasons for having these treatments. Of least importance to the subjects was duration of the treatments.

However, while there was a general trend in the information the patients desired, there were some differences. Information about how

often they will be expected to turn, about medication given for pain, and frequency of blood pressure, temperature and pulse were rated low compared to other types of information.

Explanation of how to do deep breathing and coughing was rated by the subjects as the most important item to be taught to the pre-intensive care unit patient. Although the patients wanted an explanation of how to do deep breathing and coughing they felt practice in the technique of doing deep breathing and coughing was of less importance. Five patients rated practice very important while eight patients indicated it was only helpful. The specific reasons for doing deep breathing and coughing postoperatively were of lower importance than the explanation of the technique but of more importance than practice of the technique.

Statements regarding information to be given to relatives concerning the surgical intensive care unit experience received highest ranking after deep breathing. Subjects felt that it was very important that specific information be given to relatives about where to wait, and where and when to see the doctor. Coupled with the information to be given to the relatives was information about visiting hours in the intensive care unit. In answers to the open-ended question, two patients indicated that it was important for the families to be prepared for the patients' stay in the intensive care unit.

The area of information rated as high by the fifteen subjects was that of information or explanation about intravenous fluids and blood, chest tubes, the monitor and its connections, urinary catheters, and the patient's progression from intensive care to discharge from

the hospital. Ranking lowest in this group was information about oxygen mask, what will take place the night before surgery, the amount of pain postoperatively, and information about seeing a priest, minister or rabbi, and explanation of just what intensive care is. Table 4 shows the sixteen statements subjects felt were the most important items to be taught to the pre-intensive care unit patient.

Table 4. Rank Order of the Sixteen Statements Patients Felt Most Important.

1.	Explanation of how to do deep breathing and coughing.
2.	Specific information given to your relatives about where to wait, where and when to see the doctor.
3.	Information about how your relatives will be informed as surgery progresses.
4.	Information about visiting hours in the intensive care unit.
5.	Explanation of intravenous fluids and blood.
6.	Explanation of chest tubes.
7.	Information about the monitor and the connections this involves.
8.	Information about a possible urinary catheter.
9.	Specific reasons for doing deep breathing and coughing.
10.	Information about your progression from intensive care to when you go home.
11.	Practice in the technique of deep breathing and coughing.
12.	Information about having an oxygen mask.
13.	Explanation of just what intensive care is.
14.	Information about what will take place the night before surgery.
15.	Information about the amount of pain that might be expected after surgery.
16.	Information about seeing a priest, minister or rabbi.

After wanting information or explanation about their care in the intensive care unit, the fifteen subjects indicated they preferred to know the specific reasons for having these treatments. The majority of the items marked specific reasons fell in the middle section of the statements when ranked. The exception to this was the statement regarding the specific reasons for doing deep breathing as discussed

earlier. Table 5 ranks these middle statements from the highest to the lowest.

Table 5. Rank Order of the Eight Statements Subjects Felt of Secondary Importance.

1. Specific reasons for having a urinary catheter.
2. Specific reasons for having a monitor.
3. Information regarding how often blood pressure, pulse and temperature will be taken.
4. Specific reasons for having an oxygen mask.
5. Specific reasons for having chest tubes.
6. Information about the medication that is given for pain.
7. Specific reasons for having intravenous fluids and blood.
8. Meeting the personnel in intensive care before surgery.

The subjects in this study placed low priority on knowing the approximate length of time the treatments (urinary catheter, intravenous fluids, chest tubes) would last. Placed in low priority along with the duration of treatments were the tour of the area before surgery, and discomfort caused by having chest tubes. The subjects ranked information about how often they would be expected to turn as the least important item to be taught preoperatively. Table 6 places in rank order the seven items receiving the least importance of the thirty-one statements presented in the questionnaire.

Table 6. Rank Order of the Seven Statements Subjects Felt of Least Importance.

1. Approximate length of time the pain might last.
2. Approximate length of continuance for urinary catheter.
3. Approximate time for continuance of intravenous fluids and blood.
4. Tour of the area before surgery.
5. Approximate length of continuance of chest tubes.
6. Discomfort caused by having chest tubes.
7. Information about how often you will be expected to turn.

Eleven of the patients wrote out information they would add to their preoperative instruction. Their comments were diversified and difficult to categorize. Two of the subjects indicated they preferred the families to be prepared for the experience and one patient expressed the belief that visitors should not be allowed in the intensive care area. One subject felt that clarification of the fact that because one was in the intensive care unit did not mean that he was dying was very important. Another patient felt that patients should be prepared for the constant noise. Answers to the open-ended question are given in Appendix D.

CHAPTER IV

DISCUSSION

While it is recognized that verbal behavior in response to questioning is not by itself an adequate technique for assessing a patient's experience in the hospital, it was chosen as the method of interview because of the reluctance of patients to fill out the questionnaire on their own. The reason for this reluctance was not identified nor any attempt made to identify it.

Because of the small sample size and lack of randomization, no conclusions from this study can be applied to the general population. Some of the results of the present study, however, tend to support findings of other larger studies.

It is of interest to note that in Item One, section A, four out of fifteen patients stated they had received preoperative instruction, yet in answer to the question who gave you the most helpful instructions, eight patients responded. The question construction could have misled the subjects in that it did not specify instructions "prior to going to the intensive care unit". Lindeman found in questioning subjects about the visit of the operating room nurse that one-third of the subjects visited did not recall the visit, while one-third of those patients not visited indicated that the visit was helpful.[18]

An important trend in this study was the tendency for patients to prefer general information or explanation over specific reasons.

This is congruent with the findings in studies by Meyers[20] and Robinson[25] supporting the fact that simple specific instructions are most desired by patients. In the study by Robinson patients rarely rated items which indicated a desire for detail. While it is recognized that each patient handles information in an individaul manner in concert with his own abilities, there appears to be a trend which suggests that the best preparation of surgical patients consists of giving only enough information to remove the fear of the unknown and to reserve the more complex explanation for those patients who request it. Levine and Fiedler[15] found that for the majority of the patients, it was not necessary to go into great detail but rather to give only simple explanations for the treatment or the equipment to be used and the care that it will involve.

While the sample interviewed in the present study was small in comparison to Sister Weiler's sample of one hundred, the results tend to support one another. Sister Weiler found that patients considered least important meeting the personnel from the postoperative cardiovascular surgical unit. Also ranking low was touring the postoperative unit and the approximate time that intravenous fluids, blood, urinary catheter, and the monitor would be continued.[28] All of these items ranked in the lower third of the results in this study. By itself these data would have little significance but are of greater importance when coupled with results of Sister Weiler's study. However, it must be realized that while the subjects of both studies were intensive care unit patients, one group was limited to open heart cases while the other group was a mixture of general surgical cases.

While the information regarding how many patients go to intensive care without prior knowledge is unavailable, it is known that many emergency surgical patients are admitted to the intensive care area. One-third of the subjects in this study did not know they would be in an intensive care situation. This fact, although it was not a component of the research study, does carry some implications for nurses. It has been shown that families contribute to a patients sense of well being, and if family members are distressed, then the tension can be passed on to the surgical patient.[15] Thus, while it is not always possible to give preoperative preparation to intensive care unit patients, the family should be prepared for the intensive care unit environment. The results of this study showed that patients placed a high priority on families being informed. Comments to the open-ended statement on the questionnaire, "Important to prepare the family as to what to expect after surgery", and "Really don't remember too much about the place, more important to tell the families about intensive care", lend even more support to the fact that families of emergency cases need instruction.

In today's busy and complex hospital setting, where lack of time is the usual rather than the unusual situation, it is helpful to know that patients want only a superficial explanation of their care. The important factor for nurses to realize is that patients do want some prior knowledge of their care and have a right to this information. Based on identification of needs from this group, a teaching plan was developed for use with preintensive care unit patients. The teaching plan is as follows.

Proposed Teaching Plan for Surgical Intensive Care Patients.

Introduction

Based on the effectiveness of group teaching in terms of learning opportunities[14] and the time factor, it is recommended that group teaching be the method of preoperative instruction for potential intensive care patients. It is further recommended that relatives be involved in the classes as much as possible.

It is assumed that an admission interview and initiation of a nursing care plan has been carried out prior to the classes, in order to determine any specific problem which would indicate a change in teaching method.

OBJECTIVE	CONTENT	LEARNING EXPERIENCE
Differentiate between intensive care unit and post-op surgical floor.	Definition of intensive care Change in nursing care involved Noise encountered in intensive care unit.	Discussion Patients' interpretation of ICU
Explain progression of care from surgery to home.	1. Surgical floor 2. Operating Room 3. Recovery Room 4. Intensive Care 5. Surgical Floor 6. Extended Care or 7. Home	Discussion
To acquaint patient and family to intensive care unit.	1. Give location and person who will inform family as surgery progresses. 2. Location of waiting room.	Discussion and/or pamphlet.[1]

[1] The development of a pamphlet should be done by the participating hospital including its own specific material matter.

OBJECTIVE	CONTENT	LEARNING EXPERIENCE
	3. Procedure involved in seeing physician 4. Visiting hours 5. How to contact rabbi, priest or minister.	
Explain hospital routine the night before surgery.	Discuss enema, bath, skin preparation, sleeping pill and side rails.	Discussion
To cough and deep breathe using the abdominal muscles.	1. Purpose: to keep lungs functioning properly. 2. Demonstrate proper method. a. Inhale as deeply as you can. b. Hold for a second or two. c. Exhale completely. d. Repeat several times. Then: e. Inhale deeply. f. Produce a deep abdominal cough by short, sharp expriation. 1. Not shallow throat cough. 2. Incision may be splinted with hands. 3. Flexing knees relieves strain on abdominal muscles.	
Tell about pain that might be expected postoperatively.	1. Varies with different surgeries and individuals. 2. Medication for pain.	Discussion
To describe treatments he may encounter while in the intensive care unit.	IV fluids and blood 1. needle in arm 2. tubing from needle to bottles which hang above the bed.	Demonstration of equipment.

OBJECTIVE	CONTENT	LEARNING EXPERIENCE
	3. possibility of many bottles. Monitor: 1. connections from chest to equipment at head of bed. 2. beeping sound 3. alarm system if connections come loose. Urinary Catheter: 1. to keep bladder empty 2. may feel need to urinate even with catheter in place Oxygen Mask: 1. bubbling sound 2. nasal catheter, cannula or mask. Chest tubes: 1. rubber tubing from chest wall to bottles on floor or side of bed. 2. Important not to lay on tubing.	

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of the study was to identify the type of information patients scheduled for a surgical intensive care unit want to be told prior to going to the surgical intensive care unit. Fifteen post-surgical intensive care unit patients were selected to fill out a questionnaire consisting of thirty-one statements and one open-ended question. The answers to the questionnaire were arranged in a rank-order frequency distribution.

Conclusions

It must be recognized that generalized conclusions cannot be made. Trends which can be identified from the study include:

1. Explanation of how to do deep breathing and coughing is the most important item to be taught preoperatively.

2. Next in importance is the amount of information given to the family about the intensive care unit experience.

3. A preference for explanation or information about treatments rather than the specific reasons for having these treatments was identified.

4. Of least importance was the approximate time of continuance for treatments.

Recommendations

As a result of the study, it is recommended that the following areas be considered for further study.

1. Implement teaching plan developed for the pre-surgical intensive care patient and his family.

2. A study developed to survey the type of information the families or relatives of a surgical intensive care patient would like to be told.

3. Due to the high incidence of emergency cases admitted to intensive care without the patient's prior knowledge, a study to determine the best method of preparing families for the intensive care unit environment under emergency conditions would be of value.

4. A study to determine what nurses currently employed in an intensive care setting think is important to be taught preoperatively as compared to patients just discharged from an intensive care unit.

BIBLIOGRAPHY

1. Abdellah, Faye, and Eugene Levine, "What Patients Say About Their Nursing Care", Hospitals (1957) 31(1):44-48.

2. Allen, Eleanor, "Information Viewed Most Helpful to Patients Undergoing Three Selected Diagnostic Procedures", ANA Clinical Conferences, American Nurses' Association, Appleton-Century-Crofts, New York, 1969, 206-213.

3. Boegli, Emily, and Glen Boegli, "Can Preop Learning Be Improved", AORN (November, 1972), 16:43-45.

4. Baundry, Frank, and Alfred Wiener, "Preoperative Preparation of the Surgical Patient", Surgery (June, 1968), 63(6): 885-889.

5. Brambilla, Mary A., "An Investigation of Patients' Questions About Heart Surgery: Implication for Nursing", ANA Clinical Sessions, American Nurses' Association, Dallas, Appleton-Century-Crofts, New York, 1968, 217-221.

6. DeMeyer, JoAnna, "The Environment of the Intensive Care Unit", Nursing Forum (1967) 6(3): 262-272.

7. Dodge, Joan S., "What Patients Should be Told: Patients' and Nurses' Beliefs", American Journal of Nursing (October, 1972), 72(10): 1852-1854.

8. Dooley, Kathleen, An Exploration of a Possible Extension of the Role of the Professional Nurse in the Operating Room. Unpublished masters thesis, Yale University School of Nursing, 1966.

9. Dumas, Rhetaugh, and Barbara Anderson, "Psychological Preparation Beneficial - If Based on Individual's Needs", Hospital Topics, (May, 1964), 64:79-81.

10. Dumas, Rhetaugh, and R.C. Leonard, "Effect of Nursing on the Incidence of Postoperative Vomiting", Nursing Research (Winter, 1963), 12:12-15.

11. Egbert, Lawrence D., et al., "Reduction of Postoperative Pain by Encouragement and Instruction of Patients", New England Journal of Medicine (April 16, 1964), 270: 825-827.

12. Egbert, Lawrence D., et al., "The Value of the Preoperative Visit by an Anesthetist", JAMA (1963), 185:553-555.

13. Healy, Katherine, "Does Preoperative Instruction Make a Difference?", American Journal of Nursing (January, 1968), 68(1): 62-67.

14. Hubert, Bonner, Group Dynamics: Principles and Applications. New York, Ronald Press Company, 1959, p. 14.

15. Levine, Dale C., and June P. Fiedler, "Fears, Facts and Fantasies About Pre- and Postoperative Care", Nursing Outlook (February, 1970), 18: 26-28.

16. Lindeman, Carol A., and Betty van Aernam, "Nursing Intervention With the Presurgical Patient - The Effects of Structured and Unstructured Preoperative Teaching", Nursing Research (July-August, 1971), 20(4): 319-332.

17. Lindeman, Carol A., and Steven L. Stetzer, "Effect of Preoperative Visits by Operating Room Nurses", Nursing Research (January-February, 1973), 22(1): 4-15.

18. Lindeman, Carol A., Presented at Research Colloquim at the University of Oregon School of Nursing, Fall, 1973.

19. Lisboa, Janice M., "Role of the Special Care Unit Nurse in a Preoperative Teaching Program", Nursing Clinics of North American (June, 1972), 7(2): 389-395.

20. Meyers, Mary E., "The Effect of Types of Communication on Patients' Reactions to Stress", Nursing Research (Spring, 1964), 13(2): 126-131.

21. Mezzanotte, Elizabeth J., "Group Instruction in Preparation for Surgery", American Journal of Nursing (January, 1970), 70(1): 89-91.

22. National League of Nursing Education: A Curriculum Guide for Schools of Nursing. New York, 1937, The League.

23. National League of Nursing Education: Nursing Organization Curriculum Conference, Glen Gardner, New Jersey, 1950, Libertarian Press.

24. National League of Nursing Education: Standard Curriculum for Schools of Nursing, Baltimore, 1918, The Waverly Press.

25. Robinson, Phyllis A., A Comparison of Coping Style With Information Desired by Preoperative Abdominal Surgery Patients, Unpublished masters thesis, University of Oregon, Portland, Oregon, 1972.

26. Shetler, Mary, "Operating Room Nurses Go Visiting", American Journal of Nursing (July, 1972), 72(7): 1266-1269.

27. Thaxton, Adele, "Teaching Expectant Parents What They Want to Know", American Journal of Nursing (May, 1962), 62(5): 112-114.

28. Weiler, Sister Cashel, "Postoperative Patients Evaluate Preoperative Instruction", American Journal of Nursing (July, 1968), 68(7): 1465-1467.

APPENDIX A

DATA COLLECTING TOOL

A study is being conducted to determine what to include in instructions given to patients prior to going to a surgical intensive care unit. Since you have recently gone through the experience of being in an intensive care unit, we feel your opinions will be valuable to help in this attempt. Any information or suggestions you can give will be appreciated.

I. Please encircle the letter which best fits.

A. I received instruction prior to going to the intensive area.
   a. Yes
   b. No
   c. Not sure

B. I received the most helpful instructions from
   a. Doctor
   b. Nurse
   c. Other patients or patient
   d. Relative of another patient

II. Regardless of what your actual instructions consisted of please indicate what you think should be included in the instructions given the patient before going to an intensive care unit.

Please put the appropriate number in the line provided.

4 - Very important
3 - Somewhat important
2 - Helpful
1 - Not helpful

How important do you think the following information is:

A. 1. Explanation of how to do deep breathing and coughing. _____
   2. Specific reasons for doing this. _____
   3. Practice in the technique of deep breathing and coughing. _____

B. 1. Explanation of intravenous fluids and blood. _____
   2. Specific reasons for having these. _____
   3. Approximate time for continuance. _____

C. 1. Explanation of chest tubes. _____
   2. Specific reasons for having these. _____
   3. Approximate length of continuance. _____
   4. Discomfort caused by having chest tubes. _____

D. 1. Information about a possible urinary catheter. ____
2. Specific reasons for having this. ____
3. Approximate length of continuance. ____

E. 1. Information about the monitor and the connections this involves. ____
2. Specific reasons for having this. ____

F. 1. Information about the amount of pain that might be experienced after surgery. ____
2. Approximate length of time the pain might last. ____
3. Information about the medication that is given for pain. ____

G. 1. Information about having an oxygen mask. ____
2. Specific reasons for having this. ____

H. 1. Explanation of just what intensive care is. ____
2. Tour of the area before surgery. ____
3. Meeting the personnel in intensive care before surgery. ____

I. 1. Information regarding how often blood pressure, temperature and pulse will be taken. ____
2. Information about how often you will be expected to turn. ____

J. 1. Information about what will take place the night before surgery; i.e. enema, bath, skin preparation, sleeping pill. ____
2. Information about seeing a priest, minister or rabbi. ____

K. 1. Information about visiting hours in the intensive care unit. ____
2. Information about how your relatives will be informed as surgery progresses. ____
3. Specific information given to your relatives about where to wait, where and when to see the doctor. ____
4. Information about your progression from intensive care to when you go home. ____

III. If you have any other information which you feel is necessary for the intensive care patient to know, please write it on the back of this page.

Thank you

APPENDIX B

INSTRUCTIONS GIVEN TO SUBJECTS

Regardless of what your actual instructions consisted of before surgery, please indicate what you think should be included in the instructions given the patient before going to an intensive care unit. Please answer with the appropriate number after each statement is read.

4 - Very important

3 - Somewhat important

2 - Helpful

1 - Not helpful

A slip of paper with the choice of responses was given to each subject for ease in answering the statements as each one was read. After all statements were answered, the subject was given the questionnaire and asked, "If you have any other information which you feel is necessary for the intensive care patient to know, please write it on the back of the questionnaire."

APPENDIX C

SUMMARY OF RAW DATA

Responses to Questionnaire Arranged in Frequency Distribution and Ranked from Highest to Lowest.

	Very Important	Somewhat Important	Helpful	Not Helpful
Explanation of how to do deep breathing and coughing....	11	0	4	0
Specific information given to your relatives about where to wait, where and when to see the doctor.....	8	4	4	0
Information about how your relatives will be informed as surgery progresses.....	6	5	4	0
Information about visiting hours in the intensive care unit.....	6	3	5	1
Explanation of intravenous fluids and blood.....	6	3	5	1
Explanation of chest tubes.....	6	4	3	2
Information about the monitor and the connections this involves.....	6	2	7	0
Information about a possible urinary catheter.....	5	4	5	1
Specific reasons for doing deep breathing and coughing..	6	2	6	1
Information about your progression from intensive care to when you go home.....	6	2	5	2
Practice in the technique of deep breathing and coughing.....	5	1	8	1
Information about having an oxygen mask.....	5	2	5	3
Explanation of just what intensive care is.....	4	4	4	3
Information about what will take place the night before surgery; i.e. enema, bath, skin preparation, sleeping pill.....	4	4	4	3
Information about the amount of pain that might be experienced after surgery.....	5	2	4	4
Information about seeing a priest, minister or rabbi....	4	2	5	4
Specific reasons for having a urinary catheter.....	4	0	8	3
Specific reasons for having a monitor.....	3	2	7	3
Information regarding how often blood pressure, temperature and pulse will be taken.....	3	2	6	4
Specific reasons for having an oxygen mask.....	3	1	8	3
Specific reasons for having chest tubes.....	3	1	8	3
Information about the medication that is given for pain.	4	1	7	3
Specific reasons for having intravenous fluids and blood.....	2	2	8	3
Meeting the personnel in intensive care before surgery..	3	2	4	6
Approximate length of time the pain might last.....	3	1	5	6
Approximate length of continuance for urinary catheter..	3	1	5	6
Approximate time for continuance of intravenous fluids and blood.....	3	2	3	7
Tour of the area before surgery.....	3	2	2	8
Approximate length of continuance of chest tubes.....	3	0	5	7
Discomfort caused by having chest tubes.....	1	3	4	7
Information about how often you will be expected to turn.....	2	0	5	8

APPENDIX D

RESPONSES TO OPEN-ENDED QUESTION

APPENDIX D

RESPONSES TO OPEN-ENDED QUESTION

Patients statement to open-ended question: If you have any other information which you feel is necessary for the intensive care patient to know, please write it on the back of this page.

PATIENT 1: Don't believe should have visitors in intensive care.

PATIENT 2: No response.

PATIENT 3: No response.

PATIENT 4: After coming out of surgery what you know isn't going to help - too groggy.

PATIENT 5: Most uncomfortable part is oxygen mask.

PATIENT 6: The decision to place me in I.C. was made by my surgeon because I have a susceptibility to pneumonia, but I didn't know he had made this decision and I was only there about one day.

PATIENT 7: No response.

PATIENT 8: Important to prepare the family as to what to expect after surgery.

PATIENT 9: Really don't remember too much about the place - more important to tell the families about intensive care.

PATIENT 10: No response.

PATIENT 11: Depends on the patient as to how much to tell.

PATIENT 12: I don't know of anything else you should tell the patient. It helped knowing what to expect.

PATIENT 13: Should tell the person that just because he is in intensive care doesn't mean he is dying.

PATIENT 14: Tell them about the noise.

PATIENT 15: When personnel tell you they will do something, they should do it. A sister said she would be back to visit me and she never came.

AN ABSTRACT OF THE FIELD STUDY OF

GLENNA M. CLEMENS

For the degree of MASTERS IN NURSING

Date of receiving this degree: June 7, 1974

Title: WHAT PATIENTS WANT TO BE TOLD PRIOR TO GOING TO A SURGICAL INTENSIVE CARE UNIT

Approved: [redacted]

Field Study Advisor

This investigation was instigated to identify the type of information patients scheduled for a surgical intensive care unit want to be told prior to going to the surgical intensive care unit.

Subjects for the study were selected on the basis of having been in a surgical intensive care unit. The sample used for this study were those patients, 17 years or older, discharged from the surgical intensive care unit during the period of data collection.

A questionnaire consisting of thirty-one statements and one open-ended question was used to elicit information that patients wanted to know prior to going to a surgical intensive care unit. The answers to the questionnaire were arranged in a rank-order frequency distribution.

Due to lack of randomization and the small sample size, no attempt at statistical inference was made or generalized conclusions drawn. Trends which can be identified from the study include: 1) Explanation of how to do deep breathing and coughing is the most important item to be taught preoperatively. 2) Next in importance is the amount of information given to the family

about the intensive care unit experience. 3) A preference for explanation or information about treatments rather than the specific reasons for having these treatments, and 4) Of least importance was the approximate time of continance for treatments.

Based on identification of needs from this group, a teaching plan was developed for use with preintensive care unit patients.