Question of the Week #43

Pediatrics

You have recently taken a position as director of a 4-OR freestanding ambulatory surgery center. Your patient population includes a large percentage of pediatric patients being admitted for ENT procedures, primarily tonsillectomies/adenoidectomies and myringotomies. During your first monthly staff meeting, one of your staff nurses, “Carlos” brings up a situation where the parent of a 2-year-old wanted to accompany her child into the OR. The current policy states that parents are not allowed in the OR or Phase I PACU. Carlos doesn’t feel that he was able to adequately explain the rationale behind the policy; the parent was visibly upset, and the child screamed all the way down the hall into the OR. You ask Carlos to review current studies on parental presence in the OR and ask him to bring the results back for next month’s staff meeting.

Who else should be included on the committee to review this policy? What are the benefits and disadvantages to parents accompanying their children into the OR? Provide the evidence-based rationale for your answer to support retaining or revising the current policy.

Response:

The operating room has traditionally been off-limits to the viewing public, the argument being that the surgical team could be distracted by the presence of additional persons, thus compromising patient care. Increased traffic meant an increased risk for infection. Persons unused to the culture of the OR might faint or become disruptive, leaving the hospital open to lawsuits. Much of the resistance to allowing parents or other family members into the OR was based on these anecdotes, not on evidence-based practice. Beginning in 1987, family presence during invasive procedures moved from sacred cow status to published prospective trials, in which the effects of parental presence were compared with the traditional norm of having family members wait outside the procedure room. No objective data supported the routine exclusion of families (Dudley et al, 2009).

Our partners in the emergency department have already done some ground-breaking research in allowing parents to view resuscitative attempts for their children. Although it can be argued that the stress encountered by a parent witnessing the beginning of a planned minor surgical procedure pales in comparison to a full-blown pediatric CODE, some similarities exist. The major concern of both emergency and perioperative teams is the effect the parent will have on the procedure. An emotionally overwrought parent could conceivably interrupt patient care and compromise outcomes. However, multiple studies have found no interference with patient care by family members (Dudley et al, 2009; Kingsnorth et al, 2010). Dudley et al (2009) found that “when family presence is offered in a structured program, there is no significant effect on the efficiency of the trauma resuscitation” (p. 783).

The perioperative experience is unique in that a single event, consistently performed on a majority of pediatric patients, has been identified as producing the most anxiety for a child. The most stressful part of a child’s surgical experience is anesthesia induction (Moynihan, 2007). Logically it makes sense to allow a well-prepared and motivated parent to accompany the child through this period. By being present, parents are able to emotionally support the child and reduce separation anxiety. In addition, parents can be masters at distracting their children, which is perhaps the single most effective strategy in mitigating anxiety (McMurtry et al, 2012). Families most likely to benefit from parental presence are those in which both the child and mother have a calm baseline personality (Burd et al, 2006).
Besides serving as a patient/family satisfier, decreasing preoperative anxiety can have both financial and safety components. Acute manifestations of pre-surgical anxiety can manifest postoperatively in emergence delirium, increased postoperative pain and subsequent increased use of narcotics which can delay discharge, and regressive behaviors, e.g., bedwetting, nightmares, separation and sleep anxiety, and eating disturbances (Burd et al, 2006; Short and Malik, 2009).

The patient in our scenario falls into several high-risk categories for preoperative anxiety, including age (pre-school children are at especially prone to separation anxiety), poor coping skills, and an anxious parent. The literature confirms what every perianesthesia nurse will tell you: there is a strong link between children’s and parents’ anxiety (Chahal et al, 2009; Collins and Everett, 2010). Other risk factors for preoperative anxiety include previous surgery, especially one associated with a negative or painful experience, lack of preoperative education, and parental prediction of uncooperative behavior (Burd et al, 2006; Moynihan, 2007).

Studies have been conducted which measure satisfaction from both the patient and the parent’s perspective. Although parents tend to be more satisfied with patient care when allowed to accompany their child to the OR, the jury is still out on the effect of parental presence on a child’s anxiety (ENA, 2009). Kain’s classic study found that although family members who accompanied their child to the OR were significantly less anxious, parental presence had no additional anxiolytic effect on those children who were medicated with oral Midazolam preoperatively (Moynihan, 2007). A study which measured the anxiety of Hispanic children and parental presence in PACU showed no difference in parent anxiety regardless of whether the parent was in the PACU or the waiting room. Children aged 13-18 demonstrated lower anxiety when their parent was present, while children 9-12 years showed no difference in anxiety regardless of parent placement (Roach et al, 2010). It appears that age and culture may have an influence on both parent and patient responses to parental presence during the surgical experience.

It is worth noting that even though most parents when given the option choose to accompany their child, it should not be assumed that every parent either wants to or should participate in this portion of the child’s care (Coyne and Cowley, 2007). The parent who understands his or her limits in a stressful situation and declines to accompany his or her child should be respectfully supported in that decision. An overly anxious parent who is not a good candidate for accompanying his or her child into the OR should be provided with other options to support the child.

Buy-in from the staff and facility are crucial for the success of this program. A committee dedicated to the development of a parental presence program may include surgeons, anesthesia care providers, perioperative nurses, a child life specialist and an advanced practice perioperative nurse (if available), the director of the perioperative area, the chief of surgery, a social worker, and facility legal representation. Consider the following factors while exploring the feasibility of a parental presence program; the availability of these resources must be considered in the overall plan:

- Degree of physician and staff support. Paice et al (2009) developed an opinion survey for determining staff and surgeon response to parental presence in the OR; although this tool was developed for hospitals in the UK, it could easily be adapted to hospitals in the US.
- Training of a designated “family presence facilitator” to accompany parents and escort them from the room after induction. This person should have no other patient care duties.
- Screening of family members for appropriate behaviors and responses prior to offering the option to accompany the child.
- Preparing the family member for the experience.
• Written guidelines that support uninterrupted, safe patient care.
• Staff education.
• Opportunities for feedback and evaluation as part of an ongoing performance improvement process. Dudley et al (2009) included family and staff questionnaires in their article that measure the success of the experience.

Incorporating a parental presence program is one way to address both parent and patient anxiety during the perioperative experience. Collaboration between and education of family, physicians, and staff are critical components of a successful family-centered surgical experience.

References and resources

The July 2012 AORN Journal has several articles dedicated to this topic.


Kingsnorth, J., O’Connell, K., Guzzetta, C.E., et al. (2010). Family presence during trauma activations and medical resuscitations in a pediatric emergency department: An evidence-based practice project. *Journal of Emergency Nursing, 36*(2), 115-121. Note: this article does a very nice job of describing the implementation of an evidence-based research project


