own hospital organization. Staff had a difficult time coping and our top down decision making processes only made things worse.

• We've also learned that union involvement right from the beginning is critical. If we had the opportunity to start the process over, we would involve the unions much earlier. Getting started is tough enough. Initiating the process without union involvement from the conceptual stage makes the journey even more difficult.

• A project of this nature is going to have hospital wide impact. I believe the B.C. nurses union provincial office was correct in insisting on the involvement of the other unions.

• Since the beginning people have observed the lack of any medical staff representation on the steering committee. Our medical advisory committee chairman has now agreed to participate along with another physician. It is too early to gauge any impact of this move.

• We've also learned that you need to be prepared for the people involved to spend a lot of time together. Senior management people need to be seen as strong supporters of the initiative and to allocate sufficient time to the program.

• Union and management people use a different jargon. There was a lot of time spent talking to each other, not realizing our communication differences.

• It took our committee a long time to overcome the "we can do it ourselves syndrome". (A reluctance to use outside consulting services to help the steering committee develop into an effective team was tolerated too long). Properly facilitated retreats played a large role in enabling the steering committee to achieve their progress to date.

• Finally, not only are resources within the hospital's communications department scarce, they may not be trusted initially by union participants. It took our committee a long time to understand the need for a first class communication program. We hired a firm with specialists in employee communication to handle this specific task.

Three things to remember

If I could leave only three things to remember from this presentation that will help, they would be:

1. Protect the long term health of your organization even in the face of downsizing and restructuring.

2. Work together with employees, unions and all levels of management to create solutions.

3. Keep the faith ... the early days can be tough. ■

Major Topics and Speakers from the BCORNG conference to be featured in upcoming issues:

Are You Safe Handling Wastes

By Dr. Walter F. Schlech III, M.D., Assistant Professor of Microbiology and Community Health and Epidemiology, Dalhousie University, Halifax.

Infection control practices in the Operating Room, including body substance precautions, were reviewed incorporating the most recent guidelines from the Centre for Disease Control.

Everyday Dilemmas

By Patricia Rodney, R.N., M.S.N., Nurse Education Consultant, Vancouver.

This session was highly rated as O.R. nurses frequently face serious ethical dilemmas in their practice. Ms Rodney expanded the O.R. nurses' understanding of the ethical questions facing nurses and suggested strategies to help in dealing with these dilemmas.

Painless Presentations

By Robert Goodall, M.A.of the B.C. H.A.

Delegates learned how to plan and prepare a presentation, establish a comfortable relationship with the audience and how to organize a presentation logically and effectively. The use of audio-visual aids and technique to encourage audience participation were also covered.

Synthes Lecture/Demonstration of Femoral Rods and Cannulated Screws

By Carole Griffiths, R.N.

The latest developments in the application of intramedullary rods and cannulated screws in the treatment of fractures was presented. It is hoped the presentor will submit this for the journal's September Orthopaedic Special Issue.

Doctor's Office: Can You Hold?

By Dr. S. Larry Goldenberg, M.D.

A new treatment of female incontinence by collagen injection was described. The urologist focused on female and geriatric incontinence and the etiology of incontinence in the male. Only two or three centres in Canada have experimented with this new procedure and so far successful results have been impressive. We will be hearing more about this treatment in the Fall.

(Continued on page 27)

Questions on sterile technique can lead to study and research

By Margueritte Martin R.N., B.Sc.N.

Introduction

Operating room nurses should constantly assess aseptic protocol. Relevant to this, current and changing practices must be backed by valid and reliable rationale. (Murray and Zentner, 1975).

Who Said What and Why?

As a staff nurse are you given credible rationale for change? Are there questions you want to ask about steritle technique and asepsis? If you start asking questions you will be participating in change processes toward optimal technique and safe nursing care. One reason is that decisions and practice based on reliable rationale produce accountability. This accountability is demonstrated in nursing care as one is able to explain and back-up reasons for decisions and procedures. Should your questions lead to research, remember that any study must enlist the guidance of a qualified person, educated in planning, conducting and critiquing research.

Start Somewhere

There are many issues we could consider. Let us begin with a few basic topics as they relate to the operating room:

1. Wearing apparel,
2. Masks,
3. Jewellery,
4. Perfumes and
5. Food

1. Wearing apparel

Starting at the top, hats should cover the hair. An individual who persists in not covering his or her hair could be influenced by this simple demonstration. Randomly culture a hair from a volunteer's head. The resulting growth of microorganisms would provide persuasive data.

Research that meets nursing science criteria supports maximal skin and shoe covering for operating room personnel. Studies (Davis 1985) recommend wearing O.R. scrub pants with ankle closures. These studies condemn dresses and sleeveless suits as being ineffective in preventing skin scale contamination.

Relevant to this, remember that the infection rates are in direct proportion to the number of persons in the operating room. Furthermore, the traffic or movement of the persons increases the infection risks. Considering this, shoe covers are practical preventative tools that prevent soiled shoes acting as transfer vehicles for microbes. Jean Davis, an independent hospital asepsis consultant, advocates the use of shoe covers. She suggests, "Shoe covers do reduce the lateral transfer of debris, therefore, should be used."

2. Mask

Hawthorne 1981 demonstrated that cloth masks do not filter respiratory secretions. Disposable masks should be used and handled by the ties when removed.

3. Jewellery

There is the long lasting practice of wearing neck chains and ear rings in the operating room. These are

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a source of infection because they create skin cell chaffing. To prove this point, drop a chain or an ear ring on a culture plate, incubate, and watch the microbes grow.

4. Perfumes

Another conventional grooming practice for O.R. personnel to consider as a source of infection is the use of scented cosmetics. The chemical structure of perfumes is designed to perfuse mini droplets through the air. Perfumes are effective vectors to spread microorganisms. Further considerations are that patients/ clients and other staff may be allergic to perfume or nauseated by it.

5. Food

Each operating room suite has the rule that there is to be 'no food or beverage' in the operating room. This produces a dilemma. Long surgical procedures deem that staff require nourishment, but they can not leave the surgical room. The reason for the 'no food or beverage' rule is relevant to basic microbiology. Foods act as transfer media, cell nutrients and wicks to support microbial residue and rebound growth.

You Can Do Something

If you have questions or concerns, you could suggest a research group be started in your staff development programme. This group could identify problems and find answers through research. Often, a literature review will provide enough reliable and valid data for accountable decisions.

Nurses should strive to effect change with optimal aseptic technique and safe nursing care in mind. This means that decisions are based on proven scientific information. With solid rationale, operating room nurses can sell management on the importance of research to back policies and practices.

Conclusion

Costs of nosocomial (hospital acquired) infections and litigations must be considered. Furthermore, management, will be supportive of efforts toward optimal asepsis because infections prolong hospitalization. The costs of post operative infections are phenomenal, both to patient suffering and dollars, (Donald 1985). Another consideration supporting efforts towards optimal asepsis is the potential for patients to sue because of nosocomial infection. (Ritter, 1986).

These factors may be driving forces for managers to welcome input from staff nurses. If you have concerns about sterile technique or nursing care, suggest to your unit manager that a research committee be formed, study one segment of infection control management, or write an article.

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