Behind Our Sterile Doors

By Gloria Stephens

The physical location of the Operating Room emphasises isolation. Furthermore, O.R. nurses have set up a multitude of barriers because of aseptic practices. Thus, of necessity, we have excluded other personnel from entering this 'sterile sanctum'. Consequently, we have suffered on two counts. Firstly, we may not be totally aware of what is happening in nursing generally, and secondly, we have not informed other nursing levels of the transition which has occurred in operating room nursing concepts.

It is evident to me that we must become more publicity conscious and recognize that communication is a two-way street.

How much do we know about our patients before and after surgery? We are in a position to know more about the preoperative needs of the patients and the effect of the surgical procedure, and also how the actual surgery will affect the patient post-operatively. And yet, we haven't taken adequate advantage of this factor to communicate to other nurses involved with the patient. To my knowledge, few, if any,nurses' notes are utilized to advise what has occurred to the patient while in the O.R. The anaesthesia record gives the scant information that the recovery room nurses receive.

Consider the course followed by the surgical patient: Pre-operative, Operative, Post-operative. The operation is the middle segment of the surgical treatment of the patient. Any way one looks at it, the O.R. nurse is a vital part of surgical nursing. It is the operating room nurse who fulfills the circle of "continuity of care"; who acts as the patient's advocate; and who maintains Standards of care.

We live in a society which increasingly leans toward specialization. The Registered Nurses' role in the Operating Room must be preserved and expanded. On this we agree, but this will only come about if nurses speak out and are willing to explore and broaden their horizons. Are we standing still, or moving forward with the times? We must take the step into the new decade, no longer having the excuse of "no time!"

Realistically, we should aim at new concepts of approaching our nursing care instead of abdicating functions, such as allowing the Respirologist to assist the Anaesthetist, rather than the O.R. Nurse. Why do we allow these things to happen?

Hurdles which we possibly will encounter include: budget, time and cooperation of the surgeons/management. But first, we must convince our co-workers and other related services, through staff development and continuous education that a new approach is mandatory to the survival of the operating room nurse specialty.

We must think about our role in <u>all</u> facets of nursing, not exclusively, O.R. service. To be specific – if patients are to receive the care to which they are entitled, we must accept the fact that a new "breed" of nurse is required in the operating room. Are we prepared to meet these new challenges?

As for the student, he/she will receive O.R. experience if we account for the following statements to the satisfaction of the nursing educators:

1. Identify the unique aspects of O.R. Nursing.
2. Illustrate the need for a professional nurse in making judgements, in a supportive role, and in carrying out continuity of care.
3. Select learning experiences with relevant procedures demonstrated.
4. Emphasize quality learning experience rather than quantity.
5. Develop a nursing-care plan with examples.

To ensure our place in the ranks of the true professional, we all must think, question, evaluate and act.

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