

is functioning well. With the implementation phase complete, a number of things became evident.

1. For the OR nurses, the system is easy to use, the major impact being the accurate entry of their in and out times on the OR record of each case. Inservice sessions introducing the system, prevented any major problems.

2. Although the Ottawa General OR workload measurement system is one component of an automated OR management system, it can nonetheless be introduced as a stand alone manual system. The many calculations to be done however, can be time consuming. During the pilot phase the OR computer system was not yet installed and data collected were analyzed using a P.C. and a spreadsheet package. This process seems to be a viable alternative for an institution that does not have a computerized OR Management System.

3. The reporting capability of the system is most flexible. It is now possible to generate reports of the total workload generated per case, as well as per service, by specific days or by week. To further enhance the system and to facilitate the calculation of productivity ratios, the OR Management System with its workload measurement units will have to be linked to the actual staffing information in the payroll system. In addition, case specific information from the OR will have to be integrated to data generated from the Global dimension reporting system so that total costs per case can be determined.

4. Even without the enhancements, the system has produced almost immediate benefits. As we began to analyze the data we saw which services and cases were utilizing the greatest number of nursing resources. As more data are collected nursing will have the information to determine the cost and effect of the expansion or reduction of various types of specialties or services. In addition, nursing will be able to assess the manpower costs and effects of any increase or reduction of different types of OR procedures. Data to assist the manager to make informed decisions is now readily accessible.

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The Regulated Health Professions Act

By Pat Mandy, R. N., B.A., M.P.A.

The Keynote Address to the Operating Room Nurses Association of Ontario

Our places of work, our health care system, in fact our whole world is in the midst of major unrest and change. No one knows for sure where it will all end. Sometimes we feel like Ogden Nash when he said, "Progress may have been good at one time, but it's gone too far."

At times we feel threatened or overwhelmed. We must not let this happen. We have choices and these choices will allow us to influence the constant change that surrounds us. Change will happen in spite of us. It is up to us to establish our role.

The Ministry of Health in Ontario is now establishing its role as one of leading and managing change in the health care system. The government is encouraging partnerships among those concerned with health and health care and is requiring new accountability from consumers and providers.

Change within hospitals will be a prerequisite for survival...the era of unlimited resources and unchecked growth of expenditures and services has ended. We once had an unlimited budget in health care and we exceeded it.

The pressures for change are not only financial. Numerous studies have demonstrated that different models of health care delivery can more effectively meet the needs of the consumer. It has also been demonstrated that the balances and linkages between the various institutions and agencies can and should be used to make the best use of the health care dollar.

The adjustment for nursing in this environment will be significant. Although the system shifts are in keeping with the fundamentals of our profession's beliefs, many nurses will need to learn new skills and approaches to practice. This takes place in a climate where there is a high emphasis on competence and

growing demand for public accountability. Nursing will have to redesign its role and responsibility if it is to meet the needs of society.

The government has given health care reform a very high priority. Just some of the legislation currently under review or at some stage of its development, includes the regulated health professions act and the 22 accompanying profession specific acts, the public hospitals act, the independent health facilities act, the advocacy, consent to treatment and substitute decision acts and the cancer treatment act. With little exception, the new legislation reflects a strong direction of public or consumer choice and involvement, as well as encouraging partnerships amongst health care providers and a team approach to health care.

We are about to have new health professions legislation in Ontario and it offers the nursing profession an enormous challenge.

One of the challenges of the regulated health professions act will be the development of collaborative and cooperative, rather than competing relationships with other health care providers and the public.

However the greatest challenge for nursing will be reaching agreement within the profession.

One day a group of nurses were given the opportunity to meet with God and ask her some questions. One

Author

Pat Mandy, R.N., B.A., M.P.A., is Director of Nursing, Henderson Division, Hamilton Civic Hospitals, Hamilton, Ontario. This address is an abridged version of her keynote address which compliments and supports the opinions expressed in the keynote address to the B.C.O.R.N.G. three days earlier, (See page 14).

nurse asked "Do you think that nurses will ever be recognized for their true economic worth to society?" God answered, "Yes, but not in your lifetime." The next nurse asked, "Do you think there will ever be a cure for cancer?" God replied, "Yes, but not in your lifetime." The third nurse then asked, "God do you think there will ever be agreement among all the nursing organizations in Ontario?" "Yes," said God, "but not in my lifetime."

Each of our nursing organizations have a different mandate. It is difficult to succeed in making a point with government or the public when there is conflict or disagreement amongst nurses about what that point should be. We must learn to acknowledge our differences and find those issues that bind us together, in order to strengthen our positions.

The regulated health professions act has acknowledged major change in the health system with the inclusion of 22 professions in the act. This is a remarkable shift from 1974 when the number of professions regarded as capable of self-regulation was five. One of the challenges is: that the new legislation will involve overlapping scopes of practice. When we think of overlap or conflicting areas of practice, we tend to think of the traditional professions such as medicine, occupational therapy, dietetics, midwifery and so on.

Increasingly, however, treatments considered somewhat on the fringe, such as acupuncture, transcendental meditation, yoga, and therapeutic touch, are increasingly becoming the mainstream. More nurses are becoming associated with these approaches and incorporating them into their practices. The adjustment to new approaches with an open mind can be uncomfortable - how are we as professions going to react? We must remember that minds are like parachutes...they only function when they're open.

The regulated health professions act redefines how health care providers are regulated. Instead of licensing professions, it licenses or controls, specific acts. At the same time it increases public involvement. The thrusts of the legislation are openness, quality care, consumer choice, public protection and the freedom for evolution of professional roles.

This is the legislation that will provide the framework for nursing for the next many years.

This new legislation will challenge all of the professions to demonstrate effectively what they do best. It promotes evolution among and within professional groups and it recognizes the reality of a multidisciplinary health care system where the practice of the various professions will overlap. Successful

implementation of the legislation will require new approaches as well as open communication and collaboration amongst the professions. Professionals must work together with no group assuming either a subservient or superior role. This equality will be difficult for some professions to accept.

Nurses want autonomy

Nurses want nursing to become an autonomous profession. They want to work cooperatively as equal partners with other health professionals, e.g. pharmacists, dentists, physicians, physiotherapists. Note that physicians are not singled out. In an increasing number of hospital settings, nurses feel free to confront and even challenge other professions on issues of patient care. They view certain aspects of care as within their domain, and make decisions about patients without first consulting the attending physician.

In operating rooms, nurses are identifying their independent roles. When I worked in the operating room, nurses charted very little. Today, nurses are demonstrating their responsibility and accountability for patient care by documenting the patient's problems and responses, as well as recording nursing's activities.

These changes have not been and will not be problem free. O.R. nurses work closely with physicians all of the time. Many physicians are reacting to the increased autonomy of nurses with feelings ranging from puzzlement to confusion, and not infrequently to feeling of betrayal and anger.

Physicians for the most part did not perceive nurses to be subservient in the first place and are thus confused by their efforts to gain equality.

It is not unusual for those in power to be oblivious of the fact that those under them may feel oppressed. It will take some courage and creativity but difficulties in the nurse-doctor relationship can be worked out. Patients depend on the knowledge of both professions for their safety.

The regulated health professions act can facilitate the changing roles. The broad scope for nursing in the act, allows nurses to carry out a wide range of activities in a variety of settings. The use of nurses as primary caregivers is an obvious door which is open to us. I had not related this opportunity to operating room nurses until I read the ORNAC Position Statement on "the operating room nurses' role in primary health care" in the Nov/Dec, 1991 issue of *Canadian Operating Room Nursing Journal*. It noted that while

(continued on page 24)

Value Vision enture

The 13th Biennial Meeting
of the British Columbia
Operating Room Nurses
Group (BCORNG)
April 9 - 11, 1992
Vancouver, B.C.



Program planning committees are careful about the creation and selection of an appropriate theme for their conference. They give due consideration to current issues, tensions and practices within their specialty. These days OR nurses are experiencing new pressures to change both personally and professionally, and these pressures reflect the world around us which is changing at a speed heretofore unmatched in history. The theme of the 13th biennial conference of the British Columbia Operating Room Nurses Group, "Value, Vision and Venture", was chosen because it describes important characteristics of perioperative nursing in the 1990's.

Marnie Simon, President of the BCORNG welcomed 295 OR nurse delegates from across the province in her opening remarks and introduced the conference theme. **Value** implies worth, deserving of merit; **Vision** suggests having a view, or perspective, or outlook; **Venture** insinuates movement or change, or an adventure. Strengthening of these qualities will enhance personal and professional growth.

She then presented the BCORNG 1992 "Recognition Award for Perioperative Nursing". The recipient was Gloria Stephens, current president of ORNAC, and a past president of BCORNG (1972-74). Gloria received the award for her contributions in Nursing Practice and Nursing Education, as well as her contribution to the BCORNG. From its inception in 1966, Gloria has been one of BCORNG's most active members. Her extensive work on Standards for Perioperative Nursing at the provincial and national level is recognized with this award. Gloria is a frequent speaker - three World OR Conferences, numerous national presentations, and is very active on the provincial and regional scene.

Above Photo: Gloria Stephens, (left) recipient of 1992 BCORNG Recognition Award for Perioperative Nursing with Marnie Simon, President, B.C.O.R.N.G.

Photo below: B.C.O.R.N.G. Past Presidents received special plaques recognizing their service to the provincial group. (Standing left to right) Jean Kerr, Lorna Murphy, Margaret Mellan and Susan Knoll. (Seated left to right) Marnie Simon and Joan Flower (the First President).



Past-Presidents Honored

Also honored during the conference were BCORNG past presidents - Joan Flower, the first president, (1966-68); Jean Kerr, (1974-76); Margaret Mellan, (1982-84); Susan Knoll, (1986-88), Lorna Murphy (1988 to 90) and Marnie Simon, (1990-92). Each past president was presented with a commemorative plaque in recognition of their service to BCORNG.

(Continued from page 12) operating room nurses have traditionally not been involved in the provision of initial health care services, the clinical practice of operating room nurses is developing into a perioperative practice.

This is only one example of many that demonstrates that we can increase the numbers and types of nursing practitioners. It won't happen unless we are prepared to take an active role in marketing our skills and credibility to the public and to our employers.

Unregulated auxiliary workers are another expanding force in the workplace. They usually are persons with less training than professionals, but who perform related functions. Some examples are health care aides, surgical assistants and various equipment technicians. With increased technology and an expanding aging population, the kind and numbers of auxiliary workers are growing rapidly. In many cases, they are performing functions within the scope of the practice of nursing. This may be the area of greatest conflict in the workplace, as the balance between the fiscal constraint and safe, effective health care is reconciled.

The environment in which we practice is ready for nurses to assume a leadership role. In the ministry of health document, "*Deciding the Future of Our Health Care*" it is identified that one of the new directions of the ministry of health is... "to enhance the overall status of nurses in the health care delivery system and to improve their working conditions."

The Public Hospitals Act was amended in 1989 to ensure nurses were represented on decision-making hospital committees.

For many years, operating room nurses have been proactive and involved in guiding and influencing change in the system. The Operating Room Nurses Association of Canada and the OR Journal are well established. They provide a means of communication on a nation-wide basis. The collective efforts of the group provide leverage, credibility and objectivity that can have a much higher impact and a greater chance of success than that of individual efforts.

The OR nurses groups and their associations, provincially, regionally and nationally, are vehicles that can be used to examine the role that nurses want to have in operating rooms and in the broader area of perioperative care.

How can nurses take advantage of the opportunities open to them by the regulated health professions act? Because each situation is unique, it is difficult to list activities or skills and the conditions under which activities can be performed or roles can be expanded.

Individuals and special interest groups are better able to identify what it is they want to be able to do independently or in conjunction with other regulated health professionals.

ORNAO is in an excellent position to be an advocate for O.R. nurses, to identify the issues and to facilitate expansion of roles.

The College of Nurses wants input on the development of the regulations for the controlled acts in nursing act. The college also wants input on what authorized acts in the practice of other professions should be formally delegated to nurses. The college needs to hear from O.R. nurses.

In addition, your O.R. colleagues would like some assistance in exploring the opportunities for expansion of the role of the operating room nurse. Be innovative and creative. Dare to dream. Remember a goal is only a dream with a date on it.

Nursing practice advisers at the College of Nurses are available for consultation and to assist in interpretation of standards and the new legislation. I asked one of the advisers to look up all of the issues raised in relation to nursing practice in the operating room. There were only six issues raised in the last three years. Three of those related to the role of nurses who are expected to act as surgical assistants. The others related to R.N. vs R.N.A. as circulating nurse, O.R. skills as added nursing skills, sanctioned medical acts and the role of the O.R. nurse as patient advocate. All of the questions have been better addressed by operating room nurses. The "Recommended Standards for operating room nursing practice" that were developed by the Operating Room Nurses Association of Canada (O.R.N.A.C.) and the position papers that are developed by the Canadian and provincial associations provide much better direction for nurses practicing in the operating room.

If it is not in place already, a legislative review committee should be established by ORNAO to review the many acts that are currently at various stages in the legislative process and to identify those that will have a direct impact on operating room nursing. You would then be in a position to make recommendations and to lobby in order to influence change to be in the best interest of O.R. nurses. The most urgent legislation to be addressed, because of timeframes, is the regulated health professions act.

(Editors note: ORNAO established a legislative committee at this conference.)

On an individual level, all jobs provide some opportunities for choice and career enrichment, even

within the constraints of union or management policy. For example, you have some leeway in deciding how you are going to do your work or in determining work priorities. You may also have some control over what work you can delegate. You may be able to get involved in new projects. You can volunteer for committees or new assignments.

You can make your job more interesting by learning more about your hospital or organization. How does the operating room fit into the overall programs and mission of the hospital? What are the hospital's centres of excellence? Where does the planning and decision making take place? Where does your hospital fit into the health care system as a whole?

You have to position yourselves to take advantage of the opportunities now opening, and remember, there is strength in numbers.

Nurses have made progress in the past few years in seeking and identifying a place for themselves in the

health care system. Recent enviro-nics polls have identified that nurses are the most trusted profession. We have a head start. We can take advantage of our good standing with the public and government.

We only need leadership and individual will to take advantage of the opportunities that are open to us. We need to be involved in the political process. We are limited only by our own creativity and determination.

The challenge for O.R. nurses is to be prepared to benefit from and change with the health care system in Ontario. It takes motivation to change. It takes knowledge to change. But mostly it takes courage to change. Nurses, physicians and all health care professionals must have the courage to discard obsolete roles, pay attention to role and relationship changes and be responsive to changing needs. I know from personal experience that O.R. nurses have the motivation, the knowledge and the courage to help shape their future. All you need is the vision. The responsibility is yours!



Letters to the Editor

It has now been almost two years since our patient, Lianna, first became ill and underwent the major surgeries we wrote about in the March/April 1991 issue. (Aboud, Diane and Williams, Jan, *Gas Gangrene, Part 1 & 2*, Canadian Operating Room Nursing Journal, 9(1), 11-15.) At that time, Lianna had been diagnosed with Crohn's Disease and sent home. She was re-admitted one month later (April 24, 1990) with profound anaemia. Her WBC dropped to 0.9 during that week. She woke on the morning of May 1, 1990, with severe pain in her left thigh. She had a mid-thigh amputation after a diagnosis of 'gas gangrene' was made. She had a colectomy the following day for extensive Crohn's Disease.

We have kept in touch with Lianna during her crisis and rehabilitation over the past 22 months. From May to August of 1990, nurses and doctors at the pediatric hospital focused on eradicating the Clostridium, which was detected by regular cultures from an open area on the stump. They did many surgical debridements over this time period.

During the three months prior to her discharge from hospital, Lianna was able to drive a car. That allowed her to return to high school and to travel to the hospital once a day for assessment and dressing changes. In October, 1990, she was discharged from hospital and began receiving home care.

In February, 1991, Lianna had surgery to close the colostomy. (In the article we stated she had a permanent ileostomy. This was incorrect. She had 20 cm of colon remaining which allowed for re-anastomosis).

In mid-April, 1991, Lianna received her permanent prosthesis. She had difficulty adapting to her new limb. By summer it was replaced with a new prosthesis. She is still undergoing physiotherapy but is adapting well to her new limb. Lianna's positive way of dealing with her amputation enabled her to speak with and counsel other young amputees while she was a patient in the pediatric hospital.

Lianna hopes to be able to play soccer again some day. She had been a top athlete in this sport. In the meantime, she is coaching ten-year-olds.

Many victims of gas gangrene don't survive; Lianna did. Today she is completing her first year of Commerce at the University of Ottawa.

Operating room nurses rarely have the opportunity for the in-depth patient follow up and contact which we have experienced with Lianna. Her courage and zest for life inspired all who cared for her.

**Diane Aboud, R.N.,
Operating Room,
Riverside Hospital,
Ottawa, Ontario.**