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Psychosocial preoperative preparation in a non-children's hospital without child life supports

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Psychosocial Preoperative Preparation in a Non-Children's Hospital without Child Life Supports

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Abstract

On average, 6 million children undergo general anesthesia for surgery annually in the United States (Shah et al., 2021).Anesthesia can be one of the most stress provoking experiences, with 40% to 60% of children displaying emotional and behavior stress before surgery (Boles, 2016). Psychosocial preoperative preparation in pediatrics has been seen to lower children's stress levels, enhance understanding, increase compliance, decrease length of time in recovery, and decrease analgesic use (Aranha et al., 2017; Al-Yateem et al., 2016; Dolidze et al., 2013; Tunney & Boore 2013; Wenstrom et al., 2011).

The purpose of this exploratory case study was to better understand what psychosocial preoperative preparation children are receiving in a non-pediatric hospital where child life is commonly not present. The intention was to better understand if psychosocial, developmental, and individual needs are being met for patients and families outside children's hospitals. This study was also exploring what level of understanding nurses have when asked about psychosocial preoperative preparation for their pediatric patients without the support of a certified child life specialist. Utilizing semi-structured interviews to collect data four nurses were interviewed over Zoom.

The results of this case study provide insight into the lack of preoperative support children are receiving when child life services are not available. Nurses were found to need additional support in order to provide psychosocial support to children. Through thematic content analysis the following six themes emerged:1) An environment focused on efficiency, 2) Preoperative preparation is extremely limited and variable, 3) Attention Given to the Child, 4) Parental involvement is important, 5) Lack of knowledge, 6) Staff Roles and Responsibilities. Furthermore twelve sub-themes were identified.

Chapter 1: Introduction

Undergoing surgery is seen as a common experience many children will have to navigate. On average, 6 million children undergo general anesthesia for surgery annually in the United States (Shah et al., 2021). Although the global health care community acknowledges the stress and negative consequences that can result from inadequate preparation for the pediatric surgical experience, preoperative preparation that addresses children's psychological or psychosocial needs is not offered everywhere.

Surgery has the potential to be a traumatic experience for children. When undergoing surgery children are faced with trusting healthcare providers with not only their bodies, but their emotional well-being. The surgery experience is typically an unfamiliar process where children encounter new people, environments, and objects. Anesthesia can be one of the most stress provoking experiences, with 40% to 60% of children displaying emotional and behavioral stress before surgery (Boles, 2016). Stress levels are often heightened because the process of anesthesia can be difficult to comprehend for school age children and younger because it is abstract in nature (Boles, 2016). Psychosocial preoperative preparation can enhance coping and minimize the potential stress children may experience in the preoperative setting. Psychosocial preoperative preparation in pediatrics has been seen to lower children's stress levels, enhance understanding, increase compliance, decrease length of time in recovery, and decrease analgesic use (Aranha et al., 2017; Al-Yateem et al., 2016; Dolidze et al., 2013; Tunney & Boore 2013; Wenstrom et al., 2011).

Certified Child Life Specialists (CCLS) are often the medical professionals tasked with addressing the psychosocial and educational aspect of preoperative preparation for children and their families (Dolidze et al., 2013). Trained in evidence-based practice, CCLSs use their

knowledge of child development, family systems theories, stress and coping responses to develop and implement individualized care plans to minimize stress and potential trauma (Boles 2016). CCLSs provide opportunities for developmentally appropriate interventions, such as therapeutic play, emotional expression, normalization, preparation and education for medical procedures (Boles, 2016; Dolidze et al., 2013).

It is generally accepted that preoperative preparation is beneficial for children, but preparation is not standardized and there is debate concerning which medical provider is responsible for providing this preparation to children. In the United States, most Children's Hospitals have an established child life department providing preoperative preparation. Alternatively some hospitals who provide consistent care to children do not have a child life department at all. What is unclear and starkly absent from the literature is what type and who is providing pediatric preoperative preparation outside children's hospitals in the United States. This exploratory case study will seek to better understand what psychosocial preoperative preparation children are receiving in a non-pediatric hospital where CCLS are not present.

Statement of Problem or Question

Very few research studies have focused on psychosocial preoperative preparation provided by a CCLS. There is also a diverse array of articles and literature explaining, supporting, teaching, and developing how CCLSs provides preparation in a broad sense and specifically in the preoperative setting to pediatric patients.

In the United States, there appears to be a gap in the literature of what psychosocial preoperative preparation looks like when child life is not involved.

This exploratory case study will be answering the following research questions:

1. What psychosocial preoperative preparation are children receiving in a non-children's hospital without child life supports?
    a. What does psychosocial preoperative preparation look like for nurses in a non-children's hospital without child life supports?
    b. How is psychosocial preoperative preparation being provided to children in a non-children's hospital without child life supports?

By gaining an understanding of what preoperative preparation looks like for these children experiencing surgery, we can begin to understand what the psychosocial care looks like outside a children's hospital.

Chapter 2: Literature Review

Theoretical Framework

Psychological Stress and Coping Theory

Lazarus and Folkman's (1984) Psychological Stress and Coping Theory will be used as a foundation for how children appraise stressors and in turn respond to stressors during their surgical experience. Lazarus and Folkman (1984) use the principles of primary and secondary appraisal to assert how a person's appraisal of a stressor is the driving force of the stress experience. Through ongoing reappraisal of stressors children determine if they have the resources to cope with the stressor. Although psychological stress is complex, Lazarus and Folkman's (1984) psychological stress and coping theory helps to better understand how children respond to stressful events, such as the perioperative experience.

When children encounter a stressor, they use cognitive appraisal to assess whether or not they can cope with the stressor. During the process of cognitive appraisal, if the child determines they can cope with the experienced stressor, minimal or no stress is experienced by the child

(Tunney & Boore, 2013). Alternatively if the child deems that they cannot cope with the experienced stressor the child experiences psychological stress. Numerous variables affect cognitive appraisal such as age, developmental level, temperament, previous experiences in the healthcare environment, parental support, and preparation provided to the child (Tunney & Boore, 2013).

By providing thoughtful and intentional preoperative preparation to the child, it is more likely this preparation would contribute to children making accurate appraisals of whether they can cope with the situation, ultimately reducing the child's fears and distress (Boles, 2016). Preparation should positively contribute to the child's ability to cope because the child is more likely to accurately appraise the situation and support available to them. In the preoperative setting if the child does not receive preparation it can be assumed there is a higher likelihood they would not understand what is happening and appraise surgery as threatening. CCLSs during preparation strive to affect both primary appraisal (is the situation viewed as threatening to the child) and secondary appraisal (does the child feel they can cope with the situation) by providing developmentally appropriate education, clarifying misconceptions, and rehearsing coping strategies (Dolidize et al., 2013). Using this theoretical framework, it becomes clear the importance of preoperative preparation for children and the intention behind it.

Literature Review

Anxiety and Fear in the Preoperative Setting

Physiological Effects

Several studies acknowledge that it is generally accepted that the surgical experience can bring about feelings of anxiety and fear for children (Aranha et al., 2017; Athanassiadou et al., 2012; Boles, 2016; Bray et al., 2019; Al-Yateem et al., 2016; Cropper et al., 2011; İzci et al.,

2020; Lin et al., 2019; Loof et al. 2019). Children who are anxious in the preoperative period when they are admitted for surgery and leading up to anesthesia have been observed not only to have a psychological response, but also a physiological response, such as an increase in pulse, blood pressure, and respiratory rates (İzci et al., 2020). Both Cropper et al., (2011) and Aranha et al., (2017) highlight how children who have anxiety in the preoperative setting and during anesthesia induction experience more pain postoperatively, and have been observed to show more delirium and an increase in analgesics. Children's psychological states in turn can directly affect their physiology and therefore should be valued.

Fear

Surgery is an exceptionally invasive procedure. The more invasive and unfamiliar a procedure, the more likely it is the child will be fearful. Izci et al., (2020), Loof et al., (2019), and Dolidze et al., (2013) all comment on how children often have multifaceted fears surrounding surgery characterized by fearing bodily harm, as well as perceiving medical providers, medical instruments, and the environment as threatening. Athanassiadou et al., (2012) further demonstrates how intimidating surgery can appear to children, describing how surgery can bring about fears of the child's body being mutilated. In their qualitative study exploring the effectiveness of puppet play for preoperative preparation, Athanassiadou et al., (2012) interviewed Christine, a five-and-a-half-year-old child who was having a tonsillectomy. Christine vocalized she had been a good little girl and did not understand why they were going to be cutting her throat out. Christine demonstrates the misconceptions children can have regarding the surgical experience, which can perpetuate fear (Athanassiadou et al., 2012). Each child inevitably will have unique misconceptions surrounding surgery, which can lead to enduring fears if they are not addressed.

Enduring Stress

It has been observed that 75% of children having surgery experience anxiety and 67% of children showed negative changes in behavior postoperatively (Aranha et al., 2017). Changes in negative postoperative behaviors such as separation anxiety, bed wetting, temper tantrums, crying, and night terrors etc. were seen 2 weeks up to 1year postoperatively in preschool and school age children (Lin et al., 2019). Boles (2016) agrees, stating that heightened anxiety levels in children can last 30 days after the stress provoking experience. During a time of critical development for children hospital experiences can bring about anxiety and fear. If the child experiences multiple exposures to mild stressors they can progress into toxic stressors that have been shown to have adverse effects on the child's health and development with enduring consequences (Al-Yateem et al., 2016). For a number of children the surgery experience, if negative, has the potential to affect them beyond the clinical setting impacting their everyday life.

Preoperative Preparation

Benefits of Psychological Preparation

The National Institute for Health Clinical Guidelines concluded that preoperative psychological preparation is effective in reducing anxiety for children (Aranha et al., 2017), however, how to best provide this psychological preparation is currently debated. Athanassiadou et al., (2012) broadly provided an argument and case illustration (e.g., 5-year-old patient undergoing tonsillectomy) for describing how puppet play could be used as an effective tool for emotional exploration during preparation for surgery. Although they explored this type of preparation, they did not draw any concrete conclusions on its effectiveness. Tunney and Boore (2013) set out to see if a storybook would be an effective tool in the psychologically preparing

children 5 to 11 years of age who were also undergoing a tonsillectomy and adenoidectomy. Unlike Athanassiadou et al., (2012) Tunney and Boore (2013) found there were statistically significant reductions in anxiety levels for the experimental group demonstrating that the storybook was an effective psychological preparation tool.

Lin et al., (2019) took a multifaceted approach to preoperative preparation by designing a preoperative preparation program for children ages 3 to 12 years old that encompassed a tour, video of a child's surgery experience, and familiarization of hospital equipment. They found from their quantitative study design that children who received this preparation were observed to show less negative emotional behaviors compared to children who received routine preparation (Lin et al., 2019). Hilly et al., (2015) focused on finding out if children between the ages of 3 and 18 years of age who attended a preoperative workshop would have lower postoperative maladaptive behaviors.

Wennström et al., (2011) found that children between the ages of 5 and 11 years old who received perioperative dialogue (PD) had lower salivary cortisol concentration and morphine use during their surgery experience. PD was implemented by the nurse and focused on ongoing listening to the child about their needs, feelings, expectations, thoughts, and concerns. It is imperative to notice that all these studies focus on different aspects of preoperative preparation and the common theme is that healthcare professionals are exploring what type of preparation is being provided as well as its effectiveness.

The purpose of this study was to understand the psychosocial preparation that is being offered to children in a non-children's hospital without child life presence prior to surgery. This was done by interviewing four nurses in order to gain insight and understanding of the psychosocial preoperative preparation being provided. A qualitative exploratory case study was

implemented to explore what psychosocial care looks like for children who are undergoing surgery in a non-pediatric hospital. The intention of the study is to better understand if psychosocial, developmental, and individual needs are being met for patients and families.

Developmentally Appropriate Preoperative Preparation

When faced with an unfamiliar medical procedure or surgery children need developmentally appropriate interventions to help them understand the experience. It is important children know what sensory experiences they may have, emotions they may feel, knowledge of the sequence of events, and assistance in developing a coping plan to help manage their potential fears and anxieties (Boles, 2016 and Thompson, 2009). Boles, (2016) notes preoperative preparation should be multifaceted comprised of preparation provided by a CCLS, opportunities for modeling, parental involvement, and coping skills instruction.

Child Life and Developmentally Appropriate Preparation

CCLSs are trained in evidence based developmentally appropriate techniques aimed to empower children and families when faced with stressful medical experiences, such as undergoing surgery. CCLSs make individualized assessments by gathering information about the child and family's coping, previous medical experiences, and the family's wishes concerning the medical event (Boles, 2016). With this information CCLSs develop age-appropriate preparation commonly utilizing developmentally appropriate language, play, medical play, modeling, and role rehearsal (Brewer et al., 2006 as cited in Boles, 2016). CCLS focus on building a relationship with the child and family based on trust and open communication. Family centered care is prioritized with the parents being viewed as the expert on their child.

CCLS value play and understand that play is the language of children. Play is how children communicate, explore, master skills, and is critical to the child's development.

Therefore, psychosocial developmentally appropriate preparation would involve play. Play can be for pure enjoyment or serve to comfort the child and promote normalization. Play can also be therapeutic, expressive, and part of how children learn. As children develop their cognition and how they interact and understand their environment typically evolves and advances. Piaget's theory of cognitive development is one of the theories often used to assist CCLSs in planning age-appropriate education and play activities for children of different developmental levels (Thompson, 2009).

Modeling and Coping Skills

Developmentally appropriate preoperative preparation as noted previously by Boles, (2016) would involve modeling. Bandura (1977) developed the concept of modeling where children learn by observing and potentially copying the behavior of others. Both Thompson, (2009) and Boles, (2016) stress how modeling interventions, which are often comprised of picture books, dolls, puppets, or videos help the child learn about the process of their procedure and in turn promote feelings of mastery and control. An example of this would be a child watching a video of another child going through the entire preoperative process leading up to induction and then in recovery. Modeling could also take the form of medical play with the child and CCLS playing with a doll with a toy medical kit taking the doll's vitals and potentially practice using the induction mask on the doll mirroring what the child will experience in the preoperative setting.

Developmentally psychosocial preoperative preparation would also include the development of individualized coping plans that take into account the child and family's unique needs. Boles, (2016) notes CCLS can assist the child in developing, rehearsing, and engaging in coping strategies. Coping strategies can be sensory, cognitive, or behavioral based (Thompson,

2009). Examples include procedure positioning, deep breathing, humor, and alternative focus (Thompson, 2009). CCLSs can help to support the child during anesthesia induction or procedures reminding the child of the education they received (sequence of events) and the previously rehearsed coping strategies (Brewer et. al., 2006, as cited in Boles, 2016).

Psychosocial Development and Preparation

Erik Erikson's (1963) theory of psychosocial development is also often utilized by CCLS as a framework for age-appropriate activities, potential challenges the child may have, education, and interventions for psychosocial preoperative preparation. This theory is grounded in how social, cultural, and environmental factors influence the child's development. Erikson's (1963) theory of psychosocial development has 5 stages of development the child goes through. The first stage is from birth to one years old. In this stage children are in the trust vs. mistrust stage. Separation from caregivers and unfamiliar routines, environments, and people can cause stress, therefore psychosocial child life interventions would focus on consistent care and parental involvement to meet the infant's needs (Thompson, 2009). Although there would be a focus on the parents it would still be important to talk to the infant and encourage face to face interactions with staff to build trust and familiarity in the preoperative setting. Toys would be provided that have visual, tactile, or audio stimulus.

The second stage is one to three years old when the child is in the autonomy vs doubt stage of development. In this stage children may have challenges with separation anxiety and reduced opportunities for autonomy and control. Psychosocial interventions provided by the CCLS would typically focus on opportunities for normalization through play and exploring the preoperative environment and materials (Thompson, 2009). Names would be provided for frequently used preoperative equipment as well as simple explanations for these items. Education

would be given one step at a time and be concrete, not abstract in nature due to the child's cognitive development.

The third stage is from four to five years old when the child is in the initiative vs. guilt stage of development. In this stage children may have challenges with having a sense of control and independence. They often have magical thinking and are egocentric all of which can result in fears and misunderstandings (Thompson, 2009). Child life interventions would work to increase opportunities for control, provide age-appropriate explanations and assess the child's understanding to clarify any misconceptions around the surgical experience. If possible, the child should be given a role during any procedures they may have and be encouraged to express their feelings and fears. At this stage children can also rehearse coping skills such as utilizing the induction mask to blow bubbles practicing breathing into the mask and having it on their face.

The fourth stage is from six to twelve years old when the child is in the industry vs inferiority stage of development. In this stage children may have challenges with separating from their normal activities surrounding home, school, and their peers. They may have concrete literal thoughts that result in misunderstandings and begin to experience reduced self-esteem (Thompson, 2009). In this stage CCLSs interventions would focus on fostering peer and parental support, structured activities that allow for success and a connection to home and school (Thompson, 2009). In this stage it would be important to explain to the child why specific things are being done in the preoperative setting. They should be given the opportunity to ask questions and express their concerns so any misconceptions can be addressed. Preoperative preparation should address which parts of the body will be affected in non-threatening language and to what degree. In this stage rehearsing coping skills would also be encouraged as well as providing the child with a role during the preoperative process.

The last stage is from thirteen to seventeen years old when the child is in the identity vs. role confusion stage of psychosocial development. In this stage children may struggle with privacy, peers, independent activities, decision making and be concerned with the perspectives of others (Thompson, 2009). In this stage CCLS would work to promote privacy, opportunities for choice, peer interaction, and self-expression. It would be important to provide explanations for why the surgery is necessary, what parts of the body it will affect and address any long-term consequences in a logical and honest way. In this stage adolescent may fear death or disability so clarifying and addressing their fears would be critical to reducing anxiety. Rehearsing coping strategies is also vital for this age group even though they are older. An example of this could include forming a coping plan with the child to use during their IV placement.

Chapter 3: Methods

This exploratory case study explored what psychosocial care looks like for children who are undergoing surgery in a non-pediatric hospital. An exploratory case study was chosen because as Simons (2009, as cited in Moriarty 2011) notes case studies lend to thoroughly exploring the complexity of a system in a 'real life' context. Since the psychosocial preoperative preparation children are receiving in a non-children's hospital without child life support was unknown an exploratory case study design was chosen.

Sample

Convenience sampling was used to identify four nurses who are a part of preoperative preparation in a non-children's hospital without child life support. Convenience sampling was implemented due to the difficulty of finding healthcare professionals with the time and willingness to be interviewed during the covid-19 pandemic. The population was four nurses who work with children in the preoperative setting at a non-children's hospital in California.

Swan et al., (2020) stresses that there is no absolute number of participants for a case study. As cited in Swan et al., (2020) Eisenhardt (1989) stresses that between four and ten often works well.

These four nurses were employed at three different hospitals, two of the nurses work at the same hospital. The two nurses working at the same hospital were able to provide multiple perspectives for the same facility. Three of the nurses interviewed work in the surgery department. One of the nurses interviewed works in the emergency department. All the nurses have been nurses for at least seven years with an average of twelve years experience. One of the nurses has been a nurse for over twenty years. All the nurses interviewed were females who are diverse in their ethnic and cultural backgrounds.

Data Collection

After IRB approval was obtained from Eastern Washington University, these four nurses were interviewed one on one over Zoom. Semi-structured interviews were used because they pair well with case study research. Interviews were employed with the intent to gain a rich amount of data from the four nurses working in the preoperative setting. Hancock and Algozzine (2006) emphasize how when using semi-structured interviews researchers are able to ask both predetermined questions and then have the flexibility to ask follow up questions that delve deeper into areas of interest. This in turn ideally allows both the researcher and the participant freedom and flexibility during the interview (Hancock & Algozzine, 2006).

The interviews were between thirty minutes to one hour long. Interview questions were divided into six sections beginning with questions about the nurse's role and the environment they work in. The next set of questions focused on the process of preoperative preparation. There was then a focus on the education and preparation provided to children before surgery. From

there there were questions about the child's family, individualized, and child friendly care. The interview concluded with questions regarding the child's emotions and the nurse's perspective as a medical provider about preoperative preparation. (See Appendix A for interview questions)

Data Analysis

Data from the interviews were transcribed and analyzed using content analysis, a common analysis tool employed in qualitative case studies. Erlingsson and Brysiewicz's (2017) "A Hands-on Guide to Doing Content Analysis" was used as the framework to analyze the data. After the interviews were transcribed verbatim all four transcripts were read several times to gain familiarity with the data as a whole. The goal of qualitative content analysis is to methodically reconstruct the transcript to obtain an organized and condensed summary of the main findings (Erlingsson & Brysiewicz, 2017). In several steps the raw data was analyzed during the process of creating meaning units, codes, categories, themes and then sub-themes. The process takes the material from literal content to inherent meanings (Erlingsson & Brysiewicz, 2017). Six themes and twelve sub-themes were identified.

Chapter 4: Findings

Interpretation of the four nurse's perspectives resulted in the following six themes: 1) An environment focused on efficiency, 2) Preoperative preparation is extremely limited and variable, 3) Attention Given to the Child, 4) Parental involvement is important, 5) Lack of knowledge, 6) Staff Roles and Responsibilities. The twelve sub-themes that were found were diverse in content and scope.

An Environment Focused on Efficiency

Leading up to surgery all four nurses reported a similar preoperative process. This process typically begins with taking the child's height and weight then the child changes into a

surgical gown. The child's vitals are taken followed by the interview portion and any medical surgical preparation that may be needed. One nurse compared the preoperative process to a business where children are brought in, provided with help, then sent on their way. Although one nurse reported the desire for children to know they are in a safe environment one nurse noted that "The aesthetics in pre-op…is not child friendly not at all it's very sterile it's very cold...generic." Similarly another nurse articulated pre-op has blank walls and the atmosphere is a "scary hospital". Another nurse felt the environment was traumatizing for the child.

Pre-operative Checklist

All the nurses working in the surgery department, excluding the nurse who works in the emergency department, focused on how the pre-operative checklist dictates preoperative preparation. Nurses focused on how they have to complete all the "Boxes" of the preoperative checklist or their "To do list" before the child is ready for surgery. All four nurses brought up the importance of confirming consent for surgery by having the consent form signed. One nurse stated that the "Pre-op process for pediatrics is 10 minutes basically and the only thing you really need is the consent form signed by the parent."

Preoperative Preparation is Extremely Limited and Variable

Department Variability

All four nurses reported different information when asked the timing of when developmentally appropriate preparation was being provided for pediatric patients prior to surgery. The emergency room nurse stressed that preparation would be the day of. One nurse said it starts in the Doctor's office, but was unaware when this took place or the details of this. The two nurses who work in the same department reported conflicting information for when the child first sees the Doctor and has their clinic visit, one saying it was a week before the other

reporting a month to at least two weeks before they have surgery. The surgery department nurses reported the day of surgery children arrive two hours before their scheduled surgery time.

Time Constraints

All four nurses emphasized how they are bound by being in a situation that is timed. Nurses stressed how the time they spend with the child is brief due to the time constraints of scheduled surgeries or emergent surgery in the emergency department. One nurse who works in the emergency department articulated that they use emla cream, an anesthetic used to numb the skin before starting children's intravenous lines (IVs) for surgery, but emla takes forty minutes to be effective so the cream is usually ineffective for children because nurses do not have that much time to wait before starting the IV. Another nurse reported that although they have pediatric patients they have multiple patients at a time, some of whom may be time intensive adults, stressing that they may have to spend over forty five minutes with their adult patients compared to the ten minutes they spend with the child.

Education Provided

Nurses reported a variety of responses regarding the education provided to children during the pre-operative process. One nurse communicated "No, there wouldn't be no, there wouldn't be any pre-op education" provided to children at their facility. Another nurse was vague in saying some children receive education and other children do not because some are not cognitively aware or babies. Similarly the same nurse reported that some children practice with the induction mask if they want to, but most children just focus on their electronic devices. Two nurses noted that the surgeon provides pre-op education to the child. The nurses who reported that education is provided said it was done verbally, some describing the education as basic and rudimentary. Visuals are mentioned briefly by the emergency department nurse who said she

shows the child the catheter for their IV and by another nurse who stressed during vitals she tells the child what she is going to be doing and shows them the medical tool before she uses it.

One nurse communicated where they work they do not assess if the child understands what is going to happen. Other nurses said they use verbal teach back or ask the child what they are having done to see if they understand. One nurse assumed if the child could point to the correct place on their body where they were having surgery they understood what was going on. There was also variability in if children received preparation for mask induction. Two of the nurses did not mention mask induction, one nurse reporting most receive mask preparation and another going into detail how the anesthesiologist provides mask education to the child. There was also variability in the nurses reporting if children were able to choose the scent of their induction mask.

Preparation and Age

One nurse articulated that preparation is the same for children and adults, except children receive their IV in the OR. This nurse emphasized that preparation is standardized in their department and not individualized for the child. Three of the nurses mentioned how the age of the child would affect preparation, but did not specify or elaborate how the preparation would be different. The surgery department nurses all focused on how the IV is what differentiates preparation because younger or anxious children are given their IV in the OR. At one facility the nurse said children are given their IV in the OR simultaneously with mask induction, but did not mention any preparation or education for the IV.

Attention Given to the Child

The Child's Emotions

None of the nurses mentioned positive emotions in relation to children and the pre-operative experience. Children were described as being fearful, scared, and emotional. Two of the nurses brought up that children are given pre-medications to calm them down and help with their anxiety. Two of the nurses brought up children's fears regarding needles. One nurse said the children,

> "Get emotional, they get super scared...[and tell them]"I don't want to be here"....[Then]when it's time to go back into the OR that's when they'll start crying really like they don't want to do this, its like that fight or flight response with their body they just they start to freak out and then they'll just scream and cry."

Nurses Care

It appears all the nurses care about the child's feelings and want to help address them. One nurse communicated that they try to validate the child's feelings, another similarly said they try their best to address how the child is feeling. One nurse said they strive to treat children like they are "extra special" and try to do what they can to decrease the child's anxiety. This nurse also stressed that they break pre-operative etiquette and allow children to bring comfort items like a toy or stuffed animal into the operating room, (OR) because the child's comfort is important to staff. Three of the nurses brought up how they or their colleagues view the child in relation to their own children.

Communication

One of the nurses stressed they try to involve the patient in the preoperative process and answer any questions they have. This nurse mentioned the importance of autonomy for children

in the pre-operative process. In contrast this same nurse said they felt the child's voice was heard, but also said when the child is eighteen years old they are then able to speak for themselves. This nurse expressed that if their child was having surgery in this department they would want to feel like their child is being heard and their questions are answered instead of everyone having the "rush rush attitude" they currently have and operate within. With these statements it becomes unclear if the child's voice is given adequate attention in this department.

When asked if the child's feelings are addressed one nurse focused on how the amount of time they spend with the child is brief, but they put effort into comforting them in the short amount of time they do spend with them. When asked this same question another nurse emphasized they address the child's feelings to the best of their ability but they are "not a child life specialist." Another nurse as the main example of how the child's feelings are being addressed referred to how children scream and cry so they allow a parent to come back to the OR.

Parental Involvement is Important

All four nurses reported that the child's parent is present for the majority of the time leading up to surgery. One nurse said that parents do not go back with the child into the OR. Another nurse was unaware if the parent was able to go into the OR. The two nurses who worked at the same facility said parents were sometimes allowed to go back with the child to the OR if they were a younger child or their behavior permitted it and it was given an ok by anesthesia.

Two of the nurses noted how when parents are present during invasive procedures it helps the child. One nurse said when she does the child's IV she wants to make sure they can see their parents so the process goes more smoothly. Another nurse commented that during induction children fight the medical providers less when one of their parents is present. Parents were often

referred to as sources of comfort for the child in the preoperative environment. Parents were also credited with bringing comfort items and toys from home for their child.

When asked if family centered care was prioritized at their place of work three of the nurses reported it was prioritized. One nurse stressed family centered care was part of the hospital's mission. One nurse was unaware of what family centered care was. After clarification this nurse asked if family centered care would only be in recovery, because that is when they usually see what they perceive to be family centered care.

The nurses communicated multiple times that parents were prioritized in the pre-operative preparation. It was said that most of the choices are left to parents and not the child. This came up numerous times when the nurses were asked about the education and preparation the child receives for surgery. One nurse said the surgeon provides the education, but they essentially just communicate with the parents. Similarly another nurse said "Whoever the parent is you know is involved with more of the instruction than the child." In this same theme another nurse said the main priority is to educate the parent.

Lack of Knowledge

Lack of knowledge was a running theme during the interviews with all four nurses. Multiple nurses pointed this out themselves with one nurse stating they are only able to explain so much to the child with the skills and education they have. Even though the emergency department nurse prepares the child for surgery they stressed they are not the specialist for what is going to happen in surgery and was equally perplexed why this interviewer even wanted to speak to them about psychosocial preoperative preparation for children. One nurse was unaware what coping skills were when asked about them and as previously stated another nurse was unaware what family centered care meant. All of the nurses needed clarification from the

interviewer to explain the question asking if the child has opportunities for choices within the pre-operative process.

It was also common for nurses to mention younger or older children, but not elaborate on the child's age or developmental stage in relation to the question asked. Specifics were often not given when answering a question and it was unclear how much the nurses knew about what the term psychosocial actually means. For some questions nurses gave lengthy answers with valuable information, but did not answer the original question.

Contradictions

As mentioned previously nurses often provided contradicting information about the same topic. The three most notable examples was one nurse articulating they felt the child's feeling's and voice was heard later to provide information that said the opposite of this, that there is no time to address the child's feelings and answer their questions. The second was a nurse who said the surgeon did a great job of providing preoperative education and preparation to children who later in the interview stressed the surgeon was bland and essentially just talking to the parents.

The third was a nurse describing the mask induction children experience. This nurse was consistent in communicating that the child is able to bring comfort items into the OR and that staff lets the child choose what they want to watch on the TV in the OR. They also said staff will encourage the child to pick a dream of where they want to go as they fall asleep. They said children are able to hold the mask themselves if they wish and are able to sit up during induction. This same nurse also said for children they typically apply a lidocaine cream because the child will get their IV in the OR. Stating it requires two anesthesia providers for induction one who masks the child and another who simultaneously starts the child's IV. There was no mention of the child receiving education for the IV or being prepared ahead of time.

Not a Children's Hospital

The nurses were specific in the type of pediatric surgeries they are typically involved in. The emergency department nurse said she typically sees appendicitis cases because more critical children would be transferred to a children's hospital with a pediatric intensive care unit. Another nurse said she typically sees pediatric patients two years-old and above for orthopedic and spine surgeries. The two nurses who worked in the same hospital reported they do a vast range of surgeries for all ages, such as general surgery, spine, neuro-cases, cancer, tumors, and head injuries. One of those nurses stated they see everything except cardiac cases.

All of the nurses, except one focused on how where they work is not a children or pediatric hospital. All the nurses reported the aesthetics of their departments do not look like children's hospitals (painted walls, child friendly visuals etc.) One nurse commented on how they strive to be like a pediatric hospital, but they are not one. Another nurse appeared to express irritation when asked if the environment was child friendly reminding the interviewer they are not a children's hospital, but then went on to state the staff is child friendly and does a good job.

Excluding the comfort items, toys and electronic devices the children bring with them, nurses shared what activities their department has for children. One nurse said they have stuffed animals that a kind nurse donates and stuffed animals the hospital supplies as well as Ipads. Another nurse said they have a coloring booklet with crayons and bears. In the department two of the nurses work in, it appears there are TVs, stickers, and what one nurse described as generic coloring books. There was a focus on children's stuffed animals with nurses reporting they would dress the children's stuffed animals in hospital attire, such as putting surgical caps on them.

Two nurses focused on needing more education and training in their department, one nurse saying to improve they would need a “Review of like developmental stages... like what children believe at certain ages what they're afraid of... age appropriate language to use with them in terms of like when you're explaining a procedure how to explain it to them in a way that they would understand”. Similarly, another nurse said their department needs training every quarter on psychosocial needs in relation to caring for children. One nurse said before she became a nurse she had a degree in child development and wanted to become a child life specialist, but instead pursued nursing. They stressed that a lot of their colleagues are not as interactive with the children or comfortable with pediatric patients as they are due to their unique background.

Multiple nurses brought up that they do not have the same amount of resources like a children’s hospital. One nurse commented there is only so much that they can do for the children with what they are given. Another nurse said her previous job was working at a hospital that was a pediatric receiving center and they had more tools and resources for the children, such as a variety of different toys for numerous age groups and specialists. Multiple nurses commented on their department needing more toys. One nurse commented on how they do not have, but need visuals, such as mannequins or models to use during preparation and education to explain things to the children. Another nurse said children would benefit from insightful tours of the hospital provided ahead of time.

Staff Roles and Responsibilities

Though nurses viewed their roles in diverse ways all of them focused on how they are there to help. One nurse focused on how their role as a nurse is to make sure everything necessary takes place so that the surgery can happen. Two of the nurses described themselves as

advocates for the patient. Nurses reported a variety of responses when asked who they feel should be responsible for psychosocial preoperative preparation. The nurse who said there was no education or preparation provided to children felt nurses and social workers should both be responsible. Two of the nurses expressed that education and preparation is a team effort and everyone involved has a role to play. Multiple nurses focused on the information provided to the family by the anesthesiologist and surgeon. One nurse said she felt currently the surgeon and parents should be responsible for providing education and preparation to the child and this was not the nurse's responsibility.

Social Workers

As mentioned previously the nurse who reported there is no pre-operative education or preparation provided to children noted this could potentially happen ahead of time in the doctor's office, but there would be no one to go to for psychosocial preparation and education in their department currently. This nurse said to improve their department they should involve social workers. This nurse said during their pediatric rotation in nursing school they saw how social workers were involved in preparation and education for children before surgery. They noted that social workers provided tours for the children and families as well as play opportunities and education. Stating that social workers take time to address the child's feelings and concerns regarding surgery.

Child Life Specialists

One nurse shared there is one CCLS who works at the hospital, but she is involved only when there are oncology patients that come for lumbar punctures and go under anesthesia. The nurse described the CCLS as amazing and said she does an awesome job of educating the children about what is going to happen and shares with the nurses the personalities and

preferences of the oncology patients. This nurse shared they think it would help to have a child life specialist work with them because they are important for the transition of pre-op, to the operating room (OR), and then to recovery because,

> "They can help break it down...they've got this extensive training on how to you know work with children and they can explain it better. I mean I can explain it so much... I work with a an array of ages that it's hard for me sometimes to kind of gear it down towards children."

They noted that if a CCLS came in on the days they do pediatric cases it would help children be comfortable and reduce anxiety emphasizing "I think that would make a huge difference in their experience with having surgery".

Chapter 5: Discussion

Lack of Preoperative Support for the Child

This study provides a better understanding of who and what type of psychosocial preoperative preparation children are receiving in a non-children's hospital when child life services are not offered. Loof et al., (2019) describes how children's opportunities for preparation and education are decreasing during the preoperative process in a fast paced environment structured by defined routines with massive demands. Similarly, the nurse's perspectives in this study demonstrated that the preoperative environment is an environment focused on efficiency. The pre-operative checklist and consent forms for surgery were highly prioritized, not the child's needs.

Nurses compared the pre-operative process and environment to a business and described it as timed, sterile, cold, generic, traumatic, and scary. Izci et al., (2020), Loof et al., (2019), and Dolidze et al., (2013) all comment on how children often perceive the surgical environment as

threatening. In an environment described by nurses as timed, sterile, cold, generic, traumatic, and scary it is vital that the child's needs are the main focus so they do not perceive the preoperative environment as threatening and in turn have anxiety before surgery. Aranha et al., (2017), Lin et al., (2019), and Boles (2016) all note that anxiety experienced during the preoperative process can heighten anxiety levels for children and alter their behavior when they leave the hospital and return home. Aranha et al., (2017) notes more than half, 67% of children who underwent surgery showed negative changes in their behavior postoperatively. Nurses' responses show the children's needs are not prioritized, instead the consent forms and pre-op checklist are the top priority. The child's needs should be prioritized to prevent the potential negative consequences of the anxiety children experience in the preoperative setting impacting the child when they leave the clinical setting and return home.

As noted by Boles (2016) stress levels are often heightened because the process of anesthesia can be difficult to comprehend for school age children and younger because it is abstract in nature. It is typical for children to form misconceptions around the surgical experience and in turn perpetuate fear (Athanassiadou et al., 2012). Each child inevitably will have unique misconceptions surrounding surgery, which can lead to enduring fears if they are not addressed. Without assessing the child's understanding the medical providers will not be able to clarify any misconceptions or magical thinking the child has surrounding surgery. From the nurse's responses it appears the child's understanding is not assessed at all or the assessment from the medical provider is very limited and basic. The nurses' perspectives on the assessment provided to children were divided. Two nurses reported that the child's understanding is not assessed with the remaining two nurses stating they ask the child questions to see if they have a basic understanding of the surgery they are having. The limited depth of the assessment that

takes place is demonstrated by the nurse who assumes the child understands the surgery experience if the child can simply point to the correct body part that is being operated on. In all four nurse's responses it appears none of the children are assessed to see if they understand the reason for having surgery, the specifics of their surgery, the preoperative environment, the OR, anesthesia, recovery, and medical interventions provided. If the child's understanding is not assessed it is likely the child will not receive an intervention that addresses any misconceptions, fears, or anxieties the child has. The child's psychological well being and comprehension is therefore being neglected. Previous studies (Cropper et al., 2011 and Aranha et al., 2017) highlight how children who have anxiety in the preoperative setting and during anesthesia induction experience more pain postoperatively, and have been observed to show more delirium and an increase in analgesics. Assessing children's psychological states should be valued because this can affect the pain children experience and the amount of analgesics that are administered to them.

From the information gathered it is unclear if any developmentally appropriate education is provided to the child leading up to surgery. As previously noted one nurse stressed there is never preoperative education and preparation provided to the child. This nurse emphasized that preparation in their department is the same for children and adults. Nurses who reported that preparation differs by age were not specific in how preparation differs, with the majority of them noting that when and where the IV is placed is what differentiates preparation. Getting an IV is a medical procedure not developmentally appropriate preparation and education. As noted previously when no preparation or education is provided there is a high likelihood the child will experience anxiety. Education does not only need to be provided in the first place, but also needs to be tailored to the child who receives it.

Although each child is unique, the study of child development has revealed how children go through different developmental stages that affect their physical, cognitive, social, and emotional states. It is therefore inappropriate to prepare a child for surgery the same as an adult. Expecting a child to cognitively have the same capacity as an adult or even a child in a different stage of development is unrealistic. When you add in potential disabilities, developmental delays, past experiences, and family dynamics the need for individualized care increases.

In addition numerous nurses reported that younger children were more difficult to explain things to or were too young to understand the surgery experience. Some nurse's responses were vague regarding which children received preparation and shared only some children are receiving education. It appeared none of the facilities provided a range of developmentally appropriate toys with a focus on stuffed animals, coloring, and television. It seems there are limited or no opportunities for therapeutic, expressive, and medical play. Numerous studies (Athanassiadou et al., 2012, Tunney and Boore 2013, Lin et al., 2019, Dolidze et al., 2013) have shown the benefits of developmentally appropriate play to promote children's understanding as well as normalizing the preoperative environment. With no opportunities for medical or therapeutic play children miss the opportunity to engage in the surgery experience in a way that is less threatening and potentially easier for them to understand.

Nurses emphasized how most preparation is provided verbally and is basic and rudimentary. The lack of visuals provided to children was highlighted by one nurse stating they need visuals, mannequins, or models to help better explain things to the child. The emergency room nurse stated they do not really tell children what is going to happen because surgery is not their specialty. Nurses also focused on educating the parent as opposed to the child prioritizing the parent's understanding. Another nurse, when asked if children were told what they would

see, hear, feel, and smell, reported they have never witnessed a surgeon (who provides education) give that much detail during preparation. There was variability and ambiguity surrounding if children receive preparation for their IV or mask induction. None of the nurses spoke of education for cardiac leads or pulse oximeters which typically are placed on children in the OR before anesthesia induction. If the child is uneducated and unprepared for what they will encounter during their surgical experience there is a higher likelihood they will not understand the surgery experience and deem it as threatening. Dolidze et al., (2013) and Boles (2016) note how low information paired with uncertainty leads to emotional distress. If the child is not prepared then for invasive medical procedures, such as their IV and anesthesia induction there is a higher likelihood of emotional distress. As noted previously this emotional distress not only has detrimental psychological impacts, but also physiological impacts.

Another vital component of preoperative preparation that appears to be missing is supporting children in choosing a detailed coping plan that helps them deal with the stress of having surgery. All of the nurses needed clarification from the interviewer to explain the question asking if the child has opportunities for choices within the pre-operative process. One nurse was completely unaware what coping skills were. The only rehearsal of coping skills that was brought up during the interviews was two nurses who worked in the same department when asked about mask rehearsal. They reported anesthesia allows the child to choose a scent they would like to smell. One of the nurses commented that children can practice if they wish with the mask, but they usually just want to focus on their electronic devices brought from home.

In this department nurses reported the child's IV is given in the OR simultaneous to mask induction. Nurses did not report that children were supported in rehearsing any coping skills for when they get their IV. One nurse demonstrated an attempt to provide children with a coping

skill for induction by saying they will tell children to choose a dream of where they want to go when they are asleep. Although thoughtful there is no element of choice in this for the child. None of the nurses talked about the rehearsal of coping skills for children who receive IVs. As noted by Boles (2013) theoretically by helping develop and support children's coping plans and information processing medical providers can help to lessen the pain and stress they experience during a procedure, which fosters the child's continued development and success rate of the procedure.

Several studies acknowledged that it is generally accepted that the surgical experience can bring about feelings of anxiety and fear for children (Aranha et al., 2017; Athanassiadou et al., 2012; Boles, 2016; Bray et al., 2019; Al-Yateem et al., 2016; Cropper et al., 2011; İzci et al., 2020; Lin et al., 2019; Loof et al. 2019). All four nurses aligned with these previous studies only describing children as being fearful, scared, and emotional. Previous studies (İzci et al., 2020; Cropper et al., 2011; Aranha et al., 2017) note how children's psychological states preoperatively can negatively affect their physiological responses. In this same tone in this study one nurse observed what appears to be a physiological response that when it is time to go back to the OR children often go into a fight or flight response screaming and crying. Similarly multiple nurses shared what can appear to be a fight or flight response when describing how it requires multiple medical professionals when starting the child's IV because they are usually held down. Although it appears the nurses cared and recognized children are in distress, limited actions are taken to decrease and address the child's fears and anxieties. Two nurses mentioned how children are given pre-medications to lessen their anxiety. One nurse focused on how they allow the child to bring comfort items into the OR, while another reported that allowing the child's parent to come

back to the OR calms the child down. None of these actions directly address the child's feelings and emotions or tackle the root cause of children's fears and distress.

Nurses' Need for Additional Support

Nurses were transparent in their scope of practice and what psychosocial preoperative preparation they currently are able to provide to the child. Some nurses were honest in reporting they do not attempt to provide psychosocial preoperative preparation. Other nurses emphasized that they are only able to explain so much to the child with the skills, education, and understanding they possess. One of the nurses who had a background in child development, which the nurse felt was rare for someone in her department, shared their observation that pediatric patients often make her colleagues uncomfortable. This nurse noted how her colleagues are often fearful of doing something wrong with the pediatric patients because although they see pediatric patients it is not their specialty. The preoperative preparation nurses provide and are comfortable providing should be paid attention to so children can receive quality care and medical professionals recognize the scope of care they as well as their colleagues are intending to provide.

Two nurses, when asked what they felt would improve the pre-operative preparation provided to children in their department, cited the need for more education and training for nurses. They emphasized wanting additional education on children's developmental stages, beliefs in relation to developmental stages, age appropriate language to use with children, and how to explain procedures so children will understand them. Another nurse similarly said they need training on the psychosocial needs of the children they are caring for. This information could be used to develop resources for nurses and show upper management in their departments

what additional training or education they would personally like to improve the quality of the care they provide to children.

The other two nurses took a contrasting approach, not focusing on improving their education, but instead feeling they needed another specialist in preoperative preparation who would be the person who is responsible for the child's psychosocial needs. One citing a social worker and another citing a CCLS. As noted previously at most children's hospitals there would be a CCLS responsible for providing developmentally appropriate individualized education and preparation. In a children's hospital one can also assume it would be standard for there to be licensed clinical social workers on staff. Both nurses addressed that these medical professionals spend the time to really get to know the child and their family. These medical professionals were also noted with giving the child the opportunity to play, explore, and answer any questions the child may have. The nurse who felt their department would benefit from having a CCLS working with them emphasized how CCLSs provide education the child can understand, often utilizing dolls for demonstrations. The nurses' responses show the potential gaps there may be in service providers for their department.

The results of this case study provide insight into the lack of preoperative support children are receiving when child life services are not available as well as the challenges faced by healthcare providers in providing that support. Historically the child life profession was created to fill these gaps and address the psychosocial care children are receiving in the hospital setting. Nurse's observed lack of knowledge about psychosocial education and preparation paired with their honesty regarding their scope of practice provides information for what they are aware of and comfortable doing in their practice. This information can be utilized to support the

development of resources as well as the implementation of child life programs into preoperative departments that do not currently have child life support.

Limitations

Although the sample size of nurses was small and all women, the interviews produced substantial information about the healthcare provider's perspectives and preoperative care provided to children. One limitation of this study was the inability to include an interview with a surgeon that met the criteria of the study that was willing to participate. Since surgeons also play a vital role, future studies could investigate what psychosocial preoperative preparation looks like for nurses and surgeons without child life support. Another potential limitation to this study is convenience sampling was chosen due to the difficulty of finding medical professionals to participate during the Covid-19 pandemic.

Chapter 6: Conclusion

Many children's first major medical experience is the surgery experience. Surgery has the potential to be a traumatic experience for children because it is unfamiliar, abstract in nature, and invasive, causing many children to deem it as threatening if not provided with appropriate psychosocial developmentally appropriate education and preparation.

The findings of this study illuminate the type of pre-operative care a child receives can vary greatly depending on where they are having surgery. The results of this case study provide insight into the lack of preoperative support children are receiving when child life services are not available. Nurses cared for the well-being of their pediatric patients and recognized their distress, but interventions that addressed the child's psychosocial needs were lacking. There was variability in the services nurses provided, the resources they have available to them, and the nurse's knowledge regarding psychosocial preoperative preparation. Nurses expressed they

needed additional support in their own psychosocial education and training when it comes to children or to work with a medical professional who specializes in psychosocial support such as a social worker or CCLS.

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Appendices

Appendix A, Interview Script

The PI will select one pediatric surgeon and three nurses who work with children in the preoperative setting at a non-children's hospital without child life supports to participate in a video recorded interview over zoom. The allotted time for the interview is one hour. If the medical professional ever appears uncomfortable the interview will be stopped and will not continue unless the medical professional agrees to continue. The italicized letters will not be communicated to the medical professional.

1. *Principal investigator (PI)*: Thanks for agreeing to talk with me today! I really appreciate it! I am going to be asking you questions about the preoperative preparation provided to children before surgery. As noted in the Informed Consent I sent you, our interview will be video recorded.You have the right to not answer any questions you do not feel comfortable answering. Also, you can stop this interview at any time. Do you have any questions regarding the Informed Consent or any other questions before we begin? (*Proceed to 1a or 1b)*

1a. *If the medical professional says "No":* Okay, let's get started then! (*Proceed to 2*)

1b. *If the medical professional says "Yes" the PI will answer all questions then proceed to the interview if it is okay with the medical professional (Proceed to 2). If not, the PI will say "*It is totally fine that you do not want to participate in this interview." (*End of conversation)*

PI: The first 6 questions will be about your role and the environment you work in.

2. *PI:* What is your job title?
3. *PI:* How long have you been a (nurse/surgeon etc)?
4. *PI:* Where do you work? (Hospital name will remain anonymous)
5. *PI:* What department do you work in?
6. *PI:* What types of surgeries are you typically involved in?
7. *PI:* What age range of children do you typically see?

PI: The next 4 questions will be regarding the process of preoperative preparation.

8. *PI:* When is developmentally appropriate preparation being provided for pediatric patients prior to surgery (a week before, the day of etc.)?
9. *PI:* Who is typically involved in this preparation?
10. *PI:* What is typically done to prepare the child for surgery? There will be more in-depth questions as we go, so do not worry if you miss something.
11. *PI:* Are there any opportunities for choices within the preoperative process for the child?

PI: The next 6 questions will be about the education and preparation provided to children before surgery. If medical professional says they do not provide education or preparation the

PI will skip these questions and will ask "Is there someone on staff you would be able to ask to provide education to the child?"

12. *PI:* How is the preparation being provided? (Verbal, visual, a combination of the two?)
13. *PI:* Are the children educated about their surgery beforehand and if so how? Does it appear that the child knows what to expect?
14. *PI:* Is the patient's understanding assessed? If so how?
15. *PI:* Are children told what they will see, hear, feel, smell?
16. *PI:* Does the child receive preparation for induction, mask induction or IV prep ahead of time? If so, what does this look like?
17. *PI:* Does the child have the opportunity to rehearse coping skills? (such as holding still for their IV or strategies to stay calm during induction etc.)

PI: We are about half way through the questions. The next 3 questions are about the child's family.

18. *PI:* How are parents involved in preoperative preparation?
19. *PI:* Do you typically communicate to both the child and the parents? Or just the parents?
20. *PI:* Is family centered care prioritized at your place of work?

PI: The next 6 questions are about individualized and child friendly care.

21. *PI:* Does preparation differ depending on the age of the child? If so how?
22. *PI:* Is preparation individualized or is standard preparation provided?
23. *PI:* How does pediatric preoperative preparation at your facility compare to adult preparation?
24. *PI:* Are there opportunities for play in the preoperative setting such as toys, comfort items from home? Does pre-op education for parents include the recommendation to bring something comforting from home for their child?
25. *PI:* Do you feel that the environment is made to feel child friendly? Are there play resources available in pre-op such as a playroom or mobile play cart? Are there toys available to give out to children?
26. *PI:* Do you feel like each child's unique needs are met?

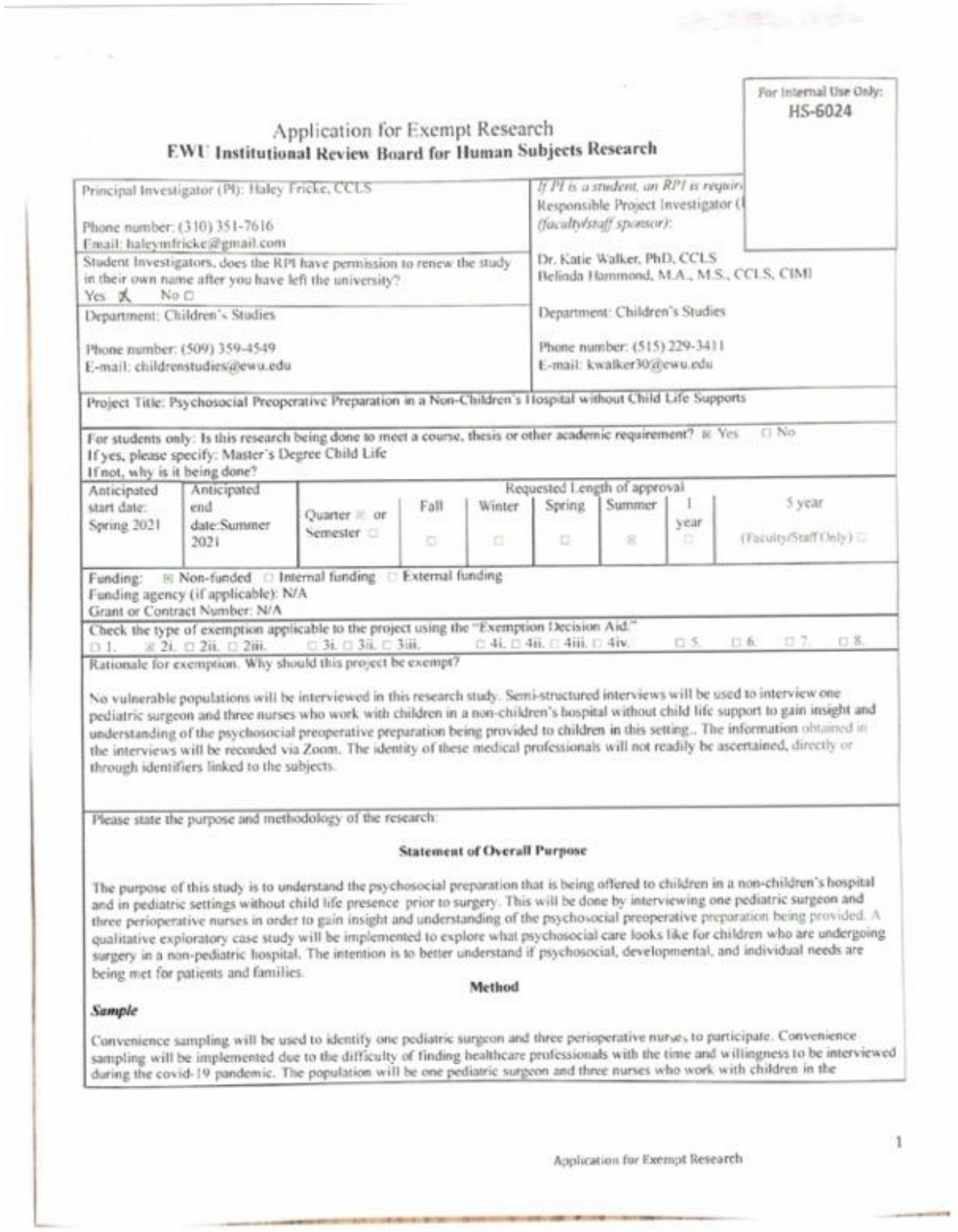
PI: These are our last 7 questions. They are about the child's emotions and your perspective as a medical provider about preoperative preparation.

27. *PI:* Are the child's feelings, concerns, questions addressed? If so how?
28. *PI:* Are there opportunities for the child to make choices?
29. *PI:* Is the child's voice being heard and acknowledged by healthcare providers? If so how?
30. *PI:* Who do you feel should be responsible for preparing the child for surgery?
31. *PI:* Did your clinical training have a focus on pediatric needs? If yes did it include psychosocial needs?
32. *PI:* How do you view your role in providing preoperative preparation?

33. *PI:* What do you feel would improve the preoperative preparation provided to children at your facility?

PI: We are all done with the interview questions. Thank you for your time and participation. Do you have any questions for me at this time?
If the medical professional has any questions they will be answered by PI before concluding the interview.

Appendix B, IRB Approval



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Application for Exempt Research
EWU Institutional Review Board for Human Subjects Research

Principal Investigator (PI): Haley Fricke, CCLS Phone number: (310) 351-7616 Email: haleymfricke@gmail.com	*If PI is a student, an RPI is requir* Responsible Project Investigator (*(faculty/staff sponsor)*: Dr. Katie Walker, PhD, CCLS Belinda Hammond, M.A., M.S., CCLS, CIMI
Student Investigators, does the RPI have permission to renew the study in their own name after you have left the university? Yes ☒ No ☐	
Department: Children's Studies Phone number: (509) 359-4549 E-mail: childrenstudies@ewu.edu	Department: Children's Studies Phone number: (515) 229-3411 E-mail: kwalker30@ewu.edu

Project Title: Psychosocial Preoperative Preparation in a Non-Children's Hospital without Child Life Supports

For students only: Is this research being done to meet a course, thesis or other academic requirement? ☒ Yes ☐ No
If yes, please specify: Master's Degree Child Life
If not, why is it being done?

Anticipated start date:	Anticipated end date:	Requested Length of approval						
		Quarter ☒ or Semester ☐	Fall ☐	Winter ☐	Spring ☐	Summer ☒	1 year ☐	5 year (Faculty/Staff Only) ☐
Spring 2021	Summer 2021							

Funding: ☒ Non-funded ☐ Internal funding ☐ External funding
Funding agency (if applicable): N/A
Grant or Contract Number: N/A

Check the type of exemption applicable to the project using the "Exemption Decision Aid."
☐ 1. ☒ 2i. ☐ 2ii. ☐ 2iii. ☐ 3i. ☐ 3ii. ☐ 3iii. ☐ 4i. ☐ 4ii. ☐ 4iii. ☐ 4iv. ☐ 5. ☐ 6. ☐ 7. ☐ 8.

Rationale for exemption. Why should this project be exempt?

No vulnerable populations will be interviewed in this research study. Semi-structured interviews will be used to interview one pediatric surgeon and three nurses who work with children in a non-children's hospital without child life support to gain insight and understanding of the psychosocial preoperative preparation being provided to children in this setting.. The information obtained in the interviews will be recorded via Zoom. The identity of these medical professionals will not readily be ascertained, directly or through identifiers linked to the subjects.

Please state the purpose and methodology of the research:

Statement of Overall Purpose

The purpose of this study is to understand the psychosocial preparation that is being offered to children in a non-children's hospital and in pediatric settings without child life presence prior to surgery. This will be done by interviewing one pediatric surgeon and three perioperative nurses in order to gain insight and understanding of the psychosocial preoperative preparation being provided. A qualitative exploratory case study will be implemented to explore what psychosocial care looks like for children who are undergoing surgery in a non-pediatric hospital. The intention is to better understand if psychosocial, developmental, and individual needs are being met for patients and families.

Method

Sample

Convenience sampling will be used to identify one pediatric surgeon and three perioperative nurses to participate. Convenience sampling will be implemented due to the difficulty of finding healthcare professionals with the time and willingness to be interviewed during the covid-19 pandemic. The population will be one pediatric surgeon and three nurses who work with children in the

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preoperative setting at a non-pediatric children's hospital in California. Ideally these four healthcare professionals will all be providing care at the same hospital to provide multiple perspectives in the same setting.

Data Collection

The participants will be interviewed one on one over zoom or by telephone. Semi-structured interviews will be used because they pair well with case study research. All interviews will be transcribed verbatim. (See Appendix A for interview questions)

Data Analysis

Data from the interviews will be analyzed using thematic content analysis, a common analysis tool employed in exploratory qualitative case studies.

Describe the procedures: what specifically will subjects do? If data is anonymous, describe the data gathering procedure for insuring anonymity.

The subjects will answer interview questions regarding the following research questions:

1. What psychosocial preoperative preparation are children receiving in a non-children's hospital without child life supports?
    a. What does psychosocial preoperative preparation look like for nurses and surgeons in a non-children's hospital without child life supports?
    b. How is psychosocial preoperative preparation being provided to children in a non-children's hospital without child life supports?

Data will be confidential, such as the medical professional's identities, personal information, and the hospital they are employed at. Due to the vast number of non-children's hospitals and medical professionals in California the information obtained will not be easily associated with the medical professionals. Records identifying participants will be kept on a password protected computer.

To ensure confidentiality to the extent permitted by law, the following measures will be taken: the participant's name will be matched with a project ID. Once the project ID has been determined the participant's names will be kept in a locked filing cabinet. The surveys and audio-recorded interviews will also be coded using the participant's project ID and will be kept in a locked cabinet. The survey and interview data will be on a password-protected computer. The identities will remain confidential and will not be used when the results are disseminated.

Attach all proposed recruitment materials (scripts, texts, emails, flyers and/or social media posts), surveys, questionnaires, cover letters, information sheets, consent forms, etc.

I certify that the information provided above is accurate and the project will be conducted in accordance with applicable Federal, State and university regulations:

PI Signature:
(unnecessary signature lines can be deleted)

× Hailey Fricke ×

× ×

× ×

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Recommendations and Action:	Date	Approve/Disapprove
RPI Signature *(Needed only if PI is a student)*: x [signature]		A ☒ D ☐
IRB Rep. or Dept. Chair: *(Needed if PI is a student OR for faculty PI if required by department)* x [signature]		A ☒ D ☐
IRB Signature: x [signature]		A ☒ D ☐
☒ Subject to the following conditions: per email discussion Approved from May 21, 2021 to May 20, 2022		

Vita

Author: Haley M. Fricke, CCLS

Place of Birth: Torrance, California

Undergraduate Schools Attended: University of California Santa Cruz
Compton College
Cabrillo College
UC Santa Barbara Extension

Degrees Awarded: Bachelor of Studio Art, Minor in Literature, 2014, University of California Santa Cruz

Honors and Awards: Graduate University Honors, Cum Laude, University of California Santa Cruz, 2014

Professional Experience: Child Life Specialist-Limited Term, Sutter Children's Center at Sutter Medical Center, Sacramento, February- July 2020

Child Life Specialist-Limited Term, Sutter Children's Center at Sutter Medical Center, Sacramento, December 2018- June 2019

Child Life Internship, Sutter Children's Center at Sutter Medical Center, Sacramento, May 2018-August 2018

Child Life Practicum, Red Cross War Memorial Children's Hospital, Cape Town, South Africa, July 2017