A SURVEY OF EIGHTY SURGICAL PATIENTS REGARDING THEIR PREOPERATIVE PREPARATION IN ONE SELECTED HOSPITAL IN OREGON

by

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A THESIS

Presented to the University of Oregon School of Nursing
and the Graduate Council of the
University of Oregon Medical School
in partial fulfillment
of the requirements for the degree of
Master of Science

June 11, 1964

APPROVED:

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ACKNOWLEDGEMENTS

The writer wishes to express her grateful appreciation to those who contributed to the investigation and completion of this study:

To Miss Lucile Gregerson, thesis adviser, for her direction, guidance, and encouragement during the preparation of this study,

To the patients who so willingly participated in this study,

To the hospital for allowing this study to be done,

To Marie Grimm, Lenore Killam, and Winnifred Tyler for their assistance and support,

To my mother, father, and sister for their constant faith, understanding, and reassurance,

To the librarian staff at the University of Oregon Medical School for their help.

m.a.l.

CHAPTER I

INTRODUCTION

INTRODUCTION TO THE PROBLEM

Surgery is one of the most ancient arts in the world. It is one of the special subdivisions of the healing arts and its aims include the cure of disease, the relief of pain, the restoration of function to the crippled limb or damaged organ, and the social and economical rehabilitation of the individual. (29)

In ancient times, the patient had to be courageous to face consciously the "surgeon's" scalpel. During hospitalization, the patient's care was done not by skilled nurses but by her predecessors who were often illiterate, rough, dirty handiwomen. Surgery, surgeons, and nurses have changed considerably since then, but the plea for relief from suffering has remained the same. (20)

Progress has enabled the operations to be painless, the hospitalization to be shorter, and the complications to be fewer. People have the same emotions; and even with modern techniques, the patient facing an operation needs courage.

Moroney (20) states that the patient's mental outlook, his fears, his hopes, and his will may be as important as the purely physical treatment of the disease. To be unaware of or to neglect these factors may make a patient prefer death to a struggle for his life. Therefore, the preoperative preparation of the patient is a subject to which an increasing amount of attention has been devoted in recent years.

West (34) states that this preparation requires the services of both the physician and the nurse. No matter how successful the surgeon's conference with the patient is, it is the nurse who is with the patient every day and who probably will be called upon to answer questions. Her responsibility is to meet not just the physical needs at the bedside but as far as possible the other needs of the patient.

What are the needs of the preoperative patient? The physical care ordered by the doctor must be carried out and explained to the patient. His mental discomfort must be relieved. Many factors may contribute to this discomfort--fear of the operation itself, fear of its outcome, or concern over financial or business or family responsibilities. Perhaps the most common of all is anxiety about the "unknown." The patient is apprehensive about what procedures to expect and what is expected of him. (34)

STATEMENT OF THE PROBLEM

The literature has established the importance of preoperative preparation. (7,15,20,33,34) The surgical patient should be instructed in the preoperative and postoperative procedures and their purposes. He must know what his participation will be postoperatively. He should feel that he is able to communicate his worries to the nurse so she may clarify any misunderstanding, provide additional information, and if necessary notify other resources. Recognition and implementation of these factors are necessary to promote the patient's optimum recovery. Dumas (8) states, "Skilled and conscientious physical and psychological preparation of the surgical patient is of crucial importance. . . ."

It is the responsibility of the registered nurse to meet the preoperative nursing needs of the surgical patient. One of the functions of the general duty nurse listed by the American Nurses' Association (11) is that she ". . . is aware of the total nursing needs of the patient and is responsible for seeing that they are fulfilled." Does the patient believe that the registered nurse is providing this important preoperative preparation?

PURPOSE OF THE STUDY

The purpose of this study was to obtain information from postoperative patients in a selected hospital to prove or disprove the following null hypothesis:

> The registered nurse does not fulfill her responsibility for preoperative preparation of the surgical patient.

This leads to the identification of certain variables which give rise to the following hypotheses:

> There is no relationship between the patient's sex and the amount of preoperative instruction he receives.
>
> There is no relationship between the type of operation a patient has and the amount of preoperative instruction he receives.
>
> There is no relationship between the preoperative instruction regarding a procedure and the preoperative instruction regarding the purpose of that procedure.
>
> There is no relationship between the fact that the patient is worried and the amount of preoperative instruction he receives.
>
> There is no difference between the amount of instruction given for the preoperative and postoperative phase of the patient's care.
>
> Nurses are not aware of the worries of their patients.

LIMITATIONS

This study was limited to the information which was

obtained by the interviewer who used a check list of preoperative activities. All interviews were completed within a five day period in February, 1964. Any adult patient who had had surgery within ten days preceding the interview and who was rational, responding, and not in critical condition was interviewed. As a result, the participants of this study numbered eighty which was the total number who met the criteria for the study in a five day period, the equivalent of one nurse's employment week.

No attempt was made in this study to ascertain how well the physical care of the patient was carried out. The study was concerned largely with determining what explanations or teaching was done for each preoperative activity and who did the teaching.

DEFINITION

For the study, these definitions were used:

Instruction of the preoperative patient refers to any explanations, teaching, information, or directions given.

Preoperative preparation is the nursing care given to the patient before surgery including:

1. explanation of preoperative and postoperative procedures and their purposes.
2. instruction regarding patient's role postoperatively.

3. recognition of patient's apprehension by the nurse.

4. institution of nursing measures to allay worries.

Much of this was covered by orders written by the surgeon or the anesthesiologist. The part of the preoperative care indicated in the four points above was usually not specifically ordered, but according to the literature is inherent in the act of nursing.

ASSUMPTIONS

For this study it was assumed that:

1. Preoperative preparation, as defined, is important to the patient for obtaining optimal recovery.

2. Registered nurses are prepared to give preoperative care and are responsible for the preoperative preparation of the surgical patient.

3. The postoperative patients were able to remember their preoperative preparation and able to indicate who gave the preparation.

4. The patients' responses to the check list were an indication of the preoperative preparation given by the registered nurses and others.

JUSTIFICATION

The literature and recent research surveys have placed emphasis upon the need for preoperative preparation of the surgical patients. An important aspect of

this preparation is teaching. Reiter (24) states,

> I believe that if a patient is given in advance some explanation of what is going to happen before, during, and after surgery, he will almost inevitably be a more relaxed and cooperative individual.

He believed this important enough to write a book for lay people explaining more common events in connection with surgical operations. Reiter (24) further states, "I have had the satisfaction of seeing how much a few words of explanations and reassurance have helped some patients over impending hurdles." It may be speculated that had he felt the patients were receiving this information, he would not have deemed it necessary to write the book.

It is the responsibility of the registered nurse to teach the preoperative patient. Bordick (1) states, "I say, first, since we recognize that a large part of patient teaching is the duty of nurses, we see no need to ask the doctors' permission to perform a nursing function."

Kron (17) states that it appears that the nursing profession is failing to give what the public considers good nursing care. The patient is most concerned with his physical comfort, with being told what to expect, and with having his questions answered. Nurses are criticized most often for their lack of communication and consideration of the personal needs of the patient. Is this not a part of

nursing, and an important part of the preoperative preparation of the patient? Krueter (16) states, "Nursing is not only the performance of skills and techniques. Nursing care is the care of people, with the responsibility of the nurse to understand people, their motivations and behavior." This is characteristic of comprehensive nursing care. The emotional needs of the patient are of prime importance. Eliason (9) states that psychological preparation of the patient cannot be over-emphasized.

The National League for Nursing in What People Can Expect of Modern Nursing Care (35) lists seven articles stating what the patient has a right to expect of modern nursing service. Two of these, which further justify this study, are that the nursing personnel will be sensitive to the patient's feelings and responsive to his needs, and that they will instruct the patient about his illness so he can help himself.

Another justification of the study is that the patient is interested in his condition, care, and cure; and he is not willing to comply unquestioningly with his treatment. He wants to know what is being done for him and his role in his treatment. Because of the shorter hospitalization, the nurse has less time to do teaching. This means the nurse must concentrate more on getting to know her patient in order to give the nursing care needed.

If a patient is able to realize how carefully his needs are anticipated, he is less fearful and more willing to cooperate. His attitude toward recovery becomes positive, and as Pearce (22) states,

> The will to get better cannot be overpraised; it goes a long way toward overcoming natural fears. When fear can be replaced by courage and determination, the patient will benefit most from the medical and surgical treatment and the nursing care, and the nurse who can inspire in her patient a state of high morale will help tremendously toward his recovery.

PROCEDURE FOR SOLUTION

Sources of data. The primary source of data was the information obtained by a check list administered to adult surgical patients in a certain hospital. The director of nurses at the selected hospital was contacted and permission was obtained to interview the patients on the surgical floors. The population was comprised of eighty postoperative patients who had had surgery within ten days preceding the interview. The respondents' names were kept anonymous.

The variables within the population included the patient's sex, the type of operation, and whether or not the patient was worried. These factors were utilized in determining if they influenced the amount of preoperative instruction.

The secondary source of data was a review of the

related literature pertaining to the preoperative preparation of the surgical patient. The nursing journals were searched as well as other recent publications on the subject.

Procedure or instrument used in collection of the data. A sample of the check list will be found in Appendix A. It is composed of 18 items: 1-14 consist of a list of activities about which instruction should be given to the patient, 15-17 deal with worries of the patient, and question 18 is concerned with any comments the patient had regarding his preoperative preparation. Only the activities most commonly performed in the nursing care of surgery patients were included. The activities unique to certain surgical procedures were thus omitted. Columns were prepared for indicating by whom instruction was given. The interpretation of the check list is found in Appendix B and the tabulation of raw data for items 1-14 will be found in Appendix C. The time required for completion did not exceed 30 minutes in any instance.

Validation of the measuring tool. The check list was submitted to a small group of registered nurses who were or previously had been involved with the care of the surgical patient. Their responses led to revision of the check list. The revised check list was administered to ten postoperative patients who had had surgery within ten days of the interview.

These responses were categorized and mock tables constructed. No further validation of the tool was required.

OVERVIEW OF THE STUDY

There are three chapters in the remainder of this study. In Chapter II, the related literature pertaining to the preoperative care of the patient is reviewed. In Chapter III, there is a report of the study with the findings and analysis of the data derived from interviewing the eighty patients. In Chapter IV, the summary, conclusions, and recommendations are presented.

CHAPTER II

REVIEW OF RELATED LITERATURE

The literature was reviewed for information regarding preoperative care. The review was confined largely to the past twenty-five years because during that time, the scope of the nurse's responsibilities has altered. In the past few decades the emphasis in nursing care has shifted from solely technical to include the psychosociological aspects of illness. Such terms as "total nursing care" and the "comprehensive approach" have come into existence. (6) The comprehensive approach is one in which the individuality of each patient is recognized and in which care is adapted to individual needs and demands. The patient receives supportive nursing care which includes the mental, physical, spiritual, and emotional aspects all of which contribute to rest, security, good hygiene, comfort, and recovery. The patient is assisted and encouraged toward the goal of rehabilitation. Brackett and Gogt (2) ask if this is realistic. In 1948, Brown (3) stated,

> Unfortunately the philosophy of essentials of patient care that has evolved from public health nursing, mental hygiene, social casework, the newer psychiatry, pediatrics, and obstetrics, or psychosomatic medicine has yet exerted but restricted influence over general duty nursing.

Although teaching patients is a vital component of comprehensive nursing, nurses frequently feel obligated to give the bedside care but according to Graffam (12) omit the teaching for various reasons. Bordick (1) mentions five arguments given by nurses regarding omission of patient teaching:

1. The patient will be more frightened if he knows.
2. Patient teaching is against hospital policy.
3. How do you get away with it?
4. We don't have time to teach patients.
5. Our doctors won't let us teach patients.

To these statements Bordick (1) has three answers:

1. Human beings in a democracy have a right to know those things that concern them. Patients are human beings.
2. Human beings are afraid of the unknown.
3. Fear is dangerous and intensifies pain.

Bordick (1) further states that the patient who understands will have less fear, less pain, will be more cooperative, and will recover faster.

To accomplish patient teaching, the nurse must be aware of those factors which contribute to successful instruction. Graffam (12) mentions seven principles of patient teaching as follows:

1. A patient tends to repeat behavior patterns until helped to gain new insights.
2. The patient must be ready to learn.
3. The patient must be motivated to learn.
4. Teaching must build upon the patient's present frame of knowledge and range of experience.
5. Teaching must be carried out on the patient's level of comprehension.
6. Teaching must be complete to avoid wrong notions.
7. Learning is facilitated by repetition.

Stafford (29) states that teaching should be appropriate for each patient. Before trying to teach, the nurse must gain some understanding of the patient as a person. This approach is mutually beneficial since it affords the patient an opportunity to become acquainted with the nurse.

Bordick (1) states, "Having taught patients and having seen the remarkable results of teaching, I am convinced that teaching is vital to the recovery of patients." She further states that patient teaching is extremely important in the ultimate postoperative recovery of patients.

According to the principles cited above (12, 29), the nurse must assess her patient and be able to give the emotional support necessary to relieve his fears and make

him ready for learning. (8,13,16,23)

Surgery frightens almost everybody. Our culture has made adults feel they must disguise their fears and behave with dignity. Since they cannot be afraid, they may show their fears in some other manner such as excessive talking or withdrawal. They may also disguise their fears since, "Patients sense what we /nurses/ expect, and often they modify their behavior to conform to our expectations. The fact that soon the patient will be completely dependent on us for his safety and survival often makes him feel especially in need of our approval and acceptance." (28)

It is necessary for the surgical nurse to have a knowledge of psychological implications in caring for the patient. Only by understanding the patient's problems is the nurse able to help. It is one of the nurse's major functions as a member of the health team to utilize her skills and knowledge to help the patient allay his anxiety and fears. It is her responsibility to evaluate both the mental and physical needs of her patients before surgery. (34)

According to Coston, Leib, Orlando, and Sheahan (5,19,21,26) each patient must be considered as a person having individual needs which must be met. The nurse must be able to recognize the symptoms of a "worried mind" and be equally qualified to offer relief. Pearce (22) states,

> The aim of a nurse, who sees a patient as one whole individual should be to ensure that anything which would embarrass or humiliate him is avoided, such as any long waiting, lack of privacy, failure to show interest and explain things to him, any ignoring of his presence or needs.

Perhaps the greatest single cause of disturbance often present in the minds of patients is a failure of communication. (30) The nurse not only must be able to instruct the patient but she also must be able to listen in order to provide the emotional support needed. When a nurse shows a warm, kind manner and has learned to listen in a way which makes the patient feel he has her whole attention, he will be better able to express himself. Then will he be more likely to express his worries which may include fears of surgery or of its outcome, hospital expenses, or business or family responsibilities. (29,30, 34) Stafford (28) maintains that time and the art of listening with empathy and warmth are needed by the nurse who is preparing the surgical patient. When the patient's emotional needs are met, he is better able to concentrate on the teaching attempted by the nursing team.

The importance of teaching in the preoperative preparation of the surgical patient cannot be minimized. Simmons (27) states,

> However well-meaning the staff, and however justifiable the treatment, if a patient worries about explanations which

> are never given or fails to understand them if they are, if he is full of misgivings and emotional sets against the procedure, and if he feels that he has been tricked or sorcered into something severer than necessary, then stressful interpersonal relationships have already complicated the situation, and they may affect the course of treatment.

The preparation of the preoperative patient needs to begin well in advance of the date of surgery. The doctor should give a careful and clear explanation of the reasons for surgery and the results. After this, it is the nurse's responsibility to explain the plan for the preoperative and postoperative care. She also should instruct the patient in ways in which he can participate in helping himself to recover quicker. (27)

If a patient knows what to expect, he is less likely to be frightened. A patient who is frightened responds poorly to surgery and is prone to complications such as cardiac arrest and irreversible shock. (10,27) Felter (10) discusses two patients who had the same operation on the same day. Eight days later one was on the road to recovery and the other was still considered in critical condition. He (10) states that although slow recovery is not always due to postoperative complications, preoperative teaching may do much to reduce the amount of postoperative care by guarding against complications. Stafford (29) states,

> It has been observed that patients exhibit increased anxiety, naturally, when they have just been told by the

> surgeons about the plans for surgery the next day. The nurse who can spend time explaining the necessary steps in preparation and what is expected of the patient, as well as what he may expect in his immediate post operative care will usually find a receptive patient.

Instruction of the preoperative patient includes many items. The reasons for the various preoperative measures and any preparations which are carried out should be explained and their usefulness discussed. For example, when a sedative is to be given the night before surgery, the patient should know he is to receive it and why. (22) Eliason (9) states that information should be given concerning pain, blood transfusions and intravenous feedings, diet before and after surgery, and activity of the patient.

Bordick (1) discussed the importance of answering the questions uppermost in the patient's mind first to clarify any false interpretations. Then the nurse should explain what the nursing staff will do for the patient and what the patient will be expected to do towards his recovery. She (1) stresses the importance of explaining the purpose of such things as coughing and deep breathing postoperatively since "cough" is interpreted by the post-operative patient as "hurt yourself." Humans avoid inflicting pain on themselves unless they believe it will help them. The patient also should be told of any equipment to be used on or for him so he will not be frightened of it. "The so-called little things are often what trigger

fear in the patient." (1)

The same principles of teaching apply to all patients; the only difference lies in what is taught. Teaching cannot be done in a hurry; it takes time. It involves not only the process of instructing, but also evaluating the patient's understanding of the teaching. (5)

Weaver (32) states that patients have a real need to understand their disease, the methods of treatment, and their own responsibilities in their treatment. When surgery is required, each patient should be individually instructed in three general areas: (1) the operative procedure, (2) the preoperative treatments, and (3) the treatments and purposes concerning the immediate postoperative period.

The nurse's role in the teaching of the surgical patient has been emphasized because the nurse has more contact than the physician with the patient. Failure of the nurse to fulfill her role of teacher may be because she is so occupied with treatments and technical procedures and recording that she does not appear to have time to teach. Another reason teaching may not get done is because the doctor and the nurse each feel the other is doing it. (3,12)

West (34) states,

> The present practice of early ambulation and delegation of non-professional care to auxiliary personnel reduces the amount of time the nurse spends at the bedside of each patient. These

> new patterns of care do not release her from supervision of the details of physical and mental care of every patient. They do have the advantage of permitting her to concentrate more of her time, and consequently nursing ability, on the acutely ill patient.

Webber (33) believes that there is no excuse for the nurse to omit the important activity of preoperative teaching of the patient.

REVIEW OF RELATED STUDIES

Cassady, June R. and John Attroichi reported on "Patients' Concerns about Surgery" (4) as a research project carried out at the Duke University Medical School and reported in Nursing Research, Fall, 1960. Forty white, general surgical, female, preoperative patients between the ages of twenty and sixty were interviewed. One conclusion was that those patients posessed: fear of death, fear of diagnosis, fear of discomfort, fear of helplessness, fear of socioeconomic implications, fear of being crippled, mained, or disabled, and fear of the unknown. Twenty-two of the patients expressed more than one fear. Six expressed no fears. The author stated that several further clinical observations could be made. The interviewer was met with great enthusiasm and the patients were all eager to talk about themselves and their illnesses. Most of them had received little information and were eager for more.

Hay, Stella J. and Helen Anderson reported on the question "Are Nurses Meeting Patients' Needs?" (14) This was a research project undertaken in conjunction with a study on rehabilitation in nursing, carried out at the University of Washington School of Nursing and reported in the December 1963 issue of the American Journal of Nursing. A group of nurses reviewed a sampling of twenty-six professional and popular books and articles dealing with the experience of illness or disablement written by or about the person who had undergone the experience. The authors realized that the reliability of data for the study could not be tested and the sampling was small. The following needs were identified in the literature:

1. The patient's need for knowledge about his condition and treatment. Twice as many doctors and nurses failed to meet this need as did meet it.

2. The need for medical and nursing care for learning and carrying out skills associated with daily living. Twenty-three percent of the nurses failed to meet this need.

3. The need for encouragement and understanding. Nurses were mentioned only rarely in relation to meeting this need. The patient turned to family, friends, and the clergy.

4. The need for relief of fear and anxiety. Less than fifty percent of the nurses met this need.

The authors state that, "Although these data have suggested some serious inadequacies in nursing care, nurses who have reviewed them have agreed that they are closer to fact than

to fancy. They have considered the data highly suggestive for improving nursing care."

Lee, Mary Eugene. Analysis of the Hospital Nursing Care Given to One Surgical Patient. (18) An unpublished Master's Thesis at the University of Texas in 1956. The purpose of this study was to analyze the nursing care given to a surgical patient by observation and interview. The patient's preoperative preparation included no teaching but the physical care was properly performed. During the first four postoperative days only one entry in the nurses' notes referred to the mental or physical comfort of the patient. According to Lee's observations and the patient's statements, the only reference made by nursing personnel pertaining to exercise in bed took place on the second postoperative day when one of the nurses "reminded" her to turn from side to side frequently. Lee stated that the nurses were not aware that the patient was worried about the health and finances of her family as well as her operation. They did not discover her need for expressing her feelings and her probable need for help in solving her problems. Yet the patient's satisfactions and dissatisfactions were all related to her own physical comfort. The patient never mentioned psychological care or teaching.

Routhier, Anita M. A Study of One Selected Patient Having Surgery of the Lung. (25) An unpublished Master's Dissertation at the Catholic University of America in 1957. The purpose of this study was to study the nursing care of one patient having lung surgery. An analysis of the data obtained showed:

1. Opportunities for patient teaching were numerous in the preoperative stage and constituted an important factor in the preparation of the patient for surgery and her postoperative recovery.

2. Demonstration of the equipment proved to be an effective means of increased understanding of the procedure. Communication skills seemed more important at this time than in any other phase of nursing care.

3. Postoperatively, the psychological needs were lessened as a result of the preoperative preparation. An important nursing need was that the patient be fully aware of the reason for physical therapy and the need for her cooperation in fully carrying out procedures. These needs being realized, she was able to learn to carry out physical therapy procedures without fear and apprehension in the period following surgery.

4. Chest tubes were not a source of worry because she knew the purpose and was frequently reassured of their proper functioning.

5. Total nursing care in the preoperative stage reduced the needs in the postoperative stage which resulted in a rapid advance to the convalescent stage, and from there to a quick and complete recovery.

Thomas, Betty J. The Determination of Psychological Considerations in a Patient Having Surgery. (21) An unpublished

Master's Dissertation at the Catholic University of America in 1958. Psychological needs were defined as those needs which give rise to human behavior and the motives that underlie it. Two conclusions were drawn: (1) Psychological needs cannot be completely detached from the other needs of the patient; total nursing care must be given to meet them effectively. (2) Teaching and offering information to both the patient and the family contribute a substantial part to the effectiveness of the nursing care given to the patient.

SUMMARY

A review of the literature reveals the importance of thorough preoperative preparation of the surgical patient. Of utmost importance is teaching by the nurse.

Most preoperative patients have fears. It is the responsibility of the nurse to discover what each patient's fears are and to initiate measures to allay these fears. Relief of these fears is conducive to learning and therefore should be done before teaching is begun or should be alleviated as a result of the instruction.

Teaching of the preoperative patient should include such instruction regarding preoperative procedures and purposes as well as the postoperative procedures and purposes. Good preoperative preparation lessens

postoperative complications. Therefore this important nursing function should not be omitted.

Although the need for adequate preoperative explanations has been recognized for a long time and frequently reported in the literature, there continue to be evidences that this important function of the registered nurse is being overlooked.

CHAPTER III

REPORT OF THE STUDY

PURPOSE OF THE STUDY

This study was undertaken for the purpose of obtaining information from postoperative patients in a selected hospital to prove or disprove the following null hypothesis:

> The registered nurse does not fulfill her responsibility for preoperative preparation of the surgical patient.

This leads to the identification of certain variables which give rise to the following hypotheses:

> There is no relationship between the patient's sex and the amount of preoperative instruction he receives.
>
> There is no relationship between the type of operation a patient has and the amount of preoperative instruction he receives.
>
> There is no relationship between the fact that the patient is worried and the amount of preoperative instruction he receives.
>
> There is no relationship between the preoperative instruction regarding a procedure and the preoperative instruction regarding the purpose of that procedure.
>
> There is no difference between the amount of instruction given for the preoperative and postoperative phase of the patient's care.

Nurses are not aware of the worries of their patients.

PROCEDURE OF THE STUDY

The method of data collection selected for the study was a prepared check list which was administered individually to eighty participants. The tool was developed and validated as described in Chapter I.

The check list was divided into three parts. The first fourteen items consisted of a list of activities commonly performed in the care of surgical patients. Each item was composed of two parts--the procedure and the purpose of that procedure. The first seven of these items dealt with instruction of the patient regarding his preoperative care and the last seven regarding his postoperative care.

Most of the items of activity are self explanatory. There are four that need elaboration. The surgical prep (activity item number one) commonly referred to shaving an area of the skin. However, if the researcher was interviewing an eye patient, this had to be altered to include the routine care of the eye before surgery, i.e., the eye drops used.

Activity number five, tubes before surgery, included any intubation such as foley catheters or levine tubes. The seventh activity, special care, included anything special to that type of surgery performed by the patient's

doctor. Thus if the patient was having surgery on the tongue, it would include oral hygiene; if the patient were having gynecology surgery, it might include a douche; if the patient were having chest surgery, it might involve use of the Bird Respirator before surgery to allow him to become acquainted with it. Activity item nine, stir-ups, included coughing, deep breathing, and activity in bed. For the eye patient it would involve instruction in trying not to cough after surgery and why, whereas for the chest patient it would involve instruction in how to cough and the importance of it.

The columns of the check list included: no one, doctor (Dr.), registered nurse (R.N.), registered nurse (R.N.) offered, student nurse (S.N.), practical nurse (P.N.) and nurse aide (N.A.), and other.

The "R.N. offered" column was included to allow for any teaching the nurse attempted to do but did not because someone else had done it. In the tabulation of the data, a panel of registered nurses decided that this be considered teaching by the registered nurse since the nurse did offer to instruct.

The next three items (15,16,17) were concerned with whether the surgical patient was worried and if so what was done to relieve his worrying and who participated

in alleviating the worry. The last question (18) was a free response attempting to elicit the patient's attitude toward his preoperative preparation. The check list is included in Appendix A.

The Director of Nursing Service was contacted and permission obtained to interview the patients for the study. The researcher used the check list for interviewing the eighty adult surgical patients in a selected hospital in Oregon.

The interviewer visited all the surgical floors in the hospital and interviewed patients who had had surgery within the last ten days preceding the interview and who were rational, responding, and not in critical condition. It was explained to each patient that the information given by them would be kept anonymous and that this information would in no way affect their present nursing care. It was emphasized that since the nursing profession is constantly trying to evaluate nursing care, his information might help improve it in the future. The patient was asked to answer the questions in relation to the instruction, explanations, information, and feelings they had before surgery.

Each patient was asked about the items in the following manner. The patient was asked if it had been explained that an area of his skin would be "prepped" or shaved before the person who did the prep came, and who did

this explaining. If no one had done this, a check was placed in that column, if the doctor had explained this, a check was placed in that column. If the patient stated he did not have a prep (such as patient having surgery on the tongue), an X was placed through the item and the item was omitted in figuring the percentages in the tabulation of the data. If the first part of the item did not apply, the second part was thus omitted. If it did apply, the participant was then asked if the reason for this shave was explained to him and who did the explaining. Again, the appropriate column was checked. This was done for each of the first fourteen items.

The next items were concerned with the patient's worries and it was stressed that the interviewer was not questioning what the worries were, only if there were any worries before surgery. The patient was asked the 15th question and if he stated he was not worried, an X was placed through the 15, 16, and 17th item. Otherwise all questions were asked. All the patients were asked to give any comment they had regarding their preparation for surgery and these were written by the interviewer and read to the patient to ensure accuracy.

TABULATION AND INTERPRETATION OF THE DATA

The data were tabulated and figures and tables constructed. Relationship between preoperative preparation and sex, type of operation, preoperative and postoperative phases, and worries were tested. Comments elicited from the patients were listed.

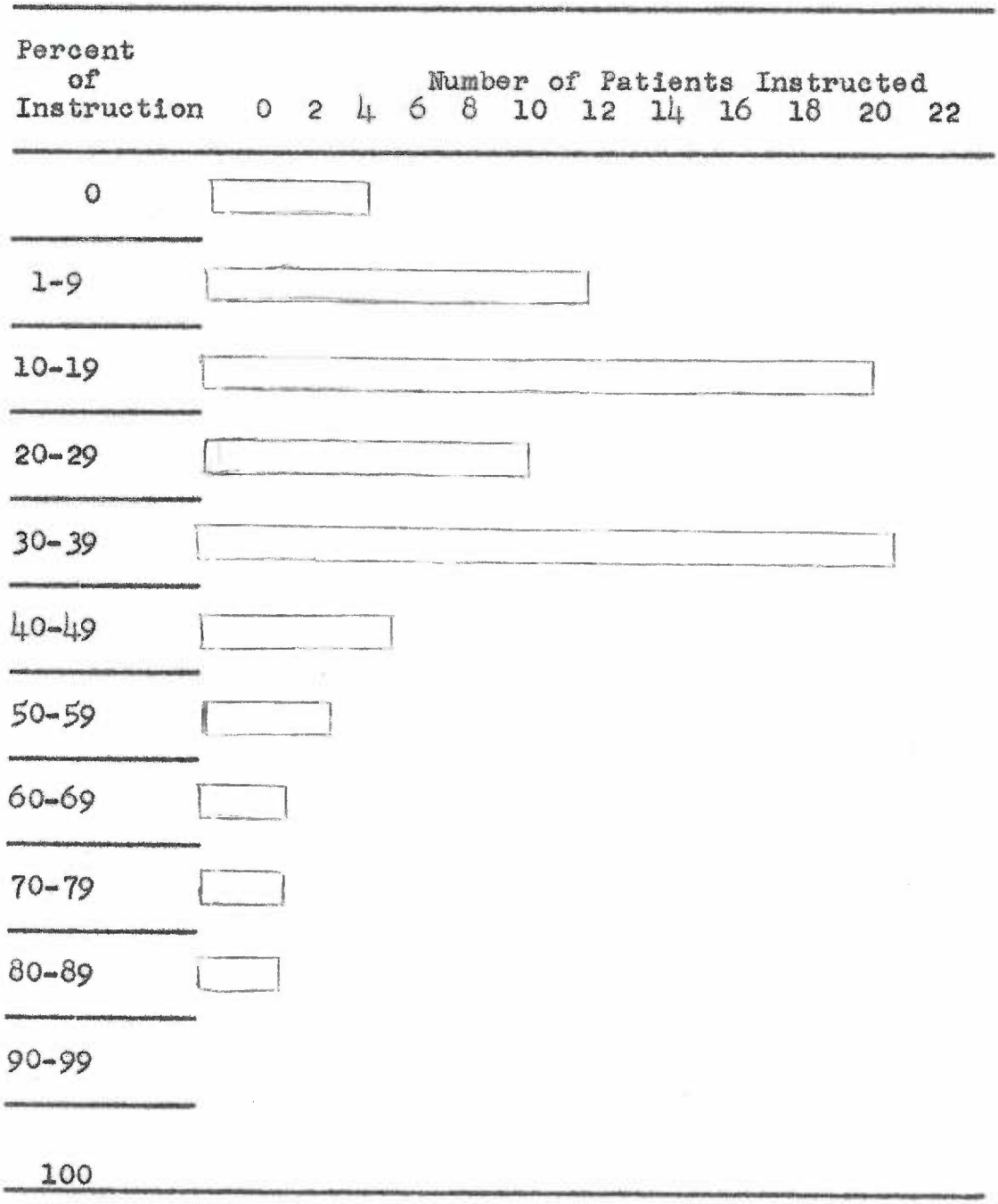
As previously stated, the first fourteen items dealt with instruction given to the patient prior to his surgery. Each item was two-fold and the response indicated an awareness of what would be done as well as recognition of the purpose underlying the preparation. All of the fourteen items were not applicable to every patient. Thus it was determined that a participant might legitimately be expected to respond to ten of the possible twenty-eight responses contained in the first fourteen items. If the respondent had been informed about only three of the ten possible, he was considered to have been instructed in about thirty percent of his preoperative care. Thus the tabulations appearing in the ensuing figures are compilations of each check list according to the items applicable to each respondent. This method of assessing the instruction given the patient was first used to determine total instruction given by each of the individuals heading a column in the check list. Because this study is largely concerned with the responsibilities of the registered nurse for effective

preoperative care, the same procedure was followed in identifying the amount of instruction given each patient by the registered nurse.

It was necessary to have a certain determinant of level of instruction for this study to test some of the hypotheses. Before the data were collected, a panel of registered nurses determined that this be set at thirty percent. The reason considered valid for accepting this figure can be stated briefly: the nurse spends much time on administrative duties and has less time to spend with the patient in actual care and teaching. Thus it was felt that if the nurse was instructing the patient in even thirty percent of his preoperative preparation, she was accomplishing something. Furthermore it was believed that the surgeon would have made some of the explanations.

Figure 1 consists of a graphic representation showing the number of patients instructed and the percent of instruction received.

Of the eighty patients interviewed, 6.25 percent or five respondents said they received no preoperative instruction. Seventy-four out of the eighty or 92.5 percent received less than fifty percent preoperative instruction which means that only six respondents or 7.5 percent said they received fifty percent or more preoperative instruction; only one person or 1.25 percent received eighty percent or



n = 80

Figure 1. Representation of Number of Patients According to Percent of Preoperative Instruction Received

more instruction. It would appear that in this situation according to the responses of the patients no one, including the registered nurse, was doing much instructing of the surgical patients. The matter becomes of strategic importance when it is summarized thus: fourteen items on the list pertained to preoperative instruction--seven to the preoperative phase and seven to the postoperative phase. Only six out of eighty patients received instruction regarding at least half of the items. This study does not attempt to determine if this situation is due to lack of nursing responsibility or if in our culture the health conscious population has become sufficiently informed to permit the omission of instruction regarding preoperative care.

There are repeated references in the literature regarding the importance of good preoperative instruction; the literature has shown many instances of the lag between what is known and what is performed. The findings of this study relate closely to the comments of Bordick, Brown, Graffam, et al. as reviewed in Chapter II.

Of the six patients who received fifty percent or more preoperative instruction, the average for the preoperative phase of instruction was 58 percent and 48 percent for the postoperative phase.

Table 1 shows a rank order correlation between preoperative instruction in procedures and preoperative instruction in the purposes of those procedures of these six patients. The rank order is determined by arranging the items of activity taught by the nurse beginning with the one taught most frequently and ending with the one taught the least. If items of activity were taught by the nurse the same number of times, these were ranked equally. The instruction in procedure and the instruction in the purposes of those procedures were ranked. The null hypothesis was formulated:

> There is no relationship between preoperative instruction in procedures and preoperative instruction in the purposes of these procedures.

This is significant at the 0.01 level of confidence of the Table of Critical Values of the Spearman Rank Order. Therefore the null hypothesis was rejected and it may be stated of these six patients who were 50 percent or more instructed that if it were known that the patient had been taught the procedure, it could be predicted that he also had been taught the purpose of that procedure. Since this applies to only six out of eighty patients and to instruction regarding at least seven out of fourteen items, little importance can be attached to these findings per se. The real importance is to the number who did not receive instruction in as many as seven activities.

Table 1. Rank Order of Preoperative Instruction in Procedures and Purposes of Those Procedures of Six Patients Considered Fifty Percent or More Instructed

Items of Activity	Instruction in Procedures	Instruction in Purposes
I.V.'s or blood	2	3
enema/laxative	2	3
pre op hypo	2	1
stir-ups	2	7.5
surgical prep	6	3
pain after surgery	6	5
oxygen	6	10.5
tubes before surgery	8.5	7.5
NPO after surgery	8.5	12.5
NPO before surgery	11	7.5
recovery room	11	12.5
vital signs	11	10
sleeping pill	13	7.5
special care	14	12.5

Using the formula $RHO = 1 - \frac{6 \sum D^2}{n (n^2-1)}$ $RHO = 0.72$

It was interesting to note that of these six patients who had fifty percent or more instruction, five

were females. This might raise questions which the study was not prepared to answer such as: Are nurses more comfortable talking with women? Are women more curious regarding what is or will be done to them? Are men more stoic because of our culture and less apt to display doubt or apprehension?

Figure 2 was constructed to depict the responses in percentages of the preoperative instruction given to males and females.

All of the five respondents (6.25 percent) who said they had no preoperative instruction were males. Of those who received fifty percent or more instruction, five were females and one was a male. However, in total, 48.7 percent (19 respondents) of the females and 34.1 percent (14 respondents) of the males received thirty percent or more instruction. Therefore 51.3 percent or 20 of the 39 females and 65.9 percent or 27 of the 41 males received less than thirty percent instruction. A Chi Square was performed in Table 2 to test the null hypothesis:

> There is no relationship between the patient's sex and the amount of preoperative instruction he receives.

The Chi Square was not significant at the 0.05 level of confidence; therefore the null hypothesis was accepted and there was no correlation between the amount of preoperative instruction and the sex of the respondent.

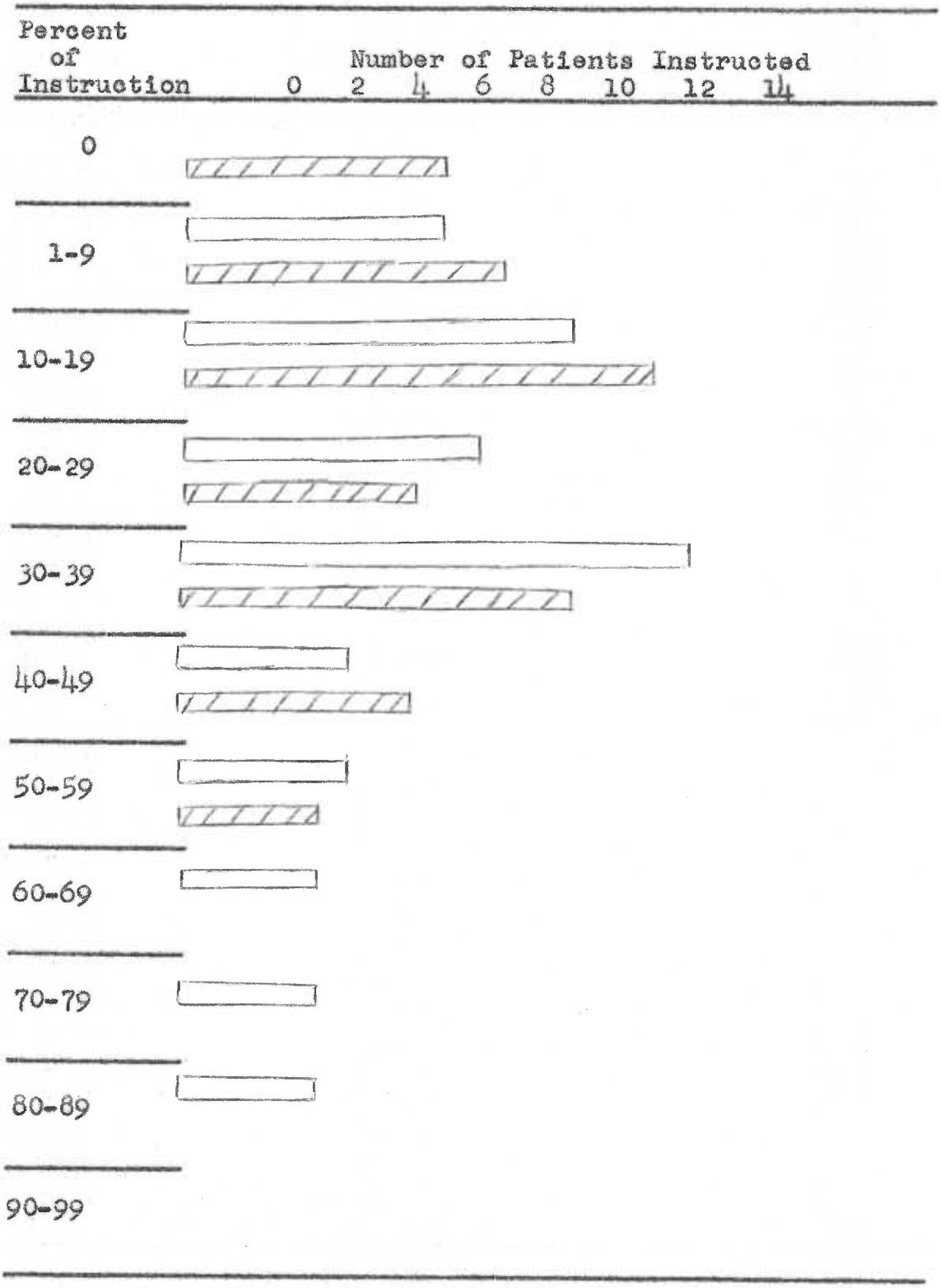


Figure 2. Responses of Eighty Patients, According to Sex, Regarding Percentage of Preoperative Instruction Received

Female Male

Table 2. Responses of Eighty Patients Tabulated According to Sex Versus Amount of Preoperative Instruction Received

Sex	Categories		
	30 Percent or More Instruction	Less than 30 Percent Instruction	Number
Male	14	27	41
Female	19	20	39
Total	33	47	80

Yates correction formula for 4 celled tables = $\chi^2 = \dfrac{\left(\left|db-ac\right|-\frac{n}{2}\right)^2}{pqrs}$

Another variable to be tested was the type of operation and whether or not this had any relationship to the amount of preoperative instruction the patient received. Thirty-eight or almost half of the patients had thoracic-abdominal surgery and forty-two patients had surgery for other conditions. The distribution of the eighty patients according to these two classifications of surgery and according to the percent of preoperative instruction received is shown in Figure 3.

Fourteen of the respondents (36.8 percent) undergoing thoracic or abdominal surgery and nineteen of the

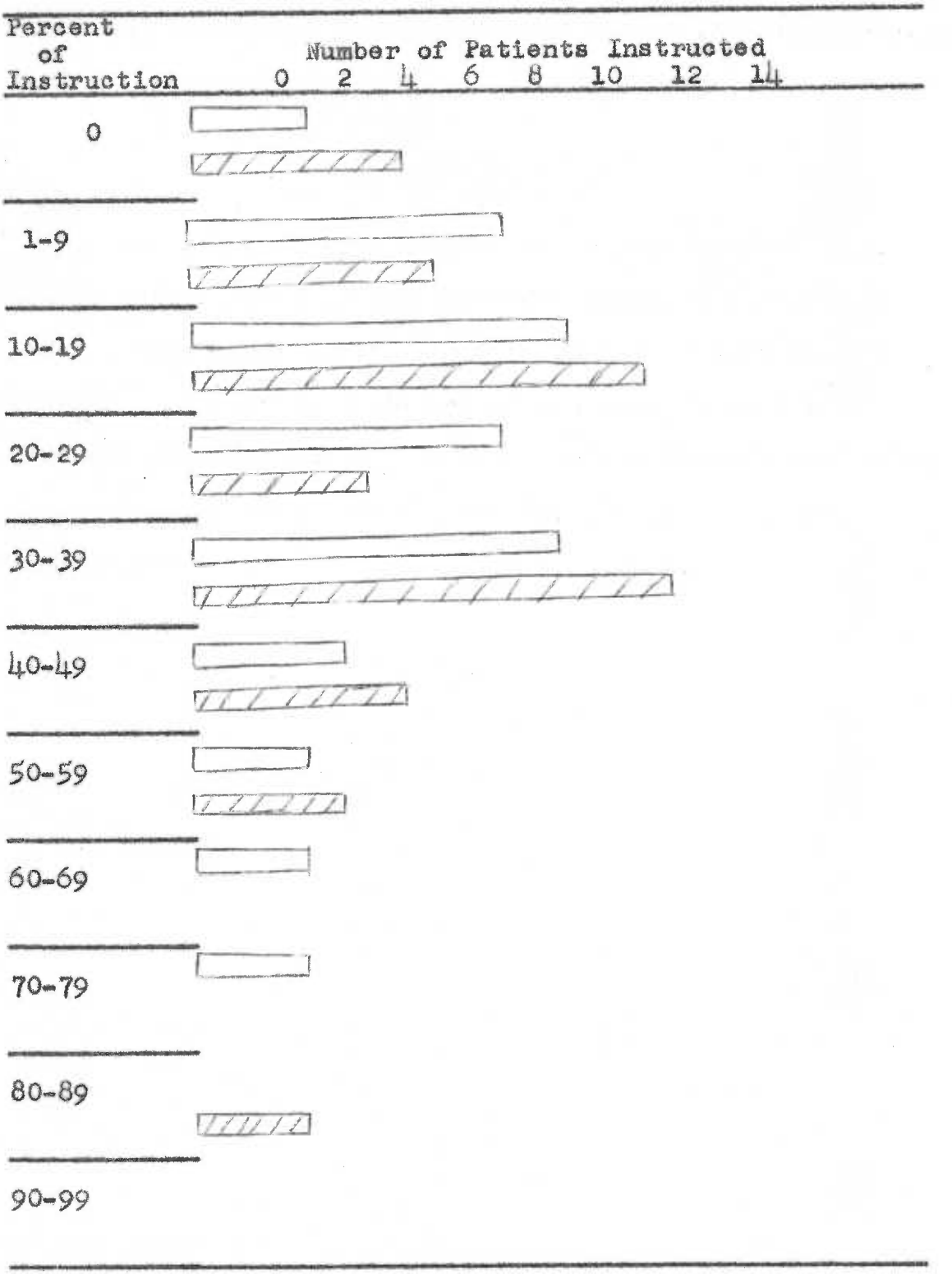


Figure 3. Distribution of Eighty Patients, According to Type of Operation and the Percent of Preoperative Instruction Received

Thoracic-abdominal Other types

respondents (45.2 percent) undergoing all other types of surgery received thirty percent or more instruction. Therefore twenty-four of those (63.2 percent) undergoing thoracic or abdominal surgery and twenty-three (54.8 percent) of those undergoing all the other types of surgery received less than thirty percent instruction. Since a lesser percentage of those respondents having thoracic-abdominal surgery received instruction such questions might be raised as: Are those members of the health team more hesitant to teach those having thoracic-abdominal surgery (which may involve a more major operation)? Do they know less about teaching patients having this surgery? Are patients having this surgery more worried and therefore less receptive to teaching? Does the teaching of the patient with this type of surgery involve more than the teaching of patients with other types of operations? Is this type of surgery becoming more common and thus the members of the health team are less concerned about it? This study makes no attempt to answer these thought-provoking questions.

A Chi Square was performed to learn if this margin of percentage difference was statistically significant. The null hypothesis was formulated:

> There is no relationship between the type of operation a patient has and the amount of preoperative instruction he receives.

Table 3. Responses of Eighty Patients Tabulated According to Type of Operation Versus Amount of Preoperative Instruction

Type of Operation	Categories		Number
	30 Percent or More Instructed	Less than 30 Percent Instructed	
Thoracic-Abdominal	14	24	38
Other Types	19	23	42
Total	33	47	80

The Chi Square was not significant at the 0.05 level of significance. Therefore the null hypothesis was accepted and there was no statistical relationship between type of operation and the amount of preoperative instruction.

Thus far the tabulation has been concerned with the giving of preoperative instruction by the doctor, nurse, or other persons. The findings show there has been very little teaching done. The percent of teaching actually done by the nurse in relation to that done by others is depicted in Figure 4.

One of the items which the National League for Nursing lists as that which the patient should expect

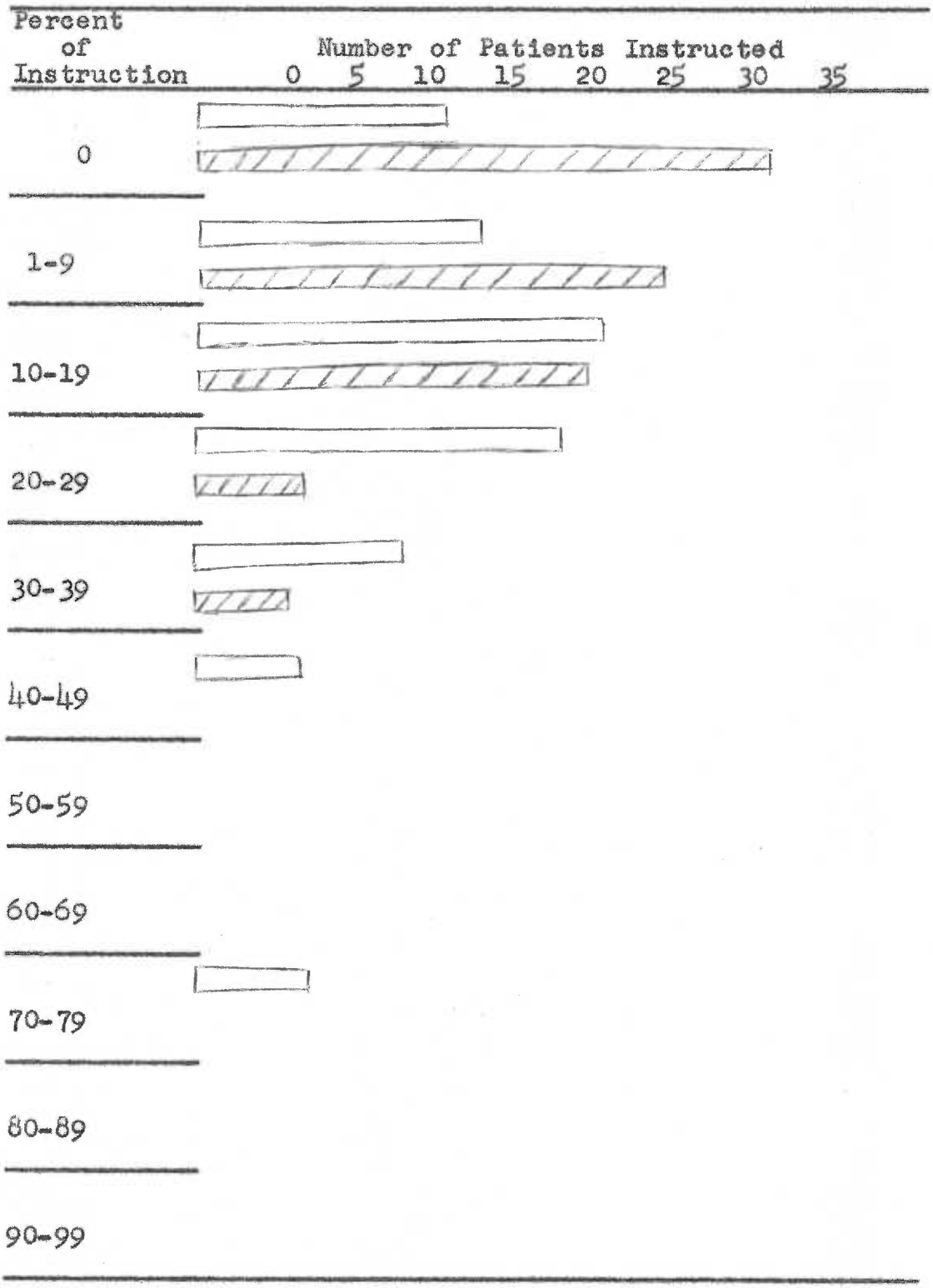


Figure 4. Responses of Eighty Patients Indicating the Percentage of Instruction Received and the Numbers Instructed by the Registered Nurse and Others

Registered Nurse ▭ Others* ▨

*Others mentioned were doctors, nurses aides, and family.

during his nursing care is explanation about his illness and his role in his care. (35) This can be applied to the surgical as well as the medical patient. Therefore, the nurse who cares for the surgical patient should be offering explanations to meet the expectations of the patient. Only three (or 3.75 percent) of all the patients interviewed were considered to be instructed by the registered nurse in fifty percent or more of the items on the check list. Fourteen (or 17.5 percent) of all the patients received thirty percent or more of the preoperative instruction which means that sixty-six of the eighty patients (or 82.5 percent) received less than thirty percent preoperative instruction by the registered nurse. Twelve patients (or 15 percent) said they received no preoperative instruction by the nurse. On the basis of these percentages, the null hypothesis that the nurse is not fulfilling her responsibility for preoperative preparation of the surgical patient was accepted.

This supports the study by Cassady and Attroichi (4) who interviewed 40 female, surgical patients and concluded that most of them had received little information about their surgery. It also supports the study by Hay and Anderson (14) who reviewed a sample of 26 professional and popular books and articles dealing with illness or disabilities and concluded that the need for knowledge of

the patient about his condition and treatment was not being met. This also agrees with Lee's (18) study of one surgical patient. She stated that there was no preoperative teaching done. However it does not support Routhier's (25) study of one selected surgical patient. She found that patient teaching constituted an important factor of the preoperative preparation of the patient and was done even to the extent that the equipment used postoperatively was demonstrated. No generalizations can be drawn, however, on the results of a study done on one patient.

Figure 5 is concerned with the preoperative phase and the postoperative phase of teaching. Of the eighty patients interviewed, only one (or 1.25 percent) received one-hundred percent instruction in the preoperative phase and no one received one-hundred percent instruction in the postoperative phase. Thirty-nine (or 48.8 percent) of the patients were thirty percent or more instructed in the preoperative phase and only nine (or 11.3 percent) in the postoperative phase. Six patients (or 7.5 percent) received no instruction in the preoperative phase and thirty (or 37.5 percent) received no instruction in the postoperative phase.

Since thirty patients (or 37.5 percent) more received thirty percent or more instruction in the preoperative phase than in the postoperative phase such

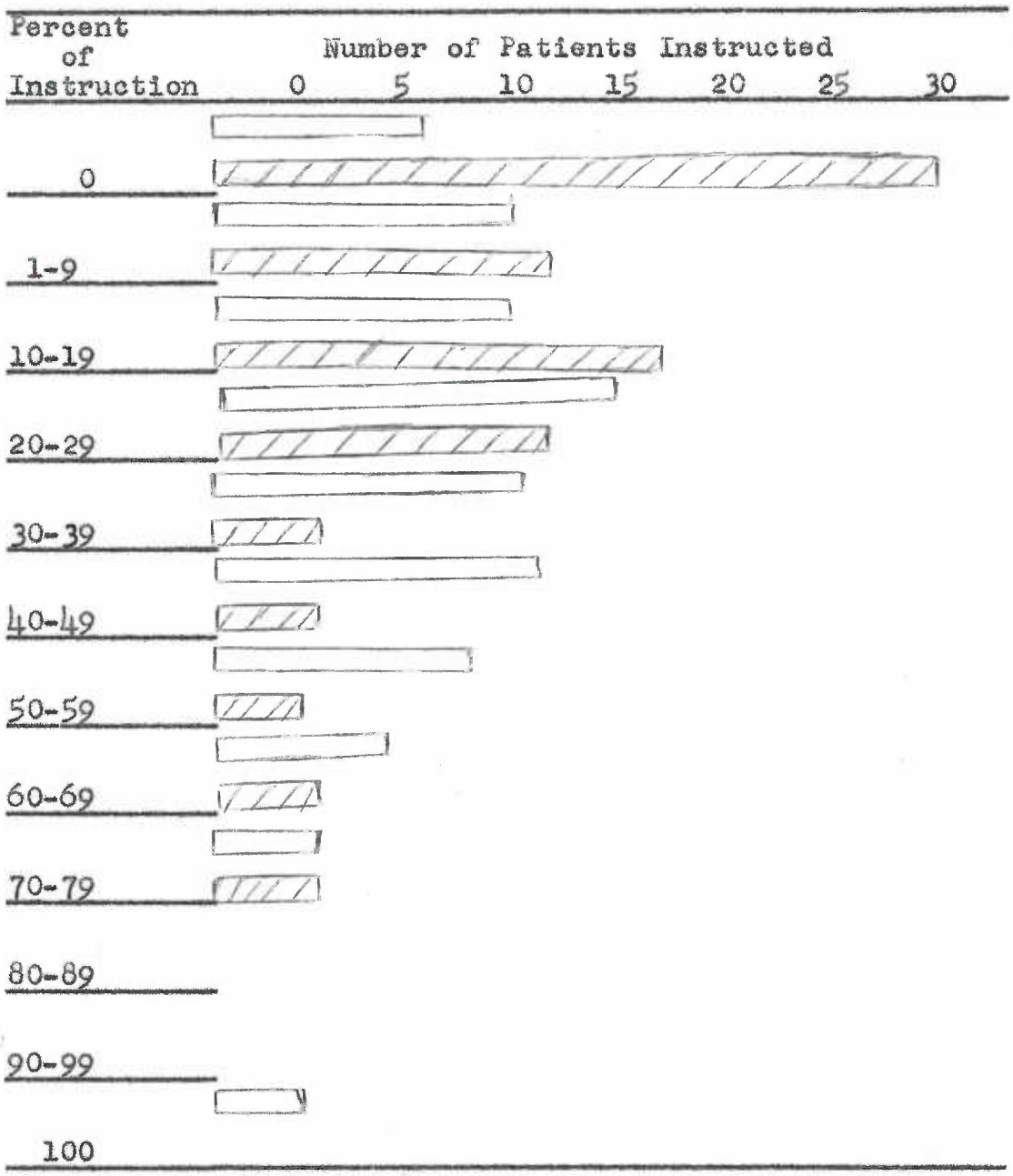


Figure 5. Response of Eighty Adult Surgical Patients Tabulated According to Percent of Preoperative Instruction Received for the Preoperative and Postoperative Phase

Preoperative Phase ▭ Postoperative Phase ▨

questions may be raised as: Do members of the health team only "have time" to do the preoperative phase of instruction? Are they more concerned with the short term goals of the surgical patient? Do they feel that instruction for the postoperative phase is not important? Does the instructor influence what phase of instruction is taught? These questions cannot be answered without more study.

Figure 6 was constructed to depict the registered nurses' instruction regarding the preoperative and postoperative phase of patient care.

Fifteen (or 18.8 percent) of the respondents received no preoperative instruction and forty-three (or 53.8 percent) received no postoperative instruction. Thirty-one (or 38.8 percent) of the respondents were thirty percent or more instructed in the preoperative phase and only seven (or 8.8 percent) were thirty percent or more instructed in the postoperative phase. The difference of 30 percent is not as great as with "anyone" who instructed the patients but it is great enough that the questions again could be raised: Do nurses only "have time" to do the preoperative phase of instruction? Are nurses more concerned with the short term goals of the surgical patient? Do nurses feel that instruction for the postoperative phase is not important? Do the administrative duties of the nurse take her away from patient teaching?

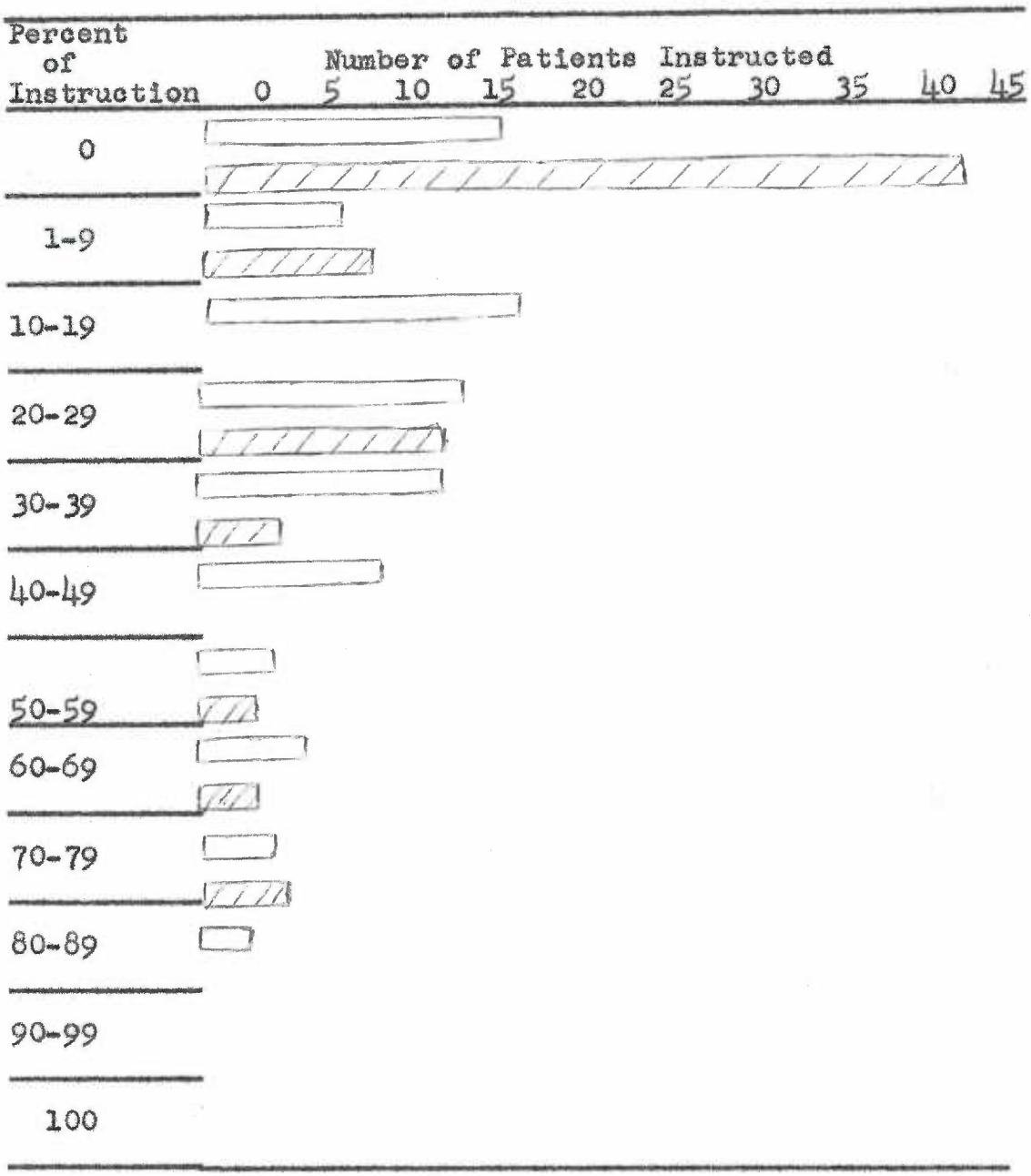


Figure 6. Responses of Eighty Patients Depicting the Percentage of Instruction Given by the Registered Nurse for the Preoperative and Postoperative Phase

Preoperative Phase ▭ Postoperative Phase ▨

On the basis of such a difference in percentage, the null hypothesis that there was no difference in the amount of instruction for the preoperative and postoperative phase was rejected and it was felt that the findings showed there was more teaching for the preoperative phase than the postoperative phase.

A rank order correlation was performed in Table 4 to test any relationship of instruction by the registered nurse between preoperative instruction in procedure and preoperative instruction in the purposes of that procedure. This table was constructed in the same manner as Table 1. The null hypothesis was formulated.

> There is no relationship between the preoperative instruction regarding a procedure and the preoperative instruction regarding the purpose of that procedure.

The result of this test was significant at the 0.01 level of confidence of the Table of Critical Values of the Spearman Rank Order. The null hypothesis was rejected; therefore if it were known that the patient had been instructed in a procedure by the registered nurse, it could be predicted that he also had been instructed in the purpose of that procedure.

It is interesting to note that instruction regarding use of sleeping pills and preoperative hypodermics led the list. It may be speculated that the nurse instructed the

Table 4. Rank Order of Preoperative Instruction of Eighty Patients in Procedures and Purposes of Those Procedures by the Registered Nurse

Items of Activity	Instruction in Procedures	Instruction in Purposes
preop hypo	1	1
sleeping pill	2	2
NPO after surgery	3	3.5
NPO before surgery	4	5
surgical prep	5	3.5
recovery room	6.5	9.5
stir-ups	6.5	6.5
pain after surgery	9	12
vital signs	9	12
I.V.'s or blood	9	8
enema/laxative	11	6.5
tubes before surgery	12	9.5
special care	13.5	12
oxygen	13.5	14

RHO = 0.87

patient in these since she was the one who gave the medications. The five highest procedures in which the nurse instructed the patients in rank order were (1) the

preoperative hypodermic, (2) the sleeping pill, (3) nothing by mouth after surgery, (4) nothing by mouth before surgery, and (5) the surgical prep. Four of these dealt with the preoperative phase of instruction. None of the five actually concerned the patient's participation post-operatively.

Items 15-17 refer to the worries of the surgical patient. Forty-two (or 52.5 percent) of the patients (22.5 percent females and 30 percent males) stated they were not worried. According to the literature (19,29,30, 34), all surgical patients have some types of worries. Cassady and Attroichi's (4) study revealed that there were only 15 percent who expressed no fears. It may be speculated that the interviewer was not with the patients for a long enough period to establish sufficient rapport with the patients so they would disclose that they were worried. Establishing rapport is an important function of the nurse on the surgical unit and can not be done in a 15 to 30 minute interview. (38,30) Another speculation may be that enough postoperative time had lapsed to permit preoperative fears to be superseded by other matters. Another speculation may be that due to our culture, people do not wish to admit that they are worried.

However, on the premise that 52.5 percent of the patients were not worried, Figure 7 was constructed to depict the relationship of the amount of preoperative instruction to the presence of worries on the part of the patients.

Fifteen (or 39.5 percent) of those worried and twelve (or 28.6 percent) of those not worried received thirty percent or more preoperative instruction. This 10.9 percent did not appear statistically significant; however a Chi Square was done in Table 5 to test the null hypothesis which was formulated:

> There is no relationship between the fact that the patient is worried and the amount of preoperative instruction he receives.

The Chi Square was not significant at the 0.05 level of confidence. Therefore the null hypothesis was accepted and there was no relationship between those who admitted being worried and the amount of preoperative instruction.

The following information was concerned with those who stated to the interviewer that they were worried before surgery. Only 37 percent of these believed that the registered nurse knew they were worried and tried to help. On this basis the null hypothesis that the nurse is not aware of the patient's worries was accepted. Another 16 percent felt someone else knew they were worried

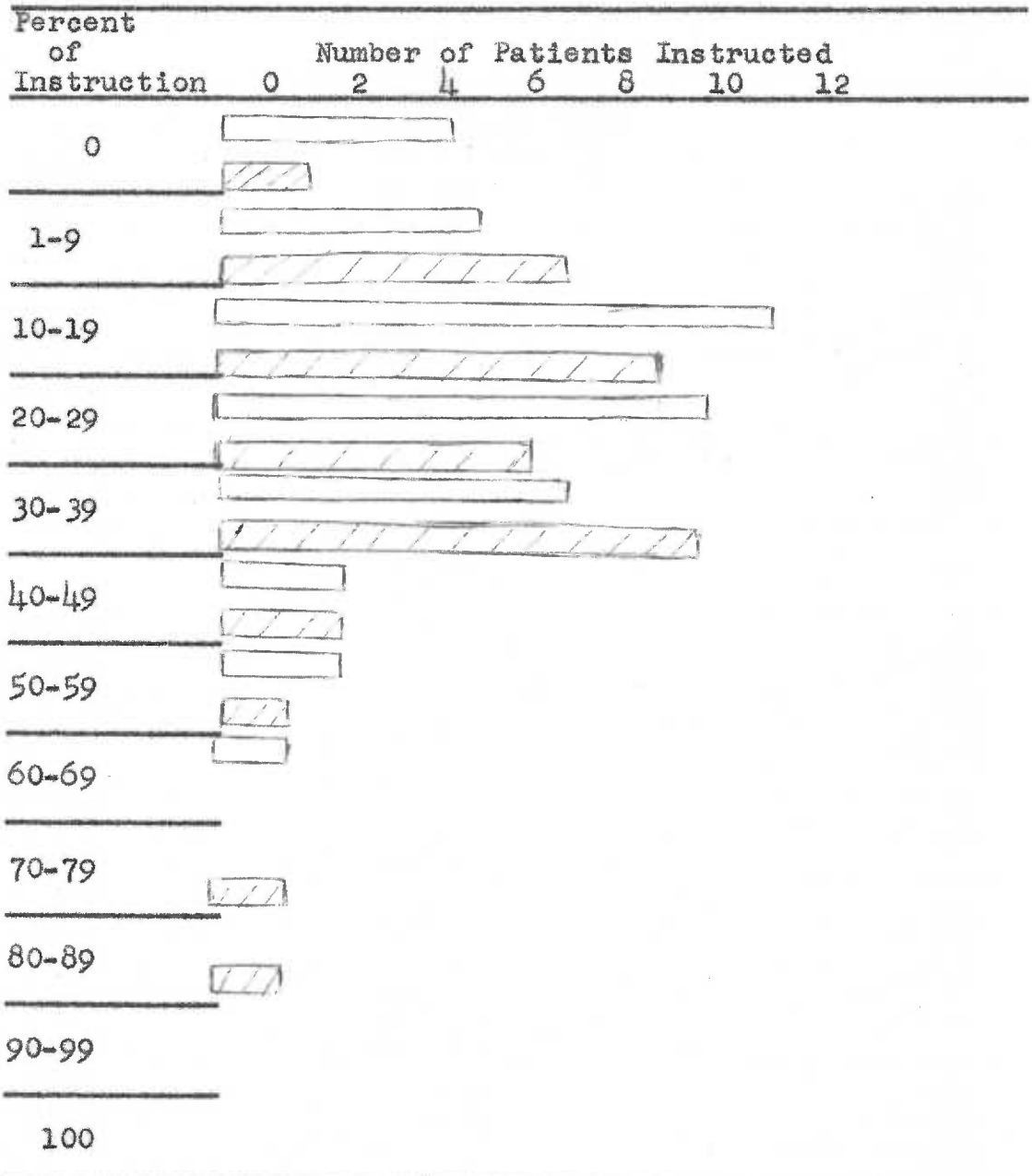


Figure 7. Responses of Eighty Patients Depicting the Percentage of Instruction Given Preoperatively by the Registered Nurse to Those Worried and Not Worried

Not worried Worried

Table 5. Responses of Eighty Patients According to Worries of Patient Versus Amount of Preoperative Instruction

Worries	Categories		
	30 Percent or More Instructed	Less than 30 Percent Instructed	Number
Worried	15	23	38
Not Worried	12	30	42
Total	27	53	80

whether they tried to help them or not. This supports Hay and Anderson's (14) study which found that less than 50 percent of the nurses met the need of relief from fear and anxiety.

The literature (10,27,29) reveals that patients who are frightened and worried respond poorly to surgery and are prone to complications; and a person who is free from anxiety is a more relaxed and cooperative patient. Forty-seven percent of those who were worried felt that nothing was done to relieve their worries. The findings show that about half of those patients who were worried went to surgery with worries which possibly the nurse could have helped relieve. The records of these patients were not reviewed to determine their postoperative course since it was felt that this would be a separate study.

The literature gives various ways for the nurse to help relieve the surgical patient's worries. Taking

time to talk to the patient is important in order to answer his questions, clarify any misunderstandings, and give the needed teaching. Explanations are important since most people have a fear of the unknown. In order to learn the patient's fears, the nurse must be an effective listener. If she gives her whole attention, the patient will be more apt to confide in her and disclose his fears. The patient also needs reassurance and encouragement by the nurse. This may take place in different ways varying from a detailed explanation of a procedure to a simple gesture of holding the patient's hand. (12,13,19,22,34)

Table 6 is concerned with the 16 patients who were worried and felt something was done to help relieve their worrying. Some had worries relieved in more than one way and by more than one person. This table denotes the ways in which they believed their worries were relieved and who relieved them.

These responses appear similar to the ways indicated in the literature. All are related to communication in some way. It would appear that the remaining twenty-two worried patients were deprived of this important aspect of nursing care. The Scottish Association Report for Mental Health (30) indicates that, "The greatest single cause of the disturbance often present in the minds of patients in a general hospital is a failure

Table 6. Responses of Sixteen Patients Who Were Worried Denoting How and By Whom Their Worries Were Relieved

How Worry Was Relieved	Worries Relieved By	
	Anyone*	Registered Nurse
Someone Listening	2	2
Someone Talking	8	6
Someone Giving Encouragement	1	
Family Being There	2	
Someone Giving Reassurance	2	
People Being "Real Kind"	2	2
Being Told What To Expect	2	2

*Anyone = doctors, nurses, nurses aides, and family.

of communication at all levels of hospital life."

The last question was a free response. The patients were asked to make any comments they wished regarding their preoperative preparation. Most of the comments also show lack of communication which in turn refer to lack of preoperative preparation. The following were the comments:

> It would have helped to know what to expect.

I listened to a nurse talk to her /patient in other bed/ before she went to surgery about what the nurses were going to do. Had I been told what she /the other patient/ had been about what was going to be done to me, I would have been much less afraid.

They didn't tell me anything!

I didn't think they wanted me to cough so I thought the doctor was mad at me the first time he had me do it. It would have helped to know this earlier. I was really scared.

They don't tell you nothing.

Would have been less frightened if was aware of what was to happen.

I wish I could have known then what I know now about what happens afterwards. This was my first operation.

I had some questions but I didn't want to bother the nurses.

The operation and afterwards was far worse than I expected.

I was surprised to wake up in the recovery room.

I didn't know I couldn't have anything to drink before surgery until I woke up and my water was gone. My wife is an R.N. and she told me about many things, thank goodness.

They didn't tell me too much but maybe they thought I'd know what was happening--I had been through it before.

They didn't explain anything to me.

They kept me in the dark.

I was here three years ago and they may have thought I knew what was going on.

I knew I would feel more relaxed if I knew what to expect so I asked many questions and if the doctor hadn't answered them and prepared me, it wouldn't have been done. That man in the hall wondered what was taking his wife so long to come from surgery. He said his wife and he didn't know about the recovery room until I went out and told him.

After surgery I was told by a nurse why everything was being done, it sure helped to know.

I felt I could talk to the nurse and ask her any questions.

I felt relieved after a discussion with the nurse.

I felt so much better after the nurse told me what would be going on.

It was just wonderful--except I didn't know what was going to happen.

These comments show that there were not many instructions or explanations given to the patients and they realized this. Those few who did talk to the nurse said they felt relieved. Those who did not receive explanations did not state that they believed this was the responsibility of the nurse. It was interesting to note that 25 percent of the eighty patients stated that their preoperative preparation was "good" or "fine." All of these 25 percent had less than thirty percent

preoperative instruction. Of these 25 percent, three patients stated they had no worries, and seventeen stated that they had some. This is interesting in relation to Lee's (18) study where she found that the patient's satisfactions and dissatisfactions were all related to her own physical comfort. The patients never once mentioned psychological care or teaching. One may question: Does the patient know what to expect from the nurse in the way of preoperative preparation? Perhaps the last comment listed concerns this. The patient stated everything was fine except no explanations were given. If he knew what to expect from nursing service, would he have been as satisfied?

The summary of the findings, the conclusions drawn and recommendations for further studies have been stated in the next chapter.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY OF THE STUDY

Advances in the social sciences and psychiatry have made people aware of the basic needs of human beings. These needs are even more intensified when a person is hospitalized for not only is he sick but also he is in a strange environment with unfamiliar people caring for him. Each person reacts differently. Moroney (20) has emphasized that each patient's mental outlook, his fears, his hopes, and his will may be as important as the purely physical treatment of the disease. This realization has placed emphasis on the psychosociological aspects of illness and such terms as comprehensive nursing care have evolved.

With the pre-surgical patient, as with all other patients, this phase is important. A review of the literature in Chapter II revealed that authorities in nursing agreed that preoperative preparation was of vital importance and that it was the responsibility of the nurse to give the preoperative preparation which should include teaching the patient, discovering his fears, and instituting measures to allay these fears.

This study was undertaken to determine if this responsibility of preoperative preparation was being fulfilled by the registered nurse. Preoperative preparation was defined as the nursing care given to the patient before surgery including:

1. explanation of preoperative and postoperative procedures and their purposes.
2. instruction regarding patient's role postoperatively.
3. recognition of patient's apprehension by the nurse.
4. institution of nursing measures to allay worries.

PURPOSE OF THE STUDY

The purpose of this study was to obtain information from postoperative patients in a selected hospital to prove or disprove the following null hypothesis.

> The registered nurse does not fulfill her responsibility for preoperative preparation of the surgical patient.

This leads to the identification of certain variables which give rise to the following hypotheses:

> There is no relationship between the patient's sex and the amount of preoperative instruction he receives.
>
> There is no relationship between the type of operation a patient has and the amount of preoperative instruction he receives.

There is no relationship between the preoperative instruction regarding a procedure and the preoperative instruction regarding the purpose of that procedure.

There is no relationship between the fact that the patient is worried and the amount of preoperative instruction he receives.

There is no difference between the amount of instruction given for the preoperative and postoperative phase of the patient's care.

Nurses are not aware of the worries of their patients.

The primary source of data was obtained by a check list administered to eighty adult surgical patients in a selected hospital in Oregon who had had surgery within ten days preceding the interview and who were rational, responding, and not in critical condition. The first fourteen items were constructed to elicit information concerning who, if anyone, gave the preoperative instruction to the patient. The next three items dealt with the patient's apprehension; and the last item was composed for free response which would reveal the patient's attitudes toward his preoperative preparation. The results of the study are shown in tabulations in Chapter III of this study.

Preoperative instruction by anyone. Of the eighty patients interviewed, five respondents or 6.25 percent had

no preoperative instruction by anyone. Seventy-four or 92.5 percent received less than fifty percent instruction which means that only six out of the eighty (or 7.5 percent) received instruction on 50 percent or more of the items on the check list.

There were six patients (five females and one male) who received fifty percent or more preoperative instruction. These patients were instructed ten percent more for the preoperative phase than for the postoperative phase. There was a high positive correlation among these six patients concerning receiving instruction regarding the nature of the procedures and the purposes of these procedures.

Chi Squares were done to test the relationship of the eighty patients between the preoperative instruction and the following variables, (1) sex and (2) type of operation. The null hypotheses were formulated:

> There is no relationship between the patient's sex and the amount of preoperative instruction he received.
>
> There is no relationship between the type of operation a patient has and the amount of preoperative instruction he receives.

Neither was significant at the 0.05 level of confidence and therefore both null hypotheses were accepted.

Preoperative instruction by the registered nurse. Only three patients or 3.75 percent of all the eighty

respondents were instructed fifty percent or more by the registered nurse. Fourteen patients or 17.5 percent received thirty percent or more instruction which means that there were sixty-six respondents or 82.5 percent who received less than thirty percent preoperative instruction by the registered nurse. On the basis of this large percentage, the null hypothesis that the registered nurse is not fulfilling her responsibility of preoperative preparation of the patient was accepted.

Much of the instruction the nurse gave was done for the preoperative phase. Thirty percent more instruction by the registered nurse was done for the preoperative phase than for the postoperative phase. This was considered a large enough percentage to reject the null hypothesis that there was no difference between the amount of instruction given for the preoperative and postoperative phase of the patient.

A high positive correlation was found regarding the instruction concerning the nature of procedures and the purposes of those procedures. Therefore the null hypothesis that there is no relationship between preoperative instruction in procedures and preoperative instruction in the purposes of those procedures was rejected.

The five items in which the patient was instructed

the most in rank order were (1) preoperative hypodermic (2) sleeping pill, (3) nothing by mouth after surgery, (4) nothing by mouth before surgery, and (5) the surgical prep. Four of these dealt with the preoperative phase of instruction. None was concerned with the patient's participation postoperatively.

Worries. Forty-two or 52.5 percent of the patients stated they were not worried. A Chi Square was done to test the relationship between the amount of preoperative instruction and worries with the null hypothesis:

> There is no relationship between the fact that the patient is worried and the amount of preoperative instruction he receives.

This was not significant at the 0.05 level of confidence; therefore the null hypothesis was accepted.

Only 37 percent of those who were worried believed that the registered nurse knew they were worried and tried to help. There were 47 percent who felt that nothing was done to attempt to relieve their worries. Thus the null hypothesis that the nurse is not aware of the worries of the patients was accepted.

Seven ways were cited in which worries were relieved. These included: (1) someone listening, (2) someone talking, (3) someone giving encouragement, (4) family being there, (5) someone giving reassurance, (6) people

being "real kind," and (7) being told what to expect. The nurse was mentioned twelve times in regard to these categories.

All but four of the statements obtained from the patients regarding their attitudes toward preoperative preparation had a negative connotation. The majority of these were concerned with the fact that they were not told what to expect. However, 25 percent of the patients commented that their preoperative preparation was "good" or "fine." All of these had less than thirty percent preoperative instruction.

CONCLUSIONS

On the basis that this information was obtained from patients in one selected hospital in Oregon, no widespread generalizations can be drawn. Therefore these conclusions are limited to the data obtained from this study.

1. Although the need for preoperative preparation as defined in Chapter I has been recognized for a long time and frequently reported in the literature, there is evidence that this important function is being overlooked by the registered nurse.

2. The patient knows more about the preoperative phase of his nursing care than the postoperative phase.

3. If a patient is aware of a procedure that is to be done, he is also aware of the purpose of that procedure.

4. Although the literature states that a worried patient is prone to postoperative complications, patients are still going to surgery without having their worries relieved.

5. Relief of the patient's worries consisted of explanation, encouragement, and reassurance. This is consistent with the literature.

6. The patient's sex and the type of operation do not influence the amount of preoperative instruction given.

RECOMMENDATIONS FOR FURTHER STUDIES

Based upon the findings of this study, it is recommended that the following studies be made.

1. Investigate curricula in schools of nursing to determine the amount of emphasis being placed on preoperative preparation of the surgical patient.

2. Conduct a survey of preoperative patients in other hospitals to determine how they are being prepared.

3. Conduct a survey of preoperative patients to discover what they say their worries are.

4. Conduct a survey of preoperative patients to discover what they expect for their preoperative preparation.

Conduct this with two groups, one which has not had a previous operation and one which has had surgery before to see if there is a difference.

5. Interview patients and their nurses to obtain opinions of each regarding the preoperative preparation.

6. Conduct a controlled study of two groups of surgical patients. One group would have intensive preoperative preparation including teaching and explicit explanations; the other group would have no planned teaching. Both would have certain common preoperative activities performed. Compare the postoperative periods for the two groups with particular attention to: pain, amount of sedation, restlessness, nausea and vomiting, cooperation of patient, and course of recovery.

7. Conduct a survey to assess or evaluate the effectiveness of the physical care of the surgical patient.

8. Conduct a study of the general population to ascertain what people believe constitutes good nursing care of surgical patients.

BIBLIOGRAPHY

1. Bordick, Katherine J. Nursing Care of Patients Having Chest Surgery. New York: The MacMillan Company, 1962.

2. Brackett, Mary E. and Joan R. Gogt. "Is Comprehensive Nursing Care a Realistic Goal?" Nursing Outlook. 9:7:402-404, July, 1961.

3. Brown, Esther Lucile. Nursing for the Future. New York: Russell Sage Foundation, 1948.

4. Cassady, June R. and John Attroichi. "Patients' Concerns About Surgery." Nursing Research. 9:4:219-221, Fall, 1960.

5. Coston, Harriet. "Patient-Centered Teaching." Nursing Outlook. 6:12:697-699, December, 1958.

6. Cowan, McCordelia, Ed., The Yearbook of Modern Nursing. New York: G. P. Putnams Sons, 1956.

7. Dumas, Rhetaugh Graves. "Psychological Preparation for Surgery." American Journal of Nursing. 63:8:52-55, August, 1963.

8. Elder, Frances. "Effective Support for Your Pre Operative Patient." R.N., May, 1962.

9. Eliason, Eldridge, L. Kraeer Ferguson, and Lillian A. Sholtes. Surgical Nursing. Philadelphia: J. B. Lippincott Company, 1955.

10. Felter, Robert, Frances West, Lydia M. Zetzsche, and Hugh Barber. Surgical Nursing. Philadelphia: F. A. Davis Company, 1959.

11. "Functions, Standards, and Qualifications for Practice of the General Duty Nurse." General Duty Nurses Section, American Nurses' Association. New York 16, N.Y.

12. Graffam, Shirley. Care of the Surgical Patient. New York: McGraw-Hill Book Company, Inc., 1960.

13. Gregg, Dorothy. "Anxiety-A Factor in Nursing Care." American Journal of Nursing. 52:11:1363-1365, November, 1952.

14. Hay, Stella J. and Helen C. Anderson. "Are Nurses Meeting Patients' Needs?" American Journal of Nursing. 63:12:96-98, December, 1963.

15. Komorita, Nori I. "Nursing Diagnosis." American Journal of Nursing. 63:12:83-88, December, 1963.

16. Kreuter, Frances Reiter. "What Is Good Nursing Care?" Nursing Outlook. 5:5:302-304, May, 1957.

17. Kron, Thora. Nursing Team Leadership. Philadelphia: W. B. Saunders Company, 1961.

18. Lee, Mary Eugenia. Analysis of the Hospital Nursing Care Given to One Surgical Patient. Unpublished Master's Thesis. The University of Texas, February, 1956.

19. Leib, Eloise. "A Student Looks at the Psychosocial Aspects of Patient Care." Nursing Outlook. 10:12: 799-800, December, 1962.

20. Moroney, James. Surgery for Nurses. Edenburgh: C. and S. Livingstone Ltd., 1959.

21. Orlando, Ida Jean. The Dynamic Nurse-Patient Relationship. New York: G. P. Putnams Sons, 1961.

22. Pearce, Evelyn C. Nurse and Patient. Philadelphia: J. B. Lippincott Company, 1953.

23. Rae, Nancy Mara. "Caring for Patients Following Open Heart Surgery." American Journal of Nursing. 63:11: 77-82, November, 1963.

24. Reiter, Benjamin R. You and Your Operation. New York: The MacMillan Company, 1957.

25. Routhier, Anita M. A Study of One Selected Patient Having Surgery of the Lung. Unpublished Master's Dissertation. The Catholic University of America, June, 1957.

26. Sheahan, Marion. "This I Believe." Nursing Outlook. 11:9:641, September, 1963.

27. Simmons, Leo W. "The Manipulation of Human Resources in Nursing Care." American Journal of Nursing. 51: 7:452-456, July 1951.

28. Smith, Dorothy W. and Claudia D. Gips. Care of the Adult Patient. Philadelphia: J. B. Lippincott Company, 1963.

29. Stafford, Edward and Doris Diller. Surgery and Surgical Nursing. Philadelphia: W. B. Saunders Company, 1958.

30. "The Worried Patient-A Failure of Communication." Scottish Association Report for Mental Health. Nursing Times, January 29, 1960.

31. Thomas, Betty J. The Determination of Psychological Considerations in Nursing a Patient Having Surgery. Unpublished Master's Dissertation. The Catholic University of America. June, 1958.

32. Weaver, Barbara and Elsie L. Williams. "Teaching the Tuberculosis Patient." American Journal of Nursing. 63:12:80-82, December, 1963.

33. Webber, Doris. "The Pre-op Pep Talk Is Still a 'Must." R.N., July, 1963.

34. West, John Petit, Manelva Wylie Keller, and Elizabeth H. Harmon. Nursing Care of the Surgical Patient. New York: The MacMillan Company, 1957.

35. "What People Can Expect of Modern Nursing Service." The National League for Nursing, Inc., 10 Columbus Circle, New York 19, N.Y.

APPENDICES

APPENDIX A

CHECK LIST

TYPE OF OPERATION _____ SEX _____

INSTRUCTION GIVEN	BY WHOM						
TYPE OF ACTIVITY	NO ONE	DR.	R.N.	R.N. OFFERED	S.N.	P.N. N.A.	OTHER, PLEASE STATE
1. surgical prep							
purpose							
2. enema/laxative							
purpose							
3. sleeping pill							
purpose							
4. preop. hypo							
purpose							
5. tubes before OR							
purpose							
6. NPO before OR							
purpose							
7. special care							
purpose							
8. recovery room							
purpose							
9. "stir-ups"							
purpose							

TYPE OF ACTIVITY	NO ONE	DR.	R.N.	R.N. OFFERED	S.N.	P.A. N.A.	OTHER, PLEASE STATE
10. pain after OR							
reason							
11. NPO after OR							
purpose							
12. vital signs							
purpose							
13. oxygen							
purpose							
14. I.V.'s or blood							
purpose							

15. Did you feel anyone knew you were worried? Yes No

Who?

16. Was anything done to relieve your worries? Yes No

By whom?

17. What was done to relieve your worries?

18. Please give any comments you have regarding your preoperative preparation.

APPENDIX B

INTERPRETATION OF THE TOOL

The tool was constructed to determine the knowledge the respondent had of the activities attendent upon his particular surgical intervention. The researcher did not feel awareness of activity would be sufficient indication of knowledge unless it included understanding of the purpose of each activity. The 15, 16, and 17th items on the tool were constructed to determine if the patient was worried and who carried out some activity to relieve these worries. The last question was constructed as a free response attempting to elicit the patient's attitude toward his preoperative preparation.

For example, Mr. X entered the hospital for a femerol endarterectomy. He responded to both parts of items one and two and to the first part of item ten as to having received instruction by the doctor. For all other items he felt he was unprepared or uninstructed. Therefore his percentage of instruction for these items or the check list included:

(1) instruction by the R.N. = 0 percent
(2) instruction by other than R.N. = 18 percent
(3) no instruction = 82 percent

The patient expressed he was not worried and had no comments to make.

Mrs. F. entered the hospital for a Billroth II. She responded to the first part of items one and two as having received instruction by the doctor and to both parts of items four, six, eleven, twelve, thirteen, and fourteen and to the first part of items eight and nine as having received instruction by the nurse. She said she was uninstructed in the remaining items. Therefore her percentage of instruction for these items on the check list included:

(1) instruction by the R.N. = 54 percent
(2) instruction by others than R.N. = 7 percent
(3) no instruction = 39 percent

She stated she had no worries but her comment was,

> I felt so much better after the nurse told me what would be going on.

Mr. M. entered the hospital for a vein ligation. He responded to the first part of the tenth item as having received instruction from the nurse. Items five, thirteen, and fourteen did not apply to this patient and thus were omitted in figuring the percentages. For all other items he felt he was uninstructed. Therefore his percentage of instruction for these items on the check list included:

(1) instruction by the R.N. = 5 percent
(2) instruction by others than R.N. = 0 percent
(3) no instruction = 95 percent

The patient stated he was not worried and had no comments to make.

APPENDIX C

TABULATION OF RAW DATA OF THE FIRST FOURTEEN ITEMS

Thoracic-abdominal operation 38 other operation 42 Male 41 Female 39

Total number of patients 80

INFORMATION GIVEN		BY WHOM						
TYPE		NO ONE	DR.	R.N.	R.N. OFFERED	S.N.	P.N. N.A.	OTHER	TOTAL
1.	surgical prep	50	7	12			6		75
	purpose	48	5	14			8		75
2.	enema/laxative	55	14	8	1		2		80
	purpose	61	6	10	1		2		80
3.	sleeping pill	39	5	31					75
	purpose	42	4	29					75
4.	preop hypo	32	3	41	2				78
	purpose	39	2	35	2				78
5.	tubes before OR	49	9	6					64
	purpose	53	5	6					64
6.	NPO before OR	33	4	12	13		18		80
	purpose	61	2	8	8		1		80
7.	special care	65	1	2					68
	purpose	62	1	5					68
8.	recovery room	63	6	10					79
	purpose	72	3	4					79

INFORMATION GIVEN		BY WHOM						
TYPE		NO ONE	DR.	R.N.	R.N. OFFERED	S.N.	P.N. N.A.	OTHER	TOTAL
9.	"Stir-ups"	71		8	1				80
	purpose	72		7	1				80
10.	pain after OR	58	12	5	3				78
	reason	74		2	2				78
11.	NPO after OR	57	3	19	1				80
	purpose	66	1	12	1				80
12.	vital signs	72	6	2					80
	purpose	77	2	1					80
13.	oxygen	34		2					36
	purpose	35		1					36
14.	I.V.'s or blood	44	5	7	1				57
	purpose	46	4	6	1				57

Typed by Louise B. Woolsey