



Psychological preparation for patients undergoing day surgery

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Abstract

Surgical and anaesthetic intervention associated with day surgery over the last 10 years has greatly improved although the position of psychological preparation has remained virtually unchanged [Ridgeway V, Mathews A. *Brit J Clin Psychol* 1982;21(4):271–80; Salmon P. *Clin Psychol Rev* 1992;12(7):681–704; Jarrett PEM. *Surgery* 1997;15(4):94–6]. Information provision, an essential component of anxiety management, has recently been highlighted as a considerable problem for day surgery patients [Mitchell MJ. *Ambul Surg* 1999a;7(2):65–73; Mitchell MJ. *Ambul Surg* 1999b;7(2):75–100]. Contemporary evidence has suggested that the ability to cope with a stressful event can be improved if the preparatory information is matched with the individual's coping style, i.e. provision is made for patients with a desire for maximum levels of information (vigilant copers) and for patients with a desire for minimal levels of information (avoidant copers) [Krohne HW, Slangen K, Kleemann PP. *Psychol Health* 1996;11(3):315–30]. A convenience sample of 120 patients undergoing non life-threatening, gynaecological laparoscopic day surgery was contacted prior to surgery and randomly assigned into two groups. Group I received an extended information booklet, group II a simple booklet and all received a coping style questionnaire. Immediately prior to surgery patients with a desire for maximum levels of information (vigilant copers) who had received the simple information were more anxious than the vigilant copers who had received the extended information (0.013, $P \leq 5\%$). Irrespective of coping style, participants who received the simple information contacted their general practitioner more than participants who had received the extended information (0.008, $P \leq 1\%$). Incorporation of the results into day surgery nursing practices are discussed and a new, pioneering anxiety management plan providing explicit guidance is outlined. © 2000 Elsevier Science B.V. All rights reserved.

Keywords: Levels of information provision; Anxiety; Control; Self-efficacy; Formalised anxiety management

1. Introduction

A number of comprehensive studies in the United Kingdom concerning day surgery have established that information provision is a considerable challenge [1–3]. International support for this has appeared in a recent review of the literature regarding patients' experiences of day surgery as information provision was also a challenge in Europe, America and Australia [4,5]. Day surgery patients also remain very anxious prior to surgery further complicating matters as an anxious patient will not retain information even when adequately provided [6–9]. These issues are central to the quality of day surgery from the patient's perspective and thereby required further investigation if good progress is to be maintained within the service.

Recent studies have suggested that not all patients require the same amount of information, i.e. some require more while others less [10–12]. In support of this notion, studies within the field of dental surgery have established that when a match between the required level of information and the actual information provided is achieved, patients are more satisfied [13–15]. This approach towards information provision concurs with one of the prominent psychological theories on coping referred to as vigilant and avoidant coping, i.e. vigilant copers should receive copious amounts of information whereas avoidant copers very little [16]. Increasing the amount of control (real or perceived) available to patients and helping to engender feelings of self-efficacy (self appraisals of ability to cope) have also led to more positive outcomes following surgery [17,18]. The utility of these theories within the day surgery arena is relatively unknown (Table 1). A quasi-experimental research study was therefore designed to dis-

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cover their usefulness within day surgery, i.e. vigilant and avoidant coping, control and self-efficacy. The aim was to construct an effective information provision plan to improve patient satisfaction and aid anxiety reduction. The hypothesis was: when an individual's coping style, i.e. vigilant and avoidant coping, is paired with the appropriate level of information an adult day surgery patient will (a) be more satisfied with the level of information provided; and (b) experience less anxiety.

2. Study design

Gynaecological patients undergoing day case laparoscopic surgery and general anaesthesia were chosen as their throughput was high and the surgical procedure was an intermediate one. Two booklets were designed and constructed for use, one with extended information and one simple information (Table 2). When provisionally constructed the booklets were sent to the day surgery unit together with the relevant questionnaires (anxiety, locus of control, self-efficacy and coping style) for medical and nursing staff approval. Following some minor alterations the study was approved by the hospital staff prior to ethical approval.

The patients employed within the study had to be restricted in order to introduce some controls. A strict criteria was adhered to, i.e. adult gynaecological patients undergoing day surgery and general anaesthesia, no day surgery within the last 12 months, non life-threatening laparoscopic surgery, aged 18 years upwards, double-blind study, English speaking participants, no chronic health problems.

All participants were contacted prior to surgery to gain initial consent then randomly allocated into one of two groups. One group received the extended booklet while the second group received the simple booklet. The information was sent by first class post the day after initial contact and included a covering letter with the

Table 1
Innate traits

Vigilant coping style	Individuals who wish to receive copious amounts of information prior to an unpleasant medical procedure
Avoidant coping style	Individuals who wish to receive small amounts of information and more relaxation advice prior to an unpleasant medical procedure
Self-efficacy	Confidence in ones' ability to behave in such a way as to produce a desirable outcome
Internal locus of control	Individuals who strongly believe they have the ability to shape their own destiny
External locus of control	Individuals who strongly believe that their destiny is influenced more by luck, fate and powerful others, i.e. doctors, nurse, employer etc

Table 2

Overview of information booklets sent via post 7–10 days prior to surgery

	Extended laparoscopy booklet	Simple laparoscopy booklet
Design	Empowering	Instructional
Definition of procedure	Yes	Very brief
Explanation of types of surgery	Yes	No
Procedural, behavioural and sensory information	Yes	Very brief
Number of diagrams	3	None
Cognitive coping strategies	Throughout	Very brief
Information regarding recovery at home	Informative explanations	Brief and containing 'do's and don'ts'
Number of pages	5	3

researcher's name, address and contact telephone number, the questionnaire pack (anxiety, locus of control, self-efficacy and coping style), information booklet and consent form. Approximately 48 h prior to surgery the participants were requested to sign the consent form, read the information booklet, complete the questionnaires and bring the completed consent form and questionnaire pack with them on the day of surgery. The day surgery staff were completely unaware of which information booklet had been received by whom.

On the day of surgery a convenient date and time was arranged with the patient in which to conduct the final postoperative telephone interview. Also the primary nurse within the day surgery unit completed a short patient adjustment to surgery questionnaire, i.e. number of questions asked, anxiety level, satisfaction with information received etc. Approximately 2–4 days after surgery the final interview was conducted by telephone and primarily concerned satisfaction with information provided (Table 3).

3. Results

A total of 120 adult day surgery patients were interviewed over a 7 month period from September 1997 through to March 1998. Not all 120 subjects were able to complete the study. Following initial consent 11 patients had their operations cancelled, two did not attend on the day of surgery, one was admitted to hospital as an in-patient prior to surgery, following initial consent two subsequently refused to take part, one did not complete one of the questionnaires correctly, one patient had to have her operation cancelled on the day of surgery, nine did not bring the question-

Table 3
Overview of quasi-experimental design

	Group I	Group II
7–10 days pre-operatively (researcher)	Initial telephone contact; initial consent; inclusion criteria checked	Initial telephone contact; initial consent; inclusion criteria checked
Approximately 48 h pre-operatively (self-rating)	Health locus of control; self-efficacy; anxiety inventory; coping style; extended information	Health locus of control; self-efficacy; anxiety inventory; coping style; simple information
Day of surgery (nurse-rating)	Adjustment to surgery questionnaire	Adjustment to surgery questionnaire
2–4 days post-operatively (researcher)	Telephone satisfaction questionnaire	Telephone satisfaction questionnaire

naire pack with them on the day of their surgery, one complained to her consultant surgeon about the study following initial consent and was therefore automatically withdrawn and five were unable to complete due to researcher ill-health. The final number of subjects who completed all aspects of the study was 87 (Fig. 1).

Firstly, an increase in age beyond the mean was negatively correlated with ratings of self-efficacy (0.02, $P \leq 5\%$), negatively correlated with the ability of the information provided on the day of surgery to reduce anxiety (0.007, $P \leq 1\%$) and negatively correlated with the nurses' ratings of patient adjustment to surgery (0.035, $P \leq 5\%$). This may suggest that successful coping with day surgery may decrease with age as the more mature patient had reduced feelings of self-efficacy, the information provided on the day had little ability to help reduce anxiety which consequently led to lower ratings of adjustment to surgery.

Using the Statistical Package for Social Sciences (SPSS) an independent *t*-test analysis was performed. It was discovered that patients with a desire for copious levels of information (vigilant copers) who only received the simple information were more anxious than the vigilant copers who received the extended information as rated by the nurses immediately prior to surgery (0.013, $P \leq 5\%$). Patients with a desire for copious levels of information (vigilant copers) who only received the simple information were more anxious concerning their general anaesthetic than the vigilant copers who received the extended information (0.029, $P \leq 5\%$). Also patients with a desire for copious levels of information (vigilant copers) who received the extended information were less anxious while waiting for surgery to commence on the day than the vigilant copers who received the simple information (0.058, $P \leq 5\%$).

Almost every patient (99%) required written information, 92% verbal information and the majority wanted this information between 1 and 3 weeks prior to surgery. A total of 74.6% patients required information concerning their operation a minimum of 1 week prior to surgery (Fig. 2). Vigilant copers required their information on average 3–4 weeks (mean) in advance whereas avoidant copers 1 week (mean) in advance. A

noteworthy point here is that not one patient stated they required the information just on the day of surgery.

The aspect of day surgery patients found to be most fearful was the general anaesthetic (54%), waiting in the day surgery unit (44%) and the possible pain and discomfort afterwards (32%) (Fig. 3). However, 63% of patients expressed being fearful of more than just one aspect. Anxiety was reduced most by being near to and speaking with the nurse (72%), the anaesthetist (48%) and the surgeon (48%) (Fig. 4). Anxiety was reduced for 76.4% of patients by two or more aspects. The nurses' ratings of patient anxiety were negatively correlated to nurses' ratings of adjustment to surgery (0.0001, $P \leq 1\%$). The more anxious patients were seen not to adjust as well to day surgery and only 28.7% had a good adjustment to surgery (Fig. 5).

When examining aspects of control, vigilant copers rated themselves as experiencing little control over events in comparison to avoidant copers (0.045, $P \leq 5\%$). This supports the top three characteristics of a vigilant copers, i.e. recalling negative events, self-pity and the search for copious levels of information, as opposed to the top characteristic of an avoidant copers which is to minimise all threats [19]. Concerning self-efficacy (feelings of being able to cope) avoidant copers experienced a higher level than the vigilant copers (0.026, $P \leq 1\%$). Patients who desired copious levels of information therefore experienced lower self-

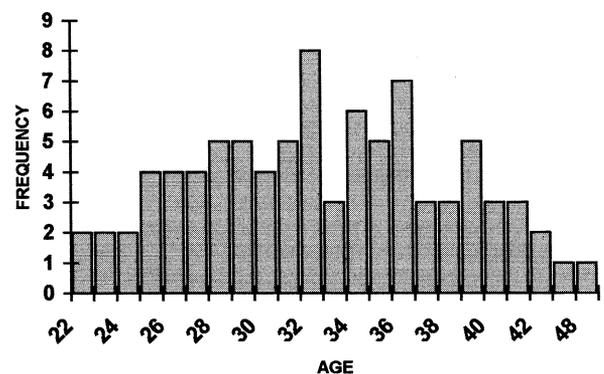
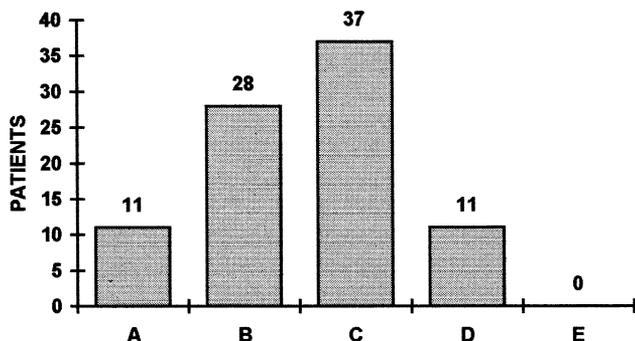


Fig. 1. Age and frequency of subjects.

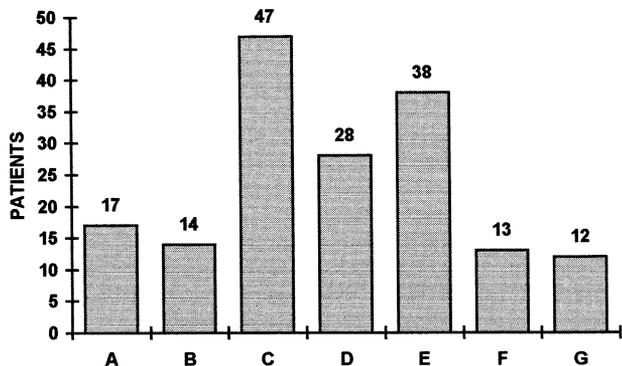


- A) MORE THAN 4 WEEKS BEFORE YOUR OPERATION
- B) 2 - 3 WEEKS BEFORE YOUR OPERATION
- C) 1 WEEK BEFORE YOUR OPERATION
- D) A FEW DAYS BEFORE YOUR OPERATION
- E) A FEW HOURS BEFORE YOUR OPERATION

Fig. 2. Ideally, when would you have preferred to receive information regarding your surgery?

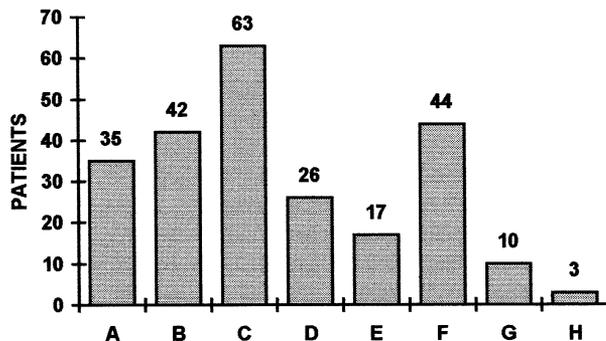
efficacy appraisals prior to surgery irrespective of the information booklet received, i.e. vigilant copers did not feel they could cope well with day surgery. Avoidant copers had more positive self-efficacy appraisals when in receipt of the simple information than the vigilant copers with the simple information (0.041, $P \leq 1\%$). Patients who desired lower levels of information and received lower levels, experienced higher appraisals of self-efficacy, i.e. had more positive feelings of being able to cope well.

Following discharge contact with community services was 18% (day surgery unit 7%, general practitioner 10%, district nurse/practice nurse 1%) (Fig. 6). Contact with the general practitioner was less in patients who were in receipt of the extended information booklet irrespective of their coping style (0.008, $P \leq 1\%$). Irre-



- A) THE OPERATION ITSELF
- B) BEING UNCONSCIOUS
- C) THE GENERAL ANAESTHETIC (BEING PUT TO SLEEP)
- D) THE POSSIBLE PAIN AND DISCOMFORT
- E) WAITING IN THE DAY SURGERY UNIT PRIOR TO YOUR OPERATION
- F) SOCIAL ARRANGEMENTS i.e. child-minding, work, etc.
- G) OTHER i.e. possibility of reduced health, hunger, possibility of nausea & vomiting, IVI being re-sited, needles, discharged too early, parking, ward layout, lack of warmth, operation being cancelled again, separation from husband.

Fig. 3. What aspects of day surgery increased your anxiety?



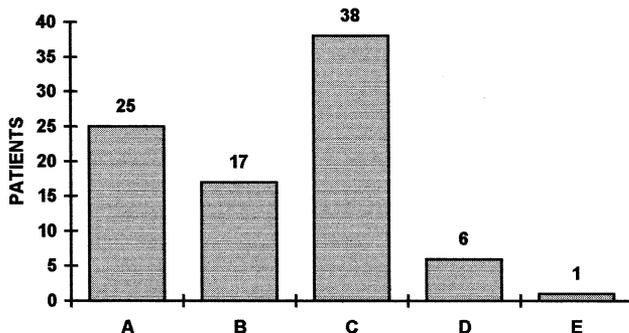
- A) YOUR SURGEON SPEAKING AND BEING WITH YOU
- B) YOUR ANAESTHETIST SPEAKING AND BEING WITH YOU
- C) YOUR NURSE SPEAKING AND BEING WITH YOU
- D) YOUR RELATIVES SPEAKING AND BEING WITH YOU
- E) OTHER PATIENTS SPEAKING AND BEING WITH YOU
- F) THE WARD SURROUNDINGS
- G) NONE OF THESE
- H) OTHER i.e. quick and efficient discharge, reading a book, personal items.

Fig. 4. What aspects of day surgery helped to reduce your anxiety?

spective of coping style, contact with the general practitioner was reduced when patients had more information at their disposal. A desire for higher levels of information was also positively correlated to contact with the day surgery unit following discharge (0.0029, $P \leq 5\%$).

4. Discussion

The hypothesis stating that when an individual's coping style, i.e. vigilant and avoidant coping, is paired with the appropriate level of information an adult day surgery patient will (a) be more satisfied with the level of information provided was rejected although only partially; and (b) experience less anxiety was upheld. These aspects and other issues relating to age, information provision, anxiety management, control, self-effi-



- A) GOOD
- B) ABOVE AVERAGE
- C) AVERAGE
- D) BELOW AVERAGE
- E) POOR

Fig. 5. Overall, how would you rate your patient's adjustment to her surgery today?

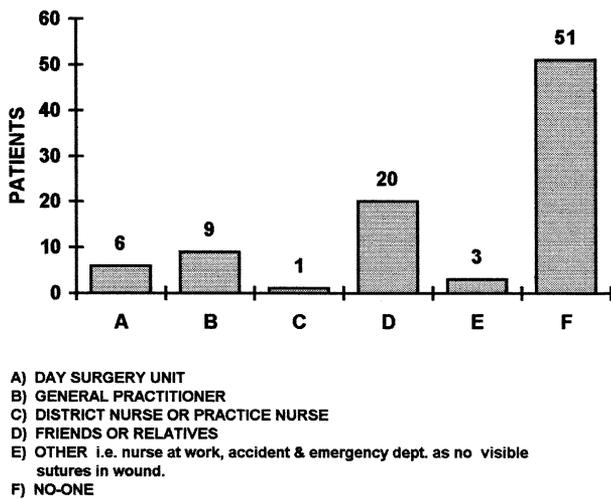


Fig. 6. Since your operation, have you contacted any of the following people for help or advice?

cacy and discharge information encompass the central findings and will be discussed in more detail.

4.1. Mature patients

A number of correlation's emanating from both nursing staff appraisal and self-appraisal related to age. The more mature participants (32–48 years) experienced reduced feelings of coping well, were helped little by the information on the day and were viewed by the nurses as adjusting poorly to their surgery. Their more mature years may indicate a possible increase in social obligations, i.e. a greater number of dependants or social commitments etc. Further support for this comes from a study by Donoghue et al. [20] in which 29% of female day surgery patients required help from one or more younger person. If this is indeed the case, day surgery, which currently requires no overnight stay in United Kingdom, may generate negative feelings of coping because the patient will be back at home that same evening. If the patient is aware that returning home too quickly to a domestic situation in which young children, for example, are depending upon them, it may result in a lack of time for personal rest and recuperation.

4.2. Information provision

Satisfaction with information and an information provision/coping style match was not identified at a significant level although there was a trend towards a significant level of satisfaction irrespective of coping style when in receipt of the extended information. A noteworthy feature of the subjects' coping styles were their fairly even spread, i.e. approximately four equal quarters (Fig. 7). This aspect of the data alone may be

a strong indication of the need for differing levels of information provision within day surgery. For example, if an information booklet provided within a day surgery unit had a simple explanation of the care and treatment then, based on the figures from this research study, 54% of patients would not be satisfied with the booklet, i.e. vigilant copers (28%) and fluctuating copers (26%) (Fig. 7).

The vast majority of patients preferred their pre-operative educational material to contain both written (98.9%) and verbal (92.2%) information. Of the patients who preferred written information 43.6% wanted diagrams, posters or charts to aid the explanation. This information was required 1 week prior to surgery for 42.5% of subjects and at 2–3 weeks for 32.1% (Fig. 2). A total of 74.6% participants required both written and verbal information concerning their operation a minimum of 1 week prior to surgery. When examining coping styles and preference for receipt of information vigilant copers required the information on average 3–4 weeks (mean) in advance and the avoidant copers 1 week (mean) in advance. Crucially, not one participant stated they preferred the information a few hours prior to surgery (Fig. 2).

4.3. Anxiety

The hypothesis stating that when an individual's coping style, i.e. vigilant and avoidant coping, is paired with the appropriate level of information an adult day surgery patient will (b) experience less anxiety was verified for three main reasons. Firstly, patients with vigilant coping styles who received the extended information were less anxious than the vigilant copers who received the simple information, as rated by the nursing staff immediately prior to surgery. The nurses clearly viewed vigilant copers who received less information than they required as more anxious. The nurses were blind to the type of information each patient had received although they firmly rated vigilant copers who received the simple information as more anxious. Sec-

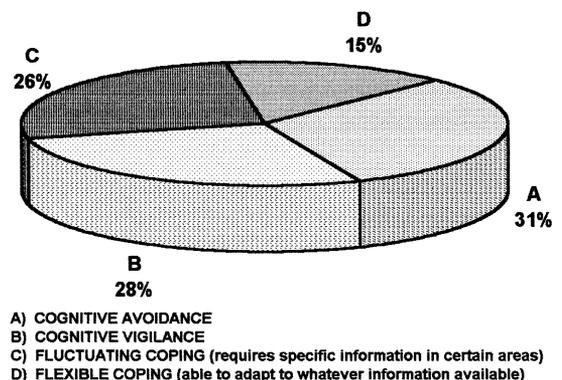


Fig. 7. Subjects' coping styles.

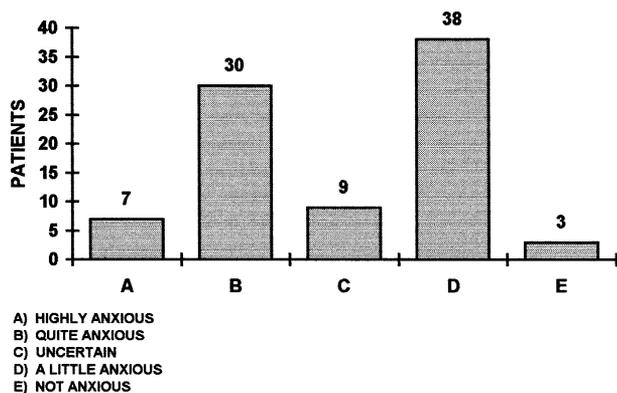


Fig. 8. How anxious would you rate your patient prior to her operation today?

only, vigilant copers who received the simple information stated they were more anxious concerning their general anaesthetic than vigilant copers who received the extended information. Finally, vigilant copers who received the extended information stated they were less anxious while waiting on the day for surgery to commence than vigilant copers who received the simple information. The vigilant participants when only in possession of the simple information clearly rated themselves as more fearful of general anaesthesia and waiting on the day for their surgery to commence. This, together with the nurses' equivalent ratings, comprehensibly endorses the need for differing levels of information provision within day surgery as some patients truly required a greater level of information to help manage their anxiety more effectively.

Only 28.7% of the patients were viewed by the nurses to have a good adjustment to day surgery (Fig. 5). A certain level of consistency was demonstrated within the nurses' ratings as the more anxious patient was seen to adjust less well to surgery and good adjustment to surgery was linked with the ability of the information to reduce anxiety. The nurses rated the vast majority of the patients as anxious on the day of surgery (97%) although this ranged from 'highly anxious' through to 'a little anxious', i.e. 34% were 'quite anxious', 38% were 'a little anxious' etc. (Fig. 8). The aspect of day surgery which generated the greatest level of anxiety was the general anaesthetic followed by the wait in the day of surgery unit (Fig. 3). Moreover, 63% of the participants stated they were anxious about more than one aspect of day surgery.

The aspect which helped to reduce anxiety the most for 72% of patients was the nurse speaking with and being close to the patient (Fig. 4). The information the nurses provide and their words of assurance are of considerable benefit. This is corroborated by 93% of participants gaining information on the day of surgery from the nurse and the nurses' actual presence being the most helpful in aiding anxiety reduction. This helps

to establish that while the physical presence of the nurse is extremely helpful the verbal provision of information by way of cognitive coping strategies is also of great benefit, i.e. telling the patient about the highly trained doctors and nurses, modern sophisticated equipment, fast and effective drugs, countless measures to ensure ample safety etc. [21]. These aspects can be both implicit and explicit as good professional conduct and an efficient well run day surgery unit will display implicit features of assurance (Fareed, 1996). Another aspect of implicit assurance is the ward surroundings which helped to reduce anxiety for 51% of the patients (Fig. 4).

4.4. Control

Vigilant copers significantly rated themselves as experiencing little control in comparison to avoidant copers believing that their destiny was more dependent upon fate, luck and powerful others. Krohne [19] states that the top three characteristics of a high vigilant copers are recalling negative events, self pity and the search for copious information. These are clearly not the traits of a person who feels in control, more akin to a person who experiences more external control appraisals. It would appear that vigilant copers require copious levels of information but place negative interpretations on all events, findings which are echoed by Miller et al. [22]. Providing copious levels of information, an appearance of control and emphasising the quality of the professional care may ultimately be the best approach to the pre-operative management of a vigilant copers.

4.5. Self-efficacy

Avoidant copers significantly rated themselves as experiencing a greater degree of self-efficacy prior to surgery than the vigilant copers, irrespective of the level of information received. From this it could be deemed that avoidant copers expected a small level of information and were happy about coping whereas vigilant copers expected a small level of information but were unhappy at the prospect of coping. As only 16% of subjects received information from their consultant and 25% from the day surgery unit, undoubtedly some vigilant copers must have received less information than they required resulting in their lower self-efficacy appraisals.

This is supported by the second point where avoidant copers who received the simple information had significantly higher self-efficacy appraisals than vigilant copers who also received the simple information. No such differences were revealed in the data when vigilant and avoidant copers both received the extended level of information indicating that being in receipt of the extended information influenced self-efficacy appraisals in

some way for vigilant copers. In view of this it may be necessary to provide vigilant copers with a greater level of support regarding their ability to cope well with day surgery especially when also in receipt of a lower level of information than they require.

4.6. *Discharge information*

Information provision had a number of significant effects on the patients' experience following discharge. As previously stated, the first part of the hypothesis was only partially correct, i.e. when an individual's coping style is paired with the appropriate level of information an adult day surgery patient will (a) be more satisfied with the level of information provided was rejected, although not completely. This resulted from an overall trend towards greater satisfaction when in receipt of the extended information irrespective of coping style. Plus, participants who were in receipt of the extended information significantly contacted their general practitioner less compared with participants who received the simple information (46 received the extended information and 41 the simple information). The main reasons for visiting the general practitioner following day surgery are to obtain medical certificates, help with pain management, advice on wound care and information [23–26].

Every participant stated that they had read the information sent to them in the post and 93% stated that they had read all of the information. Contact with the general practitioner was less when in receipt of the extended information and 59% of avoidant copers received the extended information. If it is to be assumed from this study that extended information provision for some people causes greater anxiety, i.e. for the avoidant copers, but extended information recipients visited their general practitioner less, some avoidant copers may have had to read more of the information within the extended booklet in the post-operative phase than they had originally intended. This would have removed the need to contact the general practitioner for extra information. Only 7% of the participants stated they did not read all the information booklet although this was not significantly related to an avoidant coping style. The avoidant copers who received the extended booklet may have censored the information initially and read 'all' the information 'they' required but not necessarily 'all' the booklet. It is not unreasonable to conclude that the avoidant copers extracted from the booklet the immediate information they required comfortable in the knowledge that should they require more, it was at their disposal. This may have hidden the avoidant copers' true level of satisfaction with the information received, i.e. avoidant copers who had too much information only read what they wanted and were therefore satisfied. Avoidant copers will simply self-select any information provided in order to evade potentially threatening as-

pects then state (correctly for them) that they were not made any more anxious and the information was satisfactory. Indeed, it was observed by Salmon [27] that when patients were obliged to listen to pre-operative information, anxiety actually increased. The work of Salmon may therefore support this notion as the participants in his study were a captive in-patient audience and inevitably some participants would have been avoidant copers.

Conversely, if it is also to be assumed from the evidence here that the lack of extended information provision for some patients caused greater anxiety, i.e. vigilant copers, some patients may have agreed to take part in the study simply because they were eager for more written information. Although only anecdotal evidence from the researcher's initial contact, many participants were very willing to take part in the study once it was revealed that information regarding their operation was to be sent via the post. These participants may well have been vigilant copers in pursuit of more information as in the pre-operative phase only 16% of participants stated they had received written information prior to surgery from their consultant and 25% written information from the day surgery unit. For the vigilant copers who only received the simple information (42%) no self censorship would have been necessary only the frustration and anxiety associated with searching for more information.

4.7. *Proposed nursing intervention*

An information provision/coping style match, a semblance of control and positive feelings of being able to cope well with surgery have a great deal to offer to the quality of psychological care within day surgery. A more formalised approach may also lead to improved adjustment to day surgery as only 28.7% were rated with a good adjustment by the nurses (Fig. 5). It may lead to a lower level of dependency upon the community healthcare services in the days following discharge (Fig. 6).

A number of modifications, will be necessary to the psychological management of day surgery patients in order to accommodate these innovative changes. Firstly, and most importantly, alongside the essential medical pre-assessment the patient must be able to decide which level of information they require. Time consuming questionnaires may not be required for this decision, merely an overview of the information available or the 'information pathways' available. A chart can be displayed on the wall within the clinical area highlighting these information pathways, i.e. Pathway 1, avoidant copers; Pathway 2, fluctuating copers (some patients required simple information plus a specific area of information therefore a middle pathway may sometimes be required); and Pathway 3, vigilant copers (Table 4).

Table 4
Proposed information pathway chart

	Information pathways		
	One (avoidant copier)	Two (fluctuating copier)	Three (vigilant copier)
1–3 Weeks prior to surgery (minimum)	Simple information concerning treatment, care and recovery; emphasis on relaxation; semblance of control; specific information enquiry	Simple/specific concerning treatment, care and recovery; semblance of control; positive self-efficacy encouragement; specific information enquiry	Extended information detailing treatment, care and recovery; emphasise quality of care and treatment; semblance of control; encourage positive self-efficacy appraisals
Day of surgery	Simple behavioural and procedural information; emphasis on relaxation; semblance of control; specific information enquiry; cognitive coping strategies	Simple/specific behavioural, sensory and procedural information; semblance of control; positive self-efficacy encouragement; specific information enquiry; cognitive coping strategies	Extended information detailing behavioural procedural and sensory information; emphasise quality of care and treatment; semblance of control; encourage positive self-efficacy appraisals; cognitive coping strategies
Intervention following discharge	Simple information; brief problem-solving procedures; specific information enquiry; telephone helpline number; nurse initiated telephone call	Simple/specific information; brief problem-solving procedures; telephone helpline number; nurse initiated telephone call	Extended information; detailed problem-solving procedures; telephone helpline number; nurse initiated telephone call

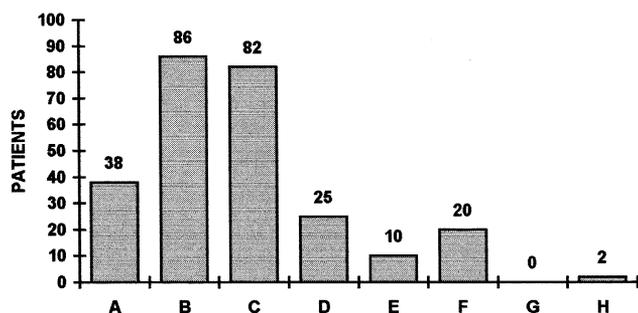
Table 5
Multi-disciplinary notes

TABLE 5
MULTI-DISCIPLINARY NOTES

ANXIETY MANAGEMENT IN DAY SURGERY	
MULTI-DISCIPLINARY NOTES	
NAME :	ADDRESS :
CONSULTANT :	TELEPHONE NO :
SURGERY :	DATE OF SURGERY : A.M. [] P.M. []
	<small>TICK APPROPRIATE BOX</small>
OUT-PATIENTS DEPARTMENT	[]
PRE-OPERATIVE CLINIC	[]
POSTAL CONTACT	[]
WRITTEN INFORMATION ONE (SIMPLE INFORMATION)	[]
TWO (SIMPLE / EXTENDED INFORMATION)	[]
THREE (EXTENDED INFORMATION)	[]
VERBAL AND WRITTEN INFORMATION	
	PROCEDURAL INFORMATION e.g. what happens next []
	BEHAVIOURAL INFORMATION e.g. what to do next []
(IF APPLICABLE TO COPING STYLE)	SENSORY INFORMATION e.g. possible pain and discomfort []
	COGNITIVE COPING STRATEGIES e.g. modern equipment, etc.. []
	RELAXATION INFORMATION e.g. structured programme []
	MODELLING e.g. visit, take home video or audio-tape []
NOTES.....	
.....	
.....	
NURSE :	
DATE :	
PRE-OPERATIVE TELEPHONE CONTACT (24 - 48 hrs pre-op.)	[]
NOTES.....	
.....	
.....	
NURSE :	
DATE :	
DAY OF SURGERY	
INFORMATION PATHWAY IDENTIFICATION TAG/ MARKING	[]
VERBAL INFORMATION	
	PROCEDURAL INFORMATION e.g. what happens next []
(IF APPLICABLE TO COPING STYLE)	BEHAVIOURAL INFORMATION e.g. what to do next []
	SENSORY INFORMATION e.g. possible pain and discomfort []
	COGNITIVE COPING STRATEGIES e.g. cognitive re-framing []
NOTES.....	
.....	
.....	
NURSE :	
DATE :	
POST-OPERATIVE TELEPHONE CONTACT (24 - 48 hrs post-op.)	[]
NOTES.....	
.....	
.....	
NURSE :	
DATE :	

This type of visual display will elicit an instant answer as most patients are aware of their coping style [9]. A simple traffic light colouring system could be utilised on the day of surgery, i.e. red-stop-very brief information as patient is an avoidant copier; amber-proceed with caution-simple and specific information as patient may be a fluctuating copier; green-go-give detailed information as patient a vigilant copier. This system could take the form of an inexpensive, appropriately coloured wrist tag or marker for the back of the hand. The whole process would only take a matter of minutes to execute, would benefit the patient enormously and save a considerable amount of time explaining unwanted or unnecessary information to highly anxious patients.

All this information together with written and verbal material could be discussed with the patient either in the pre-assessment clinic or by telephone 1–3 weeks prior to surgery. Once an information provision/coping style match has been established it can act as a guide alongside the standard methods of preparation, i.e. procedural, behavioural and sensory information [28]. Furthermore, 29% of the patients in the study required a video presentation explaining their care and treatment, 23% required a visit to the unit for a look around and 11% wanted an audio-tape presentation of their care and treatment (Fig. 9). The video and audio-tape presentation would have to be offered for viewing both within a programmed visit and as a take home package as not all the patients who wanted a video-tape required a visit. Finally, the patients may need to be contacted by telephone 24–48 h prior to surgery to check their attendance, reiterate any final instructions and answer any questions as this is a positive start to the nurse/patient relationship [29]. Nurse initiated telephone contact in the early post-operative period may reduce the need to contact the general practitioner. This



A) DIAGRAMS, POSTERS, CHARTS, etc.
 B) WRITTEN INFORMATION
 C) VERBAL INFORMATION
 D) VIDEO PRESENTATION
 E) AUDIO-TAPE PRESENTATION
 F) A HOSPITAL VISIT PRIOR TO THE DAY OF SURGERY
 G) NONE OF THESE
 H) OTHER i.e. chance to discuss the detailed information booklet, what happens during the operation.

Fig. 9. What method of receiving information would you most prefer prior to your operation?

whole system could be co-ordinated on a simple anxiety management care plan and documented on brief multi-disciplinary notes which could state any special points or specific arrangements (Table 5).

5. Conclusion

Good anxiety management and information provision are considerable challenges to current day surgery practices. Contemporary evidence suggests that offering differing levels of information, 1–3 weeks prior to surgery together with a semblance of control and the encouragement to cope well may be the way forward. If differing levels of information are readily available and these plans are adopted within day surgery, minimal disruption could be achieved. This system is quick and simple to execute, the patients will be more satisfied with the information and less anxious, time will be saved by not having to explain unwanted information, contact with the general practitioner will be reduced and it is based on contemporary research evidence.

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