and how effective the facilities RM activities are. Many facilities have risk management as a responsibility shared by many as part of their jobs, but neither supervised nor shared.

As an alternative to setting up another committee or program, senior management could create a system that confirms management's role in handling risks, sets standards on how it will be done, and receives reports and provides feedback to existing programs.

At the same time, management must empower department heads to manage risks within their departments, monitor and evaluate activities that make them more effective, identify aspects of the facilities operations where risks are not being managed, and, fulfil the obligation of the governing body to ensure that risks to patients, residents, staff, visitors and property are being managed effectively (CCHFA, 1991).

The CEO may designate him/herself or someone within the facility as the Risk Manager.

The picture of the facility-wide risk management that emerges is of risks, wherever they occur, being addressed by means of a standard process through either line risk management, or one of the risk management programs, and communicated to the risk manager, who will be responsible for the effective operation of the risk management system (CCHFA, 1991).

This distributed system of risk management respects the efforts of existing programs to manage risks. It promotes communication between risk management, line departments and their programs, and supports their activities. It also supports the motto "everyone is a risk manager", and empowers employees to manage risks. In this way, utilizing existing programs, management and staff, additional costs are limited to what the facility can afford.

Conclusion

In conclusion, this article wants to emphasize the idea that everyone is responsible for risks, and is therefore a risk manager. Education is a key component, however. If all staff at all levels understand the importance of minimizing financial loss for the institution, they then can understand that this may in fact impact on their own positions within that institution. In order to function, institutions must remain financially viable. This allows them to be in a position to provide safe, effective patient care with the right amount of resources. This in turn also allows them to be an active part of the community which they are meant to serve.

References

Canadian Council on Health Facilities Accreditation. (1991)p14-15. *Risk Management for Canadian Health Facilities.*

ECRI. (1992)p4. *Hospital Risk Control.* Pennsylvania: ECRI.

Meisenheimer, C.G. (1992)p3, p21. *Improving Quality: A Guide to Effective Programs.* Gaithersburg, Md.: Aspen Publications, Inc.

Monagle, J.F. (1985). *Risk Management: A Guide for Health Care Professionals.* Rockville, Md.: Aspen Publications, Inc.

Southwick, A.F. (1988)p565. *The Law of Hospital and Health Care Administration* (2nd. Edition). Ann Arbour, Mich: Health Administration Press.

Wilson, C.R.M. (Ed.). (1992)p265-267. *QA/CQI Strategies in Health Care Quality.* Toronto: W.B. Saunders Co.

Youngberg, B.J. (Ed.). (1994)p2. *The Risk Managers Desk Reference.* Gaithersburg, Md.: Aspen Publications, Inc.

CHCL Comprehensive Healthcare Consultants Ltd.

- Operating Room Management System*
- Department and Facility Wide Reviews
- Operational Planning
- Workload Measurement Systems*

**CHCL is the exclusive licensee in Canada for INFORM software (Information Network for Operating Room Management), The GRASP® System of NursingWorkload Measurement and GRASP MIStro®nursing resource management software.*

Ottawa
Tel: (613) 233-5634
Fax: (613) 233-0183

Toronto
Tel: (416) 977-5359
Fax: (416) 977-5617

Edmonton
Tel: (403) 481-5852
Fax: (403) 481-5852

Parse's Nursing Theory and the Practice of Perioperative Nursing

By Kimberly Andrus, R.N.

As a registered nurse with experience in perioperative nursing, I have my own philosophy of nursing consistent with theorists such as Dr. Martha Rogers and Dr. Rosemarie Rizzo Parse, in the simultaneity paradigm. In her nursing theory *Man-Living-Health : A Theory of Nursing,* Dr. Parse states that nursing is a human science and "the human sciences aim at understanding the connectedness of life itself" (Parse, 1981, 11). I, however, was educated with Roy's Adaptation Model and have been practising using that model. I did not realize, until studying theories such as Rogers' *Unitary Human Being Model* and Parse's *Human Becoming Theory,* why I was so frustrated with my nursing career. My philosophy of nursing, which is congruent with Dr. Parse's view, had been grossly inconsistent with the venue in which I practice nursing.

It is because of this theoretical work that I feel enlightened and encouraged to take my practice of perioperative nursing into a more productive and appropriate direction. I hope to utilize my interpersonal skills to more accurately reflect my philosophical beliefs in the simultaneity paradigm. This paper describes my philosophy of nursing as it relates to Parse's *Human Becoming Theory* within the nursing metaparadigm.

Abstract

Many nurse theorists have emerged in the midst of the Nursing Profession's struggle for recognition as a science. To gain autonomy we as nurses must first examine our personal philosophies of nursing. Then we can examine why so many nursing professionals experience "burn out" so early in their careers. I propose that we must change how we define our practice from the use of the medical model to our own model. Although we work closely with medicine, we are not physicians or medical aids; we are nurses.

The Human and the Environment

Based on my personal observations of people and human nature, coupled with my years of experience in perioperative nursing, I feel that every individual is unique. Although we share some similarities, no two individuals experience or react to life in exactly the same way. I also believe that because of their uniqueness, people continually make individual choices in their lives and must assume ultimate responsibility for their choices. This concept is consistent with Parse's opinion that "a person is viewed as an open being who is more than and different from the sum of the parts" (Wesley, 1995, 131) and "in having to choose how he will comport himself in a given situation, man is a thinking, feeling being, who bears responsibility for his choices" (Parse, 1974, 20).

Furthermore, like Parse, I believe that the human and his environment cannot be separated. An individual reacts to his environment in his own unique way, therefore, the two elements (the human and the

Author

Kimberly Andrus, R.N., is a perioperative nurse at Mount Sinai Hospital in Toronto.

universe) add up to a totality that is "inseparable from, complimentary to, and evolving together" (Wesley, 1995, 131).

Realizing these concepts we, as nurses, must be aware and respectful of the person to ensure he remains in control of his own nursing care. For example, in the operating room most people waiting for surgery are given heated blankets in the holding area to make them more comfortable in the cold operating room environment. I have observed many nurses and health care providers give warm blankets to people without considering how they feel. As health professionals we can assume the person is cold because he has been NPO for several hours, there is room temperature intravenous fluid (which is lower than body temperature) entering his blood stream, and he is wearing a thin hospital gown. Although we make these assumptions about the person, I feel strongly that as nursing professionals we must consider how the individual feels and allow him to assume responsibility for his own health care. Instead of imposing my assumption and belief on the person, I ask him, with a broad question, how he feels and whether he needs anything. These broad questions allow the person to be in control of his environment. This action shows that, as a Parse nurse, I am aware that "man is postulated as a unitary being simultaneously and mutually co-creating with environmental rhythmical patterns of relating"(Parse, 1981, 39).

With respect to the blanket, I make it a point to inform the person that warm blankets are available but I try to leave the decision making to the individual. Only half of the people with whom I have come in contact have asked for a warm blanket. This observation illustrates my philosophy of nursing with respect to the human and environment metaparadigms as viewed by Parse, who explains that "the human is an open being, freely choosing meaning in situation, bearing responsibility for decisions"(George, 1995, 337).

I feel that the nurse must be respectful of the individual to allow him to utilize nursing as a resource to attain his own health care goals rather than being Roy's passive, "recipient of nursing care" (Andrews and Roy, 1986, 18).

Health

I prefer Parse's view of health as a state of becoming to Roy's view of health, "as the goal of the person's behaviour and the person's ability to be an adaptive organism" (Wesley, 1995, 110). People flow with changes in their lives. It is irrelevant whether the change is positive or negative, acceptance or denial, or "adaptation" or "maladaptation" (Andrews and Roy, 1984). Unlike the totality paradigm, Parse's Human Becoming Theory defines health as an "unfolding that cannot be prescribed or described by societal norms; it can only be lived by the person" (George, 1995, 334). To define a person by his health is disrespectful of the human because it disregards the individual. This view focuses on quality of life from the person's perspective rather than as a promotion of health or a prevention of disease as it is viewed by societal norms. The following example will show that my own nursing philosophy is in line with this belief.

The people with whom I come in contact as a perioperative nurse have already made important decisions regarding their health with the assistance of medical and nursing professionals. Occasionally, upon arriving at the operating room, people are faced with more last minute decisions regarding their care. Depending on various medical rationales, the anaesthesiologist will offer the person a choice of anaesthetic (epidural/general anaesthetic). Some people become overwhelmed with this decision because they were not aware that they could choose the mode of their anaesthesia. Other factors may be involved, such as the short period of time the person is allotted to make a decision; possible anxiety related to the person's expectations of the perioperative phase of treatment; or the person's lack of knowledge of the advantages and disadvantages associated with each type of anaesthetic. As a nurse with strong convictions consistent with Parse's philosophy and theory, I move with the person in "a loving true presence to enhance" (Parse, 1992, 40) his ability to remain autonomous and make clear decisions regarding his care.

According to Parse, "true presence is a special way of *being with* in which the nurse bears witness to the person's or family's own living value of priorities" (Parse, 1992, 40). Once the aforementioned situation regarding the choice of anaesthetic presents itself, I make it a priority to remain in *true presence* with the person until he arrives at a decision and the appropriate anaesthetic is administered. I move with the person in the same way Parse describes her three specific principles.

First, in true presence, I ensure the person has all the available information required to make his decision. This is provided by myself or the anaesthesiologist, describing the advantages and disadvantages of each anaesthetic. Then I remain with him as he considers the information and what it means to him. This action is parallel to Parse's principle of *illuminating meaning*. "The nurse in true presence with the person or family invites the person or family to relate to the meaning of the situation" (Parse, 1992, 39).

Next, I remain with the person while he decides what anaesthetic he prefers. I answer any questions the person may have and encourage him to describe how he feels as he weighs the options, leaving the ultimate decision to him. This behaviour illustrates Parse's principle of *synchronizing rhythms*. "The nurse practicing from the human becoming theory does not try to calm uneven rhythms but rather goes with the rhythms set by the person or family. The nurse in true presence moves with the rhythm as the person or family discusses and recognizes the struggles of the situation (Parse, 1992, 39-40).

Finally, once the person has decided what anaesthetic he will have, I move with the person, in true presence, to the next phase: the commencement of the operative phase. Before transporting the person into the operating room, I describe to him what to expect before the anaesthetic begins and encourage him to express his feelings about his experience. Parse defines this as *mobilizing transcendence*. "Mobilizing transcendence happens in true presence with the nurse as individuals and families move beyond the moment, planning to reach the hopes and dreams that have been illuminated through the process of being with the nurse" (Parse, 1992, 40).

This example of my personal philosophy of health reflects Parse's view and demonstrates the use of Parse's practice methodology in the perioperative setting. I would prefer to extend this perioperative phase to preoperative visits. The hospital venue, however, does not acknowledge the value of this role due to the current philosophy being rooted in the totality paradigm and the current economic climate.

Nursing

Nursing, in my view, is a resource to be utilized by people to assist them in making decisions about their own health and health care. As illustrated by the previous examples, I feel that the person is clearly the expert in defining what is important to his own quality of life. By being with the person in *true presence* the nurse helps him understand his own values in a given situation. Parse defines, "true presence as an interpersonal art grounded in a strong knowledge base reflecting the belief that each person knows the way somewhere within himself" (Parse, 1992, 40). This is how I have always attempted to relate to people and my philosophy of nursing is strongly rooted in this belief.

In nursing school, I was nursing an elderly woman who, although she was alert and aware of her surroundings, was uncommunicative and withdrawn from her surroundings. The woman always refused her medications and meals and I remember accepting her refusals of her medical treatments as her own choice of how to live her life. In *true presence,* I sat with her and listened to music, talked about her pictures on her bedside table, and held her hand. The non-verbal message I received from this woman was that she was not accepting of her quality of life. I continued to spend whatever time I could with her and I was fortunate enough to be there for her when she died.

As nurses and doctors gathered around her administering oxygen, measuring vital signs, and discussing her Cheyne-Stokes respirations, I sat next to her and held her hand, talking to her and reassuring her that she was not alone because I was with her.

This beautiful connection with another human being remains as my most memorable and rewarding experience. The practice of this role demands creativity and sensitivity, traits that are artistic in nature. "Parse defines nursing as a scientific discipline, the practice of which is a performing art" (George, 1995, 334). Parse continues to describe nursing in a most eloquent fashion:

> So too, the nurse, an artist like the dancer, unfolds the meaning of the moment with a person or family consistent with personal knowledge and cherished beliefs. The nurse artist creatively lives knowledge about the human-universe-health connectedness (nursing's phenomenon of concern), which incarnates personal cherished beliefs. The knowledge and beliefs are there in the way the nurse approaches the person, the way the nurse talks and listens to the person, what the nurse is most concerned about and how the nurse moves with the flow of the person. When the nurse artist is guided by a particular nursing theory or framework, the art form reflects that theory or framework, which represents a school of thought in nursing (Parse, 1992, 147).

Conclusion

In conclusion, nursing theories are essential to the practice and growth of nursing. Without these theories we become merely aids to the medical profession.

Although I have discovered that I prefer Parse's Human Becoming Theory, I am aware that the other theories have important and relevant implications to nursing practice. I feel it is important to have a number of different theories within the nursing discipline because no one theory can clearly define the practice of nursing.

References

Andrews, Heather and Roy, Sister Callista (1986) Essentials o*f the Roy Adaptation Model.* East Norwalk, Connecticut: Appleton Century-Crofts.

George, Julia B. (1995) *Nursing Theories: The Base for Professional Nursing Practice, Fourth Edition.* Norwalk, Connecticut: Appleton and Lange.

Parse, Rosemarie Rizzo (1992) Human Becoming: Parse's Theory of Nursing. *Nursing Science Quarterly,* 5:1, 35-40.

Parse, Rosemarie Rizzo (1992) Editorial: The Performing Art of Nursing. *Nursing Science Quarterly,* 5:1, 147.

Parse, Rosemarie Rizzo (1992) Nursing Knowledge for the 21st Century: An International Commitment. *Nursing Science Quarterly,* 5:1, 8-12.

Parse, Rosemarie Rizzo (1981) *Man-Living-Health: A Theory of Nursing.* Toronto: John Wiley and Sons.

Parse, Rosemarie Rizzo (1974) *Nursing Fundamentals.* Flushing, New York: Medical Examination Publishing Company, Inc.

Wesley, Ruby L. (1995) N*ursing Theories and Models, Second Edition.* Springhouse, Pennsylvania; Springhouse Corporation.

CNF Certification Awards

Ottawa. The Canadian Nurses Foundation (CNF) is pleased to announce its first Certification Awards to nurses who recendy obtained Certification in their specialty through the Canadian Nurses Association Certification Program. Seven hundred and forty-five applications were received and the successful candidates were randomly selected by using a computer program.

The successful candidates in each specialty are:

Critical Care
Victoria Bungay, British Columbia
Betty Skarpinsky, Saskatchewan

Psychiatric/Mental Health Nursing
Beverley Boyes, Ontario
Deborah Warren, Ontario

Emergency Nursing
Pamela Miller, Ontario
Joanne Oldale, Ontario

Nephrology Nursing
Cynthia Bryson, Ontario
Kathy Pierzchala, Alberta

Neuroscience Nursing
Wendy Blackburn, Ontario
Shelly Morrish, Ontario

Occupational Health Nursing
Shirley Clark, Ontario
Marion O'Brien, Newfoundland

Perioperative Nursing ***
Linda Ferronato, Ontario
Vickie Martin, Ontario

CNF is the only national foundation committed solely to promoting the health of Canadians by helping nurses pursue their educational and research goals. The funding that makes these awards possible is acquired from nurses, corporate donors/sponsors, bequests and gifts from individuals and organizations who support the goals of the Foundation.

For further information contact:
The Executive Director
Canadian Nurses Foundation
50 Driveway, Ottawa ON K2P lE2
Tel: (613) 237-2133
Fax: (613) 237-3520

CONGRATULATIONS !

To all of Canada's "Certified Perioperative Nurses (Canada) who successfully completed their June, 1995 exams. See President's message p. 5 for more details..

BCAM STERILE "A Lesson in Asepsis"

By Regina Leonard, RN, BScN, MEd

The practice of strict asepsis is critical in the operating room as the patients are perhaps at their most vulnerable stage of their hospital stay. In the operating room the body's protective mechanisms are disrupted at several levels. The most obvious is the invasiveness of the surgical incision. The immune system is affected because of the associated stress, the digestive system is slowed down because the patient is fasting, the chances of dehydration are increased and thus the lesser the volume of fluid to transport the nutrients required for optimal homeostasis. Added to this is the increased risk for wound introduction of pathogenic microorganisms.

Operating Room personnel have a responsibility to their patients to maintain aseptic technique in order to prevent the transport of microorganisms. Contamination and eventual infection of the surgical patient may occur from four main sources: the patient, the environment, the supplies used and/or the personnel involved in the patients care.

Asepsis is defined as the condition of being free from disease causing microorganisms. Aseptic technique is the method used to maintain asepsis. The basic tenet of aseptic technique is the "surgical conscience" which is guided by the theory and clinical application of the Principles of Asepsis. The surgical conscience is the foundation on which development of O.R. personnel is built. It involves continuous assessment, planning, implementation and evaluation of patient care and personnel practices.

Abstract

This article presents the principles and rationale for aseptic practice in the operating room. The mnemonic "BCAM STERILE: has been chosen as the framework in which the principles are presented. The principles apply to all personnel who care for the patient during the intraoperative experience.

The Principles of Asepsis, listed as being anywhere from eight or more, are based on theory and consensus more so than on scientific conclusions. They are strongly recommended guidelines for optimum practice. Once these principles are understood, application becomes more obvious.

For the purpose of this presentation I have chosen the Mnemonic "BCAM STERILE" (pronounced "Become Sterile")in order to present the principles and rationale for aseptic practice. The focus is on the intraoperative phase of the patient's care, although the principles are utilized in the preoperative and postoperative phases of the patient's perioperative experience. The mnemonic breakdown is as follows:

B - Boundaries
C - Contact
A - Arms and Axilla
M - Moisture
S - Sterility
T - Touch
E - Edges
R - Reach
I - Individual Surgical Conscience
L - Level
E - Elimination

Author

Regina Leonard, RN, BScN, MEd, has experience in operating room clinical practice, management and education. She is currently Staff Nurse at the University of Alberta Hospital, Edmonton, Alberta.