

Qualitative analysis of preoperative assessment practices in elective surgery at Kenyatta and Mater Hospitals in Kenya

*Lilian Adhiambo Omondi

(PhD Student, UoN, MScN, UoN, BScN, UoN, ORN, KNH, RN)
Lecturer, School of Nursing, College of Health sciences, University of Nairobi
Contacts Tel: 2726300 Ext. 43673 or 254720861317 (mobile)
Email address: laomondi@uonbi.ac.ke

Co authors

Prof. Mary Wangari Kuria

(PhD, Psychiatry, UoN, M.Med Psych UoN, M.BChB. UoN).
Associate Professor - Department of Psychiatry, College of Health sciences, University of Nairobi.
Contacts: Tel: 254722755681 (mobile)
Email: mkuria@uonbi.ac.ke

Dr. Peter Wanzala

(PhD, Epidemiology, MPH, BDS, UoN)
Research Scientist, Centre for Public Health Research, Kenya Medical Research Institute (KEMRI).
Contacts: Tel: 254721624374 (mobile)
Email: wanzap2003@yahoo.com

*Corresponding Author

This publication is part of PhD thesis of University of Nairobi ethical permit Ref. **KNH/UON ERC-P396/11/2010**

Abstract

Preoperative patient assessment practice has been reported to vary with institutions and individual perioperative nurses.

Aim: *To evaluate preoperative assessment practices in two selected hospitals.*

Methodology

Design: *Qualitative design*

Study areas: *A public and a private hospital.*

Target population: *Theatre in-charges*

Sampling method: *Purposive*

Method: *Key informant interviews*

Study tools: *An interview guide*

Data analysis: *Content analysis of qualitative data. Data presentation was in themes, subthemes and narratives.*

Results: *Preoperative assessment practice was reported to be consistent in the private setting unlike the public setting.* **Discussion:** *Although*

the private setting conducted preoperative assessment, some omissions in key areas of focus pertinent to perioperative nursing were eminent. The public hospital was constrained from practicing by the theatre overwhelming workload and shortage of perioperative nursing staffs.

Conclusion: *Preoperative assessment practice imperative for quality surgical care is dwindling among perioperative nurses. Hence, strategies need to be put in place to enhance quality.*

Recommendation: *The study recommends facilitation of the assessment practice by providing enabling environment and use a tool as a guide to the assessment.*

Key words –elective surgery; preoperative assessment practice; preoperative assessment



tool; perioperative nurses; perioperative nursing.

Introduction

The study is part of Doctor of Philosophy (PhD) study titled determining influence of preoperative nursing assessment on patients' surgical outcomes and anxiety. Not much consideration has been given to preoperative nursing assessments where the study was conducted. To underpin the dwindling nursing assessment practice, key informant interviews with the theatre in-charges of the two selected study hospitals were conducted to assess the existing practices.

Methodology and tools

The interview guide was formulated from best practices (NATN, 1996). The two face to face interviews with the theatre in-charges were conducted independently and tape recorded. The interviews commenced with introduction and review of the participation consent. The hand-held voice recorder was turned on when the interviewees reported readiness to begin the sessions. The interviewer logically asked open ended questions and listened keenly to the interviewees' responses. The interviewer probed areas that needed clarification by either paraphrasing the statements as explained or by simply requesting for elaboration. Non-verbal communication was noted and recorded. Towards completion of the interviews, closing questions were poised to provide interviewees with opportunities for additional information, comments and or recommendations. In summary the interviewer made a quick review of the major points discussed and sought affirmation. The interviews took about 30 minutes each. The interviewees were thanked for participating. All ethical principles were observed.

The tape recorded data was transcribed and replayed severally for accuracy. Content analysis of the data into themes and subthemes was done with the help of an independent social scientist as an intercoder. Theme comparison was done and some themes merged while some further subdivided into subthemes after careful scrutiny. Data was analyzed manually because relying on computed may have yielded results that are flat and oversimplified (Becker, 1993) due the quantity of the qualitative data. Data was presented themes, subthemes and narratives.

Results

The information gathered from the key informants included their demographic characteristics and preoperative patient assessment practices. The respondents were aged between 40 – 50 years old. One represented a public setting while the other, private. One of the respondents was trained in perioperative nursing while the other was not but had exposure through experience and related short courses.

The theatre in-charges were probed on how preoperative assessment should be done in their institutions and their responses summarized in Table 1.

Table 1: How preoperative patient assessment is done.

Main responses
<i>Theme :nursing practice;</i>
In one setting, the nurses on night duty visit the patients in the wards the night before surgery. If theatre is busy, the nurses extract information from the patients file as patients are not to be visited after 10pm.
In another setting the severe shortage of nursing staff did not permit ward visits to conduct the assessment, however, patients were seen at theatre



receiving area.

Theme: *Reasons for Assessment: Subtheme: nurses:*
 Nurses conduct the assessment to alleviate patients' anxiety and to provide health education e.g. reinforcing post operative care and ensuring timely availability of recourses e.g. right prosthesis.

Theme: *assessment procedure*

Subtheme: *nurses:*

"Patients' files are checked to rule out comorbidities and deranged physiological parameters".

Theme: *patient needs assessment: subthemes:*

1. *Physiological needs;* "Patients' files are checked to rule out comorbidities and deranged parameters".

2. *Physical needs;* Patients' preparation are verified through direct enquiry from the patient or by reading the patients' file

3. *Physiological needs;* informed consent is established by asking patients about their acceptance to undergo surgery and if they have been reviewed by the surgeon and the anaesthesiologists.

4. *Spiritual need;* In one setting, it was reported that the hospital provides chaplaincy services

The study established that preoperative patient assessment through ward visits was constantly practiced in one of the study settings and not in the other. The setting where assessment was not practiced reported shortage of nursing staff and being overwhelmed with work as impediments to practice.

The assessment is not practicable... what the theatre nurses are doing is seeing patients in the receiving area... leaving theatre to go visiting patients in the wards is a challenge. Nurses are two in the theatre and there are many operations to be done, so there is no time to go and do preoperative visits (interviewee No. 2).

Participant No. 2 sentiments are congruent with that of Torrance & Serginson (1997). Although the assessment was practiced in one of

the settings, the policy on the practice needed to entrench with holistic and patients' focus approach. (Takahashi & Bever, 1989; NATN, 1996).

Assessment is usually done by nurses on night duty through preoperative ward visits. In the event of them being busy, our policies allow them to send for the patients' files because we are not supposed to wake up patients after 10pm. We usually pick the files and look at them to get at least the basic information we want, (Interviewee No. 1).

Otherwise during the ward visits

The nurse talks to the patients, takes patients' notes and writes a summary report while confirming the right patient for the right procedure. The nurses establish if the patients have comorbidities, if the investigations were deranged and if patients have given informed consents. While doing that they also check whether the patients have been reviewed by the surgeons and the anaesthesiologists and if there are ordered instructions (interviewee No. 1).

Internalizing Interviewee No. 1's statement, conducting the assessment appears more task oriented than patients' raising the question what informs the development of perioperative nursing care plans which are templates for nursing interventions? On the other hand, written operation schedules commonly referred to as theatre lists bear hardly enough information to plan care if used on its own (Pudner, 2005) without the assessment. Needless to say that those patients' psychological emotions, spiritual needs cannot be obtained from the files.

Furthermore, physically seeing the patients helps with the selection of theatre instrumentations.

Upon enquiry on how other nurses get to know the assessment information, the interviews revealed that:

The other nurses get to know about the patients' assessment through shift handing over report and through documentation written in an official theatre record book, (Interviewee No. 1).

The researcher foresees information gap that could culminate into patient care fragmentation (Smelter and Bare, 2006) because critical information regarding assessment data remains in the theatre register and not the in patients' file. Worse still is that the assessment data cannot be easily and readily retrieved for future nursing audits.

We shred the books for handing over and messages after three years but theatre registers bearing patients details remain for about five years, (interviewee No.1).

The theatre in-charges were also probed on how they ensure preoperative assessment is effective. Table 2 summarizes their responses.

Table 2: How to ensure effective preoperative patient assessment.

Main response

Theme: Frameworks:

Subthemes tools/models:

The nursing tools used to guide the assessment are preoperative checklist and World health Organization (WHO) safety Checks

Subtheme: policies; Patients are evaluated by the surgeon and anesthetists at the clinics which could be private or in the wards. One hospital reported that nurses are allowed to pick files from the wards to verify patients' preparation when unable to do ward visits. For patients undergoing major surgeries and those involving limb loss, the hospital employed chancellors to address patients' psychological and emotional needs

Theme: assessment data usage:

The data obtained from the assessment was used to plan and execute patient care.

Theme: benefit of the assessment: subtheme;

Institution; Enhances surgical proficiency, patient safety and maximizes utilization of theatre space.

Patient; Allay anxiety and address psychological trauma and grieve experienced during major surgeries and anticipated organ/limb loss respectively.

Nurses: Facilitates patients' care and fulfils duty obligations

Theme: recommendations:

There was need to formulate a tool specific perioperative nursing tool to enhance focused assessment practices and; need to improve nursing staffing in theatre to facilitate the assessment practice.

The study revealed that there were no existing assessment frameworks in the study settings. However, it was reported that World health Organization (WHO) safety checks tools and preoperative checklists were being used as guides raising the question were these tools designed for preoperative assessment? The answer is certainly no because the tools were meant for patients' safety checks. The interviews revealed that the existing institutional policies support the



assessment practices. However, the policies need to be better informed.

There is a policy that all patients requiring surgery must be seen by the surgeon, anaesthesiologists and theatre nurses 24 hours before surgery. The surgeons' see these patients in the wards or clinics and are the ones who plan the surgeries. Usually the anaesthesiologists do not work in theatre throughout and can afford some time to review patients in the wards. Theatre Nurses work day in, day out and are expected to work but because they are just two in every theatre instead of three, and surgery cannot go be done by one nurse alone, the nurses are constrained (interviewee No. 2).

The benefits of preoperative assessment (Phillips, 2004; Smelter & Bare, 2000; Rothrock & McEwen, 2007) cannot be underated.

Preoperative assessment allays anxiety. Many patients become happy to an extent of smiling when they find the theatre nurses who visited them in the ward are the ones receiving them in theatre.

The assessments also help nurses plan perioperative patient care as well as order appropriate surgical requirements e.g., it might have been said that the procedure is just an excision of a lump on the patient's back and as the theatre nurse, you could easily set the usual mini-laporotomy set. However, upon physically seeing the patient and the size of the lump, you may realize that you need a general set instead. (Interviewee No.1).

To the patient...the anxiety is reduced because the nurse will use the information that the doctor and the anaesthesiologists have written to prepare the patients and there will be no delays in theatre (interviewee No. 2).

The question arising from the interviewee No. 2 is that do anaesthesiologists and surgeons include pertinent details to perioperative nursing when assessing surgical patients?

Asked for suggestions to improve the existing assessment practices the nurses recommended that,

...we should have a formulated chart so that after doing all those preoperative visits and assessments we document what we have found (interviewee No. 1).

If we can have ideal staffing may be three nurses in the theatres...one nurse can at least find time to go and visit patients in the wards (interviewee No. 2).

Conclusion and recommendation

Theatres are increasingly becoming very busy due to increasing numbers of surgeries (Weiser, Regenbogen & Thompson, 2008). Unless something is done, constant staffing nursing staff shortages will continue to affect nurses' role performances (McGarvey, Chambers & Moore, 2004). According to Zastrow (2009), there is need for a succinct preoperative assessment tool that will ensure that the assessment quality is not compromised despite the challenges. The study therefore recommends development of such a tool that will not only suit the surgical setting like where the study was conducted but also will provide a framework for preoperative assessment practices.



Acknowledgement

1. University Management for sponsorship of PhD studies.
2. Professor from the nursing school for PhD supervision
3. Ethical Review Committee for study approval
4. The management, Nurses and all health care collaborators in the study hospital engaged in the study for support.
5. Data and Statistical support personnel for assistance with data analyses.

References.

- [1.] Phillips, N. (2004). *Berry & Kohn's Operating Room Technique*. (10thedn.). St. Louis: Mosby.
- [2.] McGarvey, H. E., Chambers, M. G. A., Moore, R.G. P., (2004). The Influence of Context on Role Behaviors of Perioperative Nurses. *AORN Journal: 80 (6)*p. 1103-1104, 1106-1112, 1114, 1117-1120. Availed from
- [3.] <http://www.Journal@Ovid Full Text>.
- [4.] NATN, (1996). Principles of Safe Practice in the Perioperative Environment. Harrogate: NATN.
- [5.] Pudner, R. (2005). *Nursing the Surgical Patient*. MedicalGoogle Books. Available from <http://www.books.google.com/books?isbn=070202757X>
- [6.] Rothrock, J. C., & McEwen D., R. (Ed). (2007). *Alexander's Care of the Patient in Surgery*. (15thedn.). St. Louis, Mosby.
- [7.] Smeltzer, S. C., Bare, B. G. (2000). *Brunner & Suddarth's Text Book of Medical surgical nursing*. (9th edn.). Philadelphia. Lippincott, Williams & Wilkins p. 315.
- [8.] Takahashi, J. J., Bever S.C. (1989). *Preoperative nursing assessment*. AORN J. 1989 Nov; 50(5):1022, 1024-9, 1031-5
- [9.] Torrance, C., & Serginson, E. (1997). *Surgical Nursing*. (12thedn.). London: Baillière Tindall.