Orderlies and Aides Merging into O.R. Attendants

By Susan Carver, RN, CPN(C)

In the 80's we saw the beginning of new technology in anesthesia and surgical techniques in the Operating Room. The Canadian Anaesthetic Society (CAS) has set high standards for noninvasive monitoring of the anesthetized patient for safe anesthesia. The new drugs used during anesthesia have the ability to provide excellent pain control with shorter recovery time both in the post anesthetic care unit and at home. In surgery, laparoscopic techniques have also decreased the time spent in the recovery phase post operatively.

The Pre-op Clinic has reduced stress for patients coming to the OR by streamlining their preparation time for surgery, allowing the Day Surgery Unit to admit and have them available for their surgery time within minutes of arriving at the hospital.

Post Anesthetic time has also been reduced, and all these new developments have been very beneficial for the patient, who is our primary concern, regardless of how it has affected the OR environment and staff.

Our elective list reached its maximum with all these advances in place, and we've had to look closely at our limitations and how to improve our situation.

In the past, during our elective schedule, nurses picked tables, processed instruments, cleaned rooms, and ordered supplies. Support staff worked only Monday to Friday, and only from 0700 to 1500hrs.

Monitors, televisions, microscopes, and lasers are quickly occupying valuable space. Operating rooms built in the fifties have run out of space in the nineties, (our OR was built in 1957). Also, a department called Biomedical Engineering has become very important to us, since our old wrench won't fix today's complex problems.

With each new procedure comes more equipment and intricate instrumentation. We have been bombarded with all of this, and when one looks around, one wonders when it all started and where it all came from. We've been so busy learning about the various new technologies, we didn't see the overall massiveness of it sneaking up on us.

We can now see how new technology has affected our OR environment. It has increased the volume of cases, limited our space, demanded more knowledge of equipment and instrumentation, and has given more responsibility to support staff.

Nurses are now working in the rooms and are unable to fill in those places where support staff can be more beneficial and cost effective. We have found it necessary to hire more support staff and to evaluate their job descriptions.

In the 80's, the support staff consisted of orderlies and aides. Orderlies were responsible for cleaning rooms and anesthetic equipment, stocking of supplies, and setting up rooms. Aides were responsible for cleaning instruments, picking tables and stocking supplies. Both groups were basically doing the same job, caring for the OR environment, and yet their responsibilties were never amalgamated. These two groups have now been merged to become known as *OR attendants*.

Abstract

It was always my belief that perioperative nurses should be in the operating room performing nursing duties, not in the role of cleaning instruments and picking tables. New technology introduced over the past decade required longer schedules for nurses and the introduction of additional support staff. Because of the longer schedules, it became more cost effective to hire support staff to assist nurses in non-nursing functions. Recently, I was involved in a program which reorganized one aspect of our OR department and merged two existing support positions into one.

Using ORNAC standards, CAS standards and CSS standards, I accepted the challenge of organizing the supplies of the department, merging orderlies and aides into one support group, training and documenting the important assignments given to this group and orienting staff to this new role.

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Functions of the OR Attendant

The OR attendant working in the operating room of the 90's does more than wash instruments and clean floors. This position has progressed into a highly technical area of expertise, caring for and handling very expensive instrumentation, storing and cleaning equipment such as televisions and microscopes, and the carts that house them, the care and handling of anesthetic equipment, restocking supplies, decontamination, disinfecting, and sterilization. The attendant is responsible for making sure that instruments and equipment in his / her care meet with certain standards, and therefore every individual should be oriented to all current and new components. The OR attendant is also responsible for maintenance of a safe, clean environment for themselves and their clients.

In certain procedures they will assist in the transfer and positioning of patients, under direct supervision of a Registered Nurse or Physician. There is a great need for flexibility, team work and good communication skills in order to make everchanging times and events flow with as little disruption as possible in routines of the department.

In June of '95, the timing was right for our department to define the role of OR attendants. Physical restructuring of the patient holding area and sterile supply room had relocated supplies and equipment. There was apparent need for staff documentation of traditional daily tasks. New technology demanded some training guidelines. We also needed at that time to question how well our cleaning methods were working, because we were developing a serious problem with rust on our instruments.

OR Attendants are responsible for the operating room environment. The overall list of tasks performed by this group is quite lengthy, therefore I will condense the job descriptions into the main areas of shift-related responsibilites, thus demonstrating that all the tasks were non-nursing functions.

We learned together and taught each other as we went through the learning process for the new role. Today the position is still evolving with the involvement of the CSS.

Two attendents arrive early, obtaining the charge nurse's schedule for the day with the room assignments. The attendents have been taught room set-up for Malignant Hyperthermia, Laser, Cat Scan, Latex Allergy, ENT, Plastics, Dental, Gynecology, General surgery, Vascular, Orthopedics, Ophthalmology, and Urology. The first table is checked for supplies and is left in the room. One attendent is designated to two rooms and is responsible to the nurses in these rooms for equipment, change-over and supplies. They also attend report.

The decontamination room attendent's duties include cleaning instruments in the department as well as sending anesthetic supplies to CSS for pasteurization. Large items such as basins and orthopedic implant instrumentation pans are also rinsed off and sent to CSS for further cleaning and sterilization. The attendents have been instructed on how to protect themselves while in the decontamination room and on the importance of removing bioburden from the instruments.

Two relief attendents care for the sterile supply area where the trays are processed. An instrument book with pictures and familiar names has been successful in the training of organizing the basic instrument sets. These attendents are also responsible for ensuring a stretcher, ICU bed or ward bed is outside the room for the case that is in progress, and that missing supplies from the pick sheets are put on the next table.

An evening attendent is responsible for picking the next day's tables and assuming the duties of the other attendents as they leave for the day. This attendent also assists PACU staff with their transfers back to the patient's floor.

Attendents are required to take the CSS course as well as all hospital mandatory reviews.

As a resource person, I became an OR attendant for several months. Slowly and deliberately, we examined storage areas for convenience and availability of supplies. Any instrument that could not be sal-

vaged or that had not been used in a number of years was disposed of appropriately. We tried to simplify storage and then we labelled, labelled, labelled.

New easy-access plastic storage bins replaced old cardboard boxes. To increase floor space, an unused scrub sink was removed, and peg boards were hung for additional storage space on the available wall space.

We tried to keep change-over time simple by having attendants remove dirty items used for the previous case. Nurses would replace these with clean items for the following case. This is where flexibility and communication became important.

We catalogued instrument trays with pictures and names familiar to our staff. Another book was started to document tasks assigned to each shift, because the staff eventually grew in number and worked extended hours during the week and on the weekends.

An orientation program was prepared emphasizing "on the job training," for as we trained the new staff, we too were learning how to work together, combining these two positons. All of us were assimilating our new responsibilities as a team.

Computer print out sheets for pick lists have now invaded our domain. These have facilitated supply/case match-ups. However, one still has to learn the language.

Ongoing in the process is a basic "how to" book, as well as updating computer print out sheets, meetings and questionaires that confirm we are indeed all learning the same things together.

There was total cooperation and participation between the attendants and nursing staff for this process to have happened. Enhanced communication skills and good team work were also part of the success. It was definitely not an easy year, and at times it was very stressful for everyone in the department. Empowerment to change our environment to suit our needs certainly made it worthwhile. To be responsible for the changes certainly gives staff a feeling of ownership of the daily routine in their work environment.

In less than six months we had become more comfortable with the position of OR attendant. The process of teaching and learning has been exceptional, and we have all developed an overall sense of teamwork.

OR attendants are a terrific group of caring individuals, and I applaud them for what they have accomplished so far. Their future can only continue to improve for them and their clients. ■

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Cervical Plexus Block for Carotid Endarterectomy: A Nursing Care Plan

By S. June Hill, RN, CPN(C)

Recent interest in cervical plexus block (CPB) used for carotid endarterectomy surgery has become "the topic of conversation" at St. Boniface General Hospital (SBGH), in Winnipeg, Manitoba. No longer are the rhythm of the respirator and beat of the monitors the only sounds heard in the theater during this major surgery. As the surgeon applies the carotid cross clamp, what appears to be a casual social conversation ranging from grandchildren to gardening is actually an intraoperative assessment tool for monitoring changes in patient speech pattern or neurological status.

Abstract

Historically, carotid surgery is identified in the operating room as a major surgical procedure. Although the surgical intervention remains the same, a regional anesthetic technique calls upon perioperative nurses to utilize their assessment and planning skills astutely preparing innovative nursing interventions that enable successful patient outcomes.

The key to a successful nursing care plan for a carotid endarterectomy performed under cervical plexus block is an awareness of the patient's physiological needs as well as the environmental influences they may be experiencing.

As the administration of regional anesthesia for major surgery become more prevalent, there is a resurgent demand for traditional holistic nursing interventions in the operating room. The perioperative nurse must couple technical expertise with intuitive assessment skills and administration of compassionate nursing care.

Historical

Traditionally at SBGH, carotid endarterectomies were performed only under general anesthesia. Late in 1996, SBGH anesthetist Dr. Matthew Cohen, incorporated use of the cervical plexus block technique which he acquired while training under Dr. Matthew Posner & Dr. Patrick Sullivan at Ottawa Civic Hospital. Shortly after, other SBGH anesthetists also began providing this alternative anesthetic method for the carotid patient.

The use of local or regional cervical block is not a new concept in vascular surgery. The first carotid endarterectomy was performed by Debakey in 1953, under local anesthetic. (Shah et al., 1994). The use of cervical plexus block was first performed by Halstead in 1884 at Bellevue; however, it was Labat who popularized the technique in America. Within the past decade, the popularity of CPB has reemerged as regional techniques provide the optimal method for monitoring continuous cerebral function during carotid endarterectomy surgery (Masters, Castresana, & Castresana, 1995).

Advantages/Disadvantages

Traditionally, general anesthesia for carotid endarterectomy has been advocated for its cerebral protective effects with the use of selected anesthetic agents. However, general anesthetics may imply a greater

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