

These duties would not be additional to the already busy shift of the circulating nurse but would be a designated position under the Nursing Department and in cooperation with the Anesthetic Department. Details of a job description require further study.

The ORNAC Standards (1993) provide an excellent background of the duties already performed by the circulating nurse in relation to anesthesia, for example:

Standard #1 - "Perioperative nursing practice requires knowledge from nursing, the sciences and the humanities".

Standard #3 - "Perioperative nursing practice requires nurses to be professionally responsible and accountable".

Clinical Standard #4 - "The operating room nurse facilitates a safe, smooth induction for each surgical patient".

* Competency 2 : Provides Physical Patient Care The Circulating Nurse Role

The circulating nurse is competent to:

2.1 review, identify and assess the physical status of the surgical patient.

2.2 adjust the standard nursing care plan to meet the specific needs of the patient.

2.3 establish priorities of patient care specific to the needs of the patient and the surgical procedure.

2.4 provide resources necessary for the surgical team to function efficiently.

2.5 provide physical comfort measures specific to each surgical patient in relation to vital functions, warmth and positioning, using supportive equipment and/or devices.

2.6 remain with the patient and provide appropriate care during the admission, pre-induction and induction period.

2.7 provide continuous, astute observation of the surgical team throughout the operative phase while meeting their needs with minimal time delays.

2.8 monitor and evaluate the physical well-being of the patient throughout the perioperative period to prevent potential impairment or injury.

*Recommended Standards for Nursing Practice, ORNAC, 1993.

2.9 re-evaluate the patient's physical status in the immediate postoperative period.

2.10 provide and assist with procedure/devices required to complete patient care following the surgical procedure.

2.11 assist in the physical patient transfer and postoperative positioning to prevent injury and facilitate the recovery.

2.12 observe for and respond appropriately to complications and unexpected events during the surgical procedure.

2.13 document any and all unusual incidents with appropriate follow up action.

Scrub Role

The scrub nurse is competent to:

2.14 apply knowledge, skills and techniques of the procedural steps of the intended surgery.

2.15 set priorities and expedite an efficient sterile set up prepared for each specific surgery.

2.16 protect the patient from physical injury resulting from unsafe practice.

2.17 observe and provide appropriate response to complications and unexpected events during the surgical procedure.

2.18 perform count procedure with the circulating nurse and account for all items in the sterile field.

2.19 display knowledge of instrument(s) and equipment used for procedures.

2.20 act as the patient's advocate during surgery.

We have been saying that OR nursing is a career for persons desiring power, status, opportunities and job satisfaction. We also have said that we must feel proud of what we do - be an inspiration to others.

The social and economic changes that we face today presents us with challenges never before thought of. Success will only be guaranteed if and when we decide to innovate, create new ideas and systems and take new risks. We must look upon the advanced role in a positive way and not concentrate on the possible barriers. Yes, by all means consider every aspect and keep seeking out solutions. ■

Yes, I Want to Walk to the OR

By Anne Porteous & Judi Tyndall

Introduction

The health consumer of today is a changing dynamic force. Clients are becoming more involved with their health care. Clients choose to have surgery, and that choice makes the consumer an active participant

Abstract

The health consumer of today is a more active participant in his or her health care. Although clients may require surgery, many of them do not consider themselves as being ill preoperatively. Health care professionals have a tendency to place the client in a dependent, ill role upon entering the health care facility. At this health care facility, clients are given the choice of either walking to the operating room, or going by stretcher. Studies found in the literature suggest that personal control is central to the reduction of clients' stress-related signs and symptoms. Nurses need to encourage client participation and assist the client to take control over those factors that are controllable. Utilizing King's (1981) conceptual framework, active client participation in mutual goal-setting, decision-making, and interactions to achieve the mutual goals in relation to health care is encouraged. All clients who attended the Preadmission Assessment Clinic were potential participants for this study. On the day of surgery, clients were asked by the nurse if they would prefer to walk to the operating room or go by stretcher. The majority of clients chose to walk to the operating room. The choice made by many of the clients is consistent with the findings in the literature stating that clients need a sense of control in what is often perceived as an uncontrollable environment.

in his or her health. Although clients may require surgery, the majority of them do not think of themselves as being ill preoperatively. Why should nurses ask these "well" clients to accept a "sick" role upon entering a health care facility?

The clinicians from the Operating Room (O.R.) and the Preadmission Assessment Clinic (P.A.C.) thought that giving clients the choice of walking the short distance to the operating room would promote client wellness. By having a choice, the client may perceive the surgical experience as less threatening and give more control to the client. Studies suggest that a sense of control is important in decreasing a client's stressful reactions to invasive medical procedures (Johnson, Fuller, Endress, & Rice, 1978; Padilla et al., 1981; Watkins, Weaver, & Odegaard, 1986). In order to determine a client's desire to walk to the O.R., a questionnaire was developed which is available from the authors on request.



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Authors

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Literature Review

The level of control that a client has over his or her personal situation usually diminishes upon entering a hospital. Studies found in the literature suggest that personal control is central to the reduction of clients' stress-related signs and symptoms (Langer & Rodin, 1976; Gibson, 1991). Neither of these studies gave clients the option of walking to the operating room.

A literature search did not reveal any information and/or research studies regarding clients walking to the operating room. Using a qualitative methodology the authors wanted to discover the following: a) Did clients like being given the choice of walking to the operating room?, b) Was the client satisfied with the choice that he or she made preoperatively?, and, c) What reason(s) were given for the client's choice to either walk or go by stretcher?

According to Gibson (1991), there is a need for health care professionals to surrender some of their control and adapt to a more collaborative client-nurse relationship. The attitude that the nurse knows what is best for the client can only foster dependency. Nurses need to encourage client participation and assist the client to take control over those factors that are controllable.

Theoretical Framework

Nursing practice at this health facility is provided within the framework of King's (1981) theory of goal attainment. Theory is useful in that it depicts events or aspects that are essential for understanding the client's world (Chinn & Jacobs, 1987). The focus of King's model (1981), is the nurse-client interaction within a systems approach. Active client participation in mutual goal-setting, decision-making, and interactions to achieve the mutual goals in relation to health care is encouraged (King, 1981).

King's model of nursing incorporates three dynamic interaction systems - personal, interpersonal, and social - which lead to development of a theory of goal attainment (King, 1981).

Personal Systems

The personal system incorporates concepts such as perception, and self. King (1981) views clients as open systems, interacting and exchanging matter, energy, and information with the environment. 'Self' is an integral part of one's human experiences. Positive experiences tend to enhance the self; negative experiences may render the self in need of assistance.

King (1981) states that the health care environment

may threaten the client's self by eliminating control over decision-making. Surgical clients often experience a loss of control which may threaten the self. Clients do not live in vacuums. They are continually being bombarded by all sorts of internal and external stimuli. This combination of stimuli dramatically affects their response to the environment (Hames & Dayle, 1986).

Surgical intervention may be perceived by clients as a threat. Consequently, anxiety may reach levels that would be detrimental. Some studies suggest that high levels of anxiety correlate with poor physical recovery (Jamison, Parris, & Maxson, 1987). Nursing studies have indicated that the psychologically prepared client will have a better postsurgical recovery than those who are psychologically unprepared (Hartfield, Cason, & Cason, 1982).

The client may become overwhelmed with anxiety related to such factors as the perceived threat to life, the complexity of the disease and its methods of treatment and an unfamiliar environment. The inability to control events may initiate a sense of powerlessness. This loss of control may affect the client's ability to make short and long term adjustment to illness (Scott, 1983).

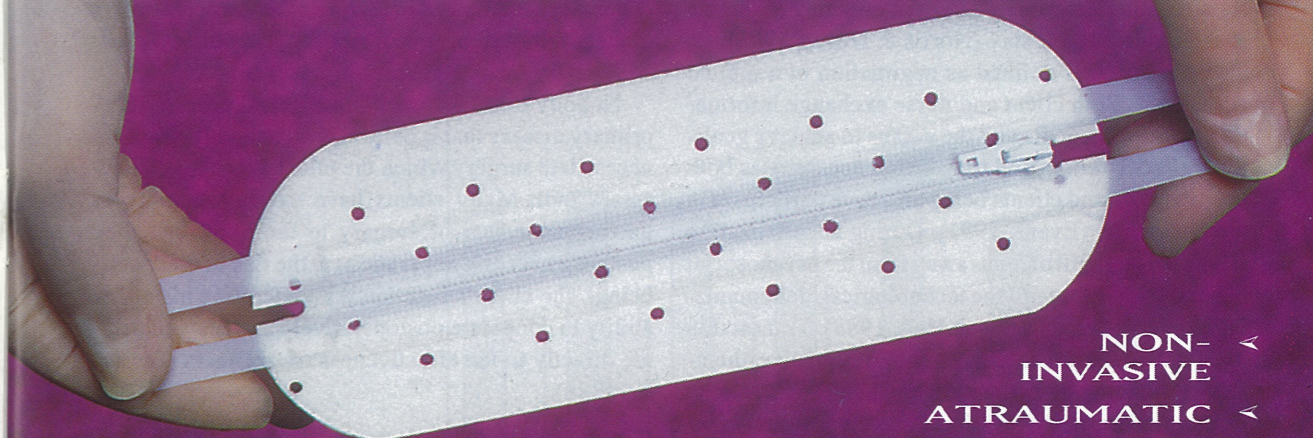
In order for a client to try to maintain the 'self', a sense of control is needed. However, the expertise and knowledge of health care professionals create inequities in power and control between professionals and clients. According to Gibson (1991), clients who perceive some degree of control viewed the surgical experience as positive, while those with limited control felt negative. Lack of control is a recurrent theme in clients' discussions of the surgical experience. Nurses and other health care professionals need to relinquish some of their control and empower their clients to make health care decisions (Gibson, 1991).

Interpersonal Systems

The interpersonal system is understood by examining such concepts as communication, transaction, and role. Communication, whether verbal or nonverbal, should facilitate interaction between individuals in the environment. According to King (1981), an individual's perceptions and 'self' influence communication patterns and style. Communication occurs when the sender accurately conveys his or her message to the receiver, to achieve mutual understanding.

There is incongruence between the perceived rights and responsibilities of clients and health professionals in three major areas: control, roles, and communica-

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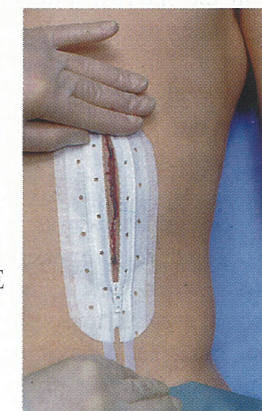
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tion. Professionals tend to assume control with minimal input from clients. There is also a tendency for health professionals to place the client in a 'sick' role. As a result clients feel powerless and may assume a passive role in their stay (Norris & Hoyer, 1993).

Transaction is defined as negotiation of a mutual agreement. Both client and nurse exchange information to agree on goals and the means to achieve goals. Mutual goal-setting and transaction necessitates both hospital staff and clients being an active participant in the interaction (Evans, 1991). During hospitalization there may be a shift of focus away from the psychosocial needs of clients toward the technological, dehumanizing aspects of care (Allen & Hall, 1988). Transaction does not occur when clients do not perceive themselves as having a responsibility in their care. The lack of transaction may be attributed to the hospital environment, stress, and the relinquishing of control to health professionals (Pinch & Spielman, 1990).

The goal of nursing "is to help individuals maintain their health so they can function in their roles" (King, 1981). Health implies continuous adaptation to stress "in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living" (King, 1981). The authors believe that giving a person a choice helps the person to maintain some control and contributes to health promotion rather than health dependency.

Social Systems

The third component of King's (1981) conceptual framework is the social system. King (1981) defines social system "...as an organized boundary system of social roles, behaviors, and practices developed to maintain values and the mechanisms to regulate the practices and rules" (p.115). Nurses and clients as individuals belong to more than one social system. Each one is influenced by expectations emanating from their own family social system. They are both strongly influenced by their respective work environments.

Nurses are in a familiar work environment and familiar routine while functioning in the hospital environment. Hospitalization can be a frightening experience for clients. Nursing staff may increase the client's sense of helplessness by trying to do everything for him or her and by describing the hospital rules and regulations as if the client no longer had any right to make decisions about his or her own care.

Hospitalization is a threatening situation that may cause the client to feel as though he or she is at the

mercy of a vast impersonal institution. His or her physical being is placed in the care of others whom he or she may never have met before. The stresses the client faces are many and real, and the client may react to them with symptoms of anxiety (Lipkin & Cohen, 1992).

Nobody looks forward to a surgical procedure. A primary disease that is painful or life-threatening may necessitate surgery which the client accepts as a necessary evil. Many clients have extreme anxiety or unreasonable fear of surgery to the point that they postpone necessary operations at the risk of their well-being. The client's reaction will determine his or her ability to cooperate postoperatively and may contribute directly to the effectiveness of treatment (Sterns, E., 1988).

Study Population

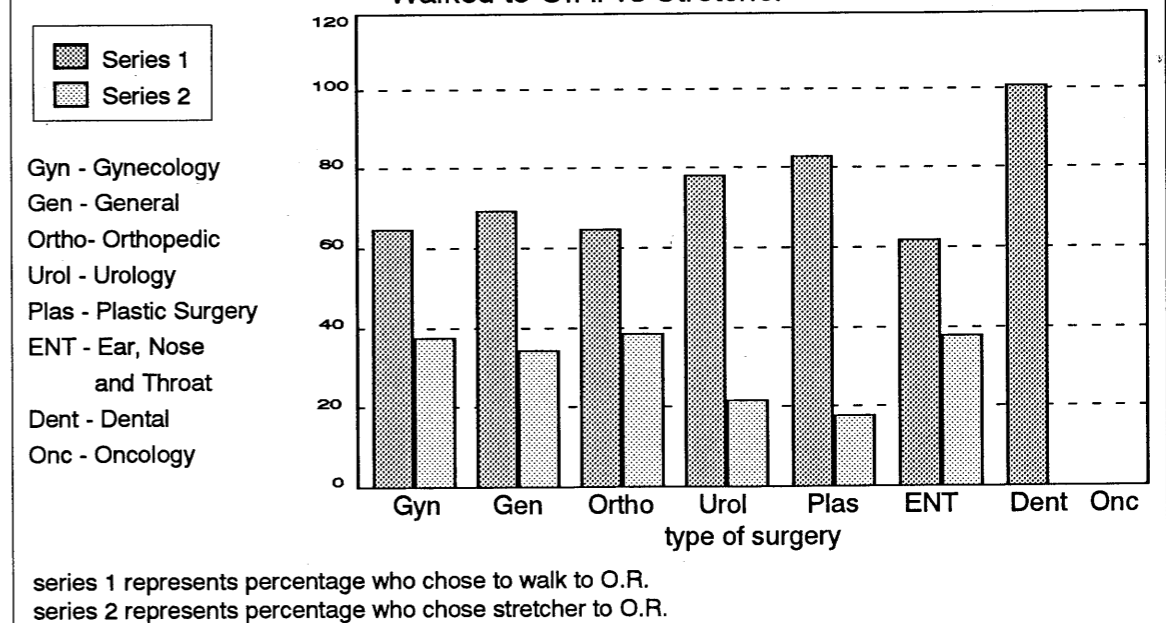
The study population consisted of all preoperative surgical clients attending the P.A.C. at a large university-affiliated teaching general hospital. Clients can be seen in the clinic up to two weeks before their scheduled date of surgery. There are fifty-four surgeons who utilize the clinic's services, representing general surgery, gynecology, oncology, orthopaedics, ears, nose and throat, urology, dental, and plastic surgery. Approximately thirty-five clients are assessed in the clinic daily.

The majority of surgical clients who come to this institution are admitted the same day as their surgery. However, there are some clients who are admitted prior to their surgery. All clients who attended the P.A.C. and were to be admitted the day of their surgery, were potential participants. Clients who were to receive preoperative sedation or who identified a physical limitation e.g. fractured leg, were excluded from answering the questionnaire.

Methodology

The operating room, located at the north end of the Same Day Surgery (SDS) hallway, is approximately 126 feet from the SDS admitting area. The P.A.C. is located at the south end of SDS hallway. Clients were seen in the P.A.C. three to fourteen days prior to their day of surgery. The idea of being given a choice to walk to the O.R. or going by stretcher was introduced to the client during this visit. The nurse in the P.A.C. conducting the assessment explained to the client that a choice of either walking to the operating room or going by stretcher would be given to the client on the morning of his or her surgery. Clients were reassured

Minor Surgeries
Walked to O.R. vs Stretcher



that their choice would not influence their care while in the hospital, or their surgery.

On the day of surgery, a nurse asked for the client's preference, and then escorted the client to either a lazy-boy chair or a stretcher in the admitting area of SDS. The client received the questionnaire and was asked by the nurse to complete the first two questions. The questions were: 1. Do you want to walk to the Operating Room? If yes, why did you choose to walk, or if no, why do you not want to walk? and, 2. Do you want to go by stretcher to the Operating Room? If yes, why did you choose to go by stretcher, or if no, why do you not want to go by stretcher?

The nurse then placed the questionnaire on the client's chart. All clients received the usual preoperative care as per hospital policy. This care included: having the client change into a hospital gown, slippers, and housecoat; starting an intravenous and administering any medications ordered by the surgeon (these medications are usually antibiotics, as the majority of clients no longer receive preoperative sedation); completing the O.R. checklist; revising information obtained in the P.A.C.; reinforcing and/or initiating client education; and ensuring the client's safety by making him or her comfortable and placing the nursing callbell within reach of the client.

Whether walking or going by stretcher, all clients were accompanied by a porter to the Patient Receiving

area in the operating room. The operating room nurse accompanied the client to the O.R. theatre, a distance of approximately 178 feet to theatre one, and 85 feet to theatre six. After arriving in the O.R. theatre, the O.R. nurse recorded the client's response to the last question from the questionnaire, "Were you satisfied with your decision to walk (or go by stretcher)?" A computer number was assigned to the completed questionnaire by the O.R. nurse. The completed questionnaire was then placed in a sealed box for the O.R. nurse clinician to retrieve. To ensure confidentiality questionnaires were kept in the O.R. nurse clinician's filing cabinet to which she alone had access.

Results

There were 250 questionnaires administered over a five week period. Ninety (36%) of the questionnaires were incomplete and therefore, excluded from the study. Some clients did not answer all the questions; some gave conflicting answers such as answering 'yes' to both questions regarding preference to walk or go by stretcher; some questionnaires did not have a computer number assigned.

The study population consisted of the following clinic services: general surgery (15%), gynecology (38.5%), oncology (1%), orthopaedics (11%) ears, nose and throat (7%), urology (18.5%), dental (1%), and plastic surgery (8%). The study population repre-



ONCE DAILY
LogiparinTM
Tinzaparin Sodium Injection

NAME OF DRUG
LogiparinTM (Tinzaparin Sodium Injection)
(Low Molecular Weight Heparin)

THERAPEUTIC CLASSIFICATION
Anticoagulant/Antithrombotic Agent

ACTION AND CLINICAL PHARMACOLOGY

LogiparinTM (Tinzaparin Sodium Injection) is a low molecular weight (LMW) heparin, produced by enzymatic depolymerization of conventional heparin from porcine mucosa. It possesses antithrombotic activity mediated through antithrombin III.

The pharmacokinetics of LogiparinTM after a single subcutaneous injection have been studied in clinical trials by the measurement of plasma levels of Xal activity, IlaI activity and APTT activity.

	Xal activity	IlaI activity	APTT activity
Absorption T _{1/2} after s.c.	199.5 min.	256.7 min.	
Bioavailability	90.1%	66.8%	
Elimination T _{1/2}	81.9 min.	71.3 min.	35.3 min.
Apparent volume of distribution	4.0 l	10.9 l	4.0 l
Time for peak activity	4-6 hours	4-6 hours	

The plasma level of Xal activity may only be used as a measure of the amount of LogiparinTM (Xal active molecules) in plasma. It is not recommended as a tool for monitoring treatment efficacy with LogiparinTM.

Results from clinical trials with LogiparinTM indicate that there is a close relationship between plasma levels of Xal activity and body weight. This indicates that dosing according to body weight is the best way to obtain precise dosing.

INDICATIONS AND CLINICAL USE

LogiparinTM (Tinzaparin) is indicated in the management of the prevention of postoperative venous thromboembolism in patients undergoing hip replacement surgery.

LogiparinTM may be used in the management of the prevention of postoperative venous thromboembolism in patients undergoing general surgery who are at high risk of developing postoperative venous thromboembolism.

(SEE PRECAUTIONS: SELECTION OF GENERAL SURGERY PATIENTS)

Postoperative administration of LogiparinTM does not preclude other prophylactic modalities including physical and mechanical methods of adjunct therapy.

CONTRAINDICATIONS

- LogiparinTM (Tinzaparin), must not be administered by intramuscular injection due to the risk of hematoma. Where possible, intramuscular injections should be avoided in patients during anticoagulant treatment.
- Allergy and hypersensitivity to LogiparinTM (Tinzaparin); acute or subacute septic endocarditis; major blood clotting disorders; history of thrombocytopenia or in patients in whom an *in vitro* platelet - aggregation test in the presence of LogiparinTM is positive; active gastrointestinal ulceration; uncontrolled severe hypertension; generalized hemorrhage tendency and other conditions/diseases involving an increased risk of hemorrhage.

WARNINGS

LOGIPARINTM SHOULD BE USED WITH CARE IN PATIENTS WITH SEVERE LIVER OR KIDNEY INSUFFICIENCY, UNCONTROLLED ARTERIAL HYPERTENSION OR A HISTORY OF GASTROINTESTINAL ULCERATION.

EXPERIENCE WITH CHILDREN AND USE DURING PREGNANCY OR LACTATION

There is currently no clinical experience with LogiparinTM in pregnant women and children. In two clinical studies performed in pregnant women during second trimester using LogiparinTM in a dose of 35-40 Xal U/kg, no transplacental passage of Xal and IlaI activities was demonstrated.

LogiparinTM should not be used in pregnant women and in children unless the therapeutic benefits to the patients outweigh the possible risks to the fetus and the patients.

It is not known whether LogiparinTM is excreted in breast milk of nursing mothers. Mothers receiving LogiparinTM should avoid breast-feeding.

LogiparinTM contains sodium bisulphite, which may cause allergic reactions including anaphylactic symptoms and life threatening or less severe asthmatic episodes in certain susceptible people.



IN STEP WITH YOUR NEEDS

The overall prevalence of sulphite sensitivity in the general population is unknown. Sulphite sensitivity is seen more frequently in asthmatics than in non-asthmatic people.

PRECAUTIONS

LogiparinTM should not be administered by intramuscular injection due to the risk of hematoma. Where possible intramuscular injections should be avoided in patients during anticoagulant treatment.

LogiparinTM should be used with caution in conjunction with drugs which affect either platelet function or the coagulation system (i.e., salicylates, vitamin K antagonists and dextran).

LABORATORY TESTS

Clinical trials with LogiparinTM, in the dosages recommended, have not been associated with clinically significant bleeding. A fall in thrombocyte counts has been observed yet no direct association to LogiparinTM has been identified.

As a precautionary measure, platelet counts should be determined prior to the start of treatment with LogiparinTM and, subsequently, twice weekly for the duration of treatment. An *in vitro* platelet-aggregation test in the presence of LogiparinTM should be performed in patients with a history of heparin-induced thrombocytopenia. In case of negative results, treatment with LogiparinTM may be instituted but the patient must be closely monitored and platelet counts determined at least once daily. A positive result contraindicates LogiparinTM.

In the case of minor bleeding, the drug should be postponed or withdrawn. When serious bleeding requires reversal of LogiparinTM, protamine sulfate (1% solution) by slow infusion will neutralize LogiparinTM. The effect of protamine sulphate should be monitored by the APTT. (For more information, please see SYMPTOM AND TREATMENT OF OVERDOSAGE.)

Selection of General Surgery Patients

LogiparinTM may be used as an adjunct in the prevention of postoperative venous thromboembolism in patients undergoing general surgery who are at high risk of developing postoperative venous thromboembolism.

General surgery patients, who have one or more of the following risk factors, are at high risk of developing postoperative venous thromboembolism: Previous venous thromboembolism; varicose veins; obesity; heart failure; malignancy; previous long bone fracture of lower limb; bed rest more than 5 days prior to surgery; predicted duration of surgery more than 30 minutes; age 60 years or above.

Drug Interactions

There has been no clinical experience with the possible interaction between LogiparinTM and other drugs other than ASA (Acetylsalicylic Acid). No evidence of an interaction between LogiparinTM and ASA on the Xal or IlaI activities was found. The bleeding time increased on the combined treatment in 7/8 subjects as expected with regard to the ASA intake, though no significant influence on the platelet aggregation was found.

LogiparinTM should be used with caution in conjunction with drugs which affect either platelet function or the coagulation system (i.e., oral anticoagulants, inhibitors of platelet aggregation, nonsteroidal anti-inflammatory agents, preparations containing acetylsalicylic acid, vitamin K antagonists and dextran).

ADVERSE REACTIONS

Hemorrhage is the main complication that can result from LogiparinTM treatment. However, the clinical trials with LogiparinTM in the dosages recommended have not been associated with hemorrhage to any clinically significant degree.

Frequent reactions (>1/100)

General: Hematoma at injection site - uncomplicated
Liver: Transient increase in aminotransferase levels - not clinically relevant

Less frequent reactions

Skin: Rash - uncomplicated

Rare (<1/1000)

General: Allergic reactions (has not been reported)
Blood: Bleeding - clinical relevance depends on the site and severity of bleeding
Thrombocytopenia - clinical relevance unknown

SKIN

Minor adverse events, such as bruising, wound hematoma, and injection site hematomas, have been noted to occur to a varying extent in all clinical studies. In addition, rashes have been reported in a few cases after administration of 3500 Xal U once daily. LogiparinTM alone or in combination with aspirin was well tolerated with only occasional bruising at the injection site seen.

LIVER

As with conventional heparin, a significant but transient increase

of the liver transaminases has been noted following administration of LogiparinTM in doses of 50 Xal U/kg b.w. once daily, as well as in higher doses. The increased levels of liver transaminases observed in the LogiparinTM studies were most probably induced by the treatment. The conclusion agrees with observations made in association with treatment using heparins. The exact mechanism associated with the increased levels of liver transaminases has not been fully elucidated. However, no consistent irreversible liver damage has ever been demonstrated due to this known heparin effect.

Clinical studies have suggested that the transaminase increase seems to be dose dependent and requires more than three days of treatment to appear. Following the administration of LogiparinTM in a dose of 150 Xal U/kg twice daily, however, all subjects showed increased plasma levels of AST and ALT from a mean of 17.8 to 128.5 U/ml and 19.3 to 257.0 U/ml respectively. These elevations correspond to a seven to twelve fold increase as compared to the post-study evaluation performed within seven days of study completion. Transaminase levels normalized within two weeks of the last dose of LogiparinTM.

In summary, LogiparinTM administered in doses of 50 Xal U/kg b.w. once daily, and 150 Xal U/kg twice daily, for five consecutive days results in markedly increased but reversible liver transaminases levels (especially ALT). Normalization of these levels occurred within two to four weeks. Clinical studies involving administration of standard heparin in doses up to 10 000 IU given i.v. every six hours or s.c. in doses of 5000 IU every eight hours or twice daily, have yielded the same effect.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

Bleeding is a symptom of LogiparinTM overdose. In recommended doses, there should be no need for an antidote but in the event of accidental administration of an overdose, protamine sulphate should be given. There is no clinical experience with overdose, but studies in animals indicate that the dose of protamine sulphate required to neutralize the hemorrhagic effects is greater for LogiparinTM than for unfractionated heparin. The effect of protamine sulphate should be monitored by the APTT. Excess bleeding is not seen in animal experiments when the APTT is brought within the normal range. If transfusions are required, fresh frozen plasma is preferred.

In the case of minor bleeding, the drug should be postponed or withdrawn. When serious bleeding requires reversal of LogiparinTM, protamine sulfate (1% solution) by slow infusion will neutralize LogiparinTM. No more than 50 mg should be administered, using a very slow i.v., during a 10-minute-period. Each mg of protamine sulfate neutralizes approximately 100 IU LogiparinTM.

DOSE AND ADMINISTRATION

Prevention of postoperative venous thromboembolism in General Surgery patients:

- LogiparinTM 3500 Xal U given by subcutaneous injection two hours before surgery followed by 3500 Xal U once daily for 7-10 days.

Prevention of postoperative venous thromboembolism in Hip Replacement Surgery patients:

- LogiparinTM 50 Xal U/kg b.w. given by subcutaneous injection two hours before surgery followed by 50 Xal U/kg b.w. once daily for 7-10 days.

PHARMACEUTICAL INFORMATION

DRUG SUBSTANCE

The active ingredient, LogiparinTM, is derived from Heparin Sodium USP by controlled enzymatic depolymerization, which results in low molecular weight heparin with a peak maximum molecular mass of 4500 ± 1500 Daltons.

STABILITY AND STORAGE RECOMMENDATIONS

The preparation should be stored at 15-25°C.

AVAILABILITY OF DOSAGE FORMS

LogiparinTM is available as aqueous solution containing benzyl alcohol and sodium bisulfite.

Presentation: LogiparinTM Injection 10,000 Xal U/ml; 2 ml vial. Each pack contains 5 vials.

Full product monograph available on request.

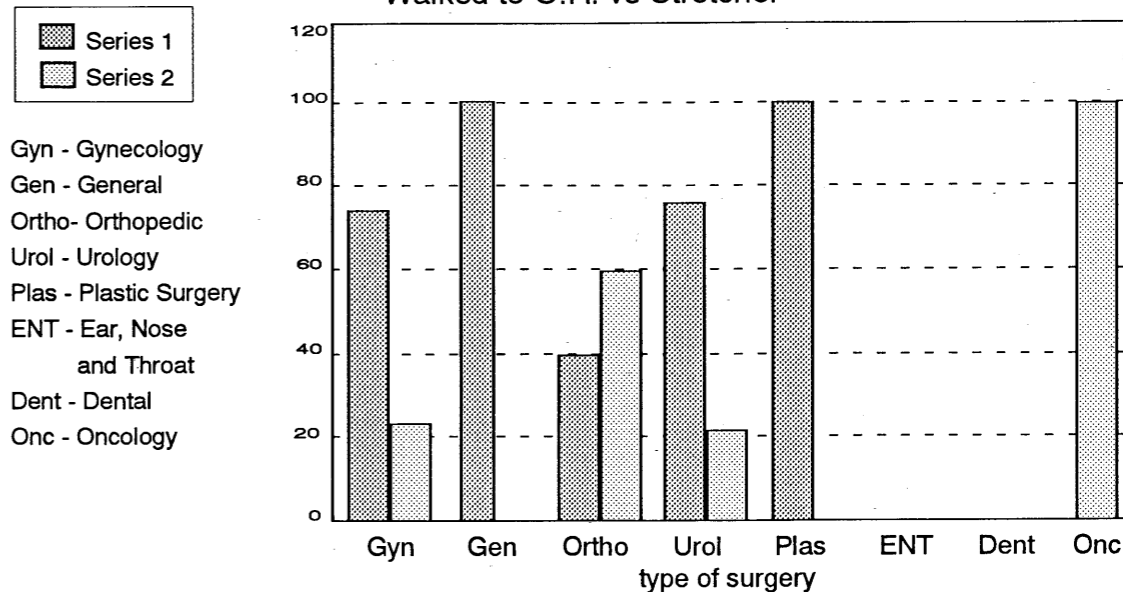
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Major Surgeries
Walked to O.R. vs Stretcher



series 1 represents percentage who chose to walk to O.R.
series 2 represents percentage who chose stretcher to O.R.

sented 37% male clients and 63% female clients. Although one of the purposes of the questionnaire was to determine the number or proportion of clients who desired to walk to the operating room, it was interesting to note that the age range of the clients willing to walk was 18-81, with the average age of 40 years (mode 37; median 45). For the clients who preferred to go by stretcher, the age range was 20-76, with an average age of 46 years (mode 24,30,66; median 47).

Of the 160 clients who completed the questionnaire (representing a 64% return rate) 111 preferred to walk (69%) and 49 (31%) preferred to go by stretcher. Eighty-three of the 111 (75%) wanted to walk because they were healthy, did not feel sick, and felt more in control. Four clients had had the choice of walking to the O.R. for previous surgeries and enjoyed the experience. Some clients stated that they would be less nervous if they could walk.

Of the 111 clients who preferred to walk, twenty-three (21%) were booked for major surgery and eighty-eight (79%) were booked for minor surgery. Of the 49 clients who preferred to go by stretcher, 10 (20.4%) were booked for major surgery and 39 (79.6%) were booked for minor surgery. Figure 1 and Figure 2 represents the study population, the preference to walk or to go by stretcher to the O.R., and the surgical classification. In this hospital the classification of

major surgeries includes such cases as total joint replacements, nephrectomies and total abdominal hysterectomies. Submucous resections, laparoscopies, inguinal hernias and breast biopsies are classified as minor surgeries. A complete list is available from the authors.

Of the 111 clients who preferred to walk, two, (1.8%) were not satisfied with their choice. The reasons given by the two clients were that he or she became uncomfortable waiting, and also that he or she would have felt more pampered on a stretcher. One hundred and nine or 98.2% of the clients were satisfied with their decision to walk to the O.R. The reasons they gave were: able to walk, not sick, felt better, less like a sick person, felt more in control, in control until the last minute, felt that I could better keep my dignity.

Of the 49 clients who went by stretcher, one (2%) was not satisfied. The reason given was that due to preoperative sedation the client had to go by stretcher but would have preferred to walk. The remaining 48 clients were satisfied with their decision stating reasons such as: more comfortable, too nervous, pain, easy way, free ride, and lazy.

Limitations

Uncontrolled extraneous variables in this study included the time between the client being seen in the

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clinic and the scheduled date of surgery. As previously stated, clients could attend the P.A.C. 3-14 days prior to their day of surgery. This allowed some clients more time to think about their choice of walking or going to the O.R. by stretcher. A potential limitation was that all nurses who worked in the P.A.C., S.D.S., and the O.R. were involved in the study. This variation could raise concern for extraneous variables in the nurses influencing the client's choice. The nurse may not have agreed with giving clients the opportunity of walking to the O.R. The manner in which the nurse approached the client could also have been a factor influencing the client's choice. For example, if the nurse was in a hurry, the nurse may have had a negative tone to her voice which may have influenced the decision made by the client.

Conclusion

On the basis of the findings from this study, we conclude that given a choice, the majority of surgical clients prefer to walk to the O.R. immediately prior to both major and minor surgeries as opposed to going by stretcher. Our results are consistent with the findings in the literature that clients need a sense of control in what is often perceived by clients as an uncontrollable environment.

Areas for future investigation would be to focus on the outcomes postoperatively. For example, does the client who perceives more control preoperatively experience a shorter hospital stay? A randomized control trial, which would provide for a higher level of evidence, would also provide for the application of stringent statistical tests.

Acknowledgements

Ms. Joan Eagle, B.Sc.N., M.N, M.Sc. Nursing Research Coordinator, Hamilton Civic Hospitals/Henderson Division.

Staff from Preadmission Assessment Clinic, Same Day Surgery and Operating Room, Hamilton Civic Hospitals/Henderson Division.

Sandy Silk, Jennifer Bowen and Loreen Hodgins.

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