

Preparation of children for elective surgery and hospitalisation: A parental perspective

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Abstract

Parents play a central role in the preparation of their child for hospitalisation and surgery. This research examined the parental perspective on educating their child for an elective admission to hospital for surgery. The study employed a qualitative descriptive design and sampled eight parents from a private hospital in Dublin, Ireland, prior to their child's discharge, after ear, nose and throat surgery. A thematic analysis revealed four themes: how parents educate themselves about surgery and hospital, factors influencing parent's decisions on the quantity of information to share, sources of education about hospitalisation and aspects of hospitalisation not discussed by parents. Findings indicated that although the internet was used as a general source of information, parents relied more on information provided by the hospital. Parents used their child's age, individual needs and level of autonomy to determine what information to communicate. Specific areas that parents found difficult to communicate included pain and fasting. This research highlights the need for hospitals to invest and support the delivery of parental education for children prior to surgery. Clarification of the children's nurses' role in the development, implementation and evaluation of education programmes that support education delivery in the home by parents is also warranted.

Keywords

Child health, education, family, nursing, perioperative nursing

Background

Advances in paediatric surgery and anaesthesia have facilitated the development of paediatric surgical services, resulting in increased numbers of day cases and elective overnight admissions

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(Bowen and Thomas, 2016). These surgical services operate within high-pressure environments that are unfamiliar to parents and their children who require surgery (Bowen and Thomas, 2016).

Familiarisation with the hospital environment and relevant equipment, including explanations of procedures, reduces anxiety for both parent and child relieving the stress of an already stressful environment (Healy, 2013). Education is an essential requirement for children undergoing elective procedures in hospitals (Healy, 2013). Parent(s) play a central role in the education of their child and are commonly the child's main source of practical and contextual information about the hospital environment and their safety (Sadegh Tabrizi et al., 2015). Literature has indicated that parents tend to self-educate using a wide range of online information when preparing their child for hospital (Pehora et al., 2015; Sebelefsky et al., 2016). Reasons for this include the availability of a variety of healthcare information, seeking answers to questions and processing the information in the comfort of their own home (Lee et al., 2015). Lamberton et al. (2016) state that the appeal of anonymity is one of the main reasons why parents seek online healthcare information prior to talking with a healthcare professional. In addition, stigma and judgement caused by parental lack of knowledge is immediately eliminated (Walsh et al., 2015). Despite these perceived advantages, over-diagnosis and scare-mongering are common themes when accessing the internet for healthcare information (Shroff et al., 2017). Reliability of online information has been found to be highly variable (Pehora et al., 2015), yet parents have viewed health information websites as trustworthy and up to date (Ballonoff Suleiman et al., 2016).

Literature showcases that current practices of perioperative education by nurses commonly commence on the day of admission (Derieg, 2016). However, Kelo et al. (2013a) noted that parental experience of shock, at the onset of education, can lead to parents feeling overwhelmed and reduces their ability to support the needs of their child, including the need to educate them. Best practice indicates that families should be contacted prior to surgery to receive education in a timely manner (Delaney et al., 2015). Parents have identified that acquiring information at least 1 week before admission gave sufficient time to comprehend the information and use it effectively to prepare themselves and their child (Healy, 2013).

This study is therefore timely as it explores the central role of parents as educators of their child for hospitalisation and surgery and the roles of healthcare professionals within this process.

Aim and objectives

To examine how parents prepare their children for an elective admission to hospital for surgery. Objectives were to:

1. Explore the type and quantity of information provided by parents to their children.
2. Describe the resources and tools used by parents to self-educate.
3. Examine the degree in which parents rely on hospital provided materials.
4. Identify appropriate educational mediums that could be used by healthcare professional to assist parents in educating their child outside of the hospital setting.

Methods

A qualitative descriptive research design, based on the philosophical tenets of naturalistic inquiry, was implemented (Lincoln and Guba, 1985; Sandelowski, 2000; Willis et al., 2016). This

methodology recognises varied, shared experiences and the inseparable nature of human interactions; thus, it provides rich details of the human experience (Kim et al., 2017; Sandelowski, 2010).

The study setting was an urban, 180-bed, adult, private, teaching hospital, with paediatric facilities, in the Republic of Ireland. Ethical approval was granted by research ethics committees in the University (REC17010) and Hospital (BEA0088) in January 2018. Consent to access parents from a weekly ear, nose and throat (ENT) surgical list was granted by central stakeholders including Director of Nursing, Clinical Operations Manager for Paediatric services and the ENT surgeon for children.

Non-probability, purposive sampling facilitated the selection of individuals that were knowledgeable or experienced in the area being researched (Palinkas et al., 2015; Polit and Beck, 2013). Parents of children aged 4 and 10 years, where the child had no previous experience of surgery, scheduled for ENT surgery between February and March 2018, were selected. This age range ensured that the parent was the central educator of their child about surgery prior to hospitalisation. All parents received an explanation about the study from the ENT surgeon, a story booklet illustrating the patient journey, written consent form and participant information sheet 2 weeks prior to surgery. Hospital admissions telephoned parents a week prior to surgery to ascertain parental interest in the study. All eight, verbally consented and written consent was collected by the researcher on admission to hospital. Data collection methods included collection of socio-demographic data and parental, semi-structured interviews, of 10–15 min duration, on the day of discharge. Interviews were recorded and conducted in a secure and private room in the hospital.

As identified by Holloway and Gavin (2016), semi-structured interviews and a topic guide allowed the researcher to address a line of topics, or broad questions, while facilitating the individual to speak freely regarding the research topic (see [Supplementary Material](#)). Criteria to ensure trustworthiness by Lincoln and Guba (1985) included credibility, transferability, dependability and confirmability. Credibility and transferability were ensured via detailed description, and oversight by an experienced researcher, of all aspects of the study including data analysis and findings. There was no relationship or contact between the nurse researcher and the parents prior to interview. Dependability and confirmability entailed completion of a reflective journal, audio-recording of interviews and the capture of rich quotes from participants. A restrictive time frame prevented implementation of extensive strategies, including member checking, which is a limitation of this study.

Data analysis

Eight interviews were transcribed verbatim and analysed using a six-phased thematic analysis for effective data interpretation (Clarke and Braun, 2016) supported by the application of NVivo software (QSR International NVivo version 12). Thematic analysis included data familiarisation, generation of initial codes, searching for themes, reviewing potential themes, defining and naming themes and writing the report. These discrete phases were not linear requiring the researcher to move back and forth within the data (Clarke and Braun, 2016).

Findings

Socio-demographic data from the sample of eight parents are presented in [Table 1](#).

Interview data revealed four central themes; how parents educate themselves prior to talking to their children, factors influencing parent's decisions on the quantity of information to share, sources

Table 1. Socio-demographic profile of the sample.

Familial relationship	
Mother	8 (100%)
Father	0 (0%)
Nationality of parent	
Irish	7 (87.5%)
European	1 (12.5%)
Age of the child	
4–6 years	5 (62.5%)
7–10 years	3 (37.5%)
Parental experience of surgery relating to their children	
Another daughter or son underwent surgery	2 (25%)
No experience of their other children undergoing surgery	6 (75%)

of education (in addition to parents) about hospitalisation and surgery and aspects of hospitalisation not discussed by parents.

How parents educate themselves prior to talking to their children

Parents indicated that they informed themselves about the impending surgery using online resources and written, but not online, information from the hospital prior to talking to their child. The internet played a key role in education within the home and family unit with most parents ($n = 5$) reporting that they did a general search using ‘Google’ to supplement their knowledge but could not recall the specific websites.

“suppose it’s just ... a go to source of information. I wouldn’t have really known where else to get medical information, like in a book or ... where to go for that” (Parent 3)

Parents did not state that they searched the hospital website for information. Parental searches on the internet primarily focused on the child’s surgical procedure or common healthcare interventions such as recording blood pressure or intravenous cannulation rather than the perioperative journey.

Parents did express an awareness of the disadvantages of blindly searching the internet with some identifying that online information may create fear and undue anxiety for parents which may adversely influence the child’s anxiety.

“I didn’t want to look up other people’s websites just in case you’d see stuff and you’d get a fright. Maybe there is stuff up on your website, if the consultant had said to look it up I would have looked it up to see what was on it [sic].” (Parent 5)

“So, I got to the stage, anxiety would have got to me, and [sic] fed into him, so I sort of said, we will know the basics and we will just sort of trust the doctors and nurses.” (Parent 6)

The above excerpt illustrates a willingness to access information from the hospital website, if directed to do so, and also showcases parental belief and trust in the information they received directly from healthcare professionals.

Most parents educated their children using a story booklet provided by the hospital rather than a hospital information sheet. This booklet detailed two children's journeys through a perioperative environment. Five out of eight parents stated that they had read the booklet with their children at home and cited it as a valuable resource.

"She read it at night time before she went to bed. And then, if she had any questions [sic] we answered them so she was well prepared." (Parent 8)

Parent's noted that the familiarity of the book improved the hospital experience for the children, with the children looking forward to meeting the central character, 'Lilly'.

"So, it was quite relevant and he has never been to hospital before. So, it just makes it a bit more familiar And he'd see posters around, so he'd see Lilly and say "there she is" and "when am I going to see her"." (Parent 3)

Three parents did not use the booklet for education, with one parent stating that they had read it but did not want to tell their child too much information, while another parent called into question the booklets transferability among different age groups. Another parent cited that the story book was unnecessary because her child had already been told the relevant information by her sister, who had previous hospital experience.

Factors influencing the quantity of information to share

Although many factors influenced parent's decisions on the quantity of information to share with their child, three were of significance: age appropriateness, tailoring information to meet the child's individual needs and facilitation of autonomy for the child.

During the interviews, parents mentioned their child's age as one of the key criteria when deciding the quantity of information to share.

"And she tends to ask so many questions, I didn't want to tell her too much either. She was happy with that much information... That was enough for her at her age." (Parent 7)

One parent, who had previously withheld information from another sibling facing surgery, considering them to be too young, revised her position believing that more information may have eased the child's anxiety.

"He was about the same age, maybe just turned 5. He was a lot more upset. I probably didn't give him as much information the first time round and he was a lot more confused by it... it was probably better to have just told him more." (Parent 4)

Parental decisions on the level of information to share were also influenced by their child's perceived temperament or disposition. Parents who perceived that their child's anxiety would be lessened by providing detailed information gave it.

"He asked questions from the get go. He wanted to know everything. But he is very like that anyway. And he deals with things a lot better if he knows everything." (Parent 9)

Some parents chose to be more selective when sharing information with their child, tailoring it to suit the specific individual needs of their child.

"I guess you know she is a very detailed child. She likes a lot of information so I purposefully avoided the whole mention of an operation or anything." (Parent 1)

In contrast, children who were viewed by parents as being more capable of managing their informational needs led the process of education and the parent assumed a supportive rather than an instructive role:

"we got a leaflet or two in the post, and my son read it himself and he asked me then if he needed to. I sort of just gave him the leaflet and let him read it, rather than saying this is going to happen." (Parent 6)

Sources of education, in addition to parents, about hospitalisation and surgery

While parents were the main source of education about the upcoming hospital experience for the child, they also identified additional informational sources including the physician (consultant) and the child's siblings. Education of the child as an outpatient by the consultant appeared to be a catalyst for conversation at home about the child's upcoming surgery.

"He showed her the grommets and everything and so she ...understood what we were doing and ... because she has been sick recently and had pain in her throat and ears, it was very easy to explain ... why we were coming into the hospital." (Parent 7)

Parents appreciated the hospital staff talking directly to their children and encouraging questions rather than passively observing information being given to their parents.

"... speaking to the child ...as a person... He was the one asking the questions ... the doctor and surgeons were talking directly to him. ... So that was great." (Parent 6)

Parents reported that it was not uncommon for them to receive feedback from family members or friends on an upcoming hospital stay and stated that having personal experience of hospitalisation was better than learning through leaflets or websites. Parents also utilised siblings with previous experience of hospitalisation, to give information to their sibling about what to expect, including medical equipment such as intravenous cannulation, or 'Freddies' as they are commonly known in Irish paediatric hospitals.

"... his brother sat down and told him all the stuff as well and that he was going to get ice-cream. ... even having his older brother ... saying "Freddie is in your hand and you know you don't touch it, ... ". So he was able ... to make him aware of it as well." (Parent 4)

Generally, parents indicated that they spoke to their child about intravenous cannulation, recognising it was a key component of a child's hospital experience. They were also prompted to do so by the hospital booklet. One parent acknowledged that the cannula would be the main stressor for her child hence she prepared her child by discussing the feeling of having a cannula in the child's hand.

"No I just kept pretending to give her a needle to show her that she wouldn't feel any pain. Just with my hands. I just kept sticking my finger down and pointing and showing her the pressure of what she would feel...." (Parent 7)

One parent also noted that her child would be an educator to a friend in class when her child was back in school.

"A friend in her class has chronic tonsils and he won't get them out, he is so scared. So she said she will tell him now." (Parent 5)

Aspects of hospitalisation not discussed by parents with children

Post-operative pain is an expected consequence of surgery; however, parents did not always educate their child about this. Reasons differed as to why this important information was withheld by the parents with the most common being lack of knowledge about potential post-operative pain.

"I suppose I properly didn't tell him that he would be maybe sore or confused or anything when he woke up. I suppose I didn't know the pain afterwards." (Parent 4)

Another parent found it difficult to convey the idea that their child's treatment might increase pain in the short term, while also reducing pain in the long term, and opted instead not to explain it to the child pre-operatively.

"I didn't want to tell her the details about that at all so I said they would put things into her ears so her ears wouldn't be sore in the future. It was hard to explain her throat to her because I said her throat would be a little bit sore for a while so in a way I think that really confused her" (Parent 7)

Fasting from food and fluids was another aspect of surgery that parents indicated was distressing and a difficult topic to communicate.

"that he will be, not starving, but he will be very upset because of not eating all day or not drinking. ... because they are small and they don't understand that they have to fast." (Parent 1)

Parental statements illustrated that they did not have full knowledge of the perioperative journey as some parents expected that their child would proceed straight to theatre on arrival and were unaware that perioperative delays might occur.

"kids should maybe be in the morning because they fast during the night, they can just come straight in in the morning and it's done." (Parent 2)

Discussion

Findings clearly identify how parents prepare their child for hospitalisation and surgery using a variety of mediums demonstrating achievement of the aim of the study. Parents were noted to commonly report use of the internet, and the search engine Google, to access information about the child's surgery yet were unable to recall specific websites. These findings are consistent with the

literature, which identifies that parents commonly use the internet to source healthcare information (Pehora et al., 2015; Sebelesky et al., 2016) but have difficulty recalling specific websites used to gather information (Shroff et al., 2017). Parents, in this study, identified that online information could cause undue anxiety for themselves and their child and thus exercised caution when accessing online information. This finding conflicts with literature suggesting that parents trust and accept the majority of information obtained online (Pehora et al., 2015; Shroff et al., 2017).

Parental accounts did not explain how they evaluated the quality of online information and how it was deciphered and consolidated for communication to their child. An evaluation of how parents make judgements about the quality of online health information (Ballonoff Suleiman et al., 2016) is important to ensure the provision of accurate age-appropriate information to the child pre-operatively. A finding that the majority of parents did not access the hospital website for information is a concern, given that hospital websites should be the authority on educational information for patients (Huerta et al., 2016). It highlights the need to explore parental use of hospital websites and to educate parents in finding reputable and accurate online information sources.

Sharing of information and inclusion in the educational process of parents and children by healthcare professionals in advance of surgery has been noted to significantly reduce parental and child anxiety levels (Capurso and Ragni, 2016). In this study, pre-operative education of the parents and the child was conducted during the initial consultation with the primary treating physician, a finding which may have arisen because the role of this physician supersedes those of other healthcare professionals in private hospitals. Resources used included an information sheet about their child's operation along with a story booklet to educate the child. Findings indicated these resources were used by parents up to 4 weeks prior to surgery, with most using the story booklet to educate their child. This finding is substantiated by literature that indicates that written informational resources, provided at least 1 week prior to surgery, are beneficial, as it allows the child and parent time to absorb and understand its content (Tsao et al., 2017). Factors used by parents to determine the type and quantity of information for their child about hospitalisation and surgery included the child's age, temperament, and/or personality, perceived individual needs and facilitation of autonomy, and these are consistent with the factors recommended for pre-operative preparation of children (Capurso and Ragni, 2016). Most parents stated, within this study, that their children were less anxious about coming into hospital and excited to meet the characters seen in the story book. A parent who chose not to use the story booklet, to avoid increasing anxiety, later reflected that withholding this information increased anxiety levels for their child on the day of their hospital visit. An increase in anxiety in children has been shown to result in a number of negative post-operative outcomes including increased post-operative recovery time, decreased control of pain as well as impacting on their ability to cope with future hospital interactions (Al-Yateem et al., 2016).

Support for the autonomy of the child was evident in this study in the parental accounts of their children showing the nurse where to apply their name bands or oxygen saturation finger probe, as per the child in the story book. Use of story books is lauded as promoting the child's autonomy (Nilsson et al., 2016) which in turn increases the child's sense of self control thus reducing the child's anxiety (Tunney and Boore, 2013). Arguably their use also provides evidence that some parents foregrounded the voice of the child which is viewed as beneficial in child orientated healthcare (Ford et al., 2018; Health Service Executive, 2015; Schalkers et al., 2015). While the story booklet was a valued resource amongst participants, one parent observed that the booklet was limited to certain age groups and did not meet the educational requirements for their ten-year-old son.

Parents clearly identified that they were not the only source of education and information for their child about the hospital visit and surgery. They viewed the child's physician as the primary educator

of the child and parent rather than other healthcare professionals including the children's nurse. As previously noted, this finding may differ significantly from practices within non-private hospitals; however, a paucity of literature and research in this area precludes a definitive conclusion. Invisibility of the role of the children's nurse as educator is unusual given its emphasis within education programmes for nurses (Ball et al., 2019). A possible explanation for its lack of prominence may lay within the promotion of family-centred care (FCC) that endorses a partnership between the nurse and the family, to provide the best care for the child (Ball et al., 2019). With widespread implementation of family-centred care as the model of choice for children's nursing, there has been a fundamental shift of the roles of both nurse and parent in the care of the child (Al-Motlaq et al., 2018). Parents are relied upon to deliver nursing care for the child, while nurse's role becomes more restricted (Coyne, 2013). With this increased reliance on parents, nurses relinquish the role of educator (Coyne, 2013). As such, Coyne et al. (2016) advocates a shift from FCC towards a more child-centred approach to avoid the pitfall of children being relegated to a non-participant status, with education directed towards the child and not directly to the parent.

Kelo et al. (2013b) suggest that children's nurses are not seen as educators within the family unit because they possess no official training on how to evaluate education needs of their patients and to effectively teach. Children's nurses are noted to have varying levels of experience from practice, but without formal training in the practice of education, nurses in general are left unaware of the impact of their teaching habits on the learner (Peter et al., 2015), both parent and child.

Some parents, in this study, also involved siblings in the provision of information about surgery and hospitalisation. Discussions took place between the child and their older siblings about the practicalities of being a patient in hospital, from a child's perspective. Siblings are an important factor in a child's life as they can have direct effects on one another's development (McHale et al., 2012). Older siblings are generally eager to disseminate teaching and guidance to their younger siblings; however, this information tends to be procedural in nature rather than conceptual (Howe et al., 2015). In healthcare settings, this suggests that most knowledge transfer between siblings is likely to be practical in nature, describing events and nursing interventions factually rather than describing the broader context of why these interventions may be happening (Howe et al., 2015). This can provide children with valuable but incomplete knowledge of their pending hospital experience. These observations are important to note particularly if parents choose to rely on siblings to teach their children about their healthcare experience. The role of the sibling as educator requires further research to assess its function and impact within paediatric healthcare.

Lastly, aspects of hospitalisation and surgery not always discussed by parents with children included pain and fasting. Pain was one of the most difficult aspects of their child's perioperative journey for parents to discuss reasons for which included not knowing that their child might experience post-operative pain and uncertainty about how to best explain it. The story book, while greatly valued as a resource, does not mention pain despite the fact that pain has long been established as the fifth vital sign in healthcare (Ball et al., 2019). The importance and impact of poorly managed pain, and its subsequent effects, have been well documented (Al-Yateem and Rossiter, 2017). In addition, a recent study, conducted in a paediatric emergency room, acknowledged the benefits of talking to children about painful procedures in advance of carrying them out (Short et al., 2017). Fasting was also repeatedly addressed by parents within the interviews who highlighted its distressing nature for their child. This parental view resulted in some parents not discussing fasting with their child although it is clearly mentioned in the story booklet.

Literature for children's nurses contends that all aspects of surgery and hospitalisation should be explained to the child and parent, including fasting (Delaney et al., 2015; Sadegh Tabrizi et al., 2015),

yet there is a paucity of research exploring the effects on the child when not educated about fasting by parents. Healthcare professionals should educate parents about the importance of explaining fasting and post-operative pain to the child while ensuring that educational hospital resources address this area.

Limitations

This study was undertaken in a private hospital with children undergoing ENT surgery. Future studies should incorporate both public and private hospitals to avoid sampling bias ensuring a representative sample of parents from diverse backgrounds and children with other conditions or more complex or long-term needs. In addition, the time constraints of the study resulted in the inclusion of a small sample size, eight parents, and precluded the completion of data saturation within the study. However, a high participation rate of 100% is considered a high response rate for a qualitative descriptive design and suggests no selection bias.

Sample selection involved speaking to parents, who could accurately relay their own perceptions and their child's experiences. Parental interviews after the fact may predispose to recall bias. In addition, speaking directly to children could have provided information that parents were unaware of and would have incorporated the child's perspective in the study.

Implications for practice

Findings of this study give rise to important implications for practice, education and research. The role of the children's nurse as a primary educator for children requiring hospitalisation and surgery, and their parents, should be prioritised and researched within practice to determine how the role is viewed and operationalised for children and families. Inclusion of the nurse in an annual review of educational hospital resources, and at key junctures in the child and family's journey in hospital, facilitates education of parents about relevant, up-to-date, cognitively appropriate, online and written educational resources. Education should address why, what, how and who should educate the child on all aspects of post-operative care, including pain and fasting, to improve the child and family's experience in hospital. Role of the sibling in pre-operative education of their sibling warrants further research to clearly delineate this role which has not been previously described.

Conclusion

This research highlights the need for hospitals to invest in education in the home for parents and children prior to surgery, including hospital-based web resources and age-appropriate educational guides. Difficult aspects of the pre-, peri- and post-operative journey need to be explored with the child and parent, by the healthcare professional, to ensure that timely and accurate information is given by the parent to the child. Clarification of the role of healthcare professionals, in particular that of the children's nurse, will facilitate clarity of roles in the development, implementation and evaluation of education programmes that support the parent to effectively deliver education to children in the home.

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Supplemental material

Supplemental material for this article is available online.

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