never had contact with the patient again, she made it very clear that she was willing to undergo any tests that would help to alleviate my concerns. I was very fortunate and grateful for her cooperation.

Through the next few weeks, I continued to take the medications. Keeping busy, in and outside the workplace, helped me cope with the side effects of the medication. During this period I lost ten pounds, which was the only bonus, and became acutely aware of problems involved taking H.I.V. medication. My Hepatitis B titre was low so I received a booster. For the next year I was routinely tested for Hepatitis and H.I.V.

If you are in a position to consent to take antiretroviral medication, be sure it's "informed consent." Perhaps in recognizing the implications of needlestick injury we can make ourselves and our coworkers practice safer use and disposal of sharps.

My injury happened two years ago and some of the medication and dosages have changed. Also, screening for H.I.V. is much quicker today. For health care workers in smaller units, you may have to call in another staff member to replace you while you seek medical attention and advice. Be prepared, be aware, and use safe practice.■

Conclusion

I want to emphasize how important it is that everyone involved in health care make themselves aware of the individual facilities' policy regarding needlestick injury. If injured, bleed wound freely, cleanse with soap and water and disinfect with alcohol or other disinfectant. Know where the closest supply of medications for exposure is kept. Be certain your first aid personnel know the medication should be taken within one hour of injury if possible. Also, a review of your injury, its implications and severity should be reassessed by yourself and health care department after beginning your medication. Your family physician can use the H.I.V./A.I.D.S. hotline numbers for more information.

Know the precautions to avoid transmission:

- Abstain from sexual intercourse or use latex condoms with non-petroleum lubricant.
- Do not become pregnant, do not breast feed.
- Do not share toothbrushes, razors, etc.
- Do not donate blood, plasma, organs, tissue or sperm.

These are some of the precautions.

There is only one place for a needle/sharp after its use and that is in an appropriate disposable container.

This includes using containers on our sterile fields. No one should put themselves or anyone working in their facility at risk by using folded towels, medicine cups, or kidney basins inappropriately for used sharps. Our advantage in the O.R. is that we are aware who our sharps have been used on. C.S.D. and Housekeeping staff do not have this advantage.

Attention all Perioperative Nurses

The Isabelle Adams Excellence in Perioperative Nursing Award

To be Awarded at the 1999 ORNAC National Conference in Halifax, Nova Scotia

Do you know of an outstanding ORNAC member, who through her dedication and commitment has made a difference in the field of perioperative nursing and deserves to be recognized for her contribution ?

The Isabelle Adams Excellence in Perioperative Nursing Award was established for this purpose on the initiative of the Operating Room Nurses of Québec in 1987. The first award was presented in Vancouver in 1988 and is presented on the year of the National Conference.

Nomination papers can be obtained through your Provincial President or by contacting:

Nora Slater
Chair, Awards Committee
11 Jason Avenue
North Tetagouche, NB E2A 4Y8

Reflections of a Canadian RNFA

Past, Present and Future

By Grace Groetzsch RN, BScN, MEd, CPNC), RNFA

At present I am one of three formally trained Registered Nurse First Assistants (RNFA) in Canada and the only one employed in that capacity. To become an RNFA one must be a registered nurse with a minimum of two years experience in perioperative nursing, and must have obtained perioperative certification (CNOR, CPN(C)), Advanced Cardiac Life Support (ACLS) and/or Basic Cardiac Life Support (BCLS) certification, letters of recommendation and liability insurance. I am currently insured through an American carrier affiliated with AORN. At present, a degree is not necessary but after 1999 in the United States a degree will be required to write the perioperative certification examination(CNOR) and hence to become an RNFA.

In 1980 the American College of Surgeons stated that an RN, with additional training was acceptable as an assistant should a surgeon, resident or fellow not be available. By 1983 RNFAs were able to assist in 17 states. As of 1996, RNFAs are recognized and practicing in all 50 states.

Jane Rothrock, an internationally recognized expert and advocate of RN First Assisting started the first RNFA program in the United States in 1985 at Delaware County Community College in Media, Pennsylvania. There are currently 19 programs affiliated with colleges and universities in the United States graduating RNFAs. I was fortunate to attend Jane's course. At present there are no RNFA programs in English speaking Canada. There is one program in Quebec and a curriculum is being developed at the British Columbia Institute of Technology (BCIT).

Most RNFA programs are structured on Jane Rothrock's model and follow AORN Recommended Education Standards for RN First Assistant Programs. Pre-course material is done by correspondence followed by six days of didactic classroom instruction with RNFA and surgeon faculty members. A supervised clinical internship encompasses one academic semester and a minimum of 120 clinical hours. My pre-course study and didactic instruction was completed between January and May, 1997. To align with the academic calender I began my internship in September. In order to develop my newly learned skills I participated in a pre-internship from June to August, 1997.

Pre-internship

Surgical and hospital, as well as nursing support are important to introduce the RNFA role. Encouraged by my OR manager, I volunteered my services three days a week as a RNFA pre-intern at my place of employment, the Orthopaedic and Arthritic Hospital, Toronto. Two days a week I continued to work as a paid perioperative staff nurse. I was reluctant to pre-intern at my own hospital for a variety of reasons. Physicians assisted routinely and I did not want to get in the way and what would happen if I failed?

Author

Grace Groetzsch RN, BScN, MEd, CPN(C), RNFA, is a full time RNFA employed by the cardiac surgeons at Sunnybrook Health Science Centre, Toronto. She is also a staff nurse in the operating room at the Orthopaedic & Arthritic Hospital, Toronto.

This is an abridged version of her presentations in April 1998 to the BCORNG Conference, Harrison Hot Springs, BC, and the ORNAO Conference, Niagara Falls, Ontario.

The RNFA is a Nursing Role

I was often asked "Are you a nurse today?" The question meant was I scrubbing/ circulating or assisting? My response was always "I'm a nurse everyday". I feel strongly that the RNFA is a nursing role and that nursing brings a unique perspective to first assisting pre-, intra- and post-operatively.

I spent much of my pre-internship on an emotional roller coaster. Some days were wonderful. Other days I felt stupid and inept. I was considered a good scrub and circulating nurse and still I had much to learn. Anticipation of the surgeon's needs and the operative sequence were still important. Now the ability to discern tissue planes was an additional requirement. I had to think and see like a surgeon. This was anatomy from a new dimension. My nursing textbooks lacked sufficient detail and medical textbooks and journals became my reading of choice. What I thought I knew, I did not know in sufficient detail.

"As the supply of Canadian physicians decreases, there will be ample opportunity for non-physicians to assist at surgery".

I spent most of my time assisting an orthopaedic surgeon, Dr. Jeffrey Gollish. I became his 'shadow'. In addition to the intra-operative assisting we did pre- and post-operative patient rounds and clinics together. I developed a true appreciation of the entire perioperative experience and how I, as a RNFA could facilitate the process. Here was a perspective outside my usual sphere and experience.

Manual dexterity was a major focus in learning knot tying and suturing. There are many ways to develop these skills all requiring guidance, practice, patience and time. The full-time physician assistants taught me a tremendous amount. It is better to be slow and precise, than to be quick and careless. Speed follows precision.

Diplomacy

Diplomatic skills are integral to the role of an RNFA. Just as you observe nursing and medical colleagues in a new light, they will also regard you differently. You need to know when to speak up and when to keep quiet; to understand what is helpful and appropriate, and what is not. You need to be articulate, intelligent and maintain a professional image.

In retrospect, I am glad that I began my RNFA career at the Orthopaedic & Arthritic Hospital with people who knew me and my abilities. As an RNFA novice, I lacked experience and professional confidence. I was often teased that the wound would close by granulation tissue by the time I had it sutured. Without the patience, support and encouragement of my colleagues I am not sure I would have succeeded in this new role.

Internship

My internship was completed at Sunnybrook Health Science Centre, Toronto. I did not know the hospital and it did not know me. The word "temporary" featured largely on my new name tag. I worked there four days a week without pay and continued one day a week as a staff nurse at the Orthopaedic & Arthritic Hospital. I interned primarily in cardiac surgery where Dr. Bernard Goldman was my mentor. I worked, however, with all the cardiac surgeons.

I spent an hour a day with the nurse practitioner and clinical fellows on the cardiac floor. I gained an understanding of the pre- and post-operative care of cardiac patients. I spoke with patients about their perioperative experience. I pulled my stethoscope out of mothballs, and listened to patient's hearts, lungs and abdomens. I reviewed cardiac rhythms. I removed pacemaker wires and chest tubes. I observed the daily progression to recovery and the impact of complications. In the operating room numerous individuals, each with his own technique, taught me to harvest the saphenous vein. In time I developed my own method and with practice gained sufficient speed to independently harvest the vein.

Unsure of where my RNFA future lay, I spent time in general surgery. The experience was very different. There was a medical student, clinical clerk, PGYI (intern), junior resident, senior resident, and in some cases a clinical fellow. Now there was also an RNFA intern. To be accepted as a potential assistant meant doing what was appropriate and sometimes that meant letting someone else assist. In spite of that, Dr. Sheriff Hanna, my mentor in general surgery, ensured that I had ample opportunity.

I had seven clinical objectives to achieve during my internship. My performance was formally evaluated bi-weekly and at the end of the internship. I worked and studied long hours, and learned a tremendous amount. On weekends, and pending sufficient energy after hours during the week, I completed the program's thirteen written internship assignments. Establishing priorities was quite a balancing act.

Courage

The acronym **COURAGE** (Carlton Cards), helps to express some of my feelings about my RNFA experience.

C *stands for confronting the dragons.* There are lots of dragons in nursing, and perioperative nurses are renowned as such. Traditionally nurses are not good at supporting nurses perceived as different. Rather than pushing you up, there's usually someone trying to pull you down. If the RNFA role is to succeed we cannot fight amongst ourselves. We need to stand united.

O *is overcoming the obstacles.* The emotions you experience along the learning curve are difficult to endure at times. For me they were the biggest obstacle of all. I've never felt so stupid in my life. I went from being a well paid independent consultant to an unpaid novice who could not accurately discern tissue planes. It was my friends and colleagues who made it tolerable to carry on.

U *is understanding the risks.* Anyone considering a career as an RNFA must understand and consider the risks involved. I gave up full-time employment to take a course that is not recognized in Canada, to work in a province where the role is considered officially outside my scope of practice, where there is no method to remunerate the position within current funding mechanisms, and hoped that I would get a job. When you set off on this journey, there may not be a prize at the end. I was lucky. The other two RNFAs in the country have not been so fortunate.

R *is really living.* I failed miserably at that. I worked long hours, saw little of my family and friends and became very tired. Thanks to some great friends and frequent flyer points, I celebrated my graduation with a ski and sun holiday.

A *is always believing.* With the exception of a few emotional lapses brought on by overwork, I always believed in myself, my ability to complete the program and find a job. My hard work paid off.

G *is going the distance.* It means working long hours. It means you do not get coffee and some days, lunch. It means you do not get to go home at the end of an eight hour shift, you go home when the work is complete.

E *is expecting the best.* Not of others, but of yourself. You need excellent clinical skills, and the ability to anticipate and react to the unexpected situations. The RNFA must be adaptable.

Financial Costs

In the end I had a certificate that said I was an RNFA and six university credits. The cost was approximately $5,000 Canadian plus lost earnings from June to December, 1997.

Financial Aspects

Tuition	$1428 US
Textbooks	$251 US
Airfare	$364 Cdn
Hotel	$636 US
Car Rental	$233 US
AORN Membership	$ 60 US
Liability Insurance	$158 US
ACLS	$195 Cdn
ACLS Pre-course	$ 35 Cdn
CPN(C)	$348 Cdn
Physical	$ 75 Cdn
Courier	$150 Cdn
Photocopy	$100 Cdn
Time/Lost Wages	$??????

Currently, I am not a hospital employee. I am employed directly by the cardiac surgeons at Sunnybrook Health Science Centre, whom I bill through my consulting business. I am paid a fixed salary irrespective of my hours. Many of my nursing colleagues have difficulty comprehending that I work for less than a staff nurse's wages. I believe it is better to be employed and demonstrating one's worth and abilities, than to be unemployed holding out for more. I have a job that I love, feel passionate about, and know is going to get better.

A Day in the Life of an RNFA

My typical day starts at 07:00 hours and finishes between 17:00 and 19:00 hours. I continue to spend time on the cardiac floor visiting patients post operatively and doing post operative wound surveillance. Two mornings a week I attend cardiac rounds. In the operating room I check the chart and X-rays for relevant information. If time permits, I assist the circulating nurse prepare the room and open supplies. At a minimum I try to ensure that the scrub nurse has gloves and enough gowns. I catheterize, position, prep and drape the patients. I harvest the saphenous vein and then assist at the chest. Depending on the type of surgery and the availability of assistants, I either first or second assist at the chest. As first assistant I help with cannulation, grafting of the conduits, decannulation and chest closure. As second assistant I keep the operative field blood free, retract and assist with chest closure.

Sixty-five percent of blood borne exposure incidents occur to the surgeon and first assistant,(Bryce, 1998). The risk of being stabbed as an RNFA is significantly higher than the risk to the scrub or circulating nurse. You learn to take precautions but you can never completely protect yourself. This is not a hazard-free position.

After closure, I apply dressings, remove drapes, help move the patient onto the bed and then assist with transfer of the patient to ICU. I spend time after transfer helping the ICU nurses get the patient settled and augmenting the report from anaesthesia.

The Future

I am often challenged to articulate where I see myself fitting in. Do I see myself in the department of surgery or in the department of nursing? I describe myself as a bridge between the two. I believe strongly that the RNFA is a nursing role and the nursing aspect brings a unique perspective throughout the patient's perioperative experience.

As the supply of Canadian physicians decreases, there will be ample opportunity for non-physicians to assist at surgery. Perioperative nurses must position themselves to fulfill that role. RNFAs understand aseptic technique, the operative sequence and the workings of the perioperative environment. With additional education, the perioperative nurse becomes the ideal first assistant. There is a growing need and many ways to solve the problem. One Ontario hospital has already hired someone outside the healthcare professions to act in this capacity. I see a challenge to ensure that surgeons and hospitals choose RNFAs as the alternative of choice when physician assistants are not available.

RN First Assisting is a demanding, yet rewarding and exciting career path. If you are able, willing and interested give RN First Assisting serious consideration.

References

Bryce, Elizabeth Ann, MD. *You Too Can Be Punctured - Reducing the risk of Blood Borne Diseases in the OR.* Presentation to the British Columbia Operating Room Nurses Group 16th Biennial Conference, April 24, 1998.

What is Courage? Positively!™ Carlton Cards, Toronto, Ontario.

Grace Groetzsch is starting a database of individuals across Canada participating, formally and informally, in the role of the RNFA or surgical assistant.

Please contact her at :

(416)781-0929,
fax (416) 781-0645,
or email, groetzsc@idirect.com.
