

International File: The Finer Points of Working in England's ORs

By Lucy Wright

Introduction

Operating room nursing practices may be perceived as universal amongst Commonwealth countries; after all, a hernia repair is a hernia repair, irrespective of the country in which it is performed, isn't it? International diverse experiences contribute to the wealth of an individual's knowledge and competence, and as they say - travel broadens the mind. After being initiated to the Canadian OR from ward nursing, my encounters with British theatre nursing practices required deeper thought about the rationale supporting my own, as I was periodically challenged during my adaptation to the British system. As expected, the principles of OR nursing are fundamentally similar in both countries. However, it is the finer points which demand open-mindedness, assertiveness, diplomacy, flexibility and most importantly, a sense of humour.

The description of my international experience and the interesting differences encountered will commence at the beginning of my story. After emigrating from Britain to Canada with my family as a child and spending twenty-two years of my life there, I wanted to familiarize myself with the country of my roots, which I had so long admired from a distance. I resisted the current trend and travelled to England two years

ago, but I frequently get asked why I came to this country with its dreary gray weather from the sunny land of opportunity. So began the frequent explanations of my origins and motivations. When asked what part of the States I am from, I feel the responsibility as the local Canadian ambassador to patiently respond, "I am actually from Canada. Halifax, Nova Scotia - do you know it?" Surprisingly, I usually have to give a geography lesson to distinguish between Nova Scotia and Newfoundland, and I thought British education was the best!

Professional Variations

So England is not much different to Canada, right? Wrong! There are many cultural and professional differences to experience by changing countries of residence. To begin with, theoretically both countries speak English. However, despite our words being the same, we do NOT speak the same language. Even after living here for two years, I still find this a frustrating hindrance. I hear the words but do not understand the message, and laughingly have to say: "Would you rephrase that, please? We are having a communication problem here." This language problem extends from every day life to professional life in the theatre. What? Are we going to a show? No, the operating theatre, which Canadians know simply as the OR. A phrase, which is much easier and quicker to say, but not linked to any historical origins. Despite my attempts, the British will not be converted, since tradition is very important over here, and understandably so, for a

Author

Lucy Wright, R.N., B.N., R.G.N., (U.K.) was a perioperative nurse working in the Cardiothoracic O.R.'s at John Radcliffe Hospital, Oxford, England, at the time of writing. She is now enrolled in a Masters program in Advanced Practice at Oxford Brooks University. She qualified in Halifax, Nova Scotia in 1985 and has worked in England two years.

Abstract

The fundamental philosophy behind quality patient care is international; the specialised area of OR nursing should be less susceptible to international differences. Yet, the experience of moving to a different country reveals the extent of the actual cultural and professional variations available. The subtle, yet real, practical differences observed by a Canadian OR nurse, after working in England for two years, are examined.

country so steeped in history.

The global geographical position of England, in relation to the European and African continents, makes it accessible for other foreigners to temporarily practice in the NHS. Thus strong accents contribute to the language difficulties encountered in English ORs. Remembering that conversations occur behind the muffling of a mask, translation time can be further delayed. Consequently, what do you do when an Egyptian surgeon asks for a mop during a seemingly routine hernia repair? How much experience does a scrub nurse really need to anticipate such a request? What could he possibly want with one, and should I ask if he wants a bucket as well? How was I to know all he wanted was another sponge?

So the Canadian scrub nurse dramatically enters, prepared to assist the surgical staffman or resident, with a cart of instruments, sponges, haemostats and the bovie to control any bleeding, to save the life of a patient with multiple injuries, admitted directly to the OR from the ER after an MVA (motor vehicle accident). Only I had to transform in to the British *theatre* nurse on the scrub side, prepared to assist the surgical *consultant* or *senior registrar*, with a *trolley* of instruments, *swabs*, *clips* and the *diathermy* to control any bleeding, to save the life of a patient with multiple injuries, admitted directly to the *operating theatre* from the *Accident and Emergency Department* after an RTA - road traffic accident).

Patient contact is limited in the British theatre nursing system, depending on where you work as a scrub nurse. There are separate rooms for the induction of anaesthesia directly connected to each OR and have been a constant feature of the British operating suite design. If there is enough staff, its advantage is reducing turn-around time between operations; the succeeding patient can be induced in a quiet, peaceful environment, while the current one is still in the OR. Additionally, some ORs have separate but connected "lay-up" rooms, where the scrub nurse can prepare for the next operation.

Specialist anaesthetic nurses, or ODAs (operating department assistants), run these anaesthetic rooms and have the responsibility of greeting and checking in the patient at the reception area. They provide the patient with emotional support and assist the anaesthetist. If you are on the other side of the doors inside the OR, you rarely experience any patient contact. Again tradition's influence exists and the nurses can be divided enough to carry on the war between surgery and anaesthesia, undermining the existence of a team

spirit. Fortunately, there is a prevailing trend to remove these barriers, by having skilled nurses functioning in both areas. This versatility will contribute to greater job satisfaction for the British OR nurse and would reduce some of the present threat facing them, concerning the validity of their role and the perceived invasion by the ODAs.

Generally, there seems to be a vague legal awareness in Britain's health care system by all groups of practitioners, yet there is change afoot. In most English ORs, untrained staff are utilized for circulating duties, which shifts the entire focus of responsibility and accountability upon the scrub nurse. She has to control the OR nursing staff from the operating table, as well as assisting in the operation. The instrument and suture counts are performed solely by the scrub nurse, however, she does count sponges with the circulator, who keeps a temporary record on a board on the wall. Consequently, only the scrub nurse signs the legal document called the theatre register, which remains outside the associated OR.

Documentation is minimal, usually consisting of a sheet with statistical information like names, times and the operation for entry on the computer. There is no separate detailed count sheet or comprehensive record of nursing care in the OR suite, but there are initial attempts to introduce perioperative nursing care plans as a permanent record. The medical records of the surgeon and the anaesthetist are the only documents which become part of the patient's chart. As much as I complained about paperwork in Canada, I became conditioned to filling in the forms, which legally described my contribution to patient care. Simply by moving country all of it is taken away, which generates a frighteningly, uncomfortable feeling and a compromise of one important aspect of OR nursing. However, a recent increase in available workshops and publications about legal aspects of health care practice reflects the professional's demand for information on this topic, and rising awareness of its implications.

Other differences involve the care of the tools of our trade, the instruments, which demonstrates how different systems can work well for various places.. In Oxford, we use prepacked sets of instruments and patient drapes sterilised in a central unit, which includes a drape to cover the cart as part of its outer wrapping. In Southampton, I witnessed two different systems. One which was similar to the Oxford style and another, which was like nothing I had ever experienced before. In the old hospital of the city of

Activities of ORNAC 1991-1993 "Moving Into the Mid-Nineties"

Southampton, there is no distinct sterilization unit. The twin OR suite uses a dirty utility area shared between the two ORs for hand washing of the used instruments by auxiliaries. The autoclaves adjoin this room, where the unwrapped instruments are counted in their trays by the qualified staff. Any necessary extras specific for the operation, are added from the cupboard shelves, and are placed along with the set of instruments into the autoclave for steam sterilisation. Surprisingly, their low infection rate is comparable to the larger modern hospital. Contrastingly, in Weymouth's small district general hospital, there is a staff employed specifically to clean, pack and sterilize the instruments between 8 am and 9 pm, Monday to Friday. If any operations were performed after hours, the qualified nurses were responsible for performing these non-nursing duties.

Even in the most progressive teaching hospitals, other non-nursing tasks are regularly undertaken by qualified nurses, because the British tend to cling to traditions. They spend their time routinely cleaning the ORs between cases and the OR furniture at the end of the day. "Weekend cleaning" is a weekly ritual, which includes damp dusting the supply shelves, and in my opinion is a waste of professional nursing time. This is a demonstration of how the importance placed on nurses' worth by nurses themselves, is indirectly proportional to the amount of non-nursing work they perform. Visionary British nursing leaders have analysed this aspect of nursing and are slowly adjusting the nursing staffing levels and attitudes, so qualified nurses are spending their time doing what they were educated to do - provide patient care.

On my arrival in the English O.R. the surgeon's title was a source of great confusion and amusement. Like Canadian doctors, the British spend several years studying to be awarded the revered title of "doctor". So how was I to know that it is an insult to call a British surgeon, doctor? In Britain, surgeons spend time and energy to enter the Royal College of Surgeons, but on completion of the series of fellowship examinations revert back to the title of "mister". So, you may ask what do you formally call Jane Smith, the female surgeon? Mr. Jane Smith has a strange ring to it, and no one really seems to be able to answer this question.

To further deliberately confuse me, the medical hierarchy uses a completely different set of titles, which in ascending order are: -house officer, senior house officer, registrar, senior registrar and consultant. It is difficult to draw comparisons with the Canadian system, except the consultant is equivalent to a

staffman, and the house officer to an intern.

Similarly, the nursing profession follows suit in its hierarchy. The charge nurse or coordinator of a particular operating room or ward is called a sister. It is a bit disconcerting to say or hear a term professionally, when it is normally used to refer to a member of a family or a nun. To generalise, British nurses have a tendency to be more subordinate to the surgeon and obstructive as a means of power play, instead of using their complementary role and being a collaborative team member. However, the younger generation of forward thinking surgeons respect the nurses for their skills and knowledge, and do value them as contributing members of the surgical team.

Cultural Variations

England is a small country, and despite its weather has a lot to offer. Its short distances between its ancient towns and villages allows you to visit many places, and enjoy the beauty and variety of the English countryside. Yet, it does take a while to get used to spending pounds and pence instead of dollars and cents; to driving on the left-hand side of the road; and to driving on motorways with a speed limit of seventy miles an hour, (which no one but me seems to adhere to). Furthermore, it can provide you with the opportunity of refining your driving skills on the narrow roads and squeezing into smaller parking spaces.

Conclusion

After being raised and educated in Canada, working and living in England has made me appreciate Canada's good and bad points, as well as opening my mind to think and try different methods. After my initial scorn of these different and seemingly inferior ways, I discovered that different does not necessarily mean wrong. However, it is human nature to cling to the familiar, and to think that our way is best.

The British National Health Service is undergoing long overdue changes at the moment, modelling itself on some aspects of the North American systems. It is an exciting time to be involved, and I am able to contribute suggestions to these ongoing changes from my Canadian experiences. Once I adjusted to this different way of life as well as to different methods of working without compromising my beliefs, I have discovered that the underlying principles of providing quality patient care is the universal link between nursing practice in the Commonwealth countries of Canada and England.

The accomplishments of the Operating Room Nurses Association of Canada (ORNAC) over the last three years are enormous, considering all the work is done by volunteer time, effort, and commitment.

The membership of ORNAC, as of March '93 totals 3114. Due to a special relationship with the Canadian Nurses' Association (CNA), ORNAC has full status as an Advisory Committee (CNA) member for '93. A "first" will occur at the ORNAC Board meeting in June, as the Executive Director CNA, Judith Oulton, will attend. ORNAC has an opportunity to submit agenda items to CNA and the following were suggested: Non-professionals into professional positions; waste management and environment protection; image of the nurse and nursing; how to cope with the changes in the health care system; how to keep competent in this age of technology; maintaining the "human touch" in health care; cost analysis & cost effective practices and yet maintain standards.

ORNAC plans to work closely with CNA on these items.

Two committees have been re-established:

Public Awareness - the mandate is to develop a statement "Scope of O.R. Nursing". Many future projects will need this statement as a foundation.

Certification for O.R. nurses - encouraging strides are being made with CNA toward this goal. If we are to maintain our status in the health care system, it is important that the opportunities for certification be made available to operating room nurses of Canada.

A Waste Management committee was formed and will be working closely with the National Exhibitors Association of Canada (NEAC), the Industry.

For the purpose of having all ORNAC statements and documents translated a **French Translation committee** was developed.

Many efforts have been made across Canada to increase subscriptions to the **Canadian O.R. Nursing Journal**. We must also encourage O.R. nurses to write high quality articles if the journal is to remain viable. The annual \$3000 Editorial Award makes the substantial effort worthwhile.

Twelve Teleconference programs per year have been conducted across Canada, and have been main-

tained over the past three years. The programs have been well supported and will continue.

ORNAC has become a very active member of the **International Planning Committee (IPC)** to assist with World O.R. Conferences. The representative from ORNAC is the Past President.

ORNAC's **philosophy and mission statements** have been developed, as well as goals and objectives for the near future. These statements may be obtained through Provincial Presidents.

The **Research Committee** along with assistance from the Research Marketing Department of 3M Canada, organized a National Questionnaire which was randomly distributed across Canada in October '92. The survey was to determine:

- current operating room nursing practices.
- opinion as to "expanded role" of the circulating and scrub nurse.

The full report of this survey will be available at the National Conference in Quebec City. The committee will be conducting a second survey during the Conference. The response ratio on the first survey was 44% and the data was substantial enough to give ORNAC a strong mandate to pursue many issues. The positions of R.N. 1st Assistant and R.N. Assistant to the Anaesthetist will be the major areas to consider and will be the future challenge of ORNAC.

ORNAC will be represented at a booth during the Canadian Anaesthetist Society (CAS) meeting in Halifax, in June.

"**O.R. Nurse Day**" is becoming a stronger celebration each year. This is an excellent method of promoting our role/image to the public, peers, and medical profession. In the future, "O.R. Nurse Day" will be any day during the 3rd week of November. Hopefully, for '93 there will be a National Proclamation, which should get everyone's attention.

New pamphlets developed during the past three years were: 1. "What is ORNAC?" - tells the history and organization of ORNAC; 2. "O.R. Nurse Day" - describes the roles and functions and image of O.R. nurses; 3. "Welcome to the Board" - to orientate new members to the Board.

Revisions were made to previously published