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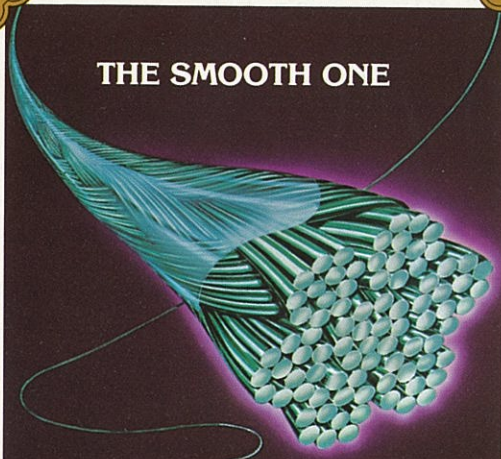
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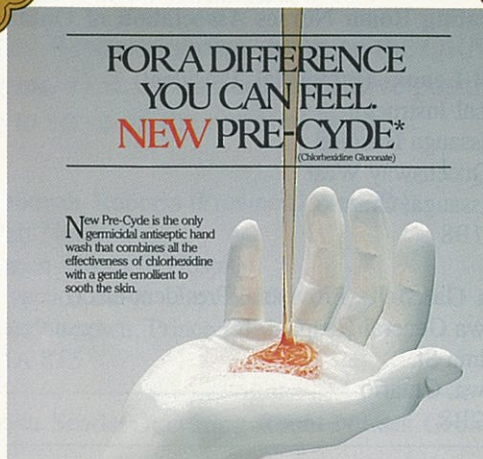
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The challenge to build... to meet the needs

By Nellie I. Beatty

To be involved in the construction of a new building of any description is always exciting. A nurse who has the opportunity to assist with the planning of a new hospital may discover that her assignment is one of the most challenging of her career.

When the renovation of an old surgical suite or the construction of a new suite is contemplated, the operating room supervisor is usually appointed to the planning committee, or the "users group." The nurse supervisor will be one of a group of professionals: architects, engineers, planners, surgeons and anaesthetists. Each of the committee members will approach the planning of a new suite from the background of his or her own discipline and particular needs.

Although the architect may have designed, and the engineer may have built a surgical suite before, only the physicians and the nurses work in such an area. The needs of the physicians may differ dramatically, depending on the medical-surgical specialty being considered. Therefore the co-ordination of the various points of view falls largely to a knowledgeable nurse who is familiar with the needs of patients, medical, nursing and support staff. In addition to recognizing the needs, the nurse must familiarize herself with the various systems required in the department and study the variety of products available. Armed with this knowledge and with her experience as an operating room administrator, the nurse supervisor will make a unique and essential contribution to the group.

Getting started

In order to prepare herself for the challenge of planning a new suite, the O.R. supervisor and the other members of the users group must try to envision the present and future needs of the hospital, the staff and the people that will be served. What

sort of surgical suite is the hospital board planning to build? What sort of suite is required to meet the needs of the community it will serve?

Research questions

The character of the surgical suite will begin to take shape when the following questions have been researched and answered:

1. What geographical area does the hospital serve?
2. Is there a predominant age group in the community population? If so, what is it? What are the most usual surgical services required by this age group?
3. What surgical services will be available?
4. Can you expect an increase or a decrease in the present patient load? By how much?
5. How many surgeons will use this surgical suite?
6. How many surgeons are on each surgical service area provided?
7. How many anaesthetists will be required? What

About the author

Nellie I. Beatty, B.Sc.N., R.N., retired last year as Director of Nursing, Operating Rooms, Walter MacKenzie Centre, University of Alberta Hospitals, Edmonton. Throughout the ten years of the construction of the MacKenzie Centre, she was a member of the Users Group appointed to plan the new surgical suite. Ms. Beatty's article is essentially the first chapter of a manual that is being written for operating room supervisors who have been appointed to a building committee.

facilities (library, offices, laboratory) does the anaesthetic department require?

8. Is the hospital a teaching hospital, a general hospital or a specialized facility?

9. Does the hospital offer programs which require students to have operating room experience? How many programs per year? Do the programs overlap? How many students are expected in each program?

To obtain a realistic picture, it is essential that the users group have the assistance of the hospital board and administration as well as physicians and nurses representing the various surgical specialties.

It is important to formulate clearly the role of the hospital for the next ten to twenty years. Too often facilities have been built without clear guidelines regarding the services to be offered. This can be very frustrating to the users and expensive to the public.

Policy statements

In addition to determining the needs of the community and the role of the hospital in serving these needs, consideration must be given to the methods by which the work within the surgical suite will be carried out. This is essential prior to the actual drawing up of any plans.

Hospital administration, with the help of the users group must formulate certain policy decisions which directly influence the size of the suite as well as its exact location within the building. These policy statements are directly related to the surgical specialties being offered and to the variety of systems required in a surgical suite. Although the details of procedures will be written at a much later date, the users group will be unable to plan realistically until the broad policies pertaining to geographical location, material management, communication, infection control, traffic control and allocated space are in place.

Location and adjacencies

The best geographical location of the surgical suite within the hospital may vary with each hospital. In a large hospital, a general meeting may be planned at which all department heads state publicly their preference of location in the new building. It is questionable whether this is helpful, as several departments may have the same preference and the hospital administration must make the final decision. However, those nursing units housing intensive care patients or patients frequently requiring STAT surgery should have access to the surgical

suite. Examples of such units are cardiac recovery and trauma units, high risk obstetrical units, neurological and neonatal intensive care units.

Material management/supply system

The lifeline of all operating rooms is the supply system. Therefore, one of their first policy decisions must pertain to the method of delivery of the hundreds of items that are required daily in an operating room. Very few surgical suites are self sufficient today: that is, very few departments wrap and sterilize their own supplies within the surgical suite. The trend is to have a central supply department prepare the supplies and deliver them, ready for use via the case cart and/or an exchange cart program.

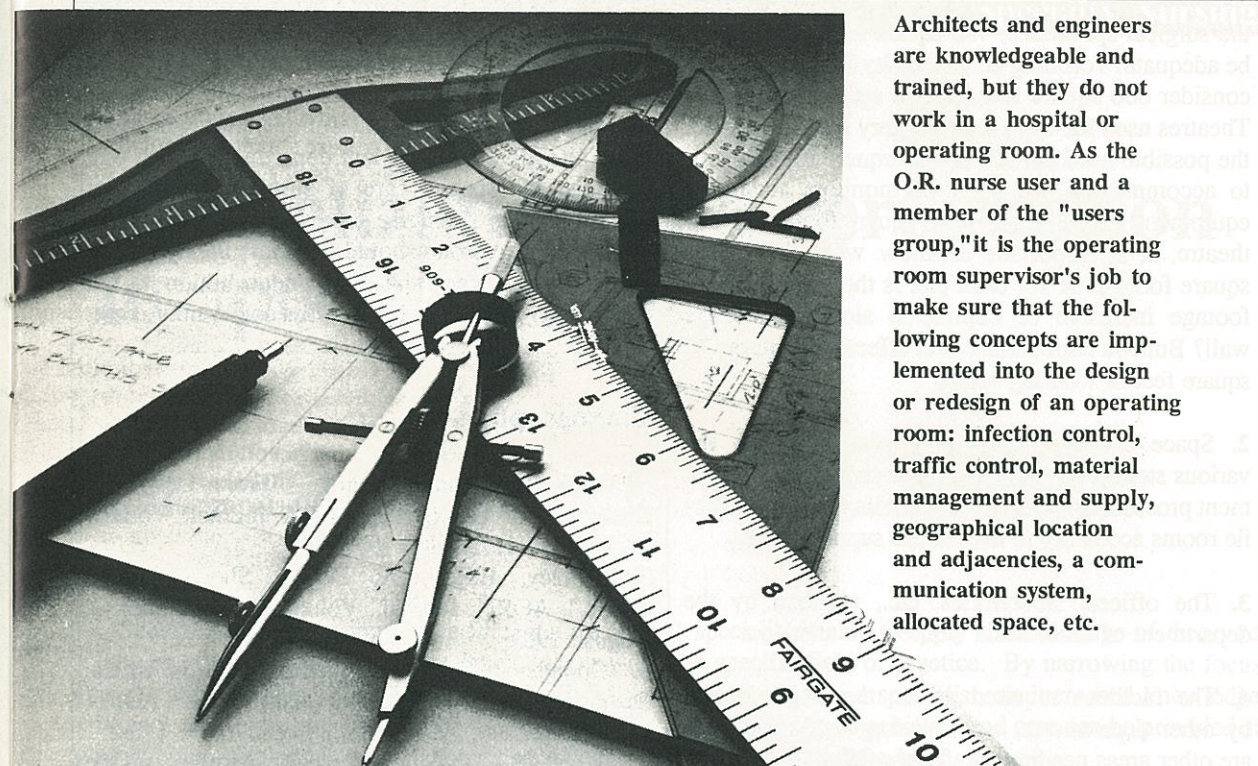
Case cart programs can be all inclusive (delivering all instruments and supplies) or they can be "supply specific" (a partial case cart system). The system chosen must be very well thought out, and instruments and supplies followed through the projected traffic route. Realistic decisions regarding the space required for decontamination rooms, instrument rooms, cart receiving and storage areas can be made when the administration and the users group have agreed upon the system for receiving supplies. The location of the central sterile supply department, relative to the surgical suite, will directly influence the choice of the supply system. If instruments and supplies are to be processed outside the surgical suite, the sterile central supply department should be located directly above, or below, or adjacent to the surgical suite. This adjacency is extremely important in reducing the turn-a-round time for surgical instruments.

The communication system

The suite will require a good communication system within the department, between hospital departments and out side the hospital. Does the hospital intend to build a computerized department? If so, space must be allocated for the computer equipment and the operators. How will visitors view surgery? Will they be permitted to enter the theatre, or will they sit in a viewing room and watch via a closed circuit television channel?

Infection control system

The control of infection is the "name of the game" in any operating room, and all procedures must be carried out with infection control in mind. What is the procedure for handling contaminated instruments or supplies? What is the required size of the decon-



Architects and engineers are knowledgeable and trained, but they do not work in a hospital or operating room. As the O.R. nurse user and a member of the "users group," it is the operating room supervisor's job to make sure that the following concepts are implemented into the design or redesign of an operating room: infection control, traffic control, material management and supply, geographical location and adjacencies, a communication system, allocated space, etc.

tamination room? The clean core area? These decisions will depend upon the supply system selected.

How will the surgical specimens be handled? Will there be space within the suite for a small pathology department where frozen sections, examinations of specimens and typing of reports can be carried out?

Traffic control

All surgical suites must be planned with the three geographical areas (interchange, sub-sterile and sterile) clearly in mind. Clean supplies must be transferred through clean areas, soiled supplies retained in a "soiled holding area" and patients and staff must have a suitable route to gain access to the theatres. A hallway (often called a racetrack) completely encircling the suites permits patients and staff easy access to theatres. However, such a plan requires a great deal of space which may be used to better advantage elsewhere. The space allocated to hallways, storage, etc., will depend to some extent, upon the available dollars for the new suite. However, it is poor economy to settle for narrow hallways and small storage areas when patients are being transported with a multitude of equipment items attached to their beds, and when the required surgical equipment seems to increase each year.

The surgical suite is one of the most complicated and expensive departments to construct. History has repeatedly shown us that operating rooms never have

enough space. In attempting to meet the space requirements of patients and staff, careful consideration must be given to each of the following:

1. Number and size of theatres.

The number and size of theatres will depend upon the number of surgical services offered, the number of surgeons on each surgical service, and the expected work load. There are definite advantages to having all the theatres the same size. In a busy suite where there is constant pressure to save surgical time, it is much easier for all concerned if any surgical procedure can be done in any theatre. It will, of course, be most efficient to allocate certain theatres to each surgical service, where special equipment for that service can be stored. Nevertheless, even in the most efficiently managed suites, it often becomes necessary, for example, to place a STAT head injury patient in a theatre other than the neurological theatre. In a general hospital without

the surgical specialties, 400 square foot theatres will be adequate. Teaching and specialty hospitals should consider 600 square foot (usable space) per theatre. Theatres used for open heart surgery should consider the possible need for 700 to 800 square foot theatres to accommodate the array of monitors and other equipment. In determining the square footage of any theatre, it is important to know what the usable square footage is: for example, is the quoted square footage inclusive of cupboards along one entire wall? Built-in cupboards could effectively cut off 30 square feet of working space.

2. Space consideration should also be given the various storage areas, decontamination rooms, instrument processing rooms, soiled holding areas and sterile rooms accessory to the chosen supply system.

3. The offices, laboratories, etc., required by the department of anaesthesia will require attention.

4. The facilities required within the surgical suite by other departments, e.g. radiology and pathology, are other areas needing careful consideration.

5. Storage space for special equipment by all surgical services is another space concern.

6. The patient holding areas.

7. The post anaesthetic recovery room.

8. Hallways wide enough to accommodate equipment and patient beds.

9. Staff facilities including dictating areas, offices for secretaries, nursing supervisors, classroom and/or library space, male and female locker rooms, staff and physician lounges.

Careful attention must be given to all the above mentioned areas. Actual measurements of equipment are usually required to justify to administration the need for a spacious suite. As mentioned previously, operating rooms are notoriously short of space. Any surgical suite larger than two theatres should build in an extra room of 400 to 500 square feet, for which nothing is planned at the time of building. Once the suite is occupied this space will undoubtedly be well used, and will provide an economical way of meeting future needs. To the uninitiated, the research and the formulation of policy statements before the actual drawings begin may seem a waste of time. However, the building or renovation of a surgical suite requires more knowledge and expertise

than is usually recognized by hospital administrators. There can be no realistic allocation of space and location for a surgical suite until the foregoing questions are answered. Careful planning will result in an attractive and efficient department which will facilitate the special care of surgical patients for years to come. The nurse supervisor who is appointed to the users group should welcome the opportunity to make a very significant contribution to her profession, the hospital and to the community. ■

Bibliography

1. O.R. Environment Panel, "From Design to Evaluation of OR Suite," AORN Journal, Volume 23, Number 1, January, 1976.
2. Foley, E.R., "OR Design Shows Nurses Touch," AORN Journal, Volume 36, Number 2, August, 1982.
3. Sprague, G.R., "Planning the OR Suite in the Operating Room: The Supervisor's Role," AORN Journal, October, 1970.
4. Knoll, S., "Infection Control Strategies in the Operating Room," Canadian O.R. Nursing Journal, Volume 4, Number 4, September, 1986.
5. "Weighing Costs and Benefits of a Case Cart System," Operating Room Manager, Volume 2, Number 6, June, 1986.

New trends in cardiology expected to reduce costs and shorten stay

Trends in cardiac surgery - new laser techniques and clot-dissolving drugs - are expected to improve survival rates, reduce lengths of stay, and lower hospital costs, according to an article in the May 20, 1988 issue of *Hospitals*.

New catheter tips have the capability to blast through arterial plaque with a hot metal tip, or drill through plaque with a rotating bit.

People with myocardial infarctions will be able to be treated immediately with clot dissolving drugs such as tissue plasminogen activator (tPA). TPA is predicted to reduce the percentage of early fatalities by up to 40% and significantly reduce the severity of heart failure. The use of tPA signals another trend - that of treating heart problems with drug therapy, aspirin, and beta blockers instead of surgery.

Future trends include increased heart-lung transplants; magnetic resonance to keep plaque pushed against the vessel wall; and development of pacemakers that will allow controlled exercise.

Specialization and certification in specialty practice

By Margaret Fitch, R.N., Ph.D.

Specialization in nursing and certification for specialty practice are rather important developments within the fabric of Canadian nursing. They will have an impact on the majority of nurses who are currently practicing. No longer are we discussing whether or not nursing should be specialized; we are caught in the debate about how we ought to respond to the mounting pressures to formalize specialty practice.

The purpose of this paper is to highlight some of the issues surrounding specialization and certification for specialty practice in general, and highlight their current development in Canada. In particular, the focus will be on clinical specialties (direct care) rather than functional specialties (research, administration, education).

Nursing beyond the basics

Definitions for the words 'special', 'specialty', 'specialize' and 'specialization' create the notion of dealing in depth with a portion of a whole or singling out a part of something on which to focus with a greater intensity. Transferring that notion to nursing practice we have a picture of specialization that has two characteristics:

1. the practice is narrowed in focus to a particular portion;
2. the practice is delivered with a greater depth of knowledge.

The focus of specialty practice on a portion of nursing practice facilitates a greater understanding of that particular area. While the generalist knows what is useful to apply in all patient situations, the

specialist is able to apply a broad range of theory to a specific field of practice. By narrowing the focus of practice as a specialist, an increased knowledge and skill can be achieved and care can be provided at a level beyond the basic.

Specialization criteria

The notion of specialization in nursing is not new but has been changing. In the first issue of the *American Journal of Nursing*, Dewitt wrote about the need for specialists to improve care. Specialization in nursing at the turn of the century meant "doing something well", caring for one group of clients only (eg., new mothers and babies) or being educated in a specialty hospital (eg., psychiatry, TB). The criteria for specialization was technical expertise.

Over the years, as more educational programs became available and issues concerning standards of practice were articulated, the notion emerged that specialization required additional educational preparation. More recently, an additional caveat has emerged that one must also be practicing regularly and almost exclusively in one's specialty. The specialist must have extended her knowledge and skill through experience and education beyond the basic generalist preparation. One does not become a specialist simply by working in an area for a number of years.

A different level of nursing care

We are generalists when we graduate from our basic programs in that we know a little about caring for individuals in a wide variety of health/illness situations. The scope of our knowledge is broad but