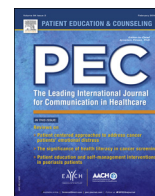




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Preoperative anxiety in ambulatory surgery: The impact of an empathic patient-centered approach on psychological and clinical outcomes

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ABSTRACT

Objective: This study aims to evaluate the influence of an empathic patient-centered approach on preoperative anxiety and surgical outcomes in ambulatory surgery patients.

Methods: A sample of 104 patients undergoing general ambulatory surgery was randomly assigned to the intervention (IG) and the control (CG) groups. Before surgery, the IG received personalized information through an empathic patient-centered interview. The CG received standardized information on surgical procedures. Anxiety was assessed before and after the preoperative interview and after the surgery. Wound healing, post-surgical recovery and satisfaction with the quality of preoperative information were assessed after the surgery.

Results: The two groups were identical at baseline regarding anxiety, socio-demographic and clinical characteristics. After the patient-centered intervention, the IG showed lower levels of preoperative anxiety ($p < 0.001$) and pain ($p < 0.001$), better surgery recovery ($p < 0.01$) and higher levels of daily activity ($p < 0.001$) and of satisfaction with the information received ($p < 0.01$) than the CG. The IG also showed better wound healing (tissue type, $p < 0.01$; local pain, $p < 0.01$).

Conclusion: An empathic patient-centered intervention can reduce preoperative anxiety and increase surgical recovery, wound healing and patient satisfaction.

Practice implications: This approach is applicable in pre-surgical interviews and can potentially be used in the routine care of various surgical contexts.

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1. Introduction

An increasing number of surgical procedures are presently performed in ambulatory surgery, representing 75% of the annual scheduled surgeries. Ambulatory surgery represents a more comfortable and less expensive alternative to conventional surgery, since it can minimize the impact of hospitalization and contribute to patients' early recovery [1,2]. Ambulatory surgery reduces waiting surgical lists, involves the patient and his or her family, and provides an individualized and humanized care, promoting faster postoperative recovery and socio-professional rehabilitation [3]. Despite these advantages and today's technical improvements and increased quality of medical interventions, ambulatory surgery may represent a disturbing moment,

triggering anxiety in patients and their families, not only because of the intervention itself, but also because of fear of the unknown [1–4]. Even if the surgery is minor (requiring only one-day recovery in the hospital), raised anxiety levels are evident and may impact outcomes, which warrants research.

Anxiety is a human response to situations of threat, a psychological reaction to stress factors, with psychological and physiological components. Surgery tends to raise anxiety levels regardless the type of operation. About 80% of adult patients submitting to a surgery report anxiety caused by anticipation of pain, separation from family, loss of independence, fear of surgical procedures and of the anesthesia, the possibility of changes in body image and of death [5,6].

High levels of anxiety have been shown to adversely influence surgical procedures and to be a contributing factor in surgical outcomes [7–10]. Studies addressing the relationship between immune responses and psychological states in inpatient care showed that preoperative anxiety is associated with a slower, more complicated and more painful postoperative recovery [9–12].

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Frequently analyzed outcomes were patients' anxiety, knowledge of what a patient retains from education, satisfaction with the procedure, pain and length of hospital stay. However, retention of patient knowledge from preoperative education and satisfaction were the only positive outcomes influenced by inpatient and outpatient standardized education when no specific communication strategies were applied [7]. In studies performed in ambulatory surgery, some patients reported feeling that nurses were not open to their concerns and a sense of abandonment during the preoperative period [5,6]. Others showed that patients' most common complaints regarding nurses' intervention were insufficient information, inadequate respect and insufficient empathy [13–16].

Many strategies for reducing anxiety have been used in both inpatient and outpatient settings, but only a few have proven successful [5,13–28]. The most effective interventions from the current literature are preoperative interventions using empathy and patient-centered approaches. Though empathy is a complex concept lacking a consensual definition, in clinical practice empathic communication has been viewed as the appreciation of the patient's emotions and expression of that awareness to the patient, leading to the latter feeling understood, respected and validated [29,30]. The patient-centered model includes exploration of the patient's main reason for the visit, concerns, expectations and need for information, emotional needs and life issues, integrating the understanding of the whole person (the patient's world) with the understanding of the disease [31,32]. The objectives of empathic patient-centered approaches are to encourage patients to express their feelings and to provide psychological support and tailored information. Successful interventions also aim to answer patients' questions in a calm, supportive and confident manner within an atmosphere of privacy, care and concern, with a nonjudgmental and respectful attitude [19–23,29–32].

These strategies have reduced the preoperative anxiety of patients in inpatient care. Interventions focused on the evaluation of individual anxiety precipitating factors, and tailored information addressing patients' needs have been associated with a better recovery including lesser need for sedatives and fewer medical and psychological complications [19–23]. Delivery of routine standardized instructions about the surgical procedures helps patients to obtain adequate information and knowledge about the surgical preparation protocol and the surgery. However empathic, patient-centered approaches have been more effective in reducing anxiety levels [5,19–23]. Studies in outpatient settings also conclude that nursing staff can contribute to reduce preoperative anxiety, namely by helping the patient to understand the surgical experience, listening and responding to patients' concerns, giving information about what they will face on the operation day and on the post-surgery period, giving them confidence within a calm environment, and reducing uncertainty by clarifying doubts [5,17–22].

Studies have demonstrated that anxiety is associated with a slower wound healing and a slower and more painful recovery [9–12]. Although research suggests that an empathic patient-centered approach is effective in reducing patients' preoperative anxiety in both inpatient and outpatient care, to the best of our knowledge no research has examined the effects of these interventions on patients' physiological outcomes, namely surgical wound healing.

The aim of this study is to evaluate the effect of a preoperative empathic patient-centered intervention on the preoperative anxiety and post-surgical recovery of patients in ambulatory surgery. This is an increasingly common procedure, but research on the effects of empathic patient-centered approaches in this context is scarce.

2. Methods

2.1. Setting

The study was conducted in a general hospital in Northern Portugal between August 2013 and July 2014.

2.2. Measures

2.2.1. Baseline socio-demographic and clinical data

Sex, age, education, residence, marital status, professional status, previous surgeries, psychiatric history, use of psychotropic drugs and type of anesthesia employed in the surgery were collected from participants' clinical records. Patients' trait anxiety (representing a stable anxiety that is characteristic of an individual, distinct from a state anxiety, which is transient and dependent upon the occurrence of particular events [33–36]) was assessed with the State-Trait Anxiety Inventory Form Y (described in Section 2.2.2). Research on socio-demographic and clinical factors showed that these variables are important anxiety predictors [37]. Regarding the surgery, the American Society of Anesthesiologists' (ASA) criteria were used to assess patients' physical status. These criteria follow an algorithm for the assessment of surgical risk, divided in six categories, from I- healthy person to VI-declared brain-dead person [8]. Ambulatory surgery guidelines [3,4,8] recommend that only patients classified as ASA I–III be accepted for ambulatory surgery. An anesthesiologist routinely performs this evaluation on all the patients and decides the type of anesthesia to be employed, either local (e.g., Monitored Anesthesia Care—MAC) or general anesthesia [8,37].

2.2.2. Outcome measures

Anxiety was assessed with the State-Trait Anxiety Inventory Form Y (STAI-Y). The STAI-Y is a 20-item self-report instrument which includes separate measures of state and trait anxiety. The original STAI was constructed by Spielberger [34] and has been adapted to more than 30 languages for cross-cultural research and clinical practice. Reliability and validity tests have provided sufficient evidence that the STAI-Y is an appropriate and adequate measure for studying anxiety in research and clinical settings. The Portuguese form of the questionnaire [33] was used in the present study. Each subtest ranges from 20 to 80, higher scores indicating greater anxiety. A cut-off point of 39–40 has been suggested for detection of clinically relevant symptoms for the state anxiety scale, with a higher score for older adults. Test–retest reliability coefficients for the Portuguese version range from 0.31 to 0.86, with temporal application intervals ranging from 1 h to 104 days [33,36].

Post-surgical clinical outcomes were collected from patients' clinical records. These data are routinely assessed by nurses one day after the surgery, according to ambulatory surgery guidelines [3,4,8]. They included pain, return to active life, and we used a surgery recovery score obtained from the presence or absence of the remaining aspects: fever, sleep, blood loss, analgesic consumption, nausea/vomiting and need for (further) healthcare resources, all self-reported. In addition, the guidelines include the assessment of patients' satisfaction with the quality of preoperative information delivered by nurses. The surgery recovery score was used as a recovery index ranging from 0 (good recovery) to 6 (poor recovery). Pain, level of activity after surgery and quality of the information received were each evaluated on Likert-type numeric rating scales ranging from 0 (painless, not active, poor quality) to 4 (excruciating pain, normal life activities, excellent quality). Numeric rating scales are self-reported simple and universal instruments with demonstrated validity and sensitivity in studies of pain in Portuguese samples [38].

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