

Nurse Anesthetists' Communication in Brief Preoperative Meeting With Orthopaedic Patients—An Interview Study

Ferid Krupic, DMSc, PhD, RNA

Purpose: To explore the experience of preoperative communication of nurse anesthetists (NAs) in brief meetings with patients in an orthopaedic setting.

Design: Qualitative research.

Methods: Three group interviews based on experiences of 18 NAs were conducted. Content data analysis was used.

Findings: The brief communication was characterized by both difficulties and opportunities. Protecting the patient's integrity, informing worried patients, lack of routines, language difficulties, being present at the meeting, protecting the patient from disturbance, and encouraging the patient to participate were stated as the main challenges in the brief meeting with patients. The NAs also gave some suggestions for improvement.

Conclusions: The Preoperative meetings need to be developed and structured to improve communication. A way to assess the results of this conversation should be developed. Other recommendations include finding a way to improve patient involvement in this dialogue and development of skills of NAs to enhance the meeting for patients.

Keywords: nurse anesthetist, experience, communication, brief meeting, orthopaedics, qualitative research.

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TO BECOME REGISTERED NURSES in Sweden, nurse anesthetists (NAs) are required to complete a specialist course in anesthetic nursing, which takes 1 year. The work the nurses perform differs when compared to other countries. In Sweden these nurses have independent responsibility for patients' anesthetic care. They administer anesthesia to all patients undergoing surgical or diag-

nostic procedures, with the direct or indirect supervision of a physician anesthesiologist, according to a plan defined by the supervising anesthesiologist.¹ These NAs are licensed and trained to handle compromised airways and to administer medication to patients, based on a written protocol or in accordance with the anesthesiologist's orders. They may also insert intravenous and arterial lines, depending on locally established protocols and the terms and conditions of service.^{1,2} The concept of anesthetic nursing is to ease the patient's discomfort and suffering by outlining the care program according to the patient's assets and needs² and to encourage purposeful communication³ between the nurse and the patient. To reduce anxiety, nurses are expected to offer personalized comfort and care, and to minimize the frequency of anxiety, nurses are expected to answer any questions the patient may have. By discussing possible medications, NAs enable the

Ferid Krupic, DMSc, PhD, RNA, Departments of Orthopaedics and Anaesthesiology, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden.

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Address correspondence to Ferid Krupic, Department of Orthopaedics, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Göteborgsvägen 31, 431 80 Mölndal, Sweden; e-mail address: ferid.krupic@gu.se.

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patient to become aware of and learn about different forms of anesthesia.³ A nurse's knowledge of a patient's medical condition, which is mandatory for NAs to know, might subsequently help to influence the management of anesthetics. These are just a few factors influencing all the tasks an NA is expected to perform before surgery.

From the point of view of anesthesia, the interaction between the NA and the patient, in which the nurse displays his or her skills in connection with each other,⁴ is the fundamental factor behind nursing care. The first preoperative encounter between NAs and patients is often brief lasting 3 to 5 minutes long. During this encounter it is important to build a rapport with the patient. In the brief meeting, the patient and the NA have time to get to know each other.⁵ At the same time, it is equally important to create a connection with the patient. Managers and care professionals anticipate that the patient benefits more during a patient-centered nursing process when actively involved in his or her care, rather than as the passive target of innovative medicine. Patients are then encouraged to be a part of and actively search for solutions to their problems.⁶ Person-centered care (PCC) is based on principles consistent with a human-scientific view of science, which presupposes that humans cannot be reduced and are connected to others and the environment around them. The key to PCC is to see the person, based on the individual's perspective, and to include the person in every aspect of care.^{7,8} PCC also means adapting the short meeting to the patient's needs. There are four elements that must be realized in order for communication between health care professionals and patients to function: caring practices, transpersonal caring relationships, the caring moment, and caring, healing modalities.¹⁷ Communication with patients is an important tool for NAs. Good communication improves patient safety.⁸ If communication is poor, the patient may feel unhappy with the care he or she received.⁹⁻¹¹ Even if the patient is sedated or confused by the situation and is anxious and frightened, some communication is still possible.^{12,13} Patients have stated that they regard communication relating to their surgery as an important aspect of care¹⁴ and the way nurses pass on information to other caregivers and physicians.¹⁵ To date, no study of how nurses feel about these conversations with

patients before orthopaedic surgery has been conducted. Therefore, it seemed appropriate to conduct a study to learn about the character of these encounters and possibly shed light on unexpected aspects of these conversations.

Person-Centered Care

PCC is one of the most important factors in good quality care according to the World Health Organization and the Institute of Medicine at the US National Academy of Science.¹⁶ PCC has been defined in various ways, including Watson's widely used theory of human caring.¹⁷ Nursing is based on caring and has ethical and philosophical implications. Nursing is also a question of connections between people, where the nurse as a human being meets the patient as another human being. In this way, dignity is preserved. The encounter must be holistic¹⁸ and Watson states that nursing is not just a matter of the nurse looking after the patient's physical needs but also his or her mental and emotional state. Authentic care is what nursing is all about, and it is the nurses' duty not only to their patients and their families but also to society as a whole and to the universe. A relationship comes into being as nurses do their job, providing care. Watson's theory includes four aspects: relational caring, transpersonal caring relationships, caring moments, and caring, healing modalities. A human-to-human connection is established as the nurse provides care. A vital consciousness is created within the care provided by the nurse and received by the patient. This model demonstrates the four "core concepts" of Watson's theory: relational caring for self and others, transpersonal caring relationships, the caring opportunity, and caring, healing modalities.^{18,19} The patient is seen as a complete human being and not just as a person with a health problem. These principles can be used in and adapted to many different situations.²⁰

Aim

The aim of this study was to explore the experience of NAs in brief meetings with orthopaedic patients in the preoperative setting.

Materials and Methods

Setting and Participants

This exploratory pilot study has a qualitative design. The study was conducted at the Department of Orthopaedic Surgery, Sahlgrenska University Hospital, Sweden. NAs were contacted by the author and asked to participate voluntarily in a group interview. Written information about the study was sent to the nurses who agreed to participate in the study. After meeting the study participants, the aim of the study was presented. NAs with at least 5 years of experience of orthopaedic anaesthesiology were asked to take part in the study, because those who have worked for at least 5 years have had more opportunity to meet many patients. Twenty-four NAs were initially recruited and 18 NAs (6 men and 12 women) participated in the interviews. Their ages varied between 35 and 55 years (median 40 years) and they had worked as NAs between 6 and 28 years (median 15 years). To obtain the information, three group interviews were conducted. There were six nurses included in each group. The demographics of the participants are presented in [Table 1](#).

Data Collection

Data were collected by the author through group interviews, using individualized open-ended questions, following an interview guide inspired by Kvale.²¹ The interviews were conducted between March and November 2017 by the author in three group interviews (six nurses in each group). The interviews began with the question “*Can you please describe your experience of communication in the brief meeting with orthopaedic patients?*”. All the study participants were urged to speak freely using their own words and to respond as comprehensively as possible. The interviewer only interrupted to pose further questions or follow-up on the information given by the nurses. The interviews, which were conducted on the surgical ward, lasted between 55 and 70 minutes and were audiotaped and transcribed verbatim. The interview guide is presented in [Table 2](#).

Data Analysis

A qualitative content analysis method in accordance with Graneheim and Lundman²² was cho-

sen for the analysis and interpretation of the data. This method is capable of condensing a large amount of data into a limited number of themes, categories, subcategories, and codes. The transcriptions were read carefully to identify the informants' experiences and perceptions. The analysis then proceeded by extracting units consisting of one or several words, sentences, or paragraphs containing aspects related to each other and addressing a specific topic in the material. The units that were related to one another by virtue of their content and context were abstracted and grouped together into a condensed unit, with a description close to the original text. The condensed text was further abstracted and labeled with a code. After that, codes that addressed similar issues were grouped together, resulting in subcategories. Subcategories that focused on the same problem were merged to create more extensive perceptions, which addressed an obvious issue.²² According to Graneheim and Lundman,²² the interpretation was performed primarily at a manifest level. One theme was also used to describe the underlying meaning in the interviews. A theme represents the latent content that was revealed in the interviews and the answers depend on the questions. The results are presented with direct quotes from the interviews.

Results

The analysis of the discussions resulted in a theme, two categories and eight subcategories. The categories, together with the subcategories, are presented in [Table 3](#).

Difficulties in the Preoperative Meeting

All the nurses in this study said they had a brief preoperative meeting with patients. They all emphasized the importance of the brief meeting with patients before surgery and many factors that affect the success of that meeting. Protecting patient integrity, informing and guiding troubled patients, repeatedly experiencing the inadequate routines at the hospital, needing more time, and working under added daily stress caused by others were all experienced by the NAs in this study as disturbing and difficult in the preoperative meeting with patients.

Table 1. Demographics of Participants in Terms of Education, Work, and Years of Experience

Demographics	Numbers
Gender	
Male	6
Female	12
Total	18
Education level	
Anesthesia nurses	11
Master's	7
Total	18
Age	
31-40 y	7
41-50 y	5
51-60 y	4
≥60 y	2
Total	18
Experience	
≤5 y	4
6-10 y	5
11-15 y	3
16-20 y	4
≥20 y	2
Total	18

PROTECTING PATIENT INTEGRITY. One of the most important tasks the NA has during the preoperative meeting is protecting the patient's integrity. All the nurses in this study mentioned that protecting the integrity of patients is important all the time and not just in the preoperative room. The process begins by closing the curtains and hiding the patient from other patients in the preoperative space. NAs must also ensure that patients are quiet, so as not to disturb other patients. All the nurses in the study mentioned not only the importance of but also the difficulties involved in asking patients questions immediately before sur-

gery. The difficulties were most often because of the fact that the patients were in the area intended for the presurgical care of patients. Questions about allergies to medication and other substances, the patients' weight and height, the status of their teeth, questions about pain and their ability to bend their neck, and questions about urination and bladder control in relation to ultrasound examination were experienced by all the NAs as difficulties in their meetings with patients. All the nurses said that they needed to explain the meaning of the questions to patients and that it all took time. Patients with dementia and anxiety were the most difficult for all the nurses in this study.

All the patients are in the same room, so sometimes it's difficult to protect privacy.

Sometimes I ask if all their teeth are glued in and the patients ask why that is so important.

We can handle all our tasks as long as patients are prepared and normal ... otherwise the whole of our work is undermined.

INFORMING WORRIED PATIENTS. All the nurses in this study found that most patients waiting for surgery are worried and anxious. They are afraid about how long the surgery will take, if they will suffer pain, and if they will sleep and wake up as planned. For some patients, it is the first time they have undergone surgery. In addition to providing medication for pain as standard for all patients, those patients who are worried are given antianxiety medication that must be prescribed by the NAs. The most difficult patient group is patients with dementia. All the nurses said that these patients need a long time and that the brief meeting becomes a long meeting in the end.

Table 2. The Interview Questions

Main Issues Raised at the Start of the Interviews	Examples of More Targeted Issues Raised During the Course of the Interviews
Can you please describe your experience of communication in the brief meeting with orthopaedic patients	Do you have any special preparation for the short preoperative meeting with patients? What is the most important thing for you to think about during the brief meeting with patients? How do you think it works with the brief meetings? What works well and what works less well in the short meeting with patients? Has the situation in Swedish health care changed over time? Is there something you want to compute?

Table 3. Overview of Categories, Subcategories, and Theme

Theme	Categories	Subcategories
Nurse anesthetic communication in the brief meeting—a complex issue	Difficulties in the perioperative meeting	Protecting patient integrity Informing worried patients
	Opportunities in the perioperative meeting	Lack of routines Language difficulties Being present at the meeting Protecting the patient from disturbances Encouraging the patient to participate Suggestions for improvement

I was asking an anxious patient questions and she just cried and stared at me.

Sometimes we ask a lot of questions and get no response, but the time goes on.

LACK OF ROUTINES. Although preoperative groups exist and despite the fact that these groups and various orthopaedic departments in the hospital meet frequently and regularly, most NAs feel that routines still fail. All the nurses in this study mentioned a large number of things that complicate intraoperative encounters with patients. Some of them are not that dangerous, but some of them put patients' lives at risk and the patient's surgery has to be postponed until the following day. The mistakes include the patient not showering adequately, not having a catheter inserted, having no surgical markings and, in the case of patients who may suffer hemorrhage, their blood group and blood tests are not available. Organizing this takes extra time and complicates the entire process.

We often only meet patients in the preoperative department, without a needle and with incomplete paperwork.

It's just a matter of organizing the procedure, but it takes time and the whole process is delayed.

LANGUAGE DIFFICULTIES. All the NAs in this study agreed that patients who were born abroad and do not understand or speak Swedish make the short intraoperative meetings very difficult and these patients make an already stressful situation even more difficult. Some of the nurses who

have been working for many years also noted that it is not just a question of the language but also the patients' religion, culture, behavior and practices, their different mentality, and upbringing. Most nurses pointed out that if you want to communicate with patients in this brief intraoperative meeting, it is necessary to know and be aware of all the factors involved with patients born abroad and that these factors may affect the meeting. The problem with interpreters who arrive late, interpreters who cannot understand medical terminology, and interpreters who interpret incorrectly also came up in the NAs' narratives.

My patient only replied yes or no.

I wanted to see the marks on the leg (hip) that was going to be operated on, she wanted a female NA to come and do it. We just have to accept it.

I was completely in control and I was about to meet my patient ... she could not speak Swedish and the interpreter was late. We just had to wait.

Opportunities in the Preoperative Meeting

In relation to managing the intraoperative meetings with patients as effectively as possible and facilitating communication with the patient, the NAs in this study mentioned some important points. Most of them mentioned that the brief preoperative meeting with patients sometimes extends to the time during which the patient is being transported to the operating theater and even while the patient is being anesthetized, depending on how urgent the patient's operation

is. Being present at the meeting, protecting the patient from disturbances, and inviting the patient to participate in the meeting were some of the points mentioned that would facilitate and ensure the success of this brief meeting.

Being Present at the Meeting

Most NAs in this study felt that these brief meetings are important and it is important that they are present and available to the patient throughout the surgery. They also found that, by acknowledging the patient and introducing themselves, they give the patients more confidence. There is also an identity check to ensure that it is the right patient. Explaining the function of the NA and the task he or she performs during surgery increases the safety of the environment for patients. The next aspect most NAs mentioned was holding the patient's hand and patting on the shoulder, not only in the preoperative space but also in the operating theater. All the NAs pointed out the importance of being present at the meeting and being focused on their patient, on one patient at a time. The nurses said it was wrong to have some other jobs to do at the same time.

I explain the entire process of the operation to patients, that I will be with them all the time to keep everything under control ... they become much more secure and feel safe.

I sit next to the patient, take his or her hand in my hand, speak calmly and sensibly so that anxiety and fear disappear.

Protecting the Patient from Disturbances

All the NAs in this study agreed that there are various disturbances for patients during the brief preoperative meeting. They also pointed out that different patients have different needs that need to be met and the goals of the NAs should be based on the patients' own wishes. Issues that were mentioned by all the NAs and which may disturb them were too many patients in the preoperative space, the patient having to wait to talk to the surgeon, fear and worry, and chatting in the operating room. Most NAs in this study agreed that this happens all the time, but that, over the years, things have become a little better. They also found that too much "turbulence" and

constant changes in health care professionals do not make things easier and aggravate the situation. They also pointed out that working well and diverting patients from negative situations depend entirely on who you work with and the team you are part of.

The health care professionals are missing ... it's difficult ... we still manage.

When I sense that the patients are nervous and fearful, I try to calm them by encouraging them and telling them everything will be all right and that they have no reason to be afraid.

Encouraging the Patient to Participate

The NAs in this study reported differences in patients seeking care at the orthopaedic department. The NAs were aware that, for some patients, their first stay in hospital is seen as a failure, for others it is a life crisis, whereas for some it is just routine. They also mentioned a group of patients not included in this list—patients with dementia. It was impossible for the NAs to encourage patients with dementia to participate. For other patients, no matter which group they belong to, this was entirely related to their concerns, fears, and past experiences. For all NAs, being involved means that the patient goes to the toilet himself or herself, is patient able to take a few steps to the operating table and keeps the mask on if he or she wants. Most NAs want to get patients involved. At least 30% of their work is done in this way. They also tell all the other occupational categories to invite patients to participate.

I once had a patient who had been operated on before. He knew all the procedures and everything went very smoothly.

When the patient participates, 50% of the job is already done.

Suggestions for Improvement

To improve communication between patients and NAs in the brief preoperative meetings, the NAs in the present study suggested a number of possible improvements. Better routines, effective communication with other colleagues, to avoid repeating

the same questions, developing a structured model for communication based on patient involvement, better coordination with the interpreting service, having a brief meeting on the orthopaedic ward the day before surgery, and reducing the high turnover of health care professionals were some of the suggestions for improvement. According to all the NAs in this study, all this could result in a better mutual understanding during the brief preoperative meeting.

Imagine meeting your patient the day before surgery, asking all the necessary questions and, the next day, meeting the patient again when everything is prepared ... that's how I want it.

Hiring a few interpreters at the hospital would not be a bad idea ... it would help us a lot.

Better routines, competence development for inexperienced NAs, and a course on difficult patients for younger colleagues were some other recommendations from the NAs in the present study.

Discussion

As the present study explored NAs' communication with patients in the brief preoperative meeting in an orthopaedic setting, a qualitative research approach was needed to analyze the data. The present study has only one author. The author felt that focus group interviews and subsequent content analysis were appropriate methods to obtain, analyze, and interpret the data. The content analysis method includes audio recording and the categorization and classification of speech and text, which creates opportunities to analyze not only the evident content but also the underlying meaning, that is, the latent content of the text.²² As the author of the present study was employed on the same unit, some degree of preunderstanding between the author and the NAs might have influenced the research process. However, this understanding may also have helped to conceptualize the study. Difficulties in studies written by one author can also be that the author has to do all the work that in the analysis of the text the author cannot directly rely on the assistance of the other coauthors and all the work on the eventual revision of the study has to be done by the author of the study alone.

The result of the study demonstrates several of the informants' characteristics, their daily work, and difficulties and opportunities to make the brief preoperative meetings more effective. In general, the factors that influence the brief preoperative meeting are the need to protect patient integrity and inform anxious patients, the lack of routines, and patients with language problems. The first reaction of the NAs in their brief communication with patients was to protect the patients' integrity before they started the conversation. Sometimes this is impossible, because many patients come to the preoperative ward at the same time. One of the ways was to move the patients somewhere else. The present study is in agreement with another study, which showed that a safety culture that promotes best practices and best outcomes is important in today's health care environment. The authors of the study emphasized that, in the various procedures performed in connection with the preoperative meeting, the safety of patients plays a central role in preoperative care and the health care environment.^{23,24} Another difficulty in the brief meeting was communication with worried and anxious patients¹⁴ and patients born outside Sweden who had language problems. A Swedish study by Sjöstedt et al²⁵ showed the importance of informing each individual patient on the basis of his or her specific needs. The authors point out that the information should include explaining the entire course of the operation, which may otherwise be perceived as an uncertain and frightening environment. Being well prepared, so the situation feels under control, makes it easier for both the staff and the patient.²⁵ The results of the present study show that, in situations where patients express concern and fear of surgery, the NA often uses nonverbal communication in the form of touching and support as proof of his or her availability. One important item mentioned by the nurses in this study, which may obstruct the brief meeting between the nurses and patients, is the daily routines on the orthopaedic wards, which do not function as well as they should. The results of the present study are in line with those of another study that show that well-established routines can lead to better care for patients.²⁴ Other difficulties that NAs described in the present study were language problems and problems with interpreters for patients who need them. In a previous study of elective orthopaedic patients, the authors

showed that preoperative information for all patients undergoing elective total hip replacement was limited. Patients expressed concern about inadequate preoperative information pertaining to the surgery, implant selection, pain relief, choice of anesthesia, having no or too little time to ask the surgeon questions, and the overall stressful situation.^{26,27} In a previous study of interpreters,^{9,28} the authors showed that expectations of interpreter-mediated consultations were high but not always fulfilled. Interpreters coming late, lacking professionalism or knowledge of medical terminology, and the use of health care professionals or relatives as interpreters were some of the problems raised and they are in line with the present study.⁹

There are four elements in Watson's theory: caring practices, transpersonal caring relationships, the caring moment, and caring, healing modalities.¹⁷ The nurse treats the person as a whole. The nurse-patient relationship becomes transpersonal and authentic when the nurse embraces the spirit of the patient and provides holistic care.¹⁹ However, not all segments of Watson's theory were realized in the present study. PCC locates the patient in the first place as a subject. It is therefore important during the brief meeting to protect patients, to inform them, to have an interpreter in place, to ensure patients are present at the meeting, to divert patients from disturbances, and to enable patients to participate.¹⁷⁻²⁰ However, this is not always possible. It is important to learn how the patient really feels and how he or she experiences the situation before orthopaedic surgery. NAs should observe and investigate other signs during the surgery that confirm the patient's statements. They need an adequate basis for clinical assessments and decisions and need data that are sufficient in scope, relevance, and credibility on the right level. By being carefully informed about the nature and course of the procedure through the care chain, the patient becomes more involved in decisions related to continued care. In this way, the patients' stress can be reduced, they may be more mentally present at the meeting and this will reduce disturbances.²⁵ Encouragement and praise create a good atmosphere and are prerequisites for good cooperation.²⁹ Although some patients want to end the short preoperative meeting, there was room for NAs to build a good

relationship and find common ground with their patients. During examinations, the NAs and the rest of the team recorded a calm, harmonious environment. Having knowledge of possible problems increases the efficiency of NAs and gives the patient more confidence at the meeting. During the brief preoperative meeting involving the patient, opportunities were also presented. For example, being present at the meeting with the patient could contribute to protection so that the patient is not distracted and would therefore be invited to participate. The observations in the study are in line with those in other studies that supported and also showed that interaction between individuals could be seen from the aspect of symbolic interaction, where in understanding human behavior the concept of meaning is a dominant fundamental factor. The interaction is based on different aspects: humans act on the basis of meaning, meaning is borrowed from human beings and their social interaction with one another and meaning is altered in a bilateral process that is used in every communication occurring between human beings. The meaning during the meeting occurring between the nurse and patient in an acute care setting is based on the nurse's flexibility when changing between psychosocial and physical care.³⁰⁻³² According to the results of this study, to overcome difficulties in communication between NAs and patients during the brief preoperative meeting, the participants in the present study even suggested a number of measures. They mentioned improving practical issues, such as better routines, effective communication with other colleagues, avoiding repeating the same questions, developing a structured model for communication based on patient involvement, improving coordination with the interpreting service, holding the brief meeting on the orthopaedic ward the day before surgery, and avoiding the high turnover of health care professionals. According to von Post and Eriksson,³³ the assessment and planning of a surgical patient's care should take place through preoperative dialogue. In the preoperative dialogue, the patient and nurse meet before surgery. The aim of the dialogue is to clarify issues that need to be explained to the patient and to plan the intraoperative period together with the patient. The intraoperative dialogue starts when the patient meets the same nurse in the surgical department.³³ For the nurse, the aim of this dialogue is

to implement his or her plan and explain to the patient what he or she is doing and why.³³ The preoperative dialogue is also time spent together, communication to create an atmosphere of confidence.^{32,34} Previous studies have shown that nurses are better prepared to meet the patient on the day of the operation if they have met the patient before and in a preoperative dialogue.^{34,35} The nurse listens and sympathizes with the patient's fears and anxieties and confidence is created between the patient and the nurse. By responding to the patient's concerns, the nurse helps the patient to cope with that "inner silent suffering that breathes fear, abandonment and hopelessness".³⁶

However, the theory from the 1990s that NAs should meet the patient on the day before surgery and conduct an exhaustive dialogue is utopian in Swedish health care today. First, the theory was presented 28 years ago and there have been changes in all disciplines such as medicine and health care. The health care in Sweden 28 years ago is not the same as it is today. There are a number of important reasons for this: the lack of health care professionals, the demand for health care is greater than the number of people employed in health care, major savings have been introduced in all spheres of society, including health care, and nowadays the number of surgical procedures is more important than the quality of the surgery and the patients' quality of life. This situation has led to the fact that short patient meetings take place in the hallway or in the toilet, or they only check the patient's identity and allergies, whereas the rest is completed in the operating room. This can lead to the employment of staff with lower skills, personnel who have come to Sweden from other countries and validated their education in Sweden, as well as staff who do not have Swedish as their mother tongue and whose language skills

are not as good as they should be. On the other hand, those who work are offered the chance to work even more. The whole situation can lead to the quality of care, together with patient and employee safety, going wrong and moving in a negative direction.

Limitations of the Study

To the best of my knowledge, this is the first study of its kind. However, the pilot study has some limitations. The NAs who work at the Department of Orthopaedic Surgery were interviewed during office hours. This can cause NAs to experience increased stress and difficulty relaxing, which can also cause the responses to their questions to be affected. The interviews in the present study were conducted by the study author who is employed on the same ward as the NA. As a result, the NAs' answers to the questions could be sparse and insufficient, which was not the case in this study.

Conclusions

In contemporary health care, brief preoperative meetings need to be developed and structured to improve communication, especially in terms of passing on information and explaining procedures in a way people can easily comprehend. Very often, body language and nonverbal communication are most significant in encouraging and comforting patients at this stressful time. A way to assess the results of this conversation should be developed. It would also be good to find a way to make patients more involved in this dialogue and to develop the nurses' skills to improve the meeting for the patients. They do not need to repeat themselves, their training needs to be more closely aligned with their actual work at the hospital, and a structured form of communication needs to be created for the preoperative conversation.

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