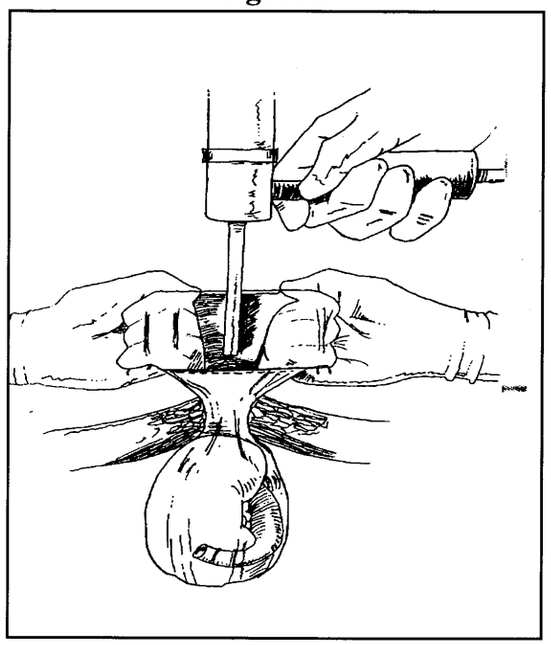
Figure B



removed from the port. The laparoscope is then placed in the upper MCL port and the sack is opened with three (3) graspers. The laparoscope is passed into the depth of the sack to open it up. The assistant uses the upper AAL port to grasp UPJ and manoeuvre the kidney into the sac. The laparoscope is moved to the periumbilical port and the drawstrings of the sac are drawn into the 12mm sheath. The intra-abdominal pressure is reduced to 5mm and a check for hemostasis is performed.

8. Tissue removal: The patient is returned to the oblique position. The laparoscope is maintained in the periumbilical port. The drawstings of the sac are pulled through the 12mm MCL as far as possible thus drawing the neck of the sack into the sheath. The drawstrings are released from the forceps, and the forceps and the 12mm sheath are removed from the abdomen.The drawstings should now rest on the abdominal wall. The drawstring are grasped and pulled by the surgeon until the neck of the sack is delivered onto the abdominal wall. The tissue morcellator is plugged in, and the handle of the morcellator is connected to suction, and the valve of the suction is in the off position. The 10mm barrel of the morcellator is firmly introduced into the sack until it contacts renal tissue. The neck of the sack is pulled up by the assistant. The morcellator is activated by depressing the foot pedal while the morcellator is moved rapidly back and forth into the renal tissue. As the renal tissue is fragmented the pieces are rapidly aspirated into the handle of the morcellator. After about 5 minutes, the morcellator is removed, the suction is turned off and the handle is removed to scrape off tissue. The process continues until all the tissue is fragmented. The empty sac is removed from the abdomen and the incisions are closed. *(Refer to Figure B.)* The fascia from the larger skin incisions are closed with Vicryl - 0 UR5 and Dexon 3-0 CE4 for skin, steri strips and mepore dressings are applied.

The patient was then transferred to I.C.U. after the 8 and 1/2 hour procedure. She was monitored very closely for 48hrs then transfered to the ward. The patient was discharged seven (7) days later and is presently doing very well.

Endoscopic surgery is the way of the future. The technique is excellent; pain management is improved, the need for hospitalization is reduced dramatically, morbidity can be avoided, and the patient is able to resume normal daily activities in a very short period of time. At Concordia Hospital, we are looking forward to advances in other laparoscopic procedures in the very near future. ■

Position Paper of the Ordre des infirmières et infirmiers du Québec

Perioperative Nursing Care

The Function of the Nurse as First Assistant

Position

The Ordre des infirmières et infirmiers du Québec, in concert with various nurses associations and certain health care settings, is in favour of the recognition of the nurse's function as first assistant. The nurse who assumes the function of first assistant during a surgical procedure is practising in the field of perioperative care, and is acting within the framework of her professional practice. The majority of the first assistant nurse's activities are conducted in the presence of the surgeon, in interrelation with him, and under his direct supervision. The nurse thus provides the clinical and technical assistance necessary for the surgeon to operate safely, and in the best interests of the user.

Report

Scientific and technological change, the development of the nursing profession, budgetary constraints, regional shortages of doctors, and quotas on residents at university hospitals all have an impact on professional practice, and on the overall work environment, particularly in the operating room.

At present, several health care institutions and numerous surgeons are making urgent demands that nurses assume the function of first assistant during the course of various types of surgery. The pressure is increased by the fact that many nurses are already faced with situations where they must provide such assistance to the surgeon. In Quebec, this situation is now common, and is tending to become widespread. A recent poll, carried out in March 1993 by the Association des infirmières et infirmiers de salles d'operation du Quebec (SOOR), confirmed that 86.6% of respondents were frequently alone with the surgeon during major operations. Moreover, 88.8% acknowledged having taken on the role of scrub nurse and first assistant simultaneously. The latter situation is deemed precarious; it could affect the quality of nurses' interventions, and endanger user safety.

Several North American groups have adopted a position in favour of recognizing the function of the nurse as first assistant. As of 1983, with the support of the American College of Surgeons, the Association of Operating Room Nurses (AORN) the largest such association in the United States made its position official. It believes that the function of first assistant is part of perioperative nursing care, and is inherent in the practice of nursing. The majority of State Boards of Nursing in the U.S. have since ratified the AORN position. In addition, the results of the recent national survey carried out by the Operating Room Nurses' Association of Canada (ORNAC), in which 361 hospitals from ten Canadian provinces participated, reveal a strong trend toward recognizing the role of the nurse as first assistant. (See National Survey page 31).

In Quebec, nurses practising in the field of perioperative nursing care, and particularly those who work in the operating room, have over the years acquired an unequalled expertise, bringing to light their specific contributions to this sector, which could be described as a nerve centre of hospital operations.

Nurses are present in every Quebec hospital where surgery is performed. Their contributions to the success of operations and to the prompt recovery of patients are indisputable. Their great versatility also allows them to intervene at different stages of the care episode, and in a variety of situations, ranging from

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Note: The position described herein was adopted by the Bureau of the Order at its regular meeting, September 29 and 30, 1994. The feminine pronoun is used in this document, without prejudice.

current and habitual care to care in emergency situations.

The knowledge and know-how of nurses are undeniable, particularly in the operating room, where they are highly valued by the surgical team, whether they be used to ensure internal service, external service, or surgical assistance.

Confident in its mission to protect the public through the monitoring of the profession by its members, and mindful of its responsibility regarding the quality of nursing offered to the population, the Order has decided to support the recognition of the function of the nurse as first assistant in the area of perioperative nursing care.

Perioperative Nursing Care

At the present time, across North America, there is an overall trend toward the development of perioperative nursing care. The concept of perioperative nursing care covers the entire care episode, during the preoperative, peroperative, and postoperative periods; the concept allows the nurse to get a global picture of the user's experience throughout the episode.

In order to manage the care episode properly, ensure the provision of quality services, and achieve the best results for the user, several Quebec nurses have taken the lead in the area of case management for target clienteles; they are convinced that they can, and indeed must, improve the organization and quality of health care. Thus, the nurse becomes the coordinator of various activities in the care episode.

Experiments in clinical case management already begun in several Quebec hospitals have given convincing results, and testify to nurses' invaluable contribution. Whether it be for clients undergoing a liver transplant, a bone marrow transplant, cardiac surgery, or a hip fracture arthroplasty, the results are the same: reduction in the length of stay, fewer consultations and laboratory tests, fewer radiology tests, improvement in the continuity of care and services, an increase in both users' and care providers' satisfaction, and improvements in care quality. In short, this approach provides an answer to the increasing costs of the health care system as well as enriches the nurses' traditional role.

In the case-management context, the nurse clinician in perioperative care is integrated into the team in order to ensure the follow-up of patients in a given specialty. Her interventions are varied, covering a range of care activities offered during the preoperative, peroperative, and postoperative periods.

In the preoperative period, among other activities, the nurse conducts a clinical assessment and a physical examination in order to identify the user's needs. She provides preoperative education and, with the user, begins to plan the care episode, including the conditions related to the user's discharge.

During the peroperative period, the nurse assumes various functions, such as those of scrub nurse and circulating nurse, and even that of first assistant. Whatever her function, the nurse's interventions are always based on the assessment data she has gathered. She is able to recognize potential risks associated with, for example, the user's position on the operating table, and to evaluate the user's condition just prior to his transfer to the recovery room.

In the postoperative period, in the spirit of continuity, the nurse ensures the communication of information relevant to the user's condition to the recovery room team. She is also responsible for postoperative education, family counselling, and the assessment of the user at discharge, as well as for follow-up in an outpatient clinic or even at the user's home.

Thus, the role of the nurse clinician specialist in perioperative care is called upon to evolve, even though, in Quebec, there is currently no established practice of nurses who, as clinicians, ensure the entirety of care during the preoperative, peroperative and postoperative periods. The Order has, however, been informed of two university hospital projects that favour integrating the nurse clinician specialist into perioperative care. Nevertheless, given the urgent necessity of responding to current needs associated with the peroperative phase, the Order is now pronouncing itself in favour of recognizing the function of the nurse as first assistant in the context of perioperative care.

The Function of the Nurse as First Assistant

The nurse who assumes the function of first assistant during an operation is practising in the field of perioperative care; she is thus acting within the framework of her professional practice. The nurse first assistant carries out the majority of her activities in the presence of the surgeon, in interrelation with him, and under his direct supervision. The nurse thus provides the clinical and technical assistance necessary for the surgeon to operate safely, and in the best interests of the user.

The nature of the activities included in the function of surgical assistance varies according to setting, type of surgery, available resources, services offered, and so on. For example, the operations performed at the Montreal Heart Institute are different from those done at the Montreal Neurological Institute or the Centre hospitalier de Montmagny. Thus, the definition of these activities must be sufficiently flexible to allow surgeons, nurses, and the health care institution the latitude necessary to act in an appropriate manner and in the best interests of the user during the course of a surgical procedure.

The duties involved in assisting must necessarily be determined by each individual institution, and governed by the rules of practice and administration of the various bodies involved. Properly speaking, the activities of assistance are numerous, diverse, and do not all need to be mentioned here. Consequently, the tasks listed below are those that currently are often carried out by nurse first assistants, or by nurses who are in the position of assisting. They are specified below for the sake of information.

- Positioning the user.
- Daubing and preparing the skin.
- Draping.
- Performing hemostasis using mechanical and thermal methods; clamping vessels, cauterizing, ligating vessels, etc.
- Ensuring the exposure of organs and tissues: suctioning, sponging, placing and holding retractors, irrigating the operating site, cutting tissues identified by the surgeon, placing sponges around the operating sites.
- Suturing facia, subcutaneous tissues, and skin.
- Selecting sutures and needles, suturing, cutting threads, tying knots.
- Using any instrument at the request of the surgeon: manipulating the laparoscope, tapping the osteotome, etc.
- Applying postoperative dressings.

When she assumes the function of first assistant, the nurse carries out highly sophisticated and specialized care activities, using technical skills and exercising the clinical judgment inherent to the practice of her profession. During an operation, for example, the nurse who acts as first assistant is always in a position to assess, detect and prevent problems related to the progress of the operation; she is also in a position to act effectively and, when necessary, take corrective or emergency measures.

Training Requirements and Qualifications

It goes without saying that the function of the nurse first assistant requires appropriate training programs. In the absence of training programs in educational institutions, and while waiting for such programs to be developed, some health care settings have established programs that are at once theoretical and practical; they are designed for nurses who have operating-room experience and who wish to take on this function.

Prior to assuming the function of first assistant, a nurse must meet certain training and experience requirements in order to ensure the quality and safety of her interventions. These requirements must be specified by the health care setting and must meet the criteria listed below, among others.

- Knowledge of professional standards, laws and regulations, policies and procedures that may bear on the function of nurse first assistant.
- Special training provided within the framework of a structured program that includes both theoretical study and practical traineeships.
- Knowledge of the responsibilities inherent in the function.
- The ability to carry out all the tasks required during the course of an operation, in an appropriate and effective manner.
- Extensive experience as a scrub nurse and circulating nurse in the operating room, corresponding to a number of years, usually five.

Methods of Implementation

In order to ensure the development and implementation of the role of first assistant in a given setting, several mechanisms must first be put into place by each centre. These mechanisms should be deployed after an agreement between the director of nursing care (DN), the council of physicians, dentists, and pharmacists (CPDP), the council of nurses (CN), and the institution's board of directors has been reached. The mechanisms are related to the following elements.

- Methods for the selection, training, and recognition of nurses likely to act as first assistants:
- skills required;
- experience required;
- evaluation of knowledge, etc.
- Methods of quality control and assessment:

- continuous assessment;
- annual assessment of performance in the context of a quality-control program

put forward by the director of nursing care.

- Rules of nursing care:
- rules governing nursing care should be established in agreement with the DN

and the CN.

- Rules of medical care:
- rules governing the surgeons who have recourse to a nurse first assistant.
- Administrative policies.

Nature of Responsibilities

The general principles and the nature of the civil and penal responsibilities pertaining to the nurse who assumes the function of first assistant are no different from those of a nurse practising in another field. Just as a physician who acts as first assistant is acting within the framework of his field of practice, the nurse who assumes the role of first assistant does so within the context of her own field of practice, giving clinical and technical assistance to the surgeon.

The surgeon remains responsible for the entire surgical intervention, and directs its progress. The nurse, in turn, assumes the function of first assistant, and carries out the majority of her interventions at the request of the surgeon, and under his supervision. However, taking into account the full extent of the autonomy conferred on her by her field of professional practice, the nurse who acts as first assistant remains fully liable for any errors that fall within her area of competence. She must therefore assess all orders she receives in the light of her knowledge. She must also conduct her interventions in an appropriate manner, using the necessary skills and exercising sound professional judgment under all circumstances.

Conclusion

The Ordre des infirmières et infirmiers du Québec considers the function of nurse first assistant to be situated in the evolving context of professional practice; it is a response adapted to the population's needs in health matters, as well as to the demands of the health and social services system in the province of Québec.

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Plein Feux Sur I.I.P.A.

(Infirmiers, Infirmières Premiers (ières) Assistant (es)

Par Claude Marcil, BScN

En 1992, les Infirmières et Infirmiers des salles d'opération du Québec créaient un comité Ad Hoc sur l'Infirmière première assistante.

C'est alors, que le comité allait entreprendre une grande aventure.

C'est lors d'un Congrès Provincial des I.I.S.O,Q. tenu précédemment que les infirmières nous demandaient de se pencher sur la question puisque particulièrement en région éloignée, la pénurie d'assistant chirurgical amène l'infirmière a jouer ce rôle.

De plus, dans les grands centres urbains, la diminution de résidents en chirurgie cause une problèmatique de plus en plus importante au niveau de l'assistance opératoire.

Le 27 mars 1992, la première rencontre avait lieu à l'hôpital Ste-Justine de Montréal.

La décision de travailler avec notre corporation professionnelle (l'Ordre des Infirmierès et Infirmiers du Québec) fut unanime dans la perspective d'une planification stratégique.

Le processus de reconnaissance de la fonction d'infirmière première assistante s'engagea avec l'O.I.I.Q.

Avant de parler de Premier Assistant, il fallait définir la réalité des soins périopératoires et le rôle de l'infirmière comme étant la professionnelle de choix pour oeuvrer dans cette discipline.

Par la suite, une enquête provinciale fut entreprise en collaboration avec l'O.I.I.Q. pour mettre à jour un premier sondage réalisè en 1989 et qui nous permettait de connaître la réalité de la pratique infirmière en soins périopératoires.

Ainsi 86.6% des répondantes nous confirmaient qu'ils leur arrivaient d'être seules avec le chirurgien lors d'une chirurgie majeure et 88.8% reconnaissaient jouer le rôle du service interne et de première assistante simultanément.

Avec l'arrivée de la nouvelle technologie (chirurgie laparoscopique), une opportunité pour les infirmières de jouer un rôle plus élargi en soins périopératoires se présentait.

Par conséquent, 87.8% nous disaient qu'elles seraient intéressées à s'inscrire à un programme universitaire de premier cycle advenant qu'un tel certificat soit mis sur pied.

La conclusion de l'enquête stimula le comité à continuer notre démarche.

Madame Jane C. Rothrock

Par la suite, un plan d'action fut établi entre nos deux organismes. Madame Louiselle Bouffard, consultante aux services professionnels de l'O.I.I.Q. de même qu'une avocate du bureau firent la visite de quelques blocs opératoires pour voir les infirmières à l'oeuvre. En juin 1993, lors d'un congrès national qui se tenait à Québec, les représentants de la corporation eurent un entretien avec Madame Jane C. Rothrock Docteur en nursing et qui est une pionnière du dossier premier assitant aux Etat-Unis.

Auteur

Bacheliers "es science", Claude Marcil est infirmier-chef, responsable de l'unité des soins périopératoires du Centre Hospitalier de Lachine , P.Q.

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