

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

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should have the will to enlarge the scope of their practice and take on the opportunities encountered to expand their role. Without the right "attitude", no change in the practice can be achieved.

Although none of these ideas is new, they are in practice the exception, rather than the rule. The trend should be reversed and the timing could not be better for these developments. For the sake of necessity, many hospitals are re-engineering for greater efficiency or are in the process of merging. They are, as Lewin would describe, in an unfreezing mode. Hospitals are open to propositions and ideas in getting more value for their dollar. More than ever, the time has come to revise the perioperative nursing role and "sell" it to administrators. The same administrator wanting to "cut" the perioperative nurse's role could become an ally if, and only if, the right justification is given. That *raison d'être* can only come from a revised and expanded role.

Perioperative nursing is at a crossroad. It is unlikely it will remain as it is. To avoid repeating history and lose more "ground", we have to "fight" with all the resources available. As with the midwives and nurse practitioners before us, we have to expand our role to offer an added value. Our future is on the "front line".

Really, war is a terrible thing.

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RNFA Update

During the past year, the Canadian RNFAs have established themselves in Québec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. The RNFA/RNFA student numbers have grown to just under a hundred in Canada.

Québec

Québec had 36 graduates last year, and are currently waiting for the final reading of an amendment to the Medical Act to allow registered nurses to assist at surgery in their province.

Ontario

Ontario has 14 RNFAs and 10 RNFA students who have formed a RNFA committee with their provincial group ORNAO for promotion of the role. Two RNFA positions have been filled at the Trillium Health Centre, Mississauga.

Manitoba

A RNFA pilot project in Winnipeg, Manitoba has been establishing the benefit to having the Registered Nurse assisting role. An amendment to the Medical Act in 1999 will allow RNFAs to assist at surgery. There are five (5) RNFA students who will be available for positions in the future.

Saskatchewan

Due to the lobbying of two RNFAs and one RNFA student in Saskatchewan, the Hospital Standard Act, 56 (1) has been deleted making it possible for Registered Nurses to assist and Pilot Projects are now being discussed.

Alberta

Alberta is addressing support for the RNFA by distributing a survey to the stakeholders within the Calgary Health Region. There two RNFAs and one RNFA student in the province.

British Columbia

B.C. has 12 RNFA students who have had an interesting year in the political arena. They have finally been allowed to complete their internships and are now being asked to prepare for possible RNFA employment.

On the National Front our association with ORNAC continues. A draft of the RNFA competencies was presented to the ORNAC Board in May, 1999. Please visit the RNFA web page on the ORNAC web site www.ornac.ca for more information about the RNFA Progress in Canada.

RNFA Update was submitted by **Susan Carver**, RNFA, Brantford General Hospital, Brantford, ON.

Managing Conflict To Gets Your Needs Met

By Margaret M. Carey, RN

When at work, we are all too often met with roadblocks, usually due to some type of disagreement. Whether it is peers with whom our opinions differ, or our inability to express our point, conflict occurs. When handling problems, they can become like clouds over the sun, blocking the reality or the sunshine behind the truth. Realistically, we are working towards the same objective - getting the job done.

When trying to reach our goals, we can have problems with communication. When it comes to communicating, some people are exceptional at it, while others, because of various limitations, lack the skills to communicate effectively. Due to one person's shyness, or another's aggression, communication can slow to a standstill, or explode into conflict. So, what do we do when faced with conflict? Do we cower away, do we forge ahead until we win, or do we adopt any of these practices?

Conflict can solve problems

What people in conflict tend not to appreciate is that their management of conflict, not the conflict itself, gets in the way. People who discuss conflict disclose information, challenge assumptions, dig into the issues and as a consequence, understand the problem thoroughly and make successful decisions.

"Conflict is the medium by which problems are recognized and solved. Conflict is not the problem, it is part of the solution. Conflict, though it can cause distress and prevent you from getting your way, is not an inevitably destructive and imposing barrier you could be better off without. Wishing we could live without conflict and avoiding discussing conflict are the real barriers. Managing conflict is an essential life skill that is too often neglected," (Tjosvold, 1993).

The following techniques are now presented for better conflict management which will help overcome the obstacles we face while working towards our goal - getting the job done efficiently and cooperatively.

One of the most common problems with conflict is not looking beyond the problem.

For example, take the proverbial sisters who quarrelled over an orange. After they finally agreed to divide the orange in half, the first sister took her half, ate the fruit, and threw away the peel, while the other sister threw away the fruit and used the peel in baking her cake. All too often the negotiators "leave money on the table" - they fail to reach agreement when they might have, or the agreement they do reach could have been better for each side. Too many negotiations end up with half an orange for each side instead of the whole fruit for one and the whole peel for the other. Why? "People get angry, depressed, fearful, hostile, frustrated, and offended. They have egos that are easily threatened. They see the world from their own personal vantage point, and they frequently confuse their perceptions with reality. Routinely, they fail to interpret what you say in the way you intend and do not mean what you understand them to say. Misunderstanding can reinforce prejudice and lead to reactions that produce counter reactions in a vicious circle: rational explanation of possible solutions becomes impossible and a negotiation fails. The purpose of the game becomes scoring points, confirming negative impressions, and apportioning blame at the expense of both parties," (Fisher et al, 1981).

Another point to emphasize is that during conflicts, during the arguments, there is the assumption "that because the other side's positions are opposed to ours, their interests must also be opposed. In many negotiations, however, a close examination of the underlying interests will reveal the existence of many more interests that are shared or compatible than ones that are opposed," (Fisher et al, 1981).

Another basic fact of negotiation is that you are not dealing with abstract representatives of the 'other sides', but with human beings. They have emotions, deeply held values, and different backgrounds and viewpoints and they are unpredictable, and so are you.

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