

best prepare this patient to be seen by his family?" I cannot help but think that this had to be one of my FINEST HOURS. I was so proud of the entire team - one of many such times, and as I reflected on this thought I wondered if this might be an example of what can be labeled as one of the greatest moments of a perioperative nurse's career. Knowing that the next generation will go the extra mile, will work to the point of exhaustion, that they will try everything possible to save a patient's life - this is more than any nurse can possibly wish for. I knew that I had that in my nursing staff.

Think about what you say, what you do, and how you behave. It all makes a difference

If "an understanding of the present relies on the knowledge of the past" (Haag-Heitman, 1999, p.7), then knowing how OR nurses of the past struggled with similar concerns, problems, and patient care issues must surely shed some measure of light on our understanding of perioperative nursing of today. Perioperative nurses in today's environment have a multitude of issues to deal with. They do it with professionalism and patience, never once scorning the gods who brought them to this place. After all, they chose to be where they are.

Each time an OR nurse comforts a patient, meticulously prepares for a procedure, helps a colleague, or assists at the bedside, they are making a difference. Each of these moments are to be savored and treasured. Any one of these acts of kindness and caring could translate to their FINEST HOUR.

Haag-Heitman (1999) states that one of the central characteristics of a profession is "the degree of personal involvement with clients". For many perioperative nurses, their degree of personal involvement with patients goes far above and beyond the call of duty. I remember how one nurse spent many off duty hours with an out-of-town family whose only child had just had a hind quarter amputation. I recall another nurse who volunteered to stay late for an emergency case involving a young man with cancer who had been to our OR many times. She had formed a special relationship with this patient and, when he was in trouble and eventually died, she wanted to be there for him. From my perspective, this was one of her FINEST HOURS, albeit a very sad one, nonetheless a very special one.

As you go about your daily routine - setting up

cases, admitting patients, trouble-shooting for equipment failures, helping others, working long hours, and going that extra mile - remember that each and every moment that you are at work can mean so much to others. Think about what you say, what you do, and how you behave. It all makes a difference. While you routinely perform many tasks without consciously being aware of your attitude and approach, others are watching and learning. I don't believe that there is a more committed, organized, or autonomous group of nurses than perioperative nurses. The fact that we have each contributed to this process may well be our legacy to healthcare - our FINEST HOUR as a specialty group. Remember your unique contribution to healthcare. As individual perioperative nurses caring daily for surgical patients you alone can make the difference.

As the Marconi advertisement, says "This could be your Finest Hour"!

Reference

Haag-Heitman, B. (1999). *Clinical Practice Development - Using Novice to Expert Theory*. (p 323). Aspen Publishers, Maryland, USA.



Royal Inland Hospital

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We are interested in hearing from qualified Registered Nurses for nursing opportunities that are available, with immediate full time positions in the Operating Room.

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If you require additional information, including an information package about the Kamloops region, please contact:

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Human Resources Department
311 Columbia Street
Kamloops BC V2C 2T1
Fax: (250) 314-2337

The RNFA - Anesthetic Team Collaborative Connection

Cheryl L. Spiece, RN, CPN(C), RNFA.

The RNFA functions as the patient's advocate in the nursing role. Understanding of the perioperative care the patient is receiving, to meet their physical and psycho-social needs, enables the RNFA to provide the patient with emotional support when they are most vulnerable - when under anaesthesia.

Pre-operatively the RNFA, functioning in an expanded role, is responsible for information obtained by reviewing the patient's chart. This review includes the surgeon's history and physical, anesthesia consult, specialist consult, nursing history, fluid balance sheet, medication record and diagnostic test results.

A patient interview introduces the RNFA to the patient while assessing for risk factors and patient needs for an individualized perioperative plan of care. The RNFA provides emotional support and perioperative patient education to help allay fear and anxiety experienced by the patient and their family members. The RNFA also acts as a liaison between the health care team members.

During my clinical internship, familiarity with individual anesthesiologist's pre-operative routines, preference of IV solution and preferred time of administration provided me with information for insertion of the IV pre-operatively in a more relaxed atmosphere, while concurrently exploring the patient's feelings and anxiety level. Reviewing the patient medication status allowed me to accurately report the medications

/ treatments administered, as ordered, and obtain any medication that may be required in the operating suite. (eg. Asthma Inhalers)

The patients were asked if they use any holistic therapy that may not have been previously reported. Some health food preparations may have an effect on bleeding/clotting times. My pre-operative assessment also included enquiry regarding any changes in health status since their visit to the surgeon's office, pre-operative clinic, or consultation with the anesthesiologist.

The center of activity in the operating room is the patient undergoing surgical intervention. The immediate concern up to the time of anesthetic induction is the patient's reaction to the events that are occurring.

Patient education regarding pre-operative procedures and monitors does much to allay fear, while decreasing the sympathetic response that affects anaesthesia. In the operating suite, the RNFA Intern continues to provide comfort and reassurance while placing the monitoring equipment on the patient, administering oxygen, as directed, and being close and available for the patient, as the anesthesiologist prepares for induction. One of the major fears encountered by the surgical patient is the fear of pain. As an RNFA Intern I was able to reinforce the patient's pre-operative education on pain management options. Support and explanation of events during regional anaesthesia provides comfort to the patient.

My assessment of the patient's general neuromuscular status, history of sleep apnea, snoring, rheumatoid arthritis, obesity and neck/ cervical spine injury/ trauma/ masses provided data for planning operative

Abstract

A requirement of the Registered Nurse First Assistant (RNFA) Clinical Internship is to explore the RNFA collaborative role with the anaesthetic team in facilitating positive patient surgical outcomes.

Author

Cheryl Spiece, RN, CPN(C), RNFA, is a staff nurse, St. Catharines General Hospital, St. Catharines, ON.

positioning needs and limits of range of motion that has implications for anesthetic induction and insertion of the endotracheal tube. As an RNFA intern I could provide extra assistance to the anesthesiologist during anesthetic induction, obtain the "Difficult Intubation Cart" if needed, and provide equipment as requested, to aid in maintaining the patient's head position for optimal airway maintenance. Patient history of decreased GI motility, hyperacidity, pregnancy, obesity, bowel obstruction, diabetes, renal failure, head trauma and emergency status are factors that affect gastro-intestinal function and may require cricoid pressure until the airway is secured. Since all surgical patients are potentially at risk from haemodynamic changes due to hypo/hyperthermia, the RNFA collaborates her findings with the anesthesiologist for the method preferred for heat increase or reduction.

Intra-operatively, I collaborated with my surgeon mentor, to assist with the surgical procedure. Effective tissue retraction decreases the risk of injury and insult to A Delta and C nerve fibers, that initiate the pain cycle response. Vigilant observation for bleeding and changes in the condition of the tissue decreases the risk of intra-operative complications that may require treatment modalities such as administration of blood or blood products and medication by the anesthesiologist. The risk of reactions as fluid/electrolyte imbalance and acid/base shift, that contribute to post operative complications. Gentle handling of viscera decreases the initiation of the sympathetic response that result in increased heart rate and hypertension. The RNFA must be acutely aware of the airway position in procedures that involve the head, neck and thorax. Improper retraction or positioning of the arms for retraction could inadvertently disconnect or kink the endotracheal tube, not readily visualized under sterile drapes. During regional anesthesia, nausea and vomiting can result from traction on structures within the abdominal cavity - a complication most undesirable for the patient and the anesthesiologist. Gentleness in all RNFA behaviors within the abdominal cavity must be observed.

Post-operatively, the RNFA communicates relevant surgical data to the PACU staff, for effective pain management. If ordered, the RNFA can assist PACU with the PCA pump. RNFA patient assessment continues after discharge from the PACU, to evaluate RNFA perioperative behaviors and planning.

As an RNFA Intern, the anesthesiologists that I followed in the operating room setting stressed the importance of reporting only new patient information

not obtained during their consultations. To maintain an effective surgical schedule and avoid overnight admissions, continuity of care and communication between surgical departments is important. As an RNFA Intern I was able to provide this communication.

During my two days of learning with the anesthesia department, my goal was to explore any unresolved issues regarding the care they deliver. We were able to discuss the properties of various anesthetic agents and indications for their use. The affinity of the anesthetic agents for fatty tissue make them ideal for cerebral uptake, although the exact mechanism is not exactly understood. I enquired about the avoidance of Diprovan in patients with egg and soy allergies. This wasn't a concern, as the portion containing the allergen is removed during production. The regulation of vaporized anesthetic agents, the achievement of their balance and expected changes throughout the anesthetic process was discussed. Monitors and the patient's ability to breathe unassisted by mechanical ventilation indicate to the anesthesiologist the amount of anesthetic agent remaining in the patient. Analgesia is administered by the anesthesiologist, depending on the intra-operative requirements such as incision, painful procedures (e.g., Orthopedic with bone involvement, tourniquet) and is regulated according to haemodynamic responses reflected on the monitors. This is the beginning of post-operative pain management.

With a high percentage of the population in this area consisting of the elderly, we discussed the implications this has on anesthesia. Older patients require less anesthetic agent and depending on the amount of body fat and size and condition of the liver, and generally take longer to eliminate the anesthetic agents. Changes in cerebral, renal and cardiovascular function, attributed to the aging process, also determine the rate of anesthetic clearance, and the patient's ability to respond to the stress of anesthesia and surgery.

The anesthesia perspective increased my awareness of their concerns for their patient's care during the operative procedure. Collaboration and communication between the RNFA and the anesthesiologist will also provide enhanced surgical patient care.

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At War For Perioperative Nurses

By Yves Panneton, RN, BSc, BBA

Not only did soldiers fight the enemy on the front line of the Crimean war, they also fought infection once injured. The problem with infection was so serious, that the "cavalry" lead by Florence Nightingale took up the challenge to fight it. Her "arsenal" included what we now term sanitation, physiotherapy, and nutrition along with nursing care. As her "enemy" retreated, she laid down the foundation of modern nursing - 150 years ago!

War is not fought only on the battlefield. With the law loosely encircling the nursing practice, the nursing profession has endured successive waves of "assaults" by other professions over the years. As a result, nursing has "lost ground" over certain aspects of its practice to the hands of other professionals such as nutritionists, physiotherapists and occupational therapists to name a few.

History has a tendency to repeat itself and today perioperative nurses are currently "under assault". Using the argument of cost saving as a "weapon", hospital administrators are trying to "disjoint" the perioperative nursing practice by, amongst other things, relegating the scrub role to RNA's and/or OR technicians.

Our "position" is to say that perioperative nurses are essential in the OR. Our "weapons", are arguments to justify our current role. Let's face it, in the majority of institutions perioperative nursing is limited to a technical role. In this case, how can we justify the cost of a nurse when the same tasks can be done by a competent technician? From a budgetary point of view, using nurses to perform technical duties is a pure waste of resources. By limiting perioperative nursing to a technical practice, we give the administrators a very powerful "weapon" against us.

To "counterattack" the administrators, we should be thinking of redefining our role by expanding it. An expanded perioperative nursing role will give the administrators more "bang for their buck", making it easier to defend our "position".

In expanding our role, many "strategies" are possible. For example, we can amplify the "basic training"

of perioperative nurses in order to include, as part of the core curriculum, some of the functions of the first assistant. This will give more flexibility to Perioperative nurses in the role of scrub person. A second option could be to cross-train perioperative nurses to work in surgical day units and PACU. In this way, perioperative nurses will be more "empowered" in perioperative care. A more accessible and immediate option is to systematically perform pre and post-operative assessments to all surgical patients including intra-operative visits to their families. The immediate impact of this "strategy" is better quality care for our patients. Of course, there could be other innovative ways to expand the role and this "list" is far from being exhaustive. The key word is to explore new avenues and share them through publications or other forums.

Notwithstanding the "strategy" we choose, we have to "deploy" on more than one "front". For instance, perioperative nursing associations could get politically involved by "selling" the advantages of an expanded perioperative nursing role to politicians. The nursing boards could attempt to "negotiate" an expanded role with other professional associations. Nursing schools could develop, at the university level, a research based core curriculum that expands the role of the perioperative nurse. This would give credibility to the perioperative "basic training" and help justify the presence of nurses in the OR. Perioperative managers, in collaboration with educators, could assess the value of an expanded perioperative practice in their hospital environments.

It is relatively easy to systematically do pre and post operative assessments on surgical patients as well as intraoperative visits to their families. In so doing, perioperative nurses gain more visibility both to the public and the hospital staff, thus increasing our value.

Above all, as good "soldiers", perioperative nurses

Author

Yves Panneton, RN, BSc, BBA, is Nurse Clinician Educator at the Montreal Neurological Hospital.