Family-Centered Care in the Perioperative Area: An International Perspective

Linda Shields, RN

The terms family-centered care and perioperative care are often heard in health care, the first usually in relation to children—though it is beginning to be used with other age groups—and the other in relation to a particular area, the OR and perioperative environment. Family-centered care has not been formally evaluated to see if it really works, though it is commonly used by pediatric health professionals.[1] Perioperative care is care delivered to any patient who is having surgery. This article explains how both models have come about and examines the way the two interact, with the aim of exploring the way family-centered care can be delivered in the perioperative setting.

Family-Centered Care Defined

Family-centered care can be defined as

> *a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients.*[2(p1318)]

The Institute for Family-Centered Care in the United States suggests that family-centered care comprises several elements[3] (Table 1) based on the core concepts of

- dignity and respect;
- information sharing;
- patient and family member participation in care and decision-making; and
- collaboration among caregivers, patients, and family members.[4]

The term *family-centered care* has come to be widely used in pediatrics, though its attainability as a model of care is in question,[5,6] and its effectiveness has never been properly tested.[1]

Historical Background of Family-Centered Care

Until the 1950s, the concept of family-centered care would have induced horror in the minds of pediatric health professionals because parents were seen as a negative factor in the care of hospitalized children.[7] In the 1920s, Sir James Spence, an English pediatrician, was the first to contest the routine exclusion of the parent in the care of hospitalized children, admitting mothers with their infants,[8,9] though these practices were contested by other physicians.[10] In the 1940s, two plastic surgeons in New Zealand admitted mothers with their infants and showed that this did not increase infection rates, which was one of the arguments used for excluding parents.[11,12] Some disagreed with the practice of admitting mothers,

ABSTRACT

- **FAMILY-CENTERED CARE developed after research showed that children were emotionally compromised if separated from their parents during traumatic episodes. Few places within the health care system are more foreign and frightening to a child than the surgical department.**
- **PERIOPERATIVE NURSING evolved as a way to care for patients admitted to the OR for surgery. Family-centered care provides a model for the care of a child within the perioperative environment.**
- **THIS ARTICLE EXAMINES the development of both family-centered care and perioperative nursing from a historical perspective and explains how family-centered care can be applied to perioperative nursing.** *AORN J* **85 (May 2007) 893-902.**

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TABLE 1
Elements of Family-Centered Care[1]

Recognizing the family as a constant in the child's life
Facilitating parent/professional collaboration at all levels of health care
Honoring the racial, ethnic, cultural, and socioeconomic diversity of families
Recognizing family strengths and individuality and respecting different methods of coping
Sharing complete and unbiased information with families on a continuous basis
Encouraging and facilitating family-to-family support and networking
Responding to child and family developmental needs as part of health care practices
Adopting policies and practices that provide families with emotional and financial support
Designing health care that is flexible, culturally competent, and responsive to family needs

1. FAQ. Institute for Family-Centered Care. 2005. Available at: http://www.familycenteredcare.org/faq.html. Accessed March 28, 2007.

going so far as to say that a mother would rather be home caring for her other children than sitting at the side of the bed of a child who would, in normal circumstances, not spend much time with his or her mother at all.[13] This study coined the term the "captive mother."[14p362] Some physicians felt that parents inhibited the recovery of children,[7] but others advocated for parental presence.[15]

Although little empirical research into the topic by nurses was found from this era, many nurses were just as equivocal in their attitudes as their physician colleagues. Some nurses were pleased to have parents stay with their children,[16] others were not convinced that it was in the best interests of the child,[17] and some were hostile toward the idea.[18] Some nurses thought that a parent's presence undermined the relationship between nurse and child.[19] One nurse described ways to ameliorate the emotional trauma in children as a result of separation from their parents, but did not advocate that parents should stay with their children.[20]

Mother-child separation was the force at the heart of the controversy. At that time, it was almost invariably mothers to whom reference was made because mothers were the primary caregivers to children while fathers went out to work. In London during World War II, psychoanalysts Dorothy Burlingham and Anna Freud,[21,22] Sigmund Freud's daughter, studied the effects of separation in nurseries they ran for children who needed long-term care, usually due to the parents' involvement in war work. They found that young children who suffered physical trauma—for example, as a result of being in a house that was bombed—maintained psychological stability if they were with their mothers.

In America, René Spitz, another psychoanalyst, began using the term *hospitalism* to refer to the psychological and growth retardation suffered by infants who were left in the hospital for a long time without their mothers.[23] This institutionalization of the child and its effect on his or her psyche caused the child not to relate to his or her parents in a normal way. A surgeon, David Levy,[24,25] propounded that young children who had undergone surgery suffered less emotional trauma if their mothers accompanied them to the hospital.

Two British men were responsible for inaugurating the substantial changes that occurred in the care of hospitalized children during the next 30 years. Together, John Bowlby, a child psychiatrist and theorist, and James Robertson, a social worker, investigated the results of separation of child and parent. Bowlby described the negative effects of breaking the emotional ties between mother and child at an early age.[26-29] Robertson focused his work on separation of child and parent because of hospital admission[30] and proselytized about the need to allow parents to accompany their children to the hospital.[31,32] In

1959, the British government set up a select committee to examine the way children were treated in children's hospitals. The resulting document, known as the Platt Report,[33] was used by governments, parents' groups, and lobby organizations to bring about changes in pediatric care worldwide.

Models of Pediatric Care

Models of care were developed that took into account the stresses that a child's hospitalization created in a family. Physical safety had been paramount, but nurses realized that when children were sick, they became increasingly dependent on their parents and found strange environments and experiences harder to assimilate. In addition, their language was inadequate to express their feelings. Nurses discerned that parents should be present and that play was an important therapeutic tool. A complete reorientation of the concept of responsibility for the child in the hospital occurred. Previously, the child had been the responsibility of the nurse and physician, but with the new model of care, the parents retained responsibility for the child.[34]

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"Care-by-parent units," in which the parents and family members live in the hospital with the sick child, were first implemented in the United States in the 1960s.[35] The "partnership-in-care" model was devised in the United Kingdom in 1988.[36] Its basic principles are that nursing care for a child in the hospital can be given by the parents with support and education from the nurse, and that family member or parental care can be given by the nurse if family members are absent. The role of family members or parents is to take on everyday care of the child, while the role of the pediatric nurse is to teach; support; and, if necessary, refer the family members to other health care professionals.

Family-centered care developed from such models. In family-centered care, the child is central, but because anything that happens to the child affects all members of his or her family, the care the child receives in relation to his or her illness or medical condition must at all times be planned around the whole family and whoever the members of that family see as an integral part of their family group. This calls for all health professionals who deal with family members to have exceptional communication and negotiation skills and for health service managers to recognize that such a model of care calls for increased staff-to-patient ratios. These requirements are necessary because the "unit" to whom care is delivered is never a single individual.[2]

It is important that all health care is supported by rigorous evidence. To that end, health care practitioners must critically examine family-centered care and how it is delivered. Although nurses can intuitively expect that family-centered care is the best for all, they must question if that is so. A recently published systematic review of family-centered care has shown that despite a very large body of literature on the topic, it has not been effectively evaluated to show whether it really works as a model of care.[1]

A Brief History of Perioperative Nursing

Although it is easy to trace the history of family-centered care, the history of perioperative nursing is much longer and more complex, and a widely recognized definition is more elusive. Operating room nursing developed early, largely influenced by wars. The Crimean War (1853-1856) and the American Civil War (1861-1965) saw the emergence of nurses who assisted with surgery.[37,38] During World War I, technology and machines became the cornerstone of armed conflict, and surgery developed exponentially, as did OR nursing. Similarly rapid advances in knowledge occurred during World War II, the Korean War, the Vietnam War, and in all armed conflicts since then.[39,40] It could be said that the development of surgery and perioperative nursing has in part been a by-product of war.

The term perioperative nursing *emerged in the 1970s and was defined as encompassing engagement with patients from their initial decision to undertake surgery to their final discharge.*

The term *perioperative nursing* seems to have emerged in the 1970s.[41] In 1978, the Association of Operating Room Nurses in the United States defined perioperative nursing as encompassing engagement with the patient from the initial decision to undertake surgery to the final discharge of the patient from the outpatient clinic.[42] By 2007, this had changed little, and the renamed AORN, the Association of periOperative Registered Nurses, stated the following:

> *AORN defines the term "perioperative nursing" as the practice of nursing directed toward patients undergoing operative and other invasive procedures. AORN recognizes the "perioperative nurse" as one who provides, manages, teaches, and/or studies the care of patients undergoing operative or other invasive procedures, in the preoperative, intraoperative, and postoperative phases of the patient's surgical experience. Perioperative nurses work on the surgical front lines, so no one is better qualified or has the capacity to advocate for and ensure patient safety in the surgical setting.*[43]

This definition is very broad, but definitions from other countries are hard to find. *The ACORN Standards for Perioperative Nursing* by the Australian College of Operating Room Nurses contains the following definitions:

> *Perioperative: the period before, during and after an anaesthetic, surgical or other procedure.*
>
> *Perioperative Environment: the service area where the provision of an anaesthetic, surgical or other procedure may be undertaken.*
>
> *Perioperative nurse: A nurse who provides patient care during the perioperative period.*[44(p9)]

The Association for Perioperative Practice in the United Kingdom defines the perioperative environment as "the area utilized immediately before, during and after the performance of a clinical intervention or clinically invasive procedure."[45] Although the American and Australian definitions are for and about nurses, the UK definition is geographic.

The geographic nature of the UK definition is not very surprising when it is examined under the prevailing state of all nursing in the United Kingdom at present. The shortage of nurses and the governmental financial restrictions placed on the National Health Service have led to the emergence of other practitioners, such as "operating department practitioners."[46] These technicians are educated by nurses but do not undergo the extensive training they would need to take on the holistic role of a perioperative nurse. At the same time, UK nurses are being allowed, indeed encouraged, to do herniorrhaphy and varicose vein surgery as a way of reducing waiting lists in the free National Health Service, thus freeing up physicians' time.[47]

Family-Centered Care in the Perioperative Setting

The question remains, "How does family-centered care fit in the perioperative setting?" Surgical departments

usually exist in a hospital or health care facility of some kind, from complicated and extensive suites in large, tertiary referral hospitals, to ambulatory care centers, to ready-made field hospitals in war or natural disaster areas. They are necessarily isolated from the rest of the hospital and from the outside world. They form a world of their own, with unique clothing, vocabulary, norms, and cultural mores. Commonly, perioperative nurses choose to work in the OR because of the differences from other types of clinical practice that such roles afford.

Perioperative nursing and family-centered care are based on the concept of holism, accounting for mental and social factors in addition to symptoms when treating the patient.

Perioperative nursing refers to the role of the nurse, the specialist knowledge needed, and what the nurse does. It relates to the tasks of the surgical procedures, the work, and development and management of care of the patient throughout the surgical experience. Family-centered care, on the other hand, can be implemented in any health care setting and is not necessarily restricted to children. Family-centered care is about the way people relate to each other; the staff members (ie, nurses, physicians, or anyone working in the respective facility); and the child and his or her family members or whoever is believed to be so by each respective family. Both models, however, are based on the concept of holism, which is defined in reference to medicine as "the treating of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease."[45]

Perioperative nursing deals with the whole treatment, needs, and relationships of the person presenting for surgery, and family-centered care deals with the whole family of a child or person admitted to a health service for care. The two models are quite different, but they have an unequivocal link of overarching holism: one relates to the role around the recipient of care (ie, the patient), and the other relates to the interaction between the nurse or other health staff member and the recipient of care (ie, the child and family members).

Some people question whether, in reality, family-centered care in the perioperative area is a "pie in the sky" idea that no health service can afford. Recent cuts in health funding in the United Kingdom has resulted in thousands of nurses losing their jobs[49,50] and the subsequent education of minimally qualified health care assistants, who are much cheaper to employ, to replace them.[51] Such reductions in staff members who understand holistic care—whether perioperative, family-centered, or both—will mean that holism is being lost; consequently, care may become fragmented, with technicians performing aspects of care. Family-centered care is not an easy concept to fully implement, which is why research shows that it is not applied correctly in many places.[3,52] Parents, in particular, might resent being made to do what they perceive to be a nurse's role.[3] If those giving care are not properly educated about the holism integral to family-centered care, it will not work effectively and children may suffer.

Nowhere is family-centered care more important, however, than in the foreign, strange, and frightening environment of the OR. This is important regardless of the country, and family-centered care has been found to be just as relevant in surgical departments in developing countries as in developed countries.[53] Research exists about the anxiety felt by children when they enter the perioperative setting, and often it relates to the various procedures to which they will be subjected.[54,55] It is difficult, however, to find research that examines parents' anxiety levels when their child is undergoing a surgical procedure. Most research about parental anxiety is related to the correlation between parents' and children's anxiety[56,57] or is related to parental presence during anesthetic induction.[58,59]

Family-centered care in Nordic countries. The Nordic countries have successfully implemented a high degree of family-centeredness in their hospitals.[60] A case study of a six-year-old boy encountered in a Swedish surgical department demonstrates the way family-centered care is applied there. The boy, who had had multiple admissions for surgery, wanted an IV rather than a gaseous induction, but the physicians and nurses could not access a vein. Rather than force the boy to have a gaseous induction, the nurses and physicians spent a great deal of time negotiating with him. The remaining children on the list stayed in the wards, and the surgical teams were delayed until the boy was anesthetized. Team members accepted this as good practice, and family members whose children's surgeries were delayed were equally tolerant because they knew that if this happened with their child, the same consideration would be shown. In addition, the father of the boy received highly considerate care. An immigrant family from Eastern Europe, the family had been living in Sweden for six years. As the boy persistently refused the gas mask, the father became agitated and began to speak roughly to him. The nurses and physicians included the father in the negotiations, explaining why they were happy to wait until the boy was ready, and in this way calmed the father, thereby minimizing the child's upset. Eventually, after about two hours, the boy had a successful and stress-free anesthetic induction.

This exemplar is only one case showing how family-centered care can be implemented. It is dependent, however, on several things:

- the cooperation and agreement of all members of the perioperative team,
- the cultural acceptance of the concept of family-centered care, and
- a system that is not profit- and time-driven.

Applying Family-Centered Care

Little literature exists that describes family-centered care in the perioperative setting.[61] The best-known application of a family-centered approach, and the most widely discussed, is parental presence during anesthesia induction. Although this practice has been controversial, it has become widely accepted, and its benefit to children has been confirmed; they are reported to have decreased levels of anxiety.[62] There is conflicting evidence, however, as to its effectiveness in providing protection for a child's emotional status. Some studies give positive results and find that it decreases anxiety in the children,[63] but others have found that premedication is more effective.[64] Parents present during anesthesia induction had increased anxiety compared to parents who were not present for their child's anesthesia induction.[59] This finding should be viewed with caution, however, because anxiety in the parent might be acceptable if the child's anxiety is decreased. Parental anxiety also can be alleviated

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with pre-induction education.[65] It is vital that parents are instructed in what will happen,[66] especially in regard to what their child will look like as he or she passes into unconsciousness and the rapidity of that process.

Family-centered care in the perioperative environment also could include allowing children to choose what to wear when they come to the OR (eg, OR scrubs, hospital pajamas, underwear). Other family-centered care practices may include nurses informing parents who are waiting in a parent's lounge or waiting area about their child's progress during surgery or allowing parents into the postanesthesia care unit to support their child.[67]

Opportunities for Research

Refinement and development of family-centered care principles continues, and these principles have wide acceptance among health care professionals. Although some aspects of family-centered care have been used in the perioperative setting (eg, parental presence during anesthesia induction), no research was found that examines the effectiveness of a holistic approach toward family-centered care in the OR. This is an important topic for study, however. Perioperative pediatric nursing practice would benefit if there were evidence that showed conclusively whether family-centered care makes a difference. After family-centered care has been properly evaluated and tested in a randomized, controlled trial, it can then be applied with confidence in the perioperative arena. Although in some countries such endeavors are at risk because perioperative nursing itself is vulnerable to cuts in health care funding and inadequate levels of education for nurses,[68] it is important that health care practitioners continue to investigate ways to incorporate family-centered care into the perioperative setting. ❖

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Call for Proposals for AORN Congress 2008

The 55th annual AORN Congress will be held in Anaheim, Calif, March 30 to April 3, 2008. The theme of Congress 2008 is "Share Your Passion; Illuminate Our Profession." You may submit a proposal to present an education session by visiting *http://www.aorn.org/education/proposal/call_for.asp*. After you successfully submit a proposal, you will receive an e-mail acknowledging receipt of your submission. The Congress Education Program Planning Committee reviews all proposals.

Proposals for Congress 2008 will be accepted through May 15, 2007. Proposals submitted after May 15, 2007, will be considered for Congress 2009. For questions or more information on speaking at Congress, contact Marisa Tapia, RN, MSN, CNS, perioperative education specialist, at *mtapia@aorn.org* or Connie McDonald, administrative assistant, Center for Perioperative Education, at *cmcdonald@aorn.org*.