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Advocacy for the Perioperative Patient

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This is to certify that **Patty Ballinger** has successfully defended her Graduate Project entitled **"Advocacy for the Perioperative Patient"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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Abstract

Thousands of surgeries and procedures happen daily. Patients place their lives and well-being in the hands of the surgical team. The operating room is a high risk environment and unfortunately, errors can occur resulting in harm and even death. Each surgical team member has a role and responsibilities during the surgical case. One main role of the perioperative nurse is patient advocacy and patient safety. However, this role can be impeded due to hierarchy and the operating room culture. Identifying the perioperative nurse's role and responsibility relating to patient advocacy will provide directions in the perioperative nurse's daily practice. An educational session designed to address the perioperative nursing role of patient advocacy is described. Watson's theoretical framework of caring, presence, and empowerment enlightens the nurses to be more fully engaged in providing care to perioperative patients.

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Advocacy for the Perioperative Patient

Chapter One: Introduction

Patients place their trust in nurses daily. They entrust nurses with their well-being, safety, and lives; this is especially true of the perioperative patient. Perioperative nursing is defined as, "the nursing care provided to patient before, during, and after surgical and invasive procedures" (Rothrock, 2011, p.1). Perioperative patients often receive medications and anesthetics that alter their judgment, safety and level of consciousness. Thus, it is imperative the perioperative nurse has a keen understanding of patient advocacy. Advocacy is defined as, "one that supports or promotes the interest of another" (Merriam-Webster, 2013). Perioperative patients are vulnerable and need the nurse to provide a safe environment, as the surgical environment can be compromised by many things. Surgeons may want to complete procedures quickly, team members may not be fully engaged or the wishes of the patient may not be clear. The key to provide for a safe environment is for the nurse to function, "as a patient advocate during times of vulnerability" (Rothrock, 2011, p.1). Watson (2008) identified patient safety as a nurse's moral responsibility to promote well-being at all levels. Watson's use of caring, presence and empowerment encourages nurses to be fully engaged in providing care to perioperative patients. Consequently, an educational module for the perioperative nursing team on the role of advocacy will be developed.

Background of the Project

Perioperative nursing begins when a patient consents to surgery and ends when the patient is discharged to the nursing unit or home. For this project, the perioperative phase begins in the pre-operative unit and ends when the patient exits the operating room.

This period of time is critical for the patient, nurses and the surgical team. The operating room (OR) is a complex, rapidly changing environment. There are multiple tasks occurring simultaneously, staff can be distracted and errors can occur. These errors can be minor or life changing. In addition, once the patient is in the operating room and anesthetized, the patient is unable to voice concerns or wishes and the surgical team must have a keen understanding of the patient's wishes.

Surgery is a high risk environment. "Surgery is a risky activity during which a variety people from different health care disciplines and teams with differing levels of experience must work together in the face of time constraints in a complex health care system" (AORN, 2012, p. 558). Thus, patient advocacy is an essential mission of the perioperative nurse.

The OR can be a complex, tense and intimidating environment for the perioperative nurse. Surgeons are pressured to complete several surgical procedures daily. Surgeons are "under significant time restraints performing highly complex and technologically intense invasive procedures" (Cima & Deschamps, 2013, p. 3). This can result in poor communication, frustration and an increased risk for errors. Cima and Deschamps state, "provider inexperience or lack of technical expertise, fatigue and excessive workload, and communication breakdowns" (p.3) contributes to errors. These issues can compromise an already stressful environment.

Purpose of the Project

The purpose of this project is to develop an educational session to empower perioperative staff emphasizing the importance of patient advocacy in a large Midwestern academic medical center. The medical center has 87 operating rooms spanning three

locations. There are approximately 200 surgeons covering twenty-one specialties. One campus is a level one trauma center providing surgical care twenty-four hours a day. I work at the level one trauma center as a circulating nurse in otorhinolaryngological surgery. Surgical procedures performed in my work unit include head and neck procedures - with and without reconstruction, as well as, laryngeal, sinus, and rhinology procedures. The surgical team includes a surgeon, anesthesiologist, surgical resident in training, certified registered nurse anesthetist (CRNA), circulating registered nurse (RN), certified surgical technologist (CST) and certified surgical assistant (CSA). Each member of the surgical team has different levels of education, training, roles and responsibilities.

The OR is a surgeon controlled environment. Historically, nurses' were perceived as subservient to other health care members (McCabe & Timmins, 2005). The nurse was to follow the directions of the surgeon without question. Hierarchy and authority was respected and obeyed. Nurses were to be nice and caring. Consequently, perioperative nurses may lack confidence to express concerns regarding their patient. They may fear the surgeon, the surgical team, retaliation, or their own lack of knowledge. The nurse may remain silent even when knowing that the best interest of the patient is not being met. Fortunately, the OR environment is changing; nurses are assuming a more active and vocal role. Therefore, a project defining perioperative patient advocacy and empowering perioperative nurses and surgical staff to be passionate patient advocates is envisioned.

Significance of the Project

Patient advocacy is a pillar of nursing. Many nurses entered the profession to make a difference in the lives of patients and the perioperative nurse makes a difference by providing a safe and dignified environment. When the patient is anesthetized during the procedure, the nurse becomes the eyes and ears and guardian of the perioperative patient. However, difficult situations and staff, as well as, lack of experience of the circulating nurse can hinder the nurse in this vital role.

Healthcare is experiencing a paradigm shift and patients are becoming active participants in their care. Traditionally, patients did not question their care. They followed and trusted the physician's recommendations without question. Technology and society have enlightened and educated patients. Information is readily available on the internet. Patients research their illnesses and often have specific, educated questions for allied health staff (Oerman & Pasma, 2001). Just as patients are becoming more active in their care, so should perioperative nurses. Nurses working in the perioperative setting must speak up, ask questions, voice concerns and offer suggestions to improve the care patients receive.

The OR culture is changing and nurses need to embrace their role in improving patient care and safety through respectful and open communication. Nationally and globally, patient safety has become a priority. Health care organizations are encouraging allied health staff to voice concerns and emphasizing that the care of the patient is everyone's responsibility. The World Health Organization (WHO) identified having surgery as a considerable risk for mortality (WHO, 2013). Every year seven million people suffer complications and one million people die after having surgery (Walker &

Wilson, 2009). These numbers are staggering, common factors included poor communication, inadequate anesthetic safety practices, and avoidable surgical infections (2013). To address these problems, the WHO developed a surgical safety checklist in 2008. Interestingly, after implementation of the WHO surgical safety checklist in eight different hospitals in different countries, "deaths were reduced by 47% and in-hospital complications by 36%" (Lai, 2009, p. 31). The checklist is not mandated or required; it was developed to be a tool to assist operating room personal in preparing and keeping patients safe. The WHO advises a surgical team member, typically a circulating nurse, be appointed responsible for the completion of the checklist (WHO, 2013). The large Midwestern hospital has utilized the surgical safety checklist for three years. Additionally, communication has been enhanced with surgical briefing prior to the surgical case and a debriefing after the case has been completed.

Perioperative nurses are accountable to their patients, the institution they work for, and the nursing profession. However, the perioperative nurses' primary obligation is their patient. Nurses function under a code of ethics and in 1950, the American Nurses Association (ANA) developed the ANA Code (Lachman, 2009). The code "provides a social contract with the society served, as well as ethical and legal guidance to all members of the profession" (p.55). Provision three of the code states, "the nurse promotes, advocates for, and strives to protect the health, safety and rights of the patient" (p.56). Therefore, requiring the perioperative nurses to advocate for their patients in the perioperative setting is mandated.

Nursing Theoretical Foundation

Nursing is guided by principles that provide the framework to enable nursing to give the best care to patients. One principle that is central to nursing is the aspect of caring (Watson, 2008). Caring is an action that begins with the nurse. In addition to providing for needs, caring involves being attentive and present with patients. Watson (2008) *Philosophy and Science of Caring* theory incorporates the nurse's own self-awareness within the theory. Nurses need to be in touch with and aware of their own thoughts, beliefs and feelings before interacting with patients. Watson encourages nurses to care for themselves, in doing so nurses have the potential to be positive life sources and energy for their patients.

Establishing trust is a second principle in the nurse-patient relationship. Patients need to trust nurses to provide for their basic human needs including respect, dignity and privacy. Watson's (2008) theory discusses the importance of nurses to form a relationship with the patient. The relationship supports the nurse and patient to share the surgical environment and experience.

A third principle guiding perioperative nurses is empowerment. Empowerment is defined as, "to promote the self-actualization or influence of" (Merriam-Webster, 2013). The perioperative nurse uses empowerment to influence change and promote safety for the patient. The nurse needs to speak up when the environment or surgical team is not conducive to the needs of the patient. The nurse must utilize his or her knowledge base, past experiences and the patient's wishes to foster a healing and safe environment. In doing so, the nurse is honoring the trust and relationship with the patient.

The fourth principle is presence. Presence is defined as, "the fact or condition of being present, position close to a person, a person's appearance" (Merriam-Webster, 2013). This definition is concrete. However, presence is also an abstract concept. Presence in nursing is multidimensional. The nurse's time while the patient is awake is limited. The nurse has limited time to interview the patient and provide reassurance upon entering the OR. It is vital that the nurse be authentically present during these times. Utilizing Watson's (2008) theory, the nurse uses his or her energy and life source in attempting to connect with the patient on a higher realm. For this connection to happen, both the nurse and patient need to be authentically present and open to the connection. "Transpersonal caring seeks to connect with and embrace the spirit or soul of the other through the presence and caring and healing and being in authentic relation, in the moment" (Parker, 2006, p.299).

Patricia Benner's (2001) Novice to Expert Nursing Theory applies to the stages the perioperative nurse transitions through. Benner's (2001) theory has five stages of nursing development. The five stages are; novice, advanced beginner, competent, proficient, and expert. Nurses transition through the stages throughout their career. However, not all nurses will become experts in their specialty. There are many factors that affect the nurses' ability to transition to the next stage including, education, proficiency, and past experiences.

Recently licensed nurses and nurses new to a specialty must learn the skills to function in that environment. Nurses new to perioperative nursing are considered novice nurses. They must learn the skills to function in the OR environment. Many operating

rooms have only one perioperative nurse thus; the nurse must possess the ability to function independently in addition to, being a surgical team member.

Autonomy is a critical skill the perioperative nurse must learn. The nurse must develop skills to work independently, provide safe care, and to advocate for the perioperative patient. Time and experience are needed for new perioperative nurses to transition to the next stage. However, it is imperative that new perioperative nurses receive a through orientation and have strong perioperative role models to shadow. It is critical that new perioperative nurses receive a solid nursing practice foundation. It is essential that this foundation is rooted in the skills to provide competent and safe care, as well as, nursing theory to guide the perioperative nurse in providing nurturing and compassionate care.

Advocacy is central to the nursing profession. Advocacy is defined as, "the act of pleading for, supporting or recommending" (Merriam-Webster, 2013). Surgical patients need advocates involved in their care for several reasons. Surgical patients often experience anxiety and fear (Lee & Lee, 2012), receive anesthetic medications, are sedated or intubated and cannot make decisions regarding their care. They are in a vulnerable state and "trust that a perioperative nurse will advocate in their best interest to ensure their privacy, dignity, rights, and safety" (Boyle, 2005, p. 251). Due to the highly complex environment, the perioperative nurse often assumes the role of patient advocate (Boyle, 2005). Ford (2012) states, "Nurses have the opportunity to act as a patient advocate in every patient encounter by focusing on the patient's specific wishes and by ensuring that care is provided in the safest manner possible" (p.425).

The operating room is a high-risk, stressful environment for patients and the surgical team. Fortunately, certain factors can be modified to improve safety, decrease stress and promote a positive healing environment for the patient and surgical team. The perioperative nurse has the unique opportunity to be authentically present with the patient. She or he can shape a caring, safe and trusting environment with the ultimate responsibility of advocating the needs and wishes of the patient. Applying Watson's (2008) theory of caring, unites the physical, emotional and spiritual needs of the patient and the surgical experience.

Chapter Two: Review of Relevant Literature

The surgical environment has undergone several changes in recent years. Changes include; how and where care is delivered, who provides the care and technological advances. Perioperative nurses have needed to adapt to these changes. The list of tasks and responsibilities of nurses continues to grow. Nurses have needed to learn more complex, technological instruments and equipment. "Perioperative nurses often serve as technology superusers responsible for keeping up with advances in OR technologies and sharing this information with their colleagues" (Stanton, 2011, p. C1). In addition to technical responsibilities, the perioperative nurse has a responsibility to provide a safe, caring, and compassionate surgical environment. The perioperative nurse's role of patient advocacy is vital to provide a safe and caring surgical environment. Boyle (2005) states,

> Protecting patients from harm is the essence of the advocacy role of nurses, and it is a critical component for patients whose family members are not readily accessible and whose only possible advocate is the nurse. This often is the case for patients who are in the OR. (p. 251)

It is imperative the perioperative nurse understands the wishes of the perioperative patient. Patients who are sedated and intubated rely on the perioperative nurse to advocate for them. Thus, perioperative nurses must possess technical and patient advocacy skills.

Nurses must have a working knowledge of the instruments and equipment. Patient safety can quickly become compromised when instruments and equipment are used incorrectly or when individuals do not have the knowledge base to use them.

Patient advocacy applies to healthcare individuals' competency with instruments and equipment. Perioperative nurses are responsible for knowing how to safely operate equipment. Stanton (2011) shares, perioperative nurses serve as resources for other surgical team members in using equipment and technology (p. C1). This highly technological environment may divert attention from the main focus, the patient. Although the patient is the focal point, the nurse and surgical team can lose site of the individuality and uniqueness of the patient. "Amid increasing technology, caring is an important component of nursing that must not be overlooked" (Watson, 1994, p.268). Thus, it is imperative that the main focus be the patient and not the diagnosis or surgery.

There are several tasks a perioperative nurse completes during the surgical procedure. "The perioperative nurse must calibrate machines, inspect equipment, count instruments, and assist the surgeon and anesthesia personnel" (Watson, 1994, p.268). Numerous tasks need to be completed, team members have different roles and responsibilities, and time is precious. Many tasks are simultaneously occurring and the environment is constantly in motion. The surgical environment can quickly become an assembly line. The surgical team can easily forget that there is a patient under the surgical drape. Patients can be seen as, *the second surgical case* or *a total hysterectomy.* Loosing site of the patient, can lead to impersonal, automatic and machinelike care.

The change in healthcare reimbursement is also affecting how the surgical environment functions. Hospitals and surgical centers are assessing OR efficiency, implementing new guidelines for first surgical case start time and turnover times between cases. Operating rooms at the academic medical center in the Midwest have a set start time and turnover time. When delays occur, this costs the surgical area money. An

empty operating room equates to increased cost and decreased employee productivity. This established amount of time, can directly affect the perioperative nurses priorities. At the academic medical center in the Midwest, the perioperative nurse historically, visited the patient prior to entering the operating room. Unfortunately, with the multiple tasks that need to occur before the patient arrives, and the quicker turnover time, many nurses omit the preoperative visit before entry to the operating room and conduct the visit when the patient enters the operating room. A quality improvement project performed at Cincinnati-based TriHealth, eliminated the perioperative nurse visit in the preoperative waiting area. 'The circulator performs the assessment as the patient arrives in the room" (Patterson, 2011, p. 18). Patterson (2011) also stated, "The change was a big one for nurses… because they must trust that the chart is complete and that the patient will be ready upon arrival in the OR" (p.18). This change directly impacts the surgical experience for the nurse and patient. The perioperative nurse loses a valuable assessment and information opportunity, a time to answer questions and the opportunity to begin the nurse/patient relationship. The preoperative visit is also an important time for the patient's safety. The nurse can assess the patient for potential problems prior to entering the OR. The nurse can ensure valuables are not with the patient, verify the patient agrees with the listed procedure and the patient does not have any medical issues that need to be addressed. These are all factors that potentially can impact the patient's safety in the OR. Shields & Werner (2002) share the "perioperative nurse may be the last healthcare professional a patient encounters before undergoing surgery" (p.20). The perioperative visit "enables perioperative nurses not only to act as patient advocate and facilitate solutions to dilemmas, but also to fulfill their legal obligations" (p.20).

The perioperative visit plays a vital role in the establishment of a trusting relationship between the patient and nurse as well as, confirmation of important information prior to the surgical procedure. Elimination of this visit further adds to the depersonalization of the operating room. The perioperative nurse may feel rushed while other team members want to move the patient to the operating room table and start the anesthesia process. This hurried and rushed behavior can be uncomfortable for the surgical patient. A recent bariatric patient stated, "I felt like everyone was in a hurry to get things done, I did not feel comfortable" (K.Bull, personal communication, September, 17, 2013). Bergbom & Westerling (2008) conducted a hermeneutic study in a Swedish hospital to understand the "importance and meaning of perioperative visits from the patient's perspective" (p. 135). The study was limited to ten patients and ten nurses. Patients valued the perioperative visit from the nurse. Patients reported the visit helped to relieve anxiety and fears and allowed questions to be answered.

The perioperative visit allows for confirmation of vital information, especially informed consent prior to the patient's entry into the OR. It is a responsibility of the perioperative nurse the patient understands and has signed the informed consent document. Shields & Werder (2002) state, "It is the nurses' responsibility to ensure that the patient has been told and that he/she understands what has been said" (p.13). If the perioperative nurse does not believe the patient understands, the nurse must advocate for the patient. The nurse must inform and request the surgeon speak with the patient prior to the patient's entry into the OR.

OR Culture

The operating room is a complex environment with a distinct culture. There are multiple healthcare workers with varying educations, experience and values. Culture is defined as, "a way of thinking, working, behaving that exists in a place or organization" (Merriam-Webster, 2013). Historically, the OR culture was hierarchical under the direction of the surgeon. "Traditionally, the surgeon was considered the leader of the OR by default, the captain of the ship" (Cima & Deschamps, 2012, p.6). This culture also viewed nurses as, "merely assistants to the real work of physicians and surgeons" (Holmes & Walker, 2008, p. 114). This cultural belief further demonstrates the hierarchal and cultural division.

One significant reason for the cultural difference is how nursing is perceived. Traditionally, nursing has been viewed as a vocation instead of a profession. Nurses were taught to be subservient, not to question the physician and be loyal to the physician (Bernard, 2004). Bernard (2004) also states, "Despite nurses' attempts to be recognized as a profession, the professional status of nursing remains elusive to many nurses; it is even invisible to the public and healthcare administrators around the world" (p. 978). Fortunately, in recent years this hierarchy has been under examination. The concept of teamwork has become a goal of many healthcare organizations. Cima and Deschamps (2012) state, "Over the last decade, team development and teamwork has become somewhat of an obsession in medicine" (p.3). Healthcare organizations are exploring teamwork to improve patient outcomes (Akerman, Johansson, Larsson, Odenrich & Rydenfalt, 2011).

Workplace Abuse

Workplace abuse is a problem in healthcare. Higgins and MacIntosh (2010) state, "health-care workers are 16 times more likely to experience abuse" (p. 321) than any other profession. Higgins and MacIntosh (2010) conducted a qualitative descriptive study in Eastern Canada focusing on perioperative nurses and physician perpetrated abuse. Perioperative nurses reported, "being belittled, ridiculed, yelled and sworn at" (p. 322). In addition to psychological abuse, the nurses also reported, "physical abuse including being kicked, pushed and having objects thrown at them" (p. 323). The study also found that when nurses reported the abuse, they were alienated, labeled as a 'trouble maker', or their report was ignored. Nurses may fear being retaliated by surgeons, the surgical team or management. Thus, the nurse may remain silent even when he or she has a question or concern. This fear may keep nurses from speaking up and advocating for the patient. Disrespectful and abusive behaviors are unacceptable, affect OR teamwork, and increase the risk for errors. These factors directly affect the patient.

National healthcare organizations have identified disrespectful and intimidating behavior as a patient safety issue. The Joint Commission (2008) found that these types of behaviors directly impact patient safety and satisfaction and stated strongly, "Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it" (Feldman, Kaplan & Mestel, 2010, p. 495). The Joint Commission went on to mandate that hospitals wanting accreditation must, "have a code of conduct that defines acceptable and inappropriate behaviors and create and implement a process for managing the behaviors that undermine a culture of safety" (p. 495). Dr. Lucian Leape from Harvard School of Public Health states, "a sense of privilege and

status can lead physicians to treat nurses and other healthcare professionals with disrespect, impairing teamwork and communication" (Dienstag et al., 2012, p.846). Leape also commented that disrespectful behavior is often from physicians, since the physician dominates the culture and sets the tone. In addition, disruptive behavior "was linked to medical errors, poor patient satisfaction, preventable adverse outcomes, increased staff turnover, and higher costs for care" (Deitte, Rawson, Thompson & Sostre, 2013, p. 1074). Deitte, Rawson, Thompson & Sostre also stated, "The most significant indirect cost is the failure to create a culture of safety and highly functional teams in health care" (2013, p. 1075). Healthcare organizations have a societal and professional responsibility to address behaviors that are not conducive to patient safety.

Advocacy

Patient advocacy is pivotal to the safe care of perioperative patients. Perioperative patients place their lives in the hands of the perioperative nurse and the surgical team. All healthcare individuals have an ethical, legal, and moral responsibility to the patient, society, and their licensing board. However, not all healthcare environments are conducive for healthcare workers especially, perioperative nurses to speak up. "Codes of professional practice remind staff of their professional and legal duties in civil, criminal, and contract law to speak up, yet the conditions that enable them to do so have been found wanting " (Reid, 2013, p. 115), the environment has not been conducive for speaking up.

Patient advocacy is an essential responsibility when caring for perioperative patients. "Advocacy is a critical issue for surgical patients who are unconscious or sedated and unable to make decisions related to their care" (Boyle, 2005, p.250).

Perioperative patients entrusts the nurse with their care. Once the patient enters the OR, the perioperative nurse assumes the care, safety, and advocacy of the patient. It is imperative the perioperative nurse understands the important role of patient advocacy. The patient is entrusting the perioperative nurse with his or her life. The OR is a high-risk environment and perioperative nurses need to be keenly aware of his or her advocacy responsibilities. The perioperative patient is relying on the nurse to protect and safeguard their physical and emotional well-being. Boyle (2005) explains, "Nurses need to have a sound professional identity and a high level of self-confidence and self-esteem to advocate in potentially risky situations" (p. 252).

The nursing profession is built on trust. Licensed nurses are entrusted by the respective board of nursing to provide competent and safe care in the best interest of their patients. Ford (2012) states, "As one of the professions most trusted by the public, nurses are responsible for providing the best care possible" (p.426). Patients place their trust in nurses. This is an enormous responsibility and should not be taken lightly. The perioperative patient further assigns the perioperative nurse the right to advocate for him or her during surgery. The patient is unable to communicate with the surgical team, family, and friends. The patient is depending on the perioperative nurse to act in his or her best interest. The nurse is not only accountable to the patient, but also the surgical team, the healthcare organization, the state licensing agency and the general public.

Communication in the OR

Clear and effective communication in the OR is vital to patient safety. A hierarchal paradigm affects the surgical teams' ability to communicate easily and ask questions. Perioperative nurses who fear repercussions, are new to the OR, or do not have

confidence that leadership will address concerns, may remain silent, not ask questions, voice concerns and not advocate for their patient (Cvetic, 2011). This encumbered communication directly affects patient care. Operating room teams "are expected to synthesize, retain, and communicate large amounts of information" (Adams et. al, 2011, p.1131). The environment is high-risk with potential for errors and compromised patient safety. In addition, communication is further affected by loud music, side-bar conversations, and egos. Hearing, understanding and communicating effectively can be a challenge however; keeping the patient safe is the ultimate responsibility of all members of the surgical team. In 2001, Dr. Tom Russell of the American College of Surgeons commented regarding communication between surgeons and nurses in the operating room. Dr. Russell stated, "The two groups must both take responsibility, and if there are questions, they should stop and clarify to be sure everyone is on the same page. No one should make assumption" (Joint Commission, 2010).

Caring

The act of caring is an essential trait of human beings. This is especially true among nurses. The ability and the degree to which one cares, varies person to person. Caring is an abstract non-tangible concept. Caring is defined as, "to feel interest or regard" (Merriam-Webster, 2013). Caring is much more than a feeling; it is an action and way of life. Arnold & Boggs (2003) define caring as, "An intentional human action characterized by commitment and sufficient level of knowledge and skill that allows the nurse to support the basic integrity of the person being cared for" (p. 607).

Nursing is more than action; it is more than tasks, checklists, and machines. Applying nursing theory to the act of nursing transforms it to the art of nursing.

Application of nursing theory elevates nursing to a higher dimension, in which caring becomes visible and tangible. Incorporating and understanding nursing theory allows the nurse to truly care for the patient. Often times, nurses are not fully aware of or focus on theory. They are concerned with the tasks and assignments that need to be completed. However, when theory is applied to these tasks and assignments they become opportunities to truly care for the patient as well as, opportunities to connect with the art of caring. Patients describe caring as, "Listening, responding, being physically present and showing concern that is comforting and relaxing" (Cecka, Meyer, & Turkovich, 2006, p.259). If nurses continue to primarily focus on the technical aspect of nursing, we risk caring to wither away and nursing to become a depersonalized discipline (Cara, 2003).

Watson's Theory of Caring

Watson (2014) *Philosophy and Science of Caring* theory is centered on the concept of caring and caring relationships. "Transpersonal caring occurs when the one caring connects with and embraces the spirit of the other through authentic, full attention in the here and now, and conveys a concern for the inner life and personal meaning of another" (Watson, 2014, p. 17). When a nurse assumes the care of a patient, several responsibilities ensue. The nurse is accountable for the well-being of the patient. The patient trusts the nurse will act in good faith and provide a safe environment and entrusts the nurse with his or her life. This is an enormous responsibility, yet one that perioperative nurses accept. To provide a safe environment, requires the perioperative nurse to be a vigilant guardian. The perioperative nurse continuously monitors the

patient and the environment for any potential harm. The nurse must immediately speak up and advocate for the safety and well-being of the patient.

There are three major conceptual elements to Watson's theory. The concepts are mainly abstract in nature and are linked together in the *caring moment.* The three concepts are:

- Ten Caritas Processes
- Transpersonal caring relationships
- Caring moment/caring occasion

The ten Caritas serve as a guide to the art of caring. Caritas is Latin and means, "to cherish, appreciate, and give special or loving attention with charity, compassion, and generosity of spirit" (Watson, 2014, p.21). When nurses care about their patient, they enter into a relationship with the patient. They care what happens to that patient and want the best possible outcomes. The perioperative nurse advocates for his or her patient to help create and facilitate this to happen.

Caritas are caring competencies that are as crucial as technological competencies (Watson, 2014, p.18). Caritas not only assist in caring for the patient, but also caring for the nurse. Watson's theory requires the nurse to be aware of his or her own bias and beliefs. He or she must have an understanding of self to fully connect and care for another. "The nurse must be self-aware of any judgmental feelings or feelings that could foster his or her crossing boundaries into intimacy" (Lachman, 2012, p. 112). Thus, Watson promotes self-care of the nurse. "This model invites, if not requires, nurses to attend to self-caring and practices that assist in their own evolution of consciousness for more fulfillment in their life and work" (Watson, 2008, p. 47). The nurse needs to have

the energy to meet the demands of nursing. Self-care allows the nurse the time, space and opportunity to restore harmony and balance. This restoration is vital for the nurse to be effective in providing care, to assist in the healing to the patient, and to successfully advocate for the patient.

Importance of Self-care

Self-care is a key element in Watson's Caring theory. Nurses need to care for their own physical, emotional, and psychological needs. If nurse do not care for themselves, then they hinder their ability to care for others. Providing for the needs of the patient can be draining physical and mentally. Watson (2008) shares, "Nurses often become pained and worn down by trying to always care, give, and be there for others without attending to the loving care needed for self" (p.47). Nurses need to have the energy to care for patients. The nurse should partake in self-care activities that help rejuvenate and restore their well-being. If a nurse does not care for his or herself, this directly affects the perioperative patient. The nurse can suffer from burnout, which impacts their ability to provide caring and compassionate care. When nurses suffer from burnout, everyone suffers, especially the perioperative patient.

Watson encourages nurses to practice mindfulness meditation on a regular basis, which is one way to prevent burnout. Mindfulness is the Buddhist concept for awareness and "is the energy of being aware to the present moment" (Watson, 2014, p. 25). In mindfulness mediation, the nurse connects with the present moment. Mindfulness is an important concept to Watson's Caring theory. It is through mindfulness, that the nurse is able to release negative feelings, pain, fear, sorrow, anger and much more. With the release of thoughts, feelings and concerns, the nurse is able to allow love and kindness

flow in, thus awakening the nurse to be present in the moment and to become the caring environment. Mindfulness helps the nurse restore his or her own balance and harmony. The nurse needs to be in harmony with him or herself before engaging with patients. If the nurse is in disharmony, this affects the energy, environment and harmony of the patient. Watson (2008) further explains that individuals who detach professional, who close off their hearts and feelings contribute "to a toxic situation or an unhealthy work environment" (p. 69).

Transpersonal Caring Relationships

Watson's theory is founded on transpersonal caring relationships. Watson's ten caritas serve as the framework to guide and assist the nurse in creating caring relationships and moments. Watson's second caritas is, "Being authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/others" (Watson, 2014, p.21). The dictionary defines presence as, "the fact or condition of being present, position close to a person, a person's appearance" (Merriam-Webster, 2007, p.304). This definition is concrete. However, presence is also an abstract concept. Presence in nursing is multidimensional. The nurse can be physically present in the room, but mentally and emotionally in another time and space. The nurse can be focused and concerned with other tasks and other patients. However, to be truly present, the nurse must consciously focus on the patient and the here and now. To be an effective patient advocate, the perioperative nurse must be physically, mentally, and emotionally present. The nurse needs to be fully engaged in the moment and in the needs of the patient.

Authentic Presence

Authentic presence takes a conscious decision by the nurse. The nurse makes a choice to be authentically present with the patient. The nurse is genuine and empathetic, drawing on his or her own self-awareness and previous experiences. The nurse becomes centered in the moment, being fully present with the patient. The nurse "seeks to go beyond the self and the here and now, reaching to deeper connections with spirit, and with the broader universal consciousness" (Watson, 2014, p. 18). When the nurse and patient are able to connect in the caring moment, amazing things can happen. The moment transcends time and space connecting love, caring and healing. Unfortunately, not all patients are able to connect with their nurse in a caring moment. It is important for the nurse to be able to detect this. The nurse must determine the needs and wishes of the patient. The patient may not be able to connect with the nurse due to physical, emotional, mental or spiritual reasons. The patient may be in disharmony. The nurse needs to assess the patient and situation. It is imperative the nurse not shy away from the patient. Each encounter with a patient can be the beginning of a caring moment and relationship.

Healing Environment

Watson's eighth caritas is, "Creating a healing environment at all levels, subtle environment for energetic authentic caring presence" (Watson, 2014, p.21). The perioperative nurse has a professional, ethical and moral obligation to provide a safe environment for the perioperative patient. Perioperative patients are vulnerable and are at risk for harm. Anesthetized patients are unable to protect themselves for harm. It is the responsibility of the perioperative nurse to be a vigilant guardian of the patient's safety. Creating a safe and healing environment takes diligence and perseverance. It is a never-

ending task. The surgical environment is always changing and the perioperative nurse needs to be attentive and observant.

Healing Environment and the Nurse

The surgical environment is not limited to the physical realm. Watson's (2008) eight caritas, encompasses not only the physical environment but also the "nonphysical, subtle environment of energy and consciousness" (p.136). Watson defines, "A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time" (Watson, 1979, p.9). The perioperative nurse promotes an environment that accepts the patient where he or she is at physically, emotionally and spiritually. This acceptance encourages the perioperative patient to trust the nurse. Through this trust, a caring moment can occur. Emotions can freely be expressed and exchanged. Providing a loving and healing environment opens the door to a higher level of being. Watson states, "wholeness, beauty, safety, comfort, dignity, and peace are potentiated" (2008, p.136). Watson further states, "In this expanded process, environment takes on an entirely new meaning whereby the nurse is *in* the environment, addressing all the above aspects of environment, but in the *Caritas Process* the nurse *becomes* or *is* the environment" (p. 136). Hence, whether the OR is state of the art, in a third world country, or the battlefield, the nurse has the opportunity to promote healing, love and caring.

The nurse can also foster a healing environment by allowing the patient to share thoughts, concerns, and feelings. Having the freedom to openly share thoughts, concerns and feelings allows the patient to release the energy that these issues have. Watson's (2008) fifth caritas is to promote and accept positive and negative feelings as you

authentically listen to another's story. The energy can be negative or positive however, having the opportunity to share feelings can be extremely therapeutic. Having surgery is stressful for patients and their family. There are so many unknowns prior to surgery. These unknowns can overwhelm patients. The perioperative nurse cannot change these unknowns however, allowing to the patient to share and authentically listening to the patient can be "a healing act in itself" (Watson, 2014, p. 85). When the perioperative nurse authentically listens, the nurse increases his or her understanding of what the perioperative patient wants. Having this understanding assists the perioperative nurse in advocating for the wants and needs of his or her patient.

The OR can be a stressful and difficult environment. There are many personalities, time constraints, complex surgical cases and critically ill patients. The potential for errors, harm and mortality exist. Unfortunately, not all risks can be avoided. However, the risks can be decreased. The surgical environment needs to change to decrease the risk of harm to patients. Addressing the surgical culture can have a positive impact on patient safety, improved communication and teamwork. Perioperative nurses have the opportunity to positively impact the lives and the surgical experience of their patients. They can promote a safer environment by speaking up with concerns and questions, being vigilant regarding patient safety, being a patient advocate, and being authentically present. Additionally, applying Watson's caritas fosters an opportunity to assist the patient into a higher level of being, in which love, caring, and healing can occur. Watson's caritas also support the perioperative nurse in advocating for the perioperative patient, which is an imperative role of the perioperative nurse.

Chapter Three: Development of Innovative Practice Model

Patient advocacy is the ultimate responsibility of all healthcare providers involved in the patient's care. This includes the chief executive officer to the environmental services worker. However, for this project, the primary focus will be on the perioperative nurse in the OR. Perioperative nurses have the critical responsibility of being a patient advocate. The nurse assumes responsibility for the health and well-being of his or her patient and must have a thorough understanding of patient advocacy.

The project envisioned is an educational session where patient advocacy and its importance is defined, reviewed and discussed. The educational session format (Appendix A, p. 52) will be a PowerPoint presentation with time for questions and answers, and reflection. The educational session will be attended by RN's, CST's, CSA's, SCT's (surgical core technicians) charge nurse, nurse manager and the nursing education specialist in the division of ENT (ear-nose-throat), Oral- Maxilla, Pediatric and Ophthalmology surgery.

Educational Session

The educational session will be an opportunity to educate and reinforce to perioperative staff in the importance of patient advocacy in the OR. It is the entire perioperative staffs' responsibility to provide for a safe OR environment.

Patient Advocacy Definition

The educational session will define what patient advocacy is. Advocacy is defined as, "one that supports or promotes the interest of another" (Merriam-Webster, 2013). It is the responsibility of the perioperative nurse and surgical team to advocate for the best interest of the patient. It is important to protect the patient from harm and respect

the wishes to the patient. The role of patient advocacy is imperative for the perioperative patient, "advocacy is a critical issue for surgical patients who are unconscious or sedated and unable to make decisions related to their care" (Boyle, 2005, p. 250).

Perioperative Nurses Responsibilities

The educational session will address the perioperative nurse's legal, ethical, moral and professional responsibility to the perioperative patient. Perioperative nurses are bound by a legal code to protect patients from harm. They must adhere to the nurse practice act of the state they are licensed, as well as the ANA code of ethics (Lachman, 2009). In addition, nurses have a responsibility to the nursing profession as a whole to uphold the values and principles of nurses worldwide. Nurses are one of the most trusted professions and have earned this trust from placing patients first.

OR Culture/Environment/Workplace Abuse

The educational session will address the OR environment and culture and the potential for workplace abuse. The OR environment and culture can be hostile and overpowering. The environment contains several different surgical team members in a confined area. The environment is highly stressful with the surgical patient's life in the hands of the surgical team. It is imperative that the perioperative nurse and surgical team address issues and concerns to protect the patient.

Historically, the OR environment and culture did not readily accept the concerns of perioperative nurses and workplace abuse occurred. Perioperative nurses were challenged with internal and external obstacles concerning patient advocacy. They faced ridicule, physical and emotional abuse and termination. Fortunately, accrediting institutions recognized the harmful effects to patient and nurses in the current OR

environment and started to address the issue. In addition, patients became more proactive in their care and perioperative nurses assumed a more proactive role in protecting and advocating for their patients. The OR culture is changing, however, it takes perioperative nurses and surgical team members to speak up and advocate for patients.

Application of Watson's Theory of Caring

The educational session will discuss Watson's (2008) *Theory of Caring* and how perioperative nurses can incorporate her theory into their daily practice. Perioperative nursing is a unique and challenging discipline. Working as a perioperative nurse for the past six years has given this writer valuable experiences in patient advocacy. I have felt the dynamics of the surgical experience of patients and families. I have wiped tears and held patients hands while they go off to sleep. I have had mothers and fathers say, *Please take care of my baby.* I have had patients and families thank me for the care I gave months after their surgery. In addition, I have also experienced the obstacles and hierarchy of surgeons that can affect safe patient care. I have been yelled at by surgeons, glared at by surgical team members and have seen instruments thrown. When I asked a question regarding the incident of surgical site infections (SSI) in Ear, Nose and Throat patients, the surgeon's response was, *why do you want to know?* The care provided by the perioperative nurse and the surgical team has a direct effect on the risks of SSI. "Perioperative nurses are expected to demonstrate strict adherence with asepsis principles to prevent surgical site infections (SSIs) as breaching of these principles poses a serious risk of infection to surgical patients" (Adams, J., El-Masri, M., & Korniewicz, D. 2011, p.7) .

Perioperative nursing is unique because the patient is often asleep during the procedure and unable to communicate with the nurse. There are several misconceptions of what a perioperative nurse does and if he or she is truly providing care since the patient is sedated. While the patient is sedated, the perioperative nurse is a vigilant guardian and a pivotal communicator with the surgical team and the patient's family. In addition, the nurse is responsible for documenting vital information in the patient's medical record. This project also intends to bring more meaning to the role of the perioperative nurse. One way to bring more meaning to the role is applying nursing theory. Connecting the perioperative nurses role and nursing theory can refocus the nurse. It can bring more meaning to the nurse which in turn can improve job satisfaction.

Application of nursing theory will bring meaning and understanding to why nurses do what they do. Ryan (2005) states,

> Nursing leadership within the healthcare system recognized that clinical practice would be strengthened through the integration of an established nursing theory. An established nursing theory would strengthen practice by providing structure and language to describe, explain, support, and guide the professional nursing practice. It would openly proclaim the beliefs and values that underpin the nursing practice, and thus it would express the essences of professional nursing that had formerly been unspoken. (p. 26)

The application of theory moves the nursing discipline to the art of nursing. It incorporates science and caring to the role of the nurse. Watson's Theory of Caring (2008) incorporates the art of caring with the technical aspects of perioperative nursing.

Watson's theory recognizes that a caring moment can happen at any time. The caring moment is not limited by time or by space.

Self-care Activities

Watson's theory recognizes that nursing is a labor intensive discipline. Nursing can be physically, emotionally, mentally and spiritually tolling for the nurse. This highly demanding profession can cause nursing burnout, depersonalization, and job dissatisfaction (Lesson, Robertson, Watts & Winter, 2013, p.26). These negative effects can cause a nurse to lose interest in his or her job. This directly affects the care provided to patients. Nurses need to utilize resources, their own inner strength, and relationships to maintain and restore personal balance and harmony. To counterbalance the demands of nursing, nurses need to find activities that they enjoy. These activities are ways to restore their hope, love, kindness, and peace. There are several ways for nurses to restore their inner strength. Watson (2008) encourages nurses to practice some form of daily mindful awareness or meditation (p.35). "This preparation can take the form of daily practice of offering gratitude, of connecting with nature; the practice of silence, journaling, prayer" (p.35). Watson (2008) further identifies that mindful awareness and meditation not only aids the nurse but also the patient (p.36). The positive, emotionally and spiritually balanced nurse is in a better state of being to help and care for patients.

Educating perioperative nurses on self-care is a key factor. Often, nurses do not care for themselves (Watson, 2008). Nurses are typically excellent care givers to others, but not to themselves. Watson (2008) states, "Nurses often become pained and worn down by trying to always care, give, and be there for others without attending to the loving care needed for self" (p. 47). This project will educate perioperative nurses that

self-care is important and can bring more meaning to their work. Self-care has vast possibilities. Self-care is specific to each nurse. It's the activities that generate joy, meaning and pleasure. The activities can be physical in nature such as exercising, traveling, volunteering, cooking and painting. It can be an individual or group activity. Activities can be nonphysical such as journaling, religious and spiritual activities, and meditation. The possible activities are endless; the important factor is that the nurse finds the activity meaningful. The educational session will educate and encourage the perioperative nurses to participate in activities that promote self- care and well-being. Self-care is essential for the nurses; it allows nurses to restore harmony which decreases the risk of burnout. Self-care places nurses in healthier states which improves patient safety and advocacy. In order to care for others, the nurses need to care for themselves.

Transpersonal Caring Relationship

The educational session will address the importance of the transpersonal caring relationship. The transpersonal relationship starts with the perioperative visit. The perioperative visit is vital to the care of the perioperative patient. Prior to the visit, the nurse should review the patient's medical record. Reviewing the informed consent, perioperative checklist, labs, medications, surgical orders, physician notes, vital signs, family contacts and other pertinent information provides the nurse with important information regarding the patient. It provides valuable information which assists the nurse in forming a plan of care. There are standard questions the nurse asks the patient such as, name, date of birth, and procedure. However, the nurse may have further questions for the patient.

Secondly, the perioperative visit is the first step in establishing a caring and trusting relationship. Many patients are anxious upon entering the OR (Bekar, Gurler, Sezer & Yilmaz, 2012, p.956). Anxiety can directly affect patients' physical, emotional and physiological well-being. The effect of anxiety causes stress on the body, depresses the immune system, and increases the risk of postoperative complications. The perioperative nurse can have a direct effect on anxiety. Respecting the patients' uniqueness and individuality the nurse can develop a care plan to reduce their anxiety (Dunlop, 1998, p.21). Dunlop (1998) further advises nurses to utilize caring actions such as, addressing the patient by name, asking the patient and family concerns they have, displaying patience, providing a quiet and calm environment and utilizing therapeutic touch (p.21). Bekar, Gurler, Sezer, and Yilmax state, "Nurses should evaluate for preoperative anxiety and fear, and encourage patients to talk about their feelings while providing time to listen" (2012, p. 961). Allowing the patient to talk exhibits compassion and caring. It fosters the sharing of the surgical experience between patients and nurse.

Applying Watson's *Caritas Process 5,* "Being Present to, and supportive of, the expression of positive and negative feelings" assists the nurse in this therapeutic intervention. Sharing feelings is therapeutic for patients. It is a valuable technique that the nurse can utilize to help patients reduce anxiety and stress. It also provides a genuine opportunity to provide reassurance to patients. Encouraging and allowing patients to voice concerns provides validation. The nurse listens and validates these concerns and feelings in a caring and understanding manner which opens the door to a trusting and caring relationship. Watson's (2008) states,

> It is through being present to and allowing constructive expression of all feelings that we create a foundation for trust and caring. When one is able to hold the tears of fears of another without being threatened or turned away, that is an act of healing and caring. When one is able, through his or her *Caritas Consciousness,* to enter into the life space of another, connecting with the inner subjective life world of emotions and thoughts, one is connecting with the deeper spirit of self and other. This is the foundation for a transpersonal caring moment and a healing relationship (p.102).

Authentic Presence

The education session will address authentic presence because it is crucial to developing a caring and transpersonal relationship. Authentic is defined as, "real or genuine; no copied of false" (Merriam –Webster, 2013). Authentic presence is more than being physically present in the space with a patient. It is being present in mind, body and spirit. Being authentically present allows the nurse the ability to enter into the patient's physical, emotional, and spiritual energy and universe.

Presence in nursing is multidimensional. Watson's Caring theory is an excellent example of how presence should be applied in nursing. The nurse is physically present in the room and attends to the physical needs of the patient. Moving from the concrete definition of presence to the abstract and applying Watson's theory, the nurse is able to connect with the patient. The nurse and the patient have a relationship and commitment to each other. Presence in its purest and most beautiful form is the connection of life forces that transcends time and space. The connection of the nurse's and patient's spirits

"goes beyond the moment and becomes part of the universal complex patterns of both their lives" (Watson, 2008, p. 78).

Authentic presence is a key factor when visiting and communicating with the perioperative patient. The perioperative nurse has a small window of time to visit with the patient. It is critical that the perioperative nurse utilizes and values this time prudently. Applying Watson's *Caritas Process 2,* Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other provide insight and the ability to be authentically present with the perioperative patient.

Authentic presence requires the nurse to mentally, emotionally, and spiritually prepare before meeting the perioperative patient. There are several extrinsic and intrinsic factors that can affect the nurse's ability to be authentic present with the perioperative patient. The nurse needs to clear his or her mind and spirit of factors that could impact the ability to be truly present with the patient. One way is to pause and center oneself. Taking a few moments to calm one's mind, taking a few deep breaths and concentrating on the moment assists the nurse in centering. The nurse can then replace his or her heart and mind with loving, caring, and compassionate thoughts and emotions. The nurse should prepare emotionally and spiritually for the patient.

Authentic presence carries into the OR. The nurse uses his or her presence to assist the patient with anxiety, fear and stress. Upon entering the OR, the nurse greets the patient and introduces the other members of the surgical team that are present. The nurse interacts with the patient using a calm reassuring voice, provides blankets for warmth and stays within eyesight of the patient. The nurse should be present at the patient's side

during induction of anesthetic. The nurse utilizes self to provide a safe, reassuring, and comforting environment. The nurse should assess if holding the patient's hand would be comforting and accepting of the patient. Many patients appreciate having the nurse at their side and holding their hand. This moment is highly stressful for the patient physically and emotionally, thus utilizing authentic presence is vital. Authentic presence fosters a caring relationship and supports the perioperative nurse to advocate for the best interest in the patient.

Empowerment

The educational session will address empowerment because the OR is a complex and intense environment. The environment can be intimidating and stressful for perioperative nurses. "ORs are unique environments that may perpetuate opportunities for abuse because of segregation and lack of public eye, even though those features are necessary for patient confidentiality and safety" (Higgins & MacIntosh, 2010, p.325). Nurses may not address concerns and advocate for the patient in fear of repercussions from surgical team members and organizational leadership. Cvetic (2011) states, "Staff members need to feel safe enough to speak up about situations that cause them concern without fear of negative consequences, and persons in positions of power need to encourage team members to collaborate and speak up" (p. 263 -264). Although, the nurse may fear verbal abuse or repercussions, the nurse has a legal, ethical, and moral responsibility to advocate for patients.

Organizations should foster a culture and environment of mutual respect. Nurses should advocate for mutual respect in the work environment and report inappropriate behaviors. A study conducted by VitalSmarts and the Association of Critical-Care Nurses

found, "The 10% of healthcare workers who confidently raise crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying in their jobs" (Ford, 2012, p.428). Raising concerns helps the patient, the nurse, and healthcare.

The Association of perioperative Registered Nurses (AORN) is an excellent resource of perioperative nurses. AORN has a wealth of information for nurses including advocacy, leadership and teambuilding. AORN also lobbies for the nurses, patients, and healthcare concerns. AORN "provides a wealth of resources to empower the perioperative nurse to advocate successfully for surgical patients. Belonging to one's professional organization can be an excellent support system for advocating for patients and the nursing profession" (Ford, 2012, p.425).

Assumptions

There are several assumptions related to this project. The first assumption is all nurses understand and incorporate nursing theory into their practice. Not all nurses received nursing theory education during nursing school. Associate Degree Nursing (ADN) curriculum does not incorporate nursing theory. Davidson (2012) states, "In associate degree nursing programs, nursing theory is barely mentioned and not discussed in detail" (p. 15). The Bachelor of Nursing Degree is mandated to have one course in nursing (p. 16). Not all perioperative nurses have the same educational level. Therefore, not all nurses will understand the importance of nursing theory.

A second assumption is nurses will speak up when patient safety is a concern. Unfortunately, not all nurses will speak up. The fear of retaliation or repercussions prevents some nurses from advocating for their patient. It is important that nurses

understand their legal responsibility to patients. Many nurses have an authentic concern for their patients, however, the OR environment can impede their concerns. The hierarchy of surgeons is still present.

The third assumption is all nurses are genuine. Regrettably, not all nurses are caring and compassionate. Some individuals enter into nursing for the financial opportunities. Some nurses enter and remain in the profession because of money. Unfortunately, some nurses become burnout and patient care suffers. Fortunately, Watson's Theory of Caring incorporates self-care activities for the nurse, in addition to caring interventions for the patient. Self-care can restore hope, faith and love for the nurse.

Conceptual Metaphor

Visual metaphors can help individuals understand and appreciate concepts. For this project the visual metaphor of a bouquet flowers represents the perioperative patient. Flowers are unique as perioperative patients. There are several different varieties of flowers. Flowers come in all shapes, sizes, colors, and hardiness with different needs for flourishing. Flowers have different needs of shade, sunshine and growing conditions. Flowers grow in multiple areas including, meadows, forests, gardens and deserts (See Appendix B, Figure B1 and Figure B2, p. 62). Just as flowers are unique, so are perioperative patients. Patients come from different backgrounds and cultures. They have different educations, life experiences, family upbringings and social class. Patient's ages vary, as does their illnesses, comorbidities and health conditions. Just as the care of flowers varies, so does the care of the patient.

Flowers need a safe and stable environment. Once flowers are cut from their roots, they need a new environment (See Appendix C, p.63). Typically, flower bouquets are placed in some type of container. The container can be anything, a vase, crystal glass, a mason jar, or a styrofoam cup (See Appendix D, Figure D1 and Figure D2, p.64, Appendix E, p. 65). Applying Benner's (2001) Novice to Expert Nurse Theory to the type of container used helps one to understand the stages of learning for perioperative nurses. The container represents the nurse's skill set and perioperative nursing experience. New nurses or nurses who have no experience in perioperative nursing are comparable to a styrofoam container. They are new to perioperative nursing, are a novice, and have many things to learn. They lack experience and need extra support to provide nursing care. They learn from other perioperative nurses and experiences in the OR. The support that they need is represented by some type of weight placed in the styrofoam cup. The weight can be stones, sand or pebbles. As the nurse's experience and skill set grows, the container can transition to something that has more stability. The nurse incorporates more skills and is always aware of his or her support networks. This is not to say, that all nurses transform into an expert nurse, however, the potential is there.

Flower bouquets that are left unattended can deteriorate. Just as flowers need attention and a safe and stable environment, so does the perioperative patient. The perioperative nurse needs to constantly assess the patient and the OR surroundings. Changes can occur quickly and nurses need to stay in tune with what is happening in the OR environment and with the patient. Just as flowers need a safe environment where they are free from being knocked over, nurses should not leave the perioperative patient unattended or in an unsafe environment.

OR's are different. The OR can be highly technical with state of the art equipment, or in a rural community or a third world country or even in battle zone. The important factor is that the perioperative nurse is aware of and has a working knowledge of the OR suite. Just as the flower bouquet needs someone to monitor its physical needs and ensure the bouquet is free from potential harm, so does the perioperative patient.

Flowers also require nurturing and caring actions. It is important to provide sunlight, warmth, water and food. Some individuals even talk to and play music for flowers and plants. The perioperative patient also needs caring and nurturing actions. Attending to the physical and emotional needs of patients is the responsibility of the perioperative nurse and can assist the patient in healing.

Nursing is much more that providing for the physical needs of patients. Incorporating theory and caring behaviors into nursing can assist the patient in higher needs. In the OR, there is always potential for patient harm. Nursing needs to be proactive and astute to changes in their patients. Nurses need to be vigilant guardians of their patients and the OR.

Nurses are taught the need for assessment, planning, intervention, and evaluation while providing nursing care. The nurse is continually assessing the patient and the nursing care being provided. This process helps the nurse to review and adjust to the needs of the patient and the environment. Therefore, it is prudent to assess and reflect on this project.

The educational session will reemphasize the important role of patient advocacy for the perioperative nurse and surgical team. Patients place their lives in the hands of the perioperative nurse and surgical team. Patients entrust the perioperative nurse and

surgical team with the responsibility of advocating for their safety, health and well-being until he or she can resume that role. This is a large responsibility that is not taken lightly. The conceptual metaphor will provide a visual aid to facilitate the learning of the importance of patient advocacy in the OR.

Chapter Four: Discussion/Evaluation of the Project

Nursing is a continually growing and evolving discipline. Nursing experience and education help shape nurses knowledge base. Discussion and evaluation help to guide nursing practice. Evaluating nursing cares and nursing experiences is imperative to understand, adjust and improve the care that is provided to patients. It is an opportunity for nurses to reflect on the care they provide and how they provide that care. Using reflection allows nurses to assess the care they have provided. Dolphin (2012) shares,

> Reflection does not simply mean thinking about a situation: it is the systematic appraisal of events that occurred and examination of their individual components to learn from the experience and to influence future practice. It requires a high level of self-awareness and conscious efforts. This effort can develop into reflexivity, which can challenge beliefs and assumptions. (p. 20)

The proposed educational session for sharing the project with the intended audience provides a starting point for perioperative staff to determine if patient advocacy is a concern. It allows for the discussion of ideas and concerns with the OR and patient advocacy. Opening the door for staff to share their thoughts, ideas, and concerns will help bring patient advocacy and the OR culture to the forefront. The OR culture will not change unless individuals speak up. I would deem this project a success if staff openly and willingly shared their concerns and ideas at the education session. I believe talking about the OR culture and staff concerns is the first step in changing it.

The proposed educational session will have an evaluation form for attendees to complete (See Appendix F, p. 66). The evaluation will address if healthcare providers are concerned with speaking up for patient safety and if so, why. The evaluation will ask

if hierarchy exists in the OR. It will also address if nurses visit with the patient in the perioperative waiting area and if perioperative nurses find this visit valuable. Lastly, the evaluation will ask if the educational session was beneficial for the attendees and if the educational session should be presented to other surgical departments. I will share the feedback from the evaluation forms with leadership in the surgical specialty. If the evaluation forms suggest presenting the in-service to other healthcare staff, this would be an indicator that patient advocacy is a potential problem in other surgical specialties. Utilizing written feedback would provide information for this writer to evaluate the appropriateness and effectiveness of the project.

The operating room is a cold, sterile and uninviting environment. There are no pretty photos on the walls, rooms are kept cold to prevent bacteria growth and large machines are constantly making noise. However, when nursing theory and caring interventions are incorporated into patient care the environment can transform. The perioperative nurse can bring warmth, compassion and a positive healing energy into the environment. The nurse can be a friendly and caring healthcare individual for the perioperative patient. Having a nurse hold the patient's hand while in the OR can relieve stress, provide compassion and empathy, and promote healing. The nurse can become the environment.

Personal Reflection

There are several things that I learned during this project. The importance of patient advocacy was reinforced. This project reminded me of my ethical, moral, and professional responsibility to advocate for my patient. There have been times when I have questioned *little* things that the surgical team has done; however, was fearful to

voice my thoughts for fear of being yelled at. From this project I have learned that no question or concern is *little* when a patient is involved.

I also learned Joint Commission's (2013) stance on unprofessional behaviors in the workplace environment. I was unaware Joint Commission had addressed these behaviors and organizations that do not address unprofessional behaviors can be fined. This is important information to know and share with other healthcare members. Organizations need to address these behaviors to protect their patients and employees.

This project has taught me the importance of incorporating nursing theory into my nursing practice. I gained a new understanding of what nurses do and why they do it. Incorporating nursing theory into my daily practice has brought meaning into the nursing cares I provide.

I have discovered the importance of visiting the patient before entry into the OR. I have found when I do not meet the patient prior to entering the OR, I feel unattached to the patient. I do not have the connection with the patient as I do when I meet the patient in the preoperative waiting area. I have also found that my assessment is not as through when done in the OR. I feel rushed and other surgical team members do not give me the time to do a thorough assessment. The other team members want to get the patient on the operating room table as quickly as possible. This hurried feeling is uncomfortable for me and possibly for the patient as well.

The importance of having a perioperative nurse in the OR has amplified since doing this project. Each surgical team member has a different focus during surgery. Anesthesia members monitor the patient hemodynamic status and level of consciousness. The CST is focused on handing instruments to the surgeon and anticipating the surgeon's

needs. The surgical resident is learning the techniques of surgery and answering the surgeon's questions. The surgeon is focused on the surgical procedure and other surgical procedures that are occurring or will be occurring. The perioperative nurse is focused on the patient and the needs of the surgical team. The nurse is the patient advocate. The nurse is constantly assessing the environment, monitoring the safety of the patient, communicating with the patient's family and assisting the surgical team with instruments and supplies. The perioperative nurse is observing the whole picture, the patient, the surgical team, and the OR environment.

Chapter Five: Conclusions and Plans for the Future

This project has several opportunities to enhance the care provided by the nurse and received by the perioperative patient. The in-service could be presented to other surgical divisions at the Midwestern hospital. I believe that every surgical department could benefit from the information provided. I believe the educational session should be incorporated into orientation for new surgical staff including RNs, CSTs and CSAs. I believe this is valuable information for new staff and is one way to improve the OR culture. It would be an excellent foundation for new staff to understand the importance of mutual respect and for speaking up for the safety of patients.

The educational session could also be presented at the local AORN chapter. The local AORN chapter has nurses from Southeastern Minnesota. This would provide an avenue to spread the information to other surgical institutions in the area. It would be also allow for networking and learning how other institutions are doing to address the OR culture.

I believe the project could be a stepping stone to the importance of studying the OR culture. The OR culture can be aggressive and intimidating. Further research should address the culture and how to change it. Change is needed for patient safety, nursing satisfaction, and improving mutual respect. Patients are at risk during surgical procedures when surgical team members are afraid to speak up. The OR environment should be a place where questions and concerns can be openly addressed without fear of retaliation or repercussions.

The care provided by perioperative nurses can be improved by incorporating theory into the care provided. Incorporating Watson's theory into the perioperative

nurse's practice can improve the care provided by bringing love and caring feelings to the patient. Nurses want what is best for patients however, when nurses are fearful, burnout, or dissatisfied in their jobs, everyone suffers.

Surgery is a high risk environment for patients and healthcare workers. Having perioperative nurses that are strong advocates for patients decreases the risks for patients and improves the OR environment. Nurses have a moral, professional, and ethical responsibility to provide the best care to patients. Patients entrust their lives in the perioperative nurse and surgical team. The perioperative nurse is a valuable team member in the OR.

References

Adams, J., El-Masir, M., & Korniewicz, D. (2011). A descriptive study exploring the principles of asepsis techniques among perioperative personnel during surgery. *Canadian Operating Room Journal, 29*(4), p. 6-24. Retrieved from http://ehis.ebscohost.com.ezproxy.augsburg.edu/ehost/pdfviewer/pdfviewer?vid=3&sid=543303db-6cf2-4792-a767-6ae99c48efbb%40sessionmgr11&hid=3

Adams, R., Bovbjerg, V., Calland, J., Guerlain, S., Lebeau, K., Peugh, J., Poole, G.,& Turrentine, F. (2011). The surgical safety checklist: Lessons learned during implementation, *American Surgeon, 77,* p. 1131 -1137.

Akerman, K., Johansson, G., Larsson, P., Odenrich, P. & Rydenfalt, C. (2011). Social structures in the operating theatre: how contradicting rationalities and trust affect work. *Journal of Advanced Nursing, 68,*(4), p. 783 -795. doi: 10.1111/j.1365-2648.2011.05779.x

Allen, G. (2012). Annals of Surgery: Protecting patients from intraoperative deviations in care. *AORN, 96*(5), p. 556 -562

Arnold, E., & Boggs, K., (2003). *Interpersonal relationships: professional communication skills for nurses.* (4th ed.). St. Louis, Missouri: Saunders

Bekar, M., Gurler, H., Sezer, H., and Yilmaz, M. (2012). Predictors of preoperative anxiety in surgical patients. *Journal of Clinical Nursing, 21,* p. 956 – 963. doi: 10.1111/j.1365-2702.2011.03799.x

Benner, P. (2001). *From Novice to Expert: Excellence and Power in Clinical Nurse Practice.* Upper Saddle River, New Jersey: Prentice Hall

Bernard, Y. (2004). From vocation to profession: the quest for professionalization of nursing. *British Journal of Nursing, 13,*(16), p. 978 -982.

Boyle, H. (2005). Patient advocacy in the perioperative setting. *AORN, 82* (2), p. 250- 262. doi: 10.1016/S0001-2092(06)60317-7

Cara, C. (2003). A pragmatic view of Jean Watson's caring theory. *International Journal of Human Caring, 7*(3), p.51 – 61.

Cecka, R., Meyer, D., & Turkovich, C. (2006). The journey: a design to develop the art of caring. *Advanced Emergency Nursing Journal, 28*(3), p. 258 – 264.

Cima, R., & Deschamps, C., (2013). Role of the surgeon in quality and safety in the operating room environment. *General, Thoracic, Cardiovascular Surgery,* 61, p. 1-8. doi: 10.1007/s11748-012-0111-6

Cvetic, E. (2011). Communication in the perioperative setting. *AORN, 94* (3), p. 261 – 270. doi: 10.1016/j.aorn.2011.01.017

Davidson, S.(2012). Challenging RN-BSN students to apply Orem's Theory to Practice. *Self-Care, Dependent-Care & Nursing, 29*(1), p. 15-19

Deitte, L., Rawson, J., Thompson, N., & Sostre, G. (2013). The cost of disruptive and unprofessional behaviors in health care. *Academic Radiology, 20*(9), p. 1074 -1076. doi: 10.1016/j.acra.2013.05.009

Dienstag, J., Edgman-Levitan, S., Healy, G., Leape, L., Mayer, R., Meyer, G., Robert, J., & Shore, M. (2012). Perspective: A culture of respect, part 1, the nature and causes of disrespectful behavior by physicians. *Academic Medicine, 87*(7), p. 845 -852. doi. 10.1097/ACM.0b013e318258338d

Dolphin, S. (2012). How nursing students can be empowered by reflective practice. *Mental Health Practice, 16* (9), p. 20-23

Dunlop, K. (1998). The practice of nursing theory in the operating room. *Today's Surgical Nurse, 20* (5), p. 18-22

Feldman, D., Kaplan, K., & Mestel, P., (2010). Creating a culture of mutual respect. *AORN, 91*(4), p. 495 – 510. doi: 10.1016/j.aorn.2009.09.031

Ford, D. (2012). Advocating for perioperative nursing and patient safety. *Perioperative Nursing Clinics, 7,* p. 425-432. doi: 10.1016/j.cpen.2012.08.007

Higgins, B.L. & MacIntosh, J. (2010). Operating room nurses' perceptions of the effects of physician-perpetrated abuse. *International Nursing Review, 57,* p. 321 -327. doi: 10.1111/j.1466-7657.2009.00767x

Joint Commission. Retrieved from www.jointcommission.org on October 10, 2013.

Lachman, V. (2009). Practical use of the nursing code of ethics; Part I. *MedSurg Nursing, 18*(1), p. 55-57.

Lachman, V. (2012). Applying the ethics of care to your nursing practice. *MedSurg Nursing, 21* (2), p. 112 – 116.

Lai, P., (2009). Surgical safety checklist saves lives? *Surgical Practice, 13,* p.31doi:10.111/j.1744-1633.2009.00443.x

Leeson, D., Robertson, N., Watts, J., & Winter, R. (2013). Evaluation of organizational culture and nurse burnout. *Nursing Management-UK, 20* (6), p. 24 – 29.

McCabe, C., & Timmins, F., (2005). How assertive are nurses in the workplace? A preliminary pilot study. *Journal of Nursing Management,* 13, p. 61 -67. doi: 10.1111/j.1365-2834.2004.00492.x

Merriam-Webster Dictionary. Available at: http://www.merriam-webster.com/dictionary/advocate. Accessed May 5, 2013.

Merriam-Webster (2007). *Webster's Dictionary for Students.* Springfield, Massassachuts: Merriam-Webster

Oerman, M.H., & Pasma, J., (2001). Evaluation by consumers of quality care information on the internet. *Journal of Nursing Care Quality, 15* (3), p. 50-58.

Parker, M. (2006). *Nursing theories & nursing practice.* (2nd ed.). Philadelphia, Pennsylvania: F.A.Davis

Patterson, P. (2011). Changing behavior to boost OR's productivity. *OR Manager, 27* (12), p. 17 – 19.

Reid, J. (2013). Speaking up: a professional imperative, *Journal of Perioperative Practice, 23*(5), p.114-118. Retrieved from http://ehis.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=6&sid=5b37c003-62ca-435b-a194-690f6bf84ba1%40sessionmgr11&hid=5

Rothrock, J. (2011). *Alexander's Care of the Patient in Surgery (14th ed.).* St.Louis, Missouri: Elsevier Mosby.

Ryan, L. (2005). The journey to integrate Watson's Caring theory with clinical practice. *International Journal of Human Caring, 9*(3), p. 26 -30.

Shield, L. & Werder, H. (2002). *Perioperative Nursing.* San Francisco, California: Greenwich Medical Media

Stanton, C. (2011). Keeping up with technology. *AORN: AORN Connections, 93*(1), p. C1, C8 & C9. doi: 10.1016/S0001-2092(10)01271-8

Walker, I., & Wilson, I. (2009). The WHO surgical checklist: the evidence, *Journal of Perioperative Practice, 19* (10), p. 362 -364.

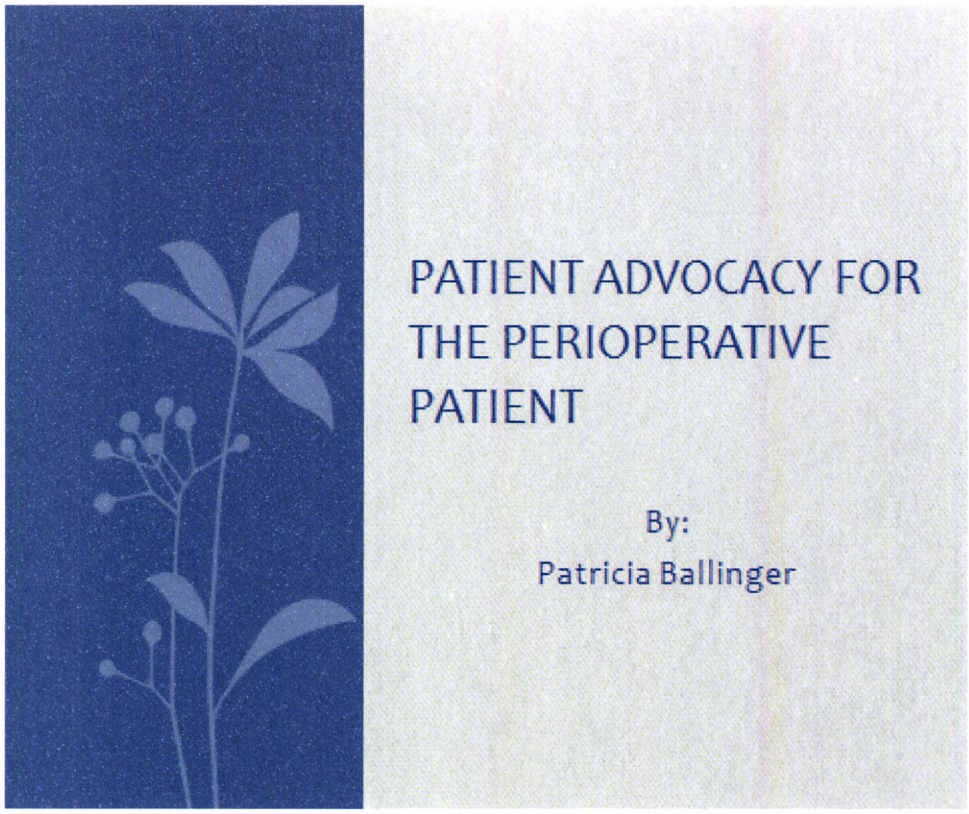
Watson, D. (1994). Technology in the perioperative environment. *AORN, 59*(1), p. 268 – 277.

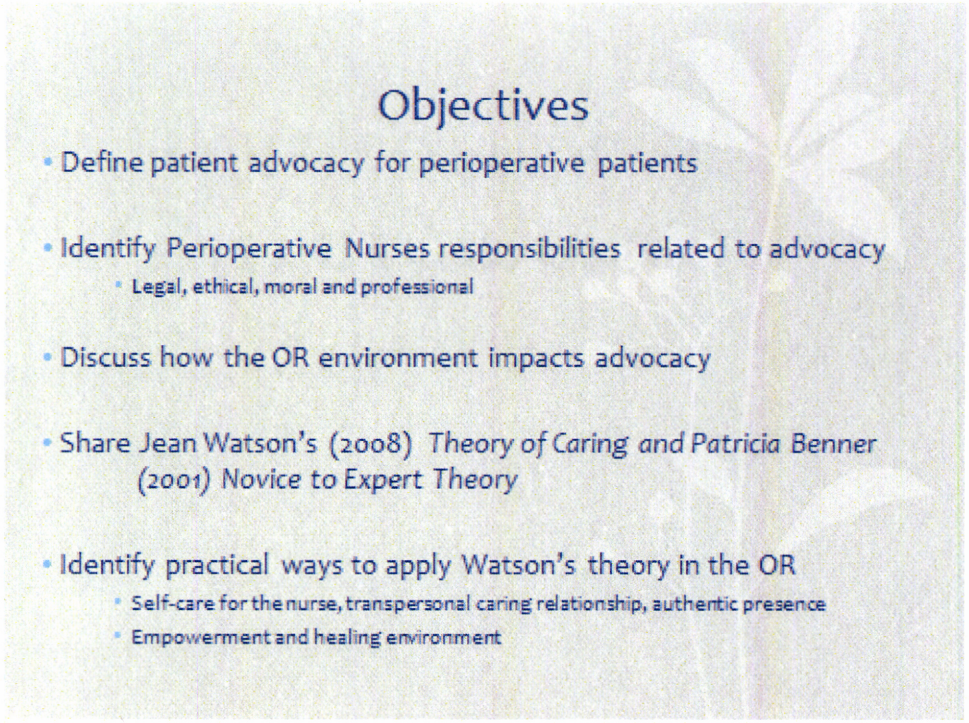
Watson, J. (2008). *Nursing: The Philosophy and Science of Caring* (Rev ed.). Boulder, Colorado: University Press of Colorado.

Watson, J. (2014). *Caring Science, Mindful Practice: Implementing Watson's Human Caring Theory.* New York City, New York: Springer Publishing Company

World Health Organization: Retrieved on June 10, 2013 from, www.who.int

Appendix A: Patient Advocacy Powerpoint





Patient Advocacy

Definition:

"one that supports or promotes the interest of another". (Merriam-Webster, 2013).

Boyle (2005) further define the importance of patient advocacy:

"advocacy is a critical issue for surgical patients who are unconscious or sedated and unable to make decisions related to their care". (Boyle, 2005, p. 250)

Legal, Ethical, Moral and Professional Responsibility

American Nurses Association (ANA) in 1950 developed the ANA Code:

"provides a social contract with society served, as well as ethical and legal guidance to all members of the profession."

(Lachman 2009, p. 55)

Provision three of the code states,

"the nurse promotes, advocates for, and strives to protect the health, safety and rights of the patient." (Lachman, 2009, p. 55)

Responsible to:

- Patient
- Healthcare Institution
- Profession
- Society

The OR and advocacy

Historically a hierarchical environment - surgeon driven

The OR Environment can be described as:

- Stressful
- Complex
- Technological
- High-risk

The OR Environment can also be described as:

- Intimidating
- Abusive
- Disrespectful
- Inappropriate Behavior

Joint Commission

Joint Commission recognized disrespectful and intimidating behaviors directly impacts patient safety

Joint Commission in 2008 mandated facilities wanting accreditation have a Code of Conduct in place.

Code of Conduct:

- Defines acceptable and inappropriate behaviors
- Process to manage behaviors that undermine a culture of safety

Patricia Benner Novice to Expert Theory

Nurses move through five stages of development

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert

Jean Watson Theory of Caring 2008

Caring is central to the nursing profession.

Care for the best interest of the patient:

- When one cares for a patient he/she are invested in the patient and the outcomes.
- He/she will advocate for the needs of the patient

Transpersonal Caring Relationship and Caring Moments

Importance of Self-Care

Watson's Caritas

Watson's Theory of Caring (2008) identifies Ten Caritas:

Caritas is Latin and defined as, "to cherish, appreciate, and give special or loving attention with charity, compassion, and generosity of spirit" (Watson, 2014, p. 21)

The caritas serve as a framework to guide and assist the nurse in creating caring relationships and moment.

Watson's Caritas

For this educational session the focus will be on:

Second Caritas: Being authentically present, enabling faith/hope/belief system: honoring subjective inner, life-world of self/others.

Fifth Caritas: Being present to, and supportive of, the expression of positive and negative feelings

Eighth Caritas: Creating a healing environment at all levels, subtle environment for energetic authentic presence

Watson and Self-Care

Watson states,

> "Nurses often become pained and worn down by trying to always care, give, and be there for others without attending to the loving care for self" (Watson, 2014, p. 47).

Self-care:

- Specific to the nurse/healthcare worker
- Promotes harmony and balance
- Important to be effective in other areas of the life
- Watson promotes mindful meditation

Second Caritas

Authentic presence:

- Being physically, emotionally and mentally present
- Builds trust
- Fosters a caring moment/relationship
- Meaningful to the patient
- Connection between patient and nurse

Fifth Caritas

Being present and supportive of expression feelings

- Encouraging patients to share
- Allowing patient's to express positive and negative feelings
- Therapeutic for patients – reduces anxiety and stress
- Creates the foundation of trust and caring

Eight Caritas

Creating a healing environment

- Ensuring the environment is safe
- Advocating for the needs of the patient
- Nurses have the ability to create a healing environment
- Empowerment to speak up

Conceptual Metaphor
Benner and the novice perioperative nurse

champagneliving.net

Conceptual Metaphor
Benner and the Expert perioperative nurse

ciwwa.com

Conceptual metaphor of perioperative patients

wallof.com

Conceptual Metaphor
The perioperative nurse and patient

fineartamerica.com

Questions

fosterthepaper.blogspot.com

References

Benner, P. (2001). *Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Upper Saddle River, New Jersey: Prentice Hall

Boyle, H. (2005). Patient advocacy in the perioperative setting. *AORN*, 82(2), p. 250-262.

Lachman, V. (2009), Practical use of the nursing code of ethics, Part 1, *MedSurg Nursing 18*(1), p. 55-57

Watson, J. (2008). *Nursing: The Philosophy and Science of Caring* (Rev. ed). Boulder, Colorado: University Press of Colorado

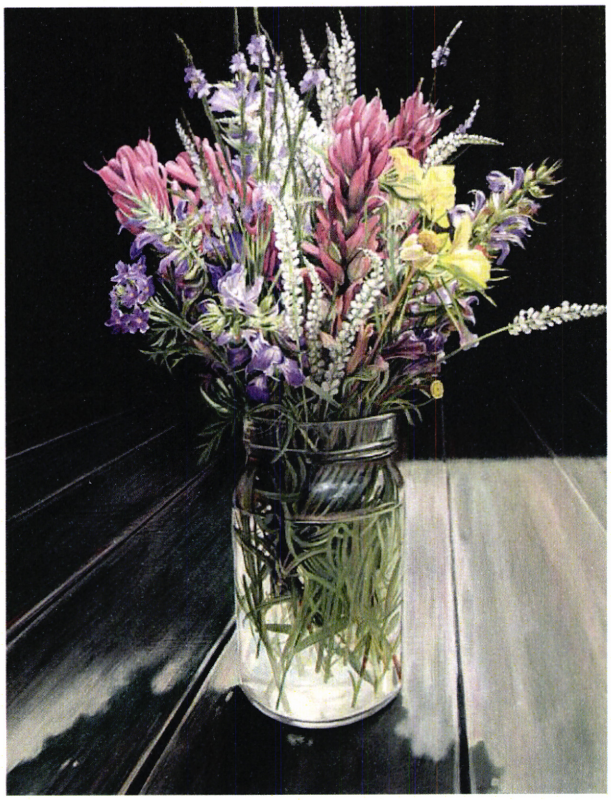
Watson, J. (2014). *Caring Science, Mindful Practice: Implementing Watson's Human Caring Theory.* New York City, New York: Springer Publishing Company

Appendix B: Flowers

Appendix B, Figure B1. Serenity
Retrieved from www.wildflowermagizine.com

Appendix B, B2, Meadow flowers
Retrieved from www.wallof.com

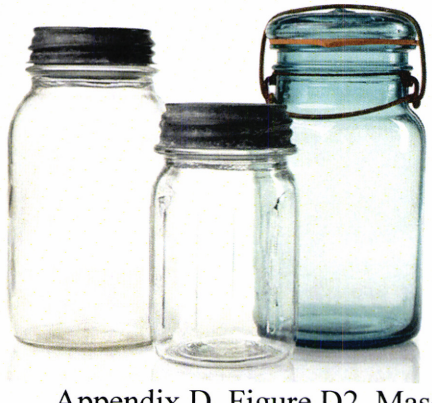
Appendix C: Flowers in Mason Jar



Appendix C, Flower Bouquet
Retrieved from www. fineartamerica.com

Appendix D: Vase Containers

Appendix D, Figure D1, Crystal Vase
Retrieved from www.ciiwa.com



Appendix D, Figure D2, Mason
Jars retrieved from www.oprah.com

Appendix E: Styrofoam Cup

Appendix E, Styrofoam Cup
Retrieved from www.champagneliving.net

Appendix F

Patient Advocacy In-Service Evaluation Form

1. Patient advocacy is an important role of OR healthcare providers?

   a. Yes b. No c. Sometimes

2. As an OR healthcare provider, have you ever felt the need to speak up for the patient?

   a. Yes b. No c. Sometimes

3. Regarding question #2, did you speak up?

   a. Yes b. No

4. Regarding question #3, if you did speak up, what was the reaction of the team and by what team member? _____

5. If you choose not to speak up, why not? _____

6. Do you believe hierarchy exists in the OR?

   a. Yes b. No c. Sometimes

7. Do you think this in-service would benefit other surgical areas? a. Yes b. No

8. Have you found this in-service beneficial to your practice?

   a. Yes b. No

If you are a perioperative nurse, please answer questions 9-11.

9. Do you visit the patient in the preoperative waiting area?

   a. Yes b. No c. Sometimes

10. If you do not visit your patient, why? _____

11. Do you find the perioperative visit beneficial? a. Yes b. No

12. Please provide any comments or suggestions for this presentation.