CANADIAN
OPERATING ROOM
NURSING JOURNAL

Volume 23, Issue 1
March 2005

19ième Conférence Nationale AIISOC
19th National Conference ORNAC

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President's Message

*By **Margaret Farley**, RN, CPN(C)*

Another season is approaching – spring, wonderful spring. I hope you will consider spending a portion of your spring with us at the **19th National Operating Room Nurses Association of Canada (*ORNAC*) Conference!**

Our hosts, *Corporation des Infirmières et Infirmiers de Salle d'Opération du Québec / Corporation of Operating Room Nurses of Quebec* (CIIOQ/CORNQ) has set aside **May 1-6, 2005** for our learning and enjoyment. The conference theme is ***Today's Projects, Tomorrow's Progress.*** Check out the brochures, posters and *ORNAC* website for more precise information.

The home of our conference was visited by explorer Jacques Cartier in 1535 and Samuel de Champlain in 1611. It hosted the World Fair in 1967 and the Summer Olympic Games in 1976. If you guessed the city of **Montreal** you'd be correct.

Our conference host city has played an enormous role in the history and development of our nation. The Port of Montreal, situated on the St. Lawrence River, offered a year-round port in the link between the Atlantic Ocean and the Great Lakes. From its humble beginnings as a village, it became highly valued as a starting point for further exploration and trade to the uncharted "wild west".

The village was initially seen on maps as Ville-Marie. Later it was seen as "la ville de montréal, or Mont Réal, and finally, by its current name of Montréal (or Montreal to we Anglophones). While you explore this city and learn more about its three hundred and fifty years of documented history, you may hear it or parts referred to as Ville-Marie, especially within the "old" portion of the city.

Today's Montreal is a vibrant metropolitan city. In "Old Montreal" you can still view many of the city's original buildings and learn more about the history of the region at the Centre d'histoire de Montréal. But the opportunities for shopping and exploration are as boundless as the history. In this city of over three million, with its extensive history, culture, and energy there is something for everyone.

Attending the conference will include the opportunity to network, shop, explore, learn, and celebrate in one of Canada's premiere cities. The location is second to none and the speakers and delegates will be, as usual, top rate. I look forward to seeing you there! Our hosts will also provide us with an exhibit hall full of adventures.

This is my last message as President of *ORNAC*. I have had the time of my life meeting and working with my perioperative peers across the country and abroad over the last two years.

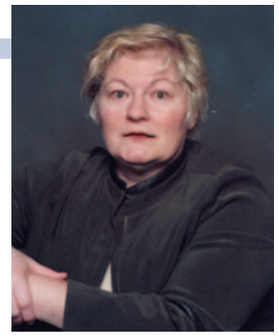
It has truly been a pleasure for me, thanks to each of you. I wish I had been able to accept every invitation, and my only regret is the difficult choices I had to make when it came to choosing what events I would attend. Every event offered the opportunity to visit interesting locations, meet fabulous people, and be exposed to excellent learning opportunities. I thank all of you who invited me and those of you who welcomed me.

I am proud to have been involved with *ORNAC* and represented such a great association. It has been a pleasure meeting and working with so many of you. Once again, thank you and keep up the great work!

***Margaret Farley**, RN, CPN(C) is President of the Operating Room Nurses' Association of Canada. She is the Perioperative Clinical Development Educator at Regina Qu'Appelle Health Region in Regina, SK.*

***Margaret Farley**, inf., CSP(C) est présidente de l'Association des infirmières et infirmiers de salles d'opération du Canada. Elle est éducatrice clinique pour le développement des soins périopératoires au Regina Qu'Appelle Health Region à Regina, SK.*

Message de la présidente



Margaret Farley, inf., CSP(C)

Une autre saison s'approche – le printemps, le merveilleux printemps. J'espère que vous penserez passer une partie de votre saison printanière à la **19e conférence nationale de l'Association des infirmières et infirmiers de salle d'opération du Canada (*AIISOC*)!**

Nos hôtes, la *Corporation des infirmières et infirmiers de salle d'opération du Québec / Corporation of Operating Room Nurses of Quebec* (CIIOQ/CORNQ), nous ont réservé le **1 au 6 mai, 2005,** pour nos activités d'apprentissage et d'amusement. Le thème de la conférence s'agit de ***Projets d'aujourd'hui, progrès de demain***. Consultez les dépliants, affiches et le site de *l'AIISOC* pour de plus amples renseignements.

L'explorateur Jacques Cartier s'est rendu sur le site de notre conférence en 1535 et Samuel de Champlain s'est mis les pieds en 1611. L'exposition mondiale et les Jeux Olympiques ont tous deux eu lieu en 1976 dans cette même ville. Si vous devinez que c'est **Montréal** dont je parle, vous avez bien raison!

La ville hôtesse de notre conférence a joué un rôle primordial dans l'histoire et le développement de notre pays. Le port de Montréal, situé sur le fleuve Saint-Laurent, offrait un port entre l'océan Atlantique et les Grands Lacs accessible toute l'année durant. De ses humbles débuts comme petit village, la ville est devenue un important lieu de départ pour l'exploration et le commerce dans le terrain vierge de l'Ouest canadien.

C'est le nom Ville-Marie qui apparaît premièrement sur les cartes géographiques. Plus tard apparaissent « la ville de montréal » ou « Mont Réal », et finalement, le nom actuel de Montréal. Lorsque vous explorez la ville et apprenez davantage sur ses trois cent cinquante années d'histoire documentée, il se peut que vous entendiez des références à « Ville-Marie », surtout dans les quartiers les plus anciens.

Le Montréal d'aujourd'hui est une ville cosmopolite et mouvementée. Dans le « vieux Montréal » vous pouvez toujours voir bon nombre de bâtiments originaux ainsi qu'apprendre davantage sur l'histoire de la ville au Centre d'histoire de Montréal. Il va sans dire que les possibilités de magasinage et d'exploration sont aussi variées que l'histoire. Dans cette ville de plus de 3 millions, avec sa vaste histoire, culture et énergie, il y a vraiment quelque chose pour tous les goûts.

Ceux et celles qui assisteront à la conférence auront l'occasion d'étendre leur réseau personnel, magasiner, explorer, apprendre et fêter une ville canadienne de première classe. Le lieu est sans égal et les conférenciers, comme toujours, de premier rang. J'espère vous y voir! Nos hôtes nous fourniront également un lieu d'exposition plein de possibilités.

Celui-ci sera mon dernier message en tant que présidente de *l'AIISOC*. Depuis les deux dernières années j'ai en un énorme plaisir en rencontrant et en travaillant avec mes collègues de salle d'opération d'un côté à l'autre du pays et à travers le monde.

Ce rôle m'a été un vrai plaisir, et je vous remercie chacune et chacun. J'aurais aimé être en mesure d'accepter chaque invitation, et mon seul regret, c'est qu'il a fallu choisir les événements auxquels je pouvais assister. Chaque événement présentait l'occasion de connaître un nouvel endroit, de rencontrer de nouvelles personnes intéressantes et de vivre de nouvelles expériences d'apprentissage. Je vous remercie tous et chacun de chaque invitation et de chaque chaleureuse bienvenue.

Je suis fière d'avoir été impliquée dans *l'AIISOC* et d'avoir représenté une association de si haute qualité. J'ai eu un grand plaisir à rencontrer et travailler avec un si grand nombre d'entre vous. Encore, merci et continuez le beau travail!

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Editorial Contents

ORNAC Conference May 1- 6

INDUSTRY HAPPENINGS

PLANIFIER POUR LA SALLE D'OPÉRATION NUMÉRIQUE EN PLEIN ESSOR

Auteur: *Rob Swart est un architecte autorisé ayant 19 années d'expérience avec Cohos Evamy, une entreprise d'architecture, design et planification nationale dont le siège social se situe à Calgary. Il a réalisé la rénovation de six salles d'opération hospitalières, a travaillé sur plusieurs installations en Alberta et se spécialise dans le domaine des soins de la santé.*

RÉSUMÉ

Les infirmières et infirmiers travaillant dans les salles d'opération d'aujourd'hui font face à de nouvelles technologies qui sont ajoutées suivant la tendance vers la réalisation de la salle d'opération numérique. Plusieurs hôpitaux à travers le pays entreprennent actuellement des rénovations afin d'inclure de nouveaux équipements. Cela exige que les infirmières et infirmiers s'adaptent aux nouveaux systèmes, se familiarisent avec les forces motrices poussant cette tendance et comprennent l'impact de celle-ci sur leur pratique quotidienne. Dans le présent article l'auteur explore les raisons pour lesquelles les salles d'opération numériques deviennent la norme et ce que les infirmières et infirmiers doivent comprendre afin de travailler efficacement dans ce nouvel environnement.

PLANNING FOR THE RAPIDLY EMERGING DIGITAL OR

Author: *Rob Swart is a registered architect with 19 years of experience with Cohos Evamy, a nationally-based architectural, design and planning firm headquartered in Calgary. He has completed six hospital OR renovations and specializes in the healthcare field, having worked on numerous facilities around Alberta.*

Courtesy Cobos Evamy

Double articulated boom systems in Digital OR Suite, University of Alberta Hospital.

ABSTRACT

Nurses working in today's operating room environments are faced with new technologies being added as the trend toward the digitalization of ORs becomes a reality. Many hospitals across the country are currently undergoing renovations to include updated equipment. This means nurses must adapt to new systems and become familiar with the driving forces behind the trend and how it will affect their daily work. Here, the author explores why digital ORs are increasingly becoming the norm and what today's nurses need to understand in order to be effective in this emerging environment.

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Digital OR (cont.)

professionals are finding themselves faced with many new challenges as they work with engineers and planners to redevelop many of the aging healthcare facilities in existence today.

The consultation process that is involved when a hospital embarks on the redevelopment of its surgical suites involves close contact with all of the stakeholders who use these facilities – this includes patients, operating room nursing staff, surgeons, administrators, manufacturers, and other healthcare workers. It is increasingly important for these users to understand the complexities of the technology so that planners, architects, and engineers can ensure that all digital changes accommodate both the technological requirements and the needs of the people using the technology. The need for digitalization is clear and it is occurring rapidly in healthcare facilities across North America. A survey of new projects in Canada and the United States, and discussions with hospital surgical teams and equipment vendors, revealed the digital revolution is a top priority for many healthcare facility planners.

Cardiac Catheterization reports, Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CT) scans, film imaging or ultrasound, patient medical history and vital signs are all becoming increasingly computerized and available in digital format.

Despite the convenience that results from the ease of access to digital information, moving into this environment does pose challenges for the nursing staff. The goal is to seamlessly integrate this new dimension of the hospital OR into the daily routine. That process begins by understanding exactly how, and why, the new digital OR is becoming predominant and what factors need to be considered in order to effectively digitalize the OR components.

In addition to updating the OR, cutting-edge technology can also be used to help provide user groups with a clearer understanding of the redevelopment process. 3D and interactive computer modeling programs can be used, in addition to traditional plan and elevation drawings, to illustrate how new equipment will be placed in the room and how it can be moved around.

CHANGES IN THE DIGITAL OR

The technology and equipment supporting MIS may be more portable, but it also requires more space in the OR than was needed in the past to support more invasive procedures. A typical OR was approximately 44 square metres. A new digital OR requires 60 square metres. The additional space is the result of several factors, including: the space required for flat-screen digital monitors, the equipment connected to them, and the service booms that house them (as well as medical gases and a range of other equipment). New double-articulated boom systems, which can swing freely about the entire OR, act as the central piece of equipment for accessing most surgical devices.

These double-articulated boom systems are central to the digitalization of the OR because they can house what used to be located on two or three freestanding carts – carts that often caused overcrowding of medical staff during surgeries and procedures. Traditional display methods resulted in the need for monitors and equipment to be centrally located for ease of viewing by the surgeon and nursing staff – this involved the dedicated use of a lot of room in the OR. In the digital OR equipment such as scope equipment, bair huggers, cautery devices, and flat-screen monitors, can be moved around the surgical suite more easily and efficiently on the double-articulated boom systems.

The University of Alberta Hospital in Edmonton (UAH) is a prime example of the trend toward digital ORs. Between 2004 and 2007 they will expand existing facilities from the current 14 ORs to 19 ORs in total, plus two procedure rooms. The Level Three surgical suite renovations include provisions to replace the existing Central Sterile Room (CSR) with a cutting-edge Central Service – Supply Product Distribution (CS-SPD) that

Continued on Page 32

ORNAC Committee Updates

As you may be aware, *ORNAC* is now working under its new organizational structure. In 2004 all *ORNAC* committees were amalgamated into three streams: communication, education, and corporate.

The **Communication** group consists of the Canadian Operating Room Nursing Journal (CORNJ), the website, Awards, and French Translation.

CORNJ committee members have been busy reviewing new submissions, assisting in the development of a readership survey (*see page 13*), and assisting in the development of a brochure to increase *ORNAC's* profile.

The website committee has continued to bring **www.ornac.ca** to new levels. The re-design of the new website (launched Fall 2004) made the site much easier to navigate. A new discussion forum allows all members access to a chat room for the discussion of perioperative practice issues.

The Awards committee has been busy developing the criteria for a new cash award, to be introduced later this year, named the *Lorne Flower Memorial Award*. Further information will be available in the near future. Work also continues on the other awards such as the Drake Thompson Writing Award, the J & J Nursing Bursary, and the Isabelle Adams Award.

The French Translation Committee is probably still recovering from the release of the French 2003 edition of the *ORNAC* Standards in the Fall of 2004. The committee has also been busy preparing for the National Conference to be held in Montreal.

The **Education** group consists of Scope of Practice, Perioperative Education, Research, and Standards.

The Scope of Practice committee is focusing its attention on the Anaesthesia Assistant role. *ORNAC* maintains a voice on a task force at the Canadian Anaesthesia Society's annual meetings. The task force has been exploring this role and how it would fit into today's Canadian OR environment.

The Perioperative Education committee is looking at developing a tool for *ORNAC* to approve courses related to perioperative nursing practice. The committee also continues to administer curriculum evaluations for the approval of perioperative programs.

The Research committee has been selecting the next recipient of the Cardinal Health Research Award scheduled for presentation at the 2005 National Conference.

The Standards committee is already in review mode after the release of the 2003 edition. Fortunately this process will not be as daunting thanks to the new modular format. Hopefully the newly reviewed module will be available at the National Conference in Montreal!

The **Corporate** group consists of Bylaws, Finance, and the National Conference.

The Bylaws committee has just completed an enormous task of an entire bylaw review. Approximately 70 revised bylaws were presented at the last *ORNAC* Board meeting for approval.

Finance has ambitiously brought *ORNAC* to the 21st century in banking terms. Long gone are the days of paper transactions!!

And last but not least, the National Conference committee has probably been the busiest of all with the big event just around the corner. The complexity of planning a conference of this scale is almost unimaginable. Countless hours and resources are required – not to mention business savvy – to conduct negotiations with all stakeholders.

ORNAC and its many activities are the combined efforts of 25 nurses from across Canada who volunteer their time because they are dedicated to the promotion and advancement of perioperative nursing. We are proud of our accomplishments to date and encourage everyone to get involved!

If you should have any questions or concerns or just want to know how to get involved, visit **www.ornac.ca** and click on the discussion forum.

19ième AIISOC Conférence / 19th ORNAC Conference

Conférence Val Shirreff Memorial Lecture

Lundi le 2 mai 2005 / Monday May 2, 2005

LE TRAVAIL D'ÉQUIPE : UNE QUESTION DE SENS ET DE SURVIE

Dans le domaine de la santé, la seule raison qui nous incite à travailler en équipe, c'est que nous devons poser des gestes pour des personnes à l'extérieur du groupe. La maîtrise du leadership d'une équipe devient alors une expérience éthique où l'ordre du sens est primordial et les valeurs de référence deviennent des éléments de soutien à nos efforts de mobilisation. Préciser des règles et des stratégies pour traduire la vision dans la réalité est alors plus facile. L'influence, la communication créatrice, le leadership, les décisions rapides et les actions justes deviennent alors des moyens de survivre en équipe.

TEAM WORK: A QUESTION OF SENSE AND SURVIVAL

In the health care field, what motivates us to work as team is the need to do things for people outside of our group. As a result, mastering team leadership becomes an ethic experience where sense is paramount and core values support our mobilization efforts. Developing rules and strategies to translate this vision into reality becomes easier. Influence, creative communication, leadership, quick decisions and just actions, therefore, become the means to survive as a team.

Keynote Speaker Roger Fournier • Directeur Général / General Director
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The *ORNAC* **J&J Medical Products Drake-Thompson Writing Award** is presented annually at *ORNAC*'s National Conference or at the Provincial Conference of the winning author.

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For more Details visit www.ORNAC.ca
and click on EDUCATION then AWARDS

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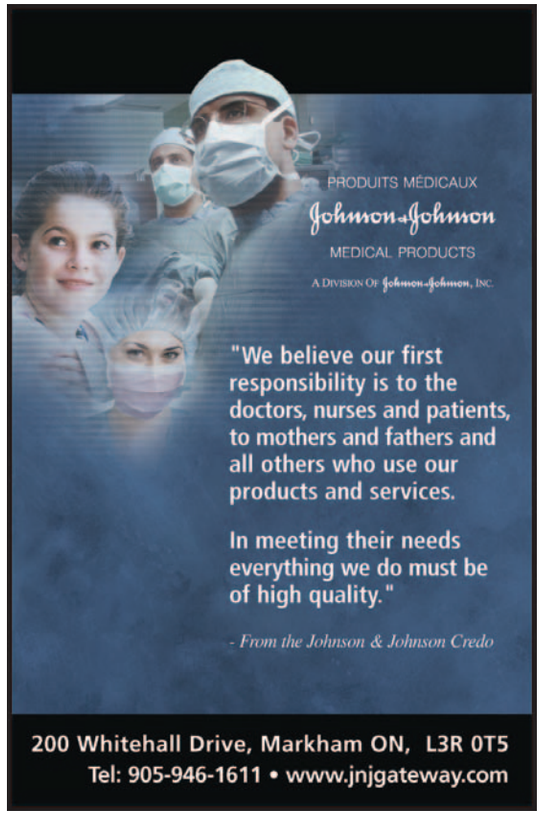

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ORNAC in a Nutshell — Fall 2004

Author: *Lynn Anderson, ORNAC Secretary*

The Fall 2004 meeting of the *ORNAC* Board & Executive was held in Toronto November 5-7. President Margaret Farley welcomed new Board members Catherine MacAulay, PE; Audrey Hiebert, MB; Susan Pardy, NL; and Sue Styles, AB.

- Guests at the Board meeting included RNFA affiliate group representative Pam Railton and *ORNAC* Auditor Stephane Delorme.

- *ORNAC's* major project for the past year has been to review/revise/rewrite our 1995 Bylaws and Rules & Regulations governing our organization. Marcy McKay, Chair of the Bylaws Committee, presented some 66 motions and at the end of the Board meeting we had revised 2004 Bylaws. This has involved a tremendous amount of work and Marcy is to be commended.

- Keynote Networks, in collaboration with *ORNAC*, has just completed the re-structuring of our website, www.*ORNAC*.ca. Keynote provided us with the software to run our own site, make all future changes, and create new sections. We now have a "virtual boardroom" where the Board & Executive can privately and securely conduct *ORNAC* business between its in-person meetings.

- The Awards Committee is seeking nominations for various Awards. Check out the *ORNAC* website and select Education and Awards for more information.

Courtesy M. Knight

L to R Margaret Farley, ORNAC; James Musela, NNAK; Marcy McKay, ORNAC.

Courtesy L. Socha

Marcy McKay, President Elect, at 2004 Board Meeting

- *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice, 5th Edition,* was released in English in Spring 2004. The French version is now also available. To date the Standards Committee has begun a review of Module Three. If anyone has any concerns, comments, or questions regarding the Standards Review, or to purchase a copy of the Standards, visit www.*ORNAC*.ca and click on Standards.

- *ORNAC* President, Margaret Farley has represented the association provincially, nationally and internationally in recent months. She has visited NL's 25th anniversary, the NB Atlantic Conference, NATN's 40th Anniversary, and QC's 30th anniversary.

- While at NATN, in October, Margaret Farley and Marcy McKay were able to meet James Musella of National Nurses Association of Kenya (NNAK). They presented him with a small gift from *ORNAC* and some Canadian memorabilia donated by various Provinces. *ORNAC* is sponsoring Kenya's IFPN membership over the next three years.

- The September 2004 issue of CORNJ had its first ever product insert. We hope our readers filled out this form and returned it for product information. If you have any suggestions or comments regarding the Journal you can contact Linda Socha, Editorial Board Chair, at journal@ornac.ca.

L'AIISOC en Bref — Automne 2004

Auteure: *Lynn Anderson, AIISOC*

La réunion du conseil d'administration de l'automne 2004 a eu lieu à Toronto du 5 au 7 novembre. La présidente Margaret Farley a accueilli les nouveaux membres du conseil : Catherine MacAulay, PE; Audrey Hiebert, MB; Susan Pardy, NL; Sue Styles, AB.

- Parmi les invités figuraient Pam Railton, représentante du groupe affilié des infirmières premières assistantes, et Stephane Delorme, auditeur.

- Depuis un an, le principal projet de *l'AIISOC* était de réviser et réécrire les règlements qui guident notre association depuis 1995. Marcy McKay, chaire du comité des règlements administratifs, a présenté 66 motions à la fin de la réunion du conseil d'administration et nous avons maintenant révisé les règlements de 2004. Cela a demandé un travail énorme de la part de Marcy et elle mérite nos plus gracieux remerciements.

- Keynote Networks, de pair avec *l'AIISOC*, vient juste de compléter la restructuration de notre site web, www.ORNAC.ca. Keynote nous a fourni les logiciels requis pour que nous puissions gérer notre propre site, faire toutes les modifications futures et créer de nouvelles sections. Nous avons maintenant une salle de conseil virtuelle où le conseil et les membres exécutifs peuvent se réunir et discuter à huis clos les affaires de *l'AIISOC* entre les réunions en personne.

- Le comité des prix est à la recherche des nominations pour plusieurs prix qui seront décernés à la conférence nationale à Montréal en mai 2005. Consultez le site web de *l'AIISOC* et sélectionnez « *Education and Awards* » pour de plus amples renseignements.

- La version anglaise de la cinquième édition des *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires, intitulée Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice*, a été publiée au printemps 2004. La version française est également disponible. Jusqu'à présent le comité des normes a débuté la révision du troisième module. Pour toute question ou commentaire au sujet de la révision des normes, ou toute demande d'exemplaire des normes, visitez www.ORNAC.ca et cliquez sur « *Standards* ».

Courtesy L. Socha

Lynn Anderson, ORNAC Secretary

- Depuis quelques mois, la présidente de *l'AIISOC*, Margaret Farley, s'est présentée au nom de l'association à l'échelle provinciale, nationale et internationale. Elle a assisté au 25e anniversaire de l'association à Terre-Neuve et Labrador, à la conférence Atlantique au Nouveau-Brunswick, au 40e anniversaire de la NATN et au 30e anniversaire de l'association au Québec.

- Pendant les célébrations du 40e de la NATN, Margaret Farley et Marcy McMay ont eu l'occasion de rencontrer James Musella de la *National Nurses Association of Kenya* (NNAK). Elles lui ont présenté un petit cadeau de la part de *l'AIISOC* et des souvenirs canadiens offerts par plusieurs provinces. *L'AIISOC* parraine la participation du Kenya à l'IFPN pendant trois ans.

- Le numéro de septembre de la Revue des soins infirmiers en salle d'opération canadienne a vu son tout premier encart. Nous espérons que nos lecteurs ont rempli le formulaire et l'ont renvoyé pour recevoir de l'information sur le produit. Si vous avez des questions ou des commentaires au sujet de la revue, veuillez contacter Linda Socha, chaire du comité de rédaction, à l'adresse suivante : journal@ornac.ca.

Communicating Pre-operative Instructions

LA COMMUNICATION DES DIRECTIVES PRÉOPÉRATOIRES

Auteure: *Kim Sheehan est une étudiante de niveau 4 en sciences infirmières dans son dernier trimestre du programme de sciences infirmières coopératif de McMaster University et Mohawk College. Cet article est le résultat d'un stage clinique en salle d'opération. L'auteure espère commencer sa maîtrise en fin d'année 2005.*

Une communication efficace est un composant clé de l'enseignement préopératoire. L'auteure discutera des facteurs qui peuvent avoir un impact sur l'apprentissage du client et l'importance de la démarche infirmière dans l'enseignement préopératoire.

COMMUNICATING PRE-OPERATIVE INSTRUCTIONS

Author: *Kim Sheehan is a Level 4 BScN student in her final term of the McMaster University-Mohawk College collaborative nursing program. This article came about as a result of a clinical placement in the Operating Room. The author hopes to begin her Masters in late 2005.*

ABSTRACT

Effective communication is a pivotal component of pre-operative teaching. The writer will discuss the factors that may affect client learning and the importance of the nursing process in pre-operative teaching.

The words "you need surgery" can set off a myriad of different emotions in any client, and the reaction the client has to those emotions could have a direct impact on the outcome of the procedure. Evidence shows that preoperative teaching is associated with fewer complications, shorter hospital stays, and increased client satisfaction.[1] Therefore, it is imperative that preoperative instructions be communicated to clients in the best possible way.

There are many theories that set out to describe or predict how people learn. However, one finding that is common to many theories is the fact that the environment, as well as internal and external personal influences plays a definite role in how and what a person learns. There are many factors affecting learning. They include motivation to learn, socioeconomic or cultural differences, language barriers, and disabilities or sensory deficits.[2] The impact of the illness itself can also be responsible for interfering with the ability of the client to process information.[3] If these factors are not fully taken into account when planning preoperative teaching, then how can one be sure learning has actually taken place?

In fact, a recent meta-analysis on the effectiveness of pre-operative teaching determined that very little attention is paid to the demographic characteristics of clients. The study concluded that preoperative teaching needs to be tailored on an individual basis taking into account the education level and ethnicity of the clients.[4] While policies can be written, and instructions can be given to clients to take home, if there are no measures in place to evaluate if the learning occurred, on the part of the clients, then how can the intervention be deemed a success?

Courtesy Jupiter Images

Nurse Performing Pre-Op Medical History

It is clear that there is a need to have evaluation measures in place to determine the effectiveness of the teaching strategies. One such example is the removal of jewellery. Clients undergoing a surgical procedure are most often required to remove all of their jewellery prior to the surgery.[5] In ideal circumstances the client should be advised of this requirement preoperatively, and most hospitals have policies in place to do so. However, clients continue to arrive for their surgery with jewellery on. As nurses, it is natural to understand the scientific reasoning behind the removal of all jewellery, but we must not forget that for some clients there might be a psychological impact. A piece of jewellery, such as a wedding band, may hold a significant symbolic or religious meaning. Removal of such an item could cause the client a significant amount of stress, which is not warranted on the day of surgery, and could adversely affect the outcome.[1]

Effectively communicating the need for removal prior to the surgery allows the client to remove the item, or have it removed professionally on his or her own terms rather than going through the trauma of having staff perhaps cut it off on the day of the surgery. This effective communication would also create a better climate between the client and staff, building a trusting relationship and leading to mutuality between nurse and client. Perioperative nursing focuses on the needs of the client undergoing a surgical intervention and when communication is client-directed and client-centered the goals and interventions are more effective.[3] Clearly if clients are still arriving on the day of surgery with jewellery on, then the specific goal has not been achieved and the intervention should be re-evaluated.

It appears clear that following through on the nursing process is vitally important. Each component of the process must be completed in order to determine the effectiveness of the intervention regardless of why it was implemented. Simply because there is a policy in place does not necessarily mean that it is effective. Evaluation of the effectiveness of the intervention should be based as much on individual client needs as it is on policy. Nursing practice needs to be assessed regularly on an ongoing basis. Failure to follow through on the nursing process can result in poor client care, client dissatisfaction, and even client injury.

Courtesy Jupiter Images

Patient Waiting in Pre-Op Holding Area

In conclusion, effective communication between nurse and client are key factors in ensuring a positive outcome to an operative experience. Catering the communication to individual client needs and evaluating its effectiveness is a necessary step to ensure that the communication and teaching strategies being implemented are effective in meeting the needs of surgical clients.

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Pearls of Wisdom – CORL CORRAL

Auteur: *Muriel Shewchuk*

Vedettes péri-opératoires La joie du travail – votre environnement est-il étoilé de vedettes?

Qu'est-ce qu'un environnement étoilé de vedettes?

Un service péri-opératoire professionnel étoilé de vedettes est le rêve de chacun et de chacune. Anticiper votre arrivée au travail pour être accueilli par des experts bien informés et pleins d'enthousiasme mettant en évidence leur initiative, humour et attitudes positives, c'est exactement ce qu'il vous faut. À la fin de la journée vous rentrez chez vous enrichi, excité et comblé, et même si vous êtes épuisé également, vous anticipez avec plaisir ce que vous allez contribuer et apprendre le lendemain. Vos collègues professionnels sont des experts en soins aux patients, mentors, modèles de rôle, amis et travailleurs d'équipe. Telles sont les vedettes péri-opératoires comme dans un rêve. C'est à vous d'ajouter votre étoile personnelle à la constellation et d'aider ceux et celles autour de vous de se montrer à la hauteur de la situation pour que tout le monde puisse devenir une vedette!

Author: *Muriel Shewchuk*

The Joy of Working – Is Your Environment Star Studded?

What is a Star Studded Environment?

A star studded Perioperative professional department is everyone's dream. The anticipation of arriving at work greeted by enthusiastic, knowledgeable experts who demonstrate initiative, positive attitudes and humour are "just what the doctor ordered". At the end of the day you return home enriched, excited and rewarded, even if exhausted, and look forward to what you will contribute and learn the next day. The professional colleagues you encounter are patient care experts, mentors, role models, friends and team players. These are the Perioperative stars dreams are made of. It's up to you to hang your personal star in the environment and help those around you rise to the occasion and let everyone be a star!

HOW DO WE ATTAIN AND SUSTAIN THIS ASTROLOGIC ENIGMA?

"Nurses want a work environment of Excellence, Safety, Goodwill and Learning with Supportive Leadership" – How Does That Look?

1. Excellence – Perioperative nurses who are stars all have a commitment to excellence in patient care**.** Remember, excellence has little to do with seniority**,** longevity or status of role. The young keeners may be a little short on experience, but the drive to move from novice to expert, armed with new and developing knowledge, based on evidence based practice is both refreshing and exciting. Guidance and mentoring of our young nurses can be an excellent opportunity to advance patient care and advocacy.

Technological acumen combined with advanced clinical knowledge and skills is a necessary combination for all our perioperative stars. Supervising, teaching and sharing of best practices for patient care is of utmost importance. Benchmarks of practice need to be understood so that there is a measure of performance – the question "how am I doing?" must be responded to with meaningful clinical discussion. There is no room for the standard response of "fine." Stars require a constant, consistent, and advancing learning environment that is valued, supported and sustained by colleagues and by all levels of leaders.

2. Safety – A star-studded environment is one of safety for all! Safety for patients is a prime responsibility and all team members are accountable. Appropriate and current policies and procedures are in place AND are followed by all team members including physicians –

Pearls of Wisdom – CORL CORRAL (cont.)

there are no exceptions to the rules. A major cause of stress for stars is nurses who cut corners in their own practice and do not ensure all other members follow the required standard. The multiple "R's" are paramount: right patient; right room; right surgeon; right consent; right site; etc.

Stars expect appropriately trained and responsible staff with the appropriate numbers and ratios to deliver safe patient care. In addition, enthusiasm and contribution to the effective team process is a must. There is no room for the lazy, disappearing, argumentative or arrogant type of individual in a star studded environment. Stars have no room for hoarders of information that presume to be superior, bully and intimidate.

Stars build, enhance, support and advance team skills. Stars understand the opportunity of an effective team over the power of one or a dysfunctional team. Stars support exiting team members and welcome new members with open arms and enthusiasm. Stars make no room for arrogance or elitism.

Stars excel in equipment, instrumentation, and technological knowledge, skills and handling. Excitement for stars is learning new skills, practicing a high level of advanced skills and teaching others. Pride is evident in every aspect of a star's work.

3. Goodwill – Stars in the workplace show respect and can expect respect for their self worth, education, knowledge, technical and life skills regardless of their longevity or seniority in the department. Stars advance – they cannot be expected to live in the "new forever phenomenon" which is often entrenched in the perioperative environment. "Nurse consumption" by colleagues is the single most destructive power tarnishing our opportunity for a star studded world. It must STOP!

Fun, laughter and a good sense of appropriate humour are essential parts of every star. Social events, which may be small and frequent, are of utmost importance. An environment that enhances team building and acknowledges friendship, support, goodwill and excellence is required to foster stars. Leaders must be a part of the goodwill and show recognition frequently.

4. Learning Environment – A learning environment does not only refer to formal in-service sessions or conferences. A learning environment requires a commitment to education at all levels and by all players. Management must ensure that that the learning thread is woven throughout the organization including physician communication and expectations. There must be a learning culture based on value for both money and time spent. Assessment of results must include gains, benefits, process of sharing and outcomes. Learning opportunities must be seized by everyone and the resources must be used wisely for both the benefit of individuals and for the greater good. Formal analysis relative to the value of learning sessions should be undertaken, with commitment to improvement.

Stars will share learning through innovative means – i.e. mini in-services; structured three to five minute reports at shift change; e-mail messaging; journal clubs; communication bulletins attached to pay cheques – as well as formal teaching sessions. Professional stars need to invest consistently in their own education. Professional stars take responsibility for their own competence through learning.

5. Supportive Leadership – Supportive leaders are a key element in the development of current and future perioperative stars. The stars expect a leader who is credible and has a frequent and attentive presence. There is no room for superficial "absentee landlords". The leader must be respectful, fair and equitable – remember, this is not necessarily equal. Open communication and active listening are of significant importance. Integrity is paramount. No one ever forgets a lie. Leaders need to remember that staff want to know what is happening. Stars need to know the broader context of their environment and understand the potential impact of what they are doing. Leaders should not filter information – stars will filter out any information they do not require.

Leadership occurs in the theatre, within the team, with the charge nurse, the educator, the managers and the executives. The leadership exhibited by each of you has major impact on the brightness of the star studded environment.

CONCLUSION

There are ten key professional attributes and influential characteristics of star performers. They are:

- Excellent Communication Skills
- Positive Leadership Skills
- High Integrity
- Professional Practice and Professionalism
- Positive Personality Traits
- Clinical Practice – Expertise to Expert
- Embracing and Influencing Change
- Participation and Contribution to Learning
- Sense of Humor
- Commitment to the Team!

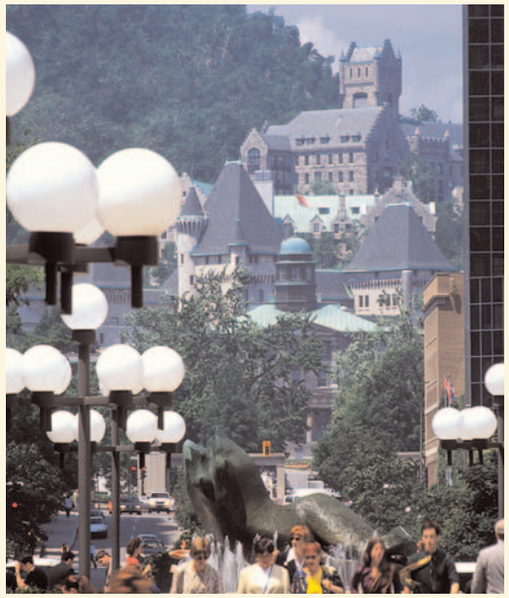
Star perioperative nurses shine with knowledge, expertise, enthusiasm, initiative, expert skills, positive attitudes, leadership, eagerness and laughter. Star-studded perioperative nurses are patient care experts, preceptors, role models, mentors, friends and team players. Stars come in the form of staff nurses, charge nurses, managers and directors. Make sure you are one of these stars How bright is your environment? Make it blindingly star studded – **it is up to you! Make it so!**

Acknowledgment: *Muriel Shewchuk presented this topic at the October 2004 Alberta Provincial ORNAA Conference in Medicine Hat, in honour of the Pat Ferguson Memorial Lecture.*

19TH NATIONAL ORNAC CONFERENCE

Please mark May 1st to 6th, 2005 on your calendar for the 19th National *ORNAC* Conference to be held in Montreal. The event will include numerous educational sessions, the opportunity to see and discuss the latest products from our medical industry exhibitors; great opportunities for networking with fellow colleagues from across the country; exciting social events, excellent tours of Montreal and endless shopping possibilities.

Montreal is a culturally rich and complex city of just over one million people. Today it is officially bilingual and proud of its status as the largest French-speaking city in North America and second-largest French-speaking city in the world. In fact, it is a wonderful example of a truly international city where newcomers feel right at home and visitors will always find someone who speaks their language.



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McGill University, Royal Victoria Hospital and Mount Royal

PROGRAM

With over 20 hours of educational programming the conference offers many opportunities to fulfill accredited continuing education requirements.

- *Val Shirreff Memorial Lecture* - **Keynote Speaker** Roger Fournier is the General Director of Hôpital Brome – Missisquoi Hospital. His presentation titled *Team Work: From the Inside Out* will introduce some of the ways to survive as a team in the health care arena.
- 7 1/2 hours of sessions by CORL selected speakers are available for those delegates interested in **leadership issues**.
- Current clinical topics such as *Robotic Assisted Surgery, Reuse of Single-use Medical Devices, Fetal Surgery, CYBERmedicine* and *Telemedicine* will be presented.
- There will also be lectures on *Organ Donation, Lung Transplantation, Transfusions & Autotransfusions*, and *Resistant Bacteria in the OR*.
- Perioperative Nurses from across the country will **showcase their research projects and case studies** with oral presentations. There will also be several **poster presentations** for the delegates to view.
- The closing sessions and ceremonies are promising to be inspirational and entertaining.

© *Canadian Tourism Commission, Pierre St-Jacques*

Montréal architectural style

MONTREAL MAY 1 - 6, 2005

SOCIAL ACTIVITIES

The social committee has been busy planning a week chock full of social activities. Some of the highlights include:

- A welcome cocktail hour kicks off the Conference on Sunday evening;
- Monday evening features dinner followed by "Disco Evolution";
- Tuesday night will feature dinner followed by Cuban entertainment;
- Wednesday's dinner will be capped off by a Country & Western evening; and on
- Thursday evening delegates will be free to explore the sights of Montreal.

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Caleche on de la Commune Street in Old Montréal

SPECIAL TOURS

Delegates can choose from a wide range of optional specially organized tours. Consider spending a half day on a private art gallery tour or a walking tour of Old Montreal. There's also an opportunity to shop and cook with a local well-known Chef, a guided tour of the Montreal Museum of Fine Arts, bird watching at the Boucherville Islands, or a cruise on the Bateau-Mouche.

For those delegates feeling a bit more adventurous, one-day and two-day tours are also available. How about a trip to Mont-Tremblant or Quebec City?

For more information, including costs and how to register, visit www.*ORNAC*.ca.

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Montréal skyline from the Old Port

ACCOMODATION

The Hyatt Regency Hotel is the host hotel and conference centre. Hotel information and registration forms can be found in the conference registration package as well as at www.*ORNAC*.ca. Please make your hotel reservations directly with the hotel and book early to receive special conference rates.

MONTREAL

For more information about Montreal visit www.tourisme-montreal.org.

REGISTRATION

Registration/information packages were mailed out to *ORNAC* members in November 2004. If you still require registration information visit www.*ORNAC*.ca.

The $425.00 registration fee (for *ORNAC* members) includes entry to all conference and social events.

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Palais des Congrès de Montréal (Convention Centre)

also incorporates a new Case Cart system. New MIS techniques, particularly endoscopic and laparoscopic procedures, benefit greatly from the new boom systems because it allows the equipment to be separated from the display monitors. This provides a clearer image to everybody who is part of the surgery or procedure, not just those located near the equipment. Data can now be recorded in real time and made available to remote locations or central monitoring desks in the OR itself. The potential now exists to have that information sent digitally to off-site teaching facilities for use in classroom settings.

Further efficiencies are being gained through overall layout and design changes. The UAH plan included moving cardiac surgery to the new Alberta Heart Institute and developing a paediatric surgical suite with six operating rooms. It has created efficiencies by making use of shared surgical support facilities. Changes were also made to the pre-operative and post-operative layout to allow for sharing of those two areas in accordance with patient demand. This change, coupled with the extension of digital technology into the rooms, has created a more efficient working environment.

Courtesy Cobos Evamy

Double articulated boom systems in Digital OR Suite, University of Alberta Hospital.

Deb Maerz, Director of Projects and Planning for the UAH, has worked closely with all stakeholders to ensure user groups are consulted and their input was included in the overall redevelopment project. She was able to comment about the digitalization of the hospital ORs and reported significant efficiencies. Her experience, based on feedback from surgeons and nurses, was that there is no longer a need to have so many electrical cords running around the inside of the ORs or the need to retrieve physical data from records departments in other areas of the hospital.

"So much of our data is available digitally now. We used to have the old x-ray view box (in the OR), but now x-rays can be sent through digitally to the monitors, as well as a Cardiac Cath or a CT scan or an MRI. You can call it all up digitally so the surgeon can see it on the screen at the same time they're actually doing the surgery," says Maerz.

MECHANICAL AND ELECTRICAL ENGINEERING CONSIDERATIONS

Since many facilities that are undergoing renovations have not been upgraded for quite some time – the UAH facility, for example, was built in 1982 and has received only minor upgrades since 1982 – planners and stakeholders must address a wide range of issues involving other services that will be affected by the upgrades. They include medical gas systems, ventilation systems, specialty exhaust systems, and domestic water systems. It may also include mechanical systems serving other areas of the facility not specific to the ORs. The increased use of cauterization devices is one such application where proper smoke ventilation, through specialty exhaust systems, is required due to the toxic gases that are produced.

The existing air supply system currently utilized in the ORs may not be effective due to changing ventilation needs caused by the new IT equipment in the digital OR. Newer digital technology produces more heat and therefore requires better ventilation. Other systems must be explored in order to ensure that ventilation rates, temperature control and pressure control capabilities are not compromised.

On the electrical side, older systems need to be upgraded to allow for current equipment and future equipment additions. In the world of the digital OR, sophisticated electronic switching systems are needed to handle the Web-based information systems, proprietary image signals from scopes and diagnostic imaging, and other signals that may arise as newer technologies are added. At the UAH, two industry-standard 19-inch stainless steel cabinet racks were implemented to house the electronic switching systems within each OR. Every unit needs to be accessible from the front and back to facilitate power and data distribution. They are linked directly to the air exhaust system and allow for cooling and negative pressure relative to the OR.

When all is said and done, the new digital OR must accomplish several things in order to be effective, efficient, and operationally sound. The layout and design must meet the medical staff's clinical needs, be compatible with building systems, and adhere to facility management standards and procedures. In the not-too-distant future, robotics and voice recognition technologies will likely become commonplace as the technology is perfected and updated. As with most work environments in the 21st century, digital technology is the norm and should be considered during all planning stages.

Courtesy Cobos Evamy

Double articulated boom systems in Digital OR Suite, University of Alberta Hospital.

ISSUES TO CONSIDER WHEN PLANNING FOR THE NEW DIGITAL OR

1. Determine the types of procedures supported (general surgery, plastics, neurological, orthopaedics, ENT, etc). The apparatus, monitoring devices, and complexity of the surgeries will begin to form the foundation of the layout and the placement of devices.

2. Locate the operating table and determine its movement during the surgery. In some procedures, such as urology, the table moves very little during the surgery. In other procedures, such as plastics, ENT, and neurosurgery, the table can be rotated 90° or 180° to provide easier access to the surgical site.

3. Locate the anaesthetic gas services and determine the type of column required: fixed, retractable or an articulated service arm. Anaesthetic gas columns are typically placed near the head of the patient on the right side. Articulated service arms are appropriate where procedures require the table to be moved during the procedure. Fixed columns can be used where little or no table movement is anticipated.

4. Establish the number of OR lights that are required. The number will depend on the type of procedures accommodated in the room and, to a lesser extent, the surgeons' use of headlights. A single hub, doubled-headed light is adequate for most procedures. Plastics, orthopaedics and Cardiac Surgery typically require two sets of lights.

Digital OR (cont.)

5. Determine how the patient enters and exits the room. This will affect the design, since equipment must be able to accommodate a range of circumstances.

6. Catalogue the equipment used in each type of surgical procedure. Is the equipment dedicated to a particular OR, or will it be necessary to move it between a number of ORs? It may be appropriate to place dedicated, frequently used equipment on an equipment boom. Equipment stacked vertically on a boom reduces overall space required, reduces OR set-up and cleaning time, and reduces the clutter that can compromise the sterile field. An articulated service column, providing services to tethered equipment carts, may, however, be more appropriate for equipment which needs to be moved between a number of operating rooms.

7. Locate cameras and microphones for telecommunications to other sites. In the past, cameras have been mounted in surgical lights. However, there is a growing consensus that independent boom-mounted cameras provide the best visualization of the surgical site.

8. Establish the number of flat screen monitors required. This is dependant on the type of procedure performed and the number of surgeons and residents present during the procedure. Typically, two or three flat screen monitors are required to display information, but the following may also need to be viewed on monitors:

   a. Video images from scopes

   b. Digital diagnostic images

   c. Medical records information

   d. Patient physiological signs

9. Determine the types and quantity of cabinets required. These can include warming cabinets, supply cabinets and table parts cabinets. Digitally equipped ORs also require equipment cabinets to accommodate electronic equipment such as routers, amplifiers, recording and playback equipment, video processors and the like. For maximum flexibility, these can also be accessible from both front and back, and be mechanically cooled to offset equipment heat loads.

10. Select the best location for the documentation centre. This is a small computer workstation from which communications, information retrieval, and charting can occur. The documentation station should be located away from the sterile field. It should have a clear view of the OR table in order to facilitate charting. The documentation station might also need to be located in close proximity to the equipment cabinets as it is often necessary for the circulating nurse or other staff member to access the documentation equipment during a procedure.

11. Consider ceiling heights in relation to the height of articulated service arms (also known as equipment booms). The number of electrical hubs available, plus the space constraints of the ceiling height, will affect how many OR lights and equipment booms can be provided and where they should be located.

12. Co-ordinate the ceiling plan. This includes mechanical services, lighting equipment mounts, and how the electrical/ communications services are linked to the building infrastructure.

13. Accommodate the needs of other elements in the room. This includes x-ray view boxes (which will be phased out entirely over the next five to ten years) and clocks or other devices.

14. Consider if the OR will need to accommodate infectious cases? If yes, new CSA standards require that the OR be equipped with a positively pressurized vestibule at all entrances.

SARS

LE SYNDROME RESPIRATOIRE AIGU SÉVÈRE ET SES EFFETS SUR LES SOINS DE SANTÉ

Comment le Canada a fait face à cette crise

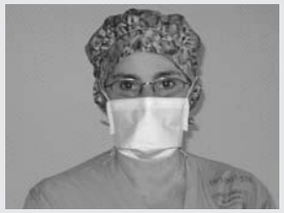
Auteures: *Margaret Farley, infirmière autorisée, CPN(C), est une éducatrice au développement clinique des soins en salle d'opération, Regina Qu'Appelle Health Region, Regina, Saskatchewan.*

Linda M. Socha, infirmière autorisée, baccalauréat en sciences infirmières, infirmière immatriculé première assistante, CPN(C), CEBT, est la coordonnatrice des dons de tissus au Saskatchewan Transplant Program à Saskatoon.

Résumé

- L'épidémie mondiale du syndrome respiratoire aigu sévère (SRAS) a eu un effet indirect sur tous les établissements sanitaires des pays touchés tout en mettant les pays non touchés en état d'alerte.
- Les professionnels de la santé ont le devoir d'être au courant des mesures de prévention des infections afin de prévenir la propagation du SRAS.
- Cet article examine cette nouvelle maladie et la façon dont elle a influencé la prestation des soins médicaux au Canada.

Les salles d'opération du monde entier adoptent quotidiennement les nouvelles technologies et les nouvelles techniques chirurgicales. Le personnel infirmier, cependant, peut souvent oublier l'impacte que la découverte d'une nouvelle maladie peut avoir sur l'exercice de sa profession. Il est important de minimiser les risques d'une telle découverte autant pour le personnel infirmier que pour les patients, les membres de leurs familles et amis, pour ne pas oublier la population mondiale en général.



Courtesy L. Socha

Mask being worn correctly

SEVERE ACUTE RESPIRATORY SYNDROME AND ITS EFFECTS ON HEALTH CARE

How Canada Has Dealt With This Ordeal

Authors: *Margaret Farley, RN, CPN(C), is Perioperative Clinical Development Educator, Regina Qu'Appelle Health Region, Regina, Saskatchewan.*

Linda M. Socha RN, BSN, RNFA, CPN(C), RNFA, CEBT, is the Tissue Donor Coordinator for the Saskatchewan Transplant Program in Saskatoon.

In Brief

- The global epidemic of severe acute respiratory syndrome (SARS) indirectly has affected all health care facilities in affected nations and has unaffected nations on alert.
- Health care practitioners need to be aware of infection control measures to prevent the spread of SARS.
- This article looks at this new disease and how it has affected the delivery of health care in Canada.

Surgical suites worldwide embrace progress in technology and new surgical techniques daily. Nurses, however, often forget about the impact that discovery of a new disease could have on nursing practice. It is important to minimize the risks of such a discovery for health care providers as well as patients, family members, friends, and the world population in general.

BIRTH OF A NEW DISEASE

November 2002 is the estimated birth date of severe acute respiratory syndrome (SARS), although global knowledge of the disease was not achieved until February 2003.[1,2] It is believed to have originated in the Guangdong Province of China.[3] A Chinese nephrologist carried the disease to Hong Kong where 12 hotel guests contracted the virus in February 2003. Most affected hotel guests occupied the same floor as the physician. The disease then spread to Singapore, Toronto, and Hanoi, Vietnam – the race was on.[4]

The initial diagnosis was made on the Chinese nephrologist in Hong Kong in March 2003, and the world has witnessed the impact ever since.[3] A physician in Hanoi informed the World Health Organization (WHO) in February 2003 that a "novel" severe pneumonia had been detected. This information prompted WHO to issue a global alert, and health care professionals worldwide began to consider the concept of a new respiratory disease. Infectious disease experts worldwide began the journey to identify, name, analyze, control, and isolate the virus and to find a solution to the outbreak. Approximately 30 countries in Asia, North America, and Europe have been affected directly.[5] Outside the hot spots such as Toronto and Hong Kong, SARS has resulted in global awareness and planning for an outbreak to begin hastily.

Severe acute respiratory syndrome is a new infectious disease that can cause a potentially lethal respiratory illness. It is spread by close person-to-person contact.[1,6,7] The signs and symptoms of SARS include, but are not limited to, fever greater than 100° F (38°C), rigor, headache, general malaise, cough, myalgia, difficulty breathing, and dyspnea.[1,3,5,7] Fever often is followed by rapidly progressive respiratory compromise. Usually symptoms occur two to seven days after infection but have been found to occur as long as 10 days after infection. The severity of this disease is varied and unpredictable, from mild to fatal. In some patients, the illness is severe enough to require intubation and mechanical ventilation. Treatment also has varied; regimens have consisted of antibiotics, steroids, and treatment of symptoms.[4,7]

Severe acute respiratory syndrome has been classified as a coronavirus.[1,4,8] There are three known groups of coronavirus associated with various diseases in humans and animals,8 including gastroenteritis and upper and lower respiratory tract diseases. It has been suggested that SARS is a fourth type of coronavirus. In immune-competent individuals, the coronavirus primarily causes only mild to moderate signs and symptoms. The most common disease associated with the coronavirus is the common cold. Noteworthy is that in animals, the coronavirus may cause moderate to severe illness. This leads researchers to believe the same can be held true for humans; SARS confirms the theory. Today presents a different scene for respiratory ailments; there is a new, infectious, potentially lethal virus.

THE IMPACT OF SARS IN CANADA

Late June 2003 marked a SARS milestone – 100 days of known cases. Health care professionals have learned a great deal in a short time. The WHO sponsored an international SARS conference around the time of the milestone. The conference was held in Malaysia, and approximately 1,400 delegates reviewed and studied the new disease. Severe acute respiratory syndrome has left a definite impression – more than 800 deaths and numerous secondary consequences. In Canada alone, tourism dropped in many affected locations, resulting in spin-off consequences such as people employed in tourism being laid off; segregation of portions of the population, such as health care workers; and high health care costs.

Infection control. Countless infection control departments throughout Canada, along with professionals in occupational health and safety departments, worked numerous hours preparing for the possibly imminent arrival of the first case of SARS at their facilities. These departments ensure that adequate plans, guidelines, and procedures are in place in the event that there is a possible/probable SARS case. Infection control measures are paramount. In developing these measures, many things were considered (*Table 1*). These considerations are not presented in order of importance, and further precautions may be used. Infection control departments provide guidelines and education sessions about using and following precautions. If family members and visitors are allowed to visit patients with SARS, it is imperative that staff members take time to teach them the proper procedure for donning and removing personal protective wear (PPW), as well as proper hand washing. Visitors and staff members entering a patient room must sign a contact list. Free access to the remainder of the building by visitors should be curtailed or denied. After patients are discharged, precautions must continue with terminal cleaning. The recommendation is to clean twice and allow the room to stand empty for a minimum of one hour with the door closed and labeled to allow proper air ventilation. Supplies remaining in the room must be removed and destroyed. Curtains or blinds must be taken down carefully to prevent aerosolization and then cleaned. Full PPW must be worn by cleaning staff members, which is time consuming, costly, and absolutely necessary. Containing the epidemic is not an easy chore.

Infection control guidelines from such agencies as the Centers for Disease Control and Prevention (CDC), Health Canada, and WHO are to be followed. Another source of information is the National Institute of Allergy and Infectious Diseases, which provides information, surveillance, epidemiology, and research. These organizations provide updates on outbreaks, as well as guidance and information. They also issue travel alerts regarding affected areas. In-depth discussions of their suggestions are beyond the scope of this article. Most health care workers should be familiar with these types of recommendations because of prior experience with vancomycin-resistant enterococci, methicillin-resistant Staphylococcus aureus, and influenza on a regular basis. In fact, it has been suggested that the SARS outbreak is a very strenuous test of readiness for a pandemic.

Surgery and SARS. Surgical suites have not escaped SARS. Normally, patients with infectious diseases are postponed from surgery, if possible; however, there may be an urgent need to provide surgical services to patients with SARS. Keep the number of staff members in the theatre to a minimum – have additional staff members in another theatre to help gather necessary equipment and supplies. Place signage on entrances to the theatre noting precautions to be taken. Take measures to prevent spread of the infection. Airborne and droplet precautions should be adhered to throughout surgical suites and postanesthesia care units. Patients should wear a mask during transport from the ward to the surgical suite, if possible. Staff members assisting in patient transfer should wear full PPW during transfer and remove PPW and wash their hands when leaving the surgical suite.

Careful consideration should be given to the induction and extubation phases in which surgical team members have close contact with and exposure to a patient's respiratory system. Full face shields as well as full PPW should be worn. Full face shields are very important, especially if the planned surgery includes bronchoscopy. Oral suction should be handled gently to prevent aerosols from spreading when placing equipment. Touching equipment with gloves used for intubation/extubation should be minimized, or gloves should be changed. The anesthesia cart should be placed outside the theatre but close enough for quick access – this helps prevent contamination.

Specimens obtained from patients should be handled carefully, and biosafety precautions in handling, testing, and transporting should be followed. Place specimens gently in a container, wipe the container with a facility-approved cleaning agent, mark the container as infectious, and place it in a bag for transport to the laboratory. Make gentle, precise movements when removing and placing items such as laryngoscope blades or bronchoscopes on the table to prevent splatter and to decrease aerosolization of particles.

Careful handling and decontamination of the surgical suite, equipment, instrumentation, laundry, and garbage is important. Place linens in hampers instead of tossing them to prevent aerosolization of particles. Due to the close proximity of blood and body fluids, all personnel should wear PPW, including gowns, gloves, masks, and protective eye shields, throughout the surgical intervention, cleaning, and recovery period. This includes theatre-cleaning staff members, service aides, porters, circulating staff members, and recovery room staff members. After completing a procedure on a patient with SARS, the supplies left in the theatre should be disposed. Be sure to communicate the patient's potential for infection with SARS throughout the surgical experience – notify personnel in the postanesthesia care unit.

Rapid means of travel has made many things possible. The world shrinks with technology but becomes a vast pool of possibilities when faced with an outbreak such as SARS. Canadian transplantation programs had to implement

additional donor screening measures to reduce theoretical risks of SARS transmission through transplantation. Donors who were exposed to SARS-affected areas, who have come in contact with people who have SARS, or who have a history of SARS are being deferre. Visiting procurement teams are required to complete a screening tool to determine their SARS exposure and, therefore, their ability to travel to other facilities. Increased screening of possible donors, recipients, and visiting teams has increased the cost to and workload of facilities. One major challenge is balancing the benefits of transplantation to a recipient with the public health risk of potential secondary SARS transmission from the recipient to hospital staff members and other close contacts.

The effects of SARS. The arrival of SARS has affected nursing practice. Health care facilities throughout Canada have plans and guidelines in place to care for their first patient with SARS. Perhaps the most noticeable change is the highly visible presence of posters strategically placed in facilities in Regina and Saskatoon. They depict someone wearing a mask with the caption: "Respect the health of others. If you have a cough, wear a mask. Ask a nurse for a mask." Until recently in the Toronto region, anyone going into a hospital was met by screeners who squirted hand-cleaning solution on their hands and asked them to fill out a questionnaire about SARS. People are checking and changing travel plans based on outbreak areas. The emergence of a new virulent respiratory illness warrants further research. Will it behave as the cold and flu? Perhaps. Hopefully, health care will be better prepared for the next wave. The WHO believes the global outbreak had been contained as of July 2003.[9] Along with this announcement, the organization asked global authorities and experts to be aware and continue surveillance, because the world has not yet been declared disease free.

THE FUTURE OF SARS

There is much to learn from and about SARS. There is no cure, no vaccine, no specific treatment, and no idea whether it will recur seasonally. Certainly more is known now than in February 2003. The SARS outbreak is several months old, yet no one can predict the outcome, scope, or potential magnitude of this virus. These issues alone present major global challenges. Historical evidence shows that face-to-face contact is the usual mode of transmission, and although viral respiratory infections are well-known, there are no foolproof cures. Hopefully, a collegial effort and the sharing of clinical results and global communication regarding infectious outbreaks will keep science ahead of this new respiratory foe. A Canadian commission investigating the spread of SARS held public hearings at the end of September 2003 to seek information from the public and health care workers who were affected directly by the SARS outbreak. The independent Commission to Investigate the Introduction and Spread of SARS hopes to use this information to strengthen the system in preparation of potential future epidemics.

On Aug 6, 2003, Canada's Health Care Ministries released directives stating that hospitals finally can relax how they screen outpatients, staff members, and visitors for SARS at entrances to facilities.[10] Screening still will be in place for all patients admitted to ERs and for all direct admissions, but each facility is to determine its own visiting policies.

Unknown quantities of time and resources have been spent rapidly preparing for the possibility of other Canadian facilities receiving a patient with SARS. The costs for Ontario and the Toronto region have been immense, and the costs to the Canadian health care system have been immeasurable. Awareness of the disease and the possibilities it may pose has everyone taking note. Diseases are not new, but the fear of the unknown is one of the most frightening aspects of health care. Practitioners deal with illness daily, but SARS once again has reminded them of the fragile hold science has over disease.

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TABLE 1: Considerations for Developing Infection Control Measures for Severe Acute Respiratory Syndrome (SARS)

Determine whether one facility in the region should be chosen as the designated site for SARS cases.

Determine what infection control measures should be employed –airborne and contact precautions are to be used.

Isolate patients suspected of having SARS as soon as possible.

Use negative pressure rooms and private patient rooms with separate bathrooms – keep doors closed.

Have all staff members who treat patients wear personal protective wear (PPW).

Have alcohol hand gel/rubs available near doors so health care workers may clean their hands after removal of PPW and before washing.

Use disposable equipment whenever possible.

Have patients wear masks when feasible.

Place as many patients with SARS or suspected of having SARS in the same unit or ward as possible.

Use dedicated equipment on patients with SARS when possible—leave only essential supplies and equipment in patient rooms.

Decrease patient movement/transport.

Restrict visitors to the facility, ward, and patient.

Allow only essential staff members in patient rooms.

Wear PPW to greet patients arriving in the emergency room who are suspected of having SARS.

Handle specimens carefully using appropriate biosafety precautions—label specimens as infectious.

Take care with treatments involving aerosolizing therapy.

Report possible SARS patients to appropriate authorities (ie, public health, infection control department, infectious disease specialists).

Use guidelines from appropriate regulatory bodies (eg, Centers for Disease Control and Prevention, World Health Organization, Health Canada).

Allow only symptom-free health care workers from endemic areas to return to work.

Monitor health care workers for at least 10 days after possible exposure.

Educate patients, staff members, families, and the public.

Continued on Page 45

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A Thank You Message

I bring you New Year greetings from Kenya. It is with great pleasure that I write this note to the Operating Room Nurses Association of Canada (*ORNAC*). I wish to express my gratitude and that of the Operating Room Nurses of Kenya for the support you extended to us last year (2004).

I had the pleasure of meeting Ms. Margaret Farley, the *ORNAC* President, during the 40th NATN Congress in Harrogate, UK, last October. It was a great encounter for me to meet the person through whom the Theatre Nurses Chapter of National Nurses Association of Kenya was able to join the International Federation of perioperative Nurses. We in Kenya cannot really find the right words to express our feelings.

I am delighted to inform *ORNAC* that our membership to IFPN has already started bearing fruit. In November 2004 the President of IFPN, Kate Woodhead, along with two colleagues from Friends of African Nursing (FOAN) visited our country and attended our 22nd Theatre Nurses Annual Conference in Mombasa City. Kate highlighted elaborate plans to set up a Library that will assist Theatre Nurses in Kenya with accessing knowledge through books and journals.

The office of the Chief Nursing Officer – Ministry of Health has undertaken to facilitate with the running of the Library for the benefit of all Kenyans.

The NNAK, Theatre Nurses Chapter, wishes to nurture this relationship further in the future by exploring more areas of co-operation. The *ORNAC* journal I am receiving has already proved a very useful material to our Theatres. We note with great interest your forthcoming 19th National *ORNAC* Conference in May; what a brilliant theme you have chosen (*Today's projects, Tomorrow's progress*)! I hope to be able to attend.

Long Live *ORNAC*
James Musela RN

Clinical Nurse Instructor – Operating Theatres
Aga Khan Hospital, Nairobi
Outgoing Chairman – Theatre Nurses Chapter
National Nurses Association of Kenya - NNAK

UPCOMING EVENTS

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Alberta	Red Deer	October 2005
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Nova Scotia	Antigonish	June 10 & 11, 2005
Newfoundland & Labrador	St. John's	September 22-24, 2005

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www.ornac.ca

19th National	Montreal, PQ	May 1-6, 2005

INTERNATIONAL CONFERENCES

NATN (www.natn.org)	Harrogate, UK	October 10-13, 2005
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WORLD	Barcelona, Spain	September 25-29, 2005

ANAESTHESIA CONFERENCES

CAS (www.cas.ca)	Vancouver, BC	June 17-21, 2005

SARS (cont.)

Reprinted with permission, SSM – Surgical Services Management ™ 9 (October 2003) pp 20-25.

UPDATE FROM THE AUTHORS:

Today we know more about SARS and its impact on our health care system than we did at the time of this article's original publication. Shortly after this article appeared, Health Canada released a document titled *Learning from SARS – Renewal of Public Health in Canada* (October 2003). This 234 page document, based on World Health Organization (WHO) guidelines for alerting and verifying public health management of SARS, is located on the Health Canada website (www.hc-sc.gc.ca), reports on two major elements: the short-term assessment of what was learned from current public health practices when dealing with outbreaks such as SARS and the necessary long-term actions needed to control and prevent such infectious diseases. This third party analysis of, and recommendations regarding, current public health practices as well as the lessons learned from the outbreak will influence future infectious disease control practices. The analysis sets out a plan for renewal of public health systems and an increase in Canada's capacity to detect, prevent, manage and understand infectious disease outbreaks.

We now see varying policies/guidelines for infectious disease control, reporting, and surveillance in place in health care facilities across the country. As a result of the 2002/2003 SARS outbreak health care facilities are paying increased attention to communicable diseases, infection control practices, surveillance practices and general preparedness. Federal, Provincial, and Municipal/County funds have been allocated to accommodate further training and infection control practices. In addition, Health Canada has created the position of Chief Public Health Officer (CPHO) to demonstrate its commitment to the protection and improvement of the health of Canadians.

The Canadian SARS story included both tragedy and heroism within healthcare. We quickly learned we were not as prepared as we should have been when it came to infection control/public health issues, but thousands of healthcare workers rose to the challenge. No doubt future threats to our public health will be unpredictable in their timing and location. But as a result of the time and commitment invested since 2003 Canada is better prepared for future situations.

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LA COMMUNICATION ENTRE INFIRMIÈRE ET MÉDECIN DANS L'ENVIRONNEMENT PÉRI-OPÉRATOIRE: TRANSFORMER LES SOINS DE SANTÉ PAR DISCOURS ET ACTIONS

Auteure: *Marlene Weeks, infirmière autorisée, baccalauréat en sciences infirmières, maîtrise en sciences infirmières, CPN(C), est infirmière de salle d'opération au Royal Jubilee Diagnostic and Treatment Centre à Victoria, C.-B.*

Dans un article récent par Weeks[1], le discours traitant de la communication entre infirmière et médecin en situation de soins actifs est présenté et analysé selon les principes de l'analyse critique du discours[2]. Ce premier article permet une compréhension des éléments informant le discours entre infirmière et médecin ainsi que le rôle de celui-ci dans la reproduction de la dominance des médecins sur les infirmières. Cette compréhension permet une exploration plus poussée du rôle du discours au sein de la contestation de cette dominance. Le but de cet article est de suggérer des actions qui visent la transformation de la prestation des soins de santé.

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NURSE PHYSICIAN COMMUNICATION IN THE PERIOPERATIVE ENVIRONMENT: DISCOURSE AND ACTIONS TO TRANSFORM HEALTH CARE

Author: *Marlene Weeks, RN, BScN, MHS, CPN(C), is a perioperative staff nurse at the Royal Jubilee Diagnostic and Treatment Centre in Victoria, BC.*

ABSTRACT

In a previous article by Weeks[1], discourse regarding nurse physician communication within acute care settings is presented and analyzed following the principles of critical discourse analysis (CDA)[2]. An understanding of what shapes nurse physician communication discourse and its role in the reproduction of the dominance of nurses by physicians is gained in this previous article. This understanding allows for further exploration of the role of discourse in the challenge of that dominance leading to suggested actions to transform health care delivery, which is the focus in this article.

Does inappropriate communication and perhaps verbal abuse still exist in the perioperative environment? If so, is this directed from physician to nurse, from nurse to physician, or both? Are certain patterns of communication accepted as the norm and allowed to occur without question? How do these patterns influence the health care team? The patients and patient care?

Chances are that every operating room has a story or two regarding communication issues. When you bring together a variety of individuals and professions in one area it is virtually impossible to have consistently flawless communication patterns. However, when certain patterns have the potential to negatively impact the work environment and patient care, action must be taken.

In order to take action, it is important to first understand the foundation of communication patterns and the surrounding discourse. In this article understanding is provided as aspects of nurse physician communication discourse presented in Weeks[1] are summarized. The extent to which this discourse is present in the perioperative environment and how it influences health care delivery in this setting is also explored. Thoughts on discourses of resistance presented in Weeks[1] are summarized, and, based on the discourses of resistance, actions to transform health care in the perioperative environment are suggested. Finally, conclusions are drawn regarding the importance of a critical perspective in shaping health care delivery.

NURSE PHYSICIAN COMMUNICATION DISCOURSE SUMMARIZED

Much discourse regarding nurse physician communication comes from the nursing community. It focuses on ineffective communication patterns and provides resources to help nurses to become more effective communicators.[3,4,5] It is claimed nurses continue to utilize the passive voice and deflective patterns when dealing with nurse physician communication issues.[6,7] When discourse regarding nurse physician communication arises from the medical community it focuses on legal aspects and expectations of physicians in regard to transfer of patient health data.[8,9]

The empirical/analytical perspective (experience and observation) dominates nurse physician communication discourse with a focus on the impact of effective communication as an aspect of collaboration that correlates with positive patient outcomes in acute care settings.[10,11,12,13] Other empirical research explores physician verbal abuse of nurses and the resulting negative effects on patient care and nurses job satisfaction.[14,15,16,17] While less prevalent, the interpretive paradigm is evident in literature and illustrates a focus on gaining understanding of the actual nurse physician relationship and communication patterns.[4,18,19,20]

Despite this interpretive focus that could lead towards a critical perspective (getting to the meat and potatoes of issues underlying established communication patterns), true unconstrained discourse is lacking while traditional links to empirical research and negative aspects of the nurse physician relationship dominate the discourse. For example, cultural factors influencing nurse physician communication related to gender role socialization such as role and goal conflict, and status and education difference are presented in the discourse.[3,19,21,22] However, rather than being challenged, cultural norms are seemingly accepted in that it is suggested nurses understand and enhance communication patterns by recognizing and accepting the influence of cultural factors.[4,18,19,20,23,24] It is in regard to cultural norms that power relations are depicted in the discourse. Historically nurses have exhibited behaviour common to oppressed groups seeking approval from their oppressors – for this purpose, physicians.[16,25,26,27] Many nurses continue to view themselves as subordinate to physicians [19] and the media often perpetuates the portrayal of nurses as intellectually inferior to physicians.[28] The medical community perceives any struggle by nurses for autonomy and revised communication patterns as a possible encroachment on physician territory.[19,29] This is a potential basis for the view that while enhanced communication is necessary, a power shift is not required in order to achieve this. [23] Thus the interests of some physicians are served by allowing them to maintain superiority and ultimate power.

PERIOPERATIVE NURSE PHYSICIAN COMMUNICATION DISCOURSE

Superiority and power are predominant themes in the perioperative environment. This is because multidisciplinary teams work in a stressful patient care environment where team roles are often neither clearly articulated nor agreed upon by team members and hierarchy predominates based on historical stereotypes of the nurse physician relationship.[7,14] The potential for interpersonal conflict and verbal abuse rises in such hierarchal environments where power overrides effective communication.[5]

Despite many informal anecdotal accounts among nurses regarding ineffective perioperative nurse physician communication, limited formal literature exists. When it is found, this literature is often related to verbal abuse of nurses by surgeons.[14,15] Only one study was found that looked specifically at understanding perioperative nurse surgeon communication patterns, and the authors of this study report finding no other studies addressing the topic from this focus.[7] This study reveals the acceptance of cultural norms by nurses as evidenced by utilization of discursive strategies (changing the subject) to meet nursing goals while minimizing nurse physician tension.
In predominant perioperative nursing education texts emphasis is generally placed on the importance of communication for patient safety

and teamwork.[30,31] While verbal abuse is deemed inappropriate, however, excuses for harsh criticism of nurses by surgeons are made with comments such as "Keep in mind that much that is said is not personally directed".[31] Perhaps such comments have evolved from coping measures used by perioperative nurses who cannot leave an abusive situation in the midst of surgery.

Commentary from surgeons indicates a different perspective than that of nurses regarding the impact of hierarchy on teamwork. Surgeons often support hierarchies and, when they are positioned at the top, usually perceive teamwork and communication to be more effective than nurses do in such an environment.[32,33]

DISCOURSE INFLUENCE ON PERIOPERATIVE CARE DELIVERY

It is impossible for the different perceptions of surgeons and nurses regarding communication and subsequent actions not to influence perioperative care delivery. If nurses and physicians disagree on the dynamics of inter-professional communication, potentially detrimental patterns will continue. Verbal abuse, notorious in the perioperative environment, results in staff shortages due to absenteeism and difficulty recruiting nurses, which affects surgical schedules, turnover time and the level of nursing expertise available to patients.[15]

Even more significant is the observation that links surgical error to interpersonal aspects of functioning in the perioperative environment.[7] Nurses certainly associate effective communication with higher quality patient care.[10,11,12,13,32,33] However, the assertion is also made that not enough formal evidence exists to prove this correlation.[34]

DISCOURSES OF RESISTANCE SUMMARIZED

From an empirical standpoint, the question is raised regarding the ability of studies to adequately support the link between positive nurse physician communication and improved patient outcome due to lack of scientific rigour.[35] Organizations that choose to function in a hierarchal manner could cling to this view in support of maintaining strict lines of command and control.

Support for such a structure by physicians interested in maintaining actual or perceived power results in resistance to collaboratively driven inter-professional communication patterns. Evidence of physician resistance already exists indirectly in the form of lack of physician input into the discourse regarding what can be done to enhance nurse physician communication. More directly it exists when physicians place emphasis on the importance of understanding physician directed communication.[8,9,23]

Nurses who are accustomed to and prefer working 'under' physicians' authority and are not comfortable with or not willing to develop new roles in collaborative working relationships, may also resist the discourse surrounding changed nurse physician communication patterns. The result may be a resistance to the challenge of the cultural norms underlying nurse physician communication.

Any confusion on behalf of patients regarding who is responsible for their care could lead to further resistance to the change of the hierarchal nature of the nurse physician relationship. Some patients who continue to view physicians as the ultimate "gatekeepers" to health care may be reluctant to risk losing favour with their physician for fear of not finding another.

ACTIONS TO TRANSFORM HEALTH CARE

Patients must not be placed in the middle of the polarities in the nurse physician communication debate. Rather, it is imperative that their needs be placed as the reason for nurses and physicians to engage in logical debate toward the ultimate goal of collaborative patient advocacy.

Perioperative patients are particularly vulnerable to the influence of communication on care delivery. The most common recommendation for improving patient safety in the perioperative environment is to improve communication.[32] A critical look at the cultural norms underlying nurse physician communication discourse and discourses of resistance allows for suggested actions to transform healthcare that are related to research, leadership and education, and clinical practice.

RESEARCH

The need for further research regarding perioperative nurse physician communication is evident since only one published formal study directly addressing the role of communication among nurses and surgeons in the perioperative environment could be located.[7] Research is needed to not only look at the superficial nature of the communication, but to also look more closely at cultural factors underlying the verbal exchanges. Great consideration must also be given to how communication patterns affect patient care delivery in addition to its impact on the relationship between physicians and nurses.

The lack of empirical research is provided as rationale for the opinion that not enough evidence exists to prove the correlation between effective nurse physician communication and positive patient outcomes.[34] However, this perspective needs to be challenged as it is with critical discourse analysis and the use of grounded theory by Epsin and Lingard.[7] There may be additional methods of research, as yet unexplored, available for investigating the relationship between effective nurse physician communication and positive patient outcomes. For example, by recognizing that perioperative nurses and surgeons are in the optimal position to be immersed in nurse physician communication we bring to the forefront the potential for collaboration on methods of naturalistic inquiry such as heuristic research.

LEADERSHIP AND EDUCATION

Nurses' use of discursive strategies, passive voice and deflective patterns when dealing with nurse physician communication issues is partially a result of gender related leadership. Many of the leaders within the nursing profession are women who have experienced gender role socialization that impacts nurse physician communication. While strategies are offered to assist nurses in dealing with communication issues – particularly verbal abuse – little leadership is provided in the way of encouraging nurses to challenge the cultural norms that lay the foundation for dated communication processes between nurses and physicians. Nursing leadership needs to question comments that recommend nurses enhance communication patterns by recognizing and accepting the influence of cultural factors, and – even more alarming – suggesting nurses should learn more about individual physician preference as a way of coping with verbal abuse.[14] Suggesting this method as a way of 'coping' with verbal abuse actually leads to avoidance and does not prompt nurses and physicians to address faulty communication patterns.

One area where leadership is making progress is in regard to formal education. Joint education for nurses and physicians is suggested as a foundation to collaborative practice.[19,36] A good starting point is for nursing and medical faculties to partner in collaborative curricula that includes communication courses illustrating the effects of positive communication on teamwork and patient outcomes. It is prudent for medical and nursing students to study aspects of inter-professional teamwork together rather than in isolation from each other. Eventually they will be practicing together.

CLINICAL PRACTICE

Informally, physicians and nurses in the clinical environment already collaborate to teach perioperative nursing students and residents about surgical procedures. However, the underlying cultural factors impacting nurse physician communication and subsequent patient care are normally not addressed. Rarely does either professional group consider or discuss what the environment must be like for the other. The exclusionary and inclusionary concepts of othering (methods of engaging with others) presented in Canales[37] have merit here. The exclusionary aspects of the power that physicians hold, within hierarchal systems, and the resulting domination and subordination of nurses, can be exposed and discussed. The impact of such exclusionary practices on communication patterns can then be evaluated in order to prompt

a shift toward more inclusionary practices that combine the potential collaborative power of nurses and physicians. This will in turn lead to the development of more effective teamwork and more positive surgical patient outcomes.

As understanding and respect for each other's skill and knowledge increases, both nurses and physicians need to consider and present the clinical benefits of collaborative partnerships to patients. This will allow patients to understand the different, yet equally important, roles both professionals have in care delivery, thus challenging historical stereotypes.

CONCLUSION

If nurses and physicians communicate effectively with each other, the ultimate benefits to patients of truly collaborative inter-professional practice can be fully realized. Gaining awareness of and reflecting on the discourse and discourses of resistance that shape the standing perspectives on nurse physician communication are the first steps of gaining a critical perspective on the issue. However, in order to transform health care one must go a step further and take action. Through collaboration in research, leadership and education, and clinical practice, nurses and physicians can challenge the historically stereotypical nature of their inter-professional communication. This action will allow them to move into a new era where mutual respect and understanding replaces traditional hierarchy and turf protecting. Adopting all processes of a critical perspective in regard to nurse physician communication – awareness, reflection, *and* action – will enable nurses and physicians to collaborate on the crucial transformation of health care delivery to where patient care is the primary focus.

For more information on this topic please contact the author at mbweeks@shaw.ca.

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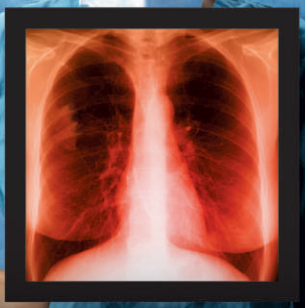
SURGICAL SMOKE



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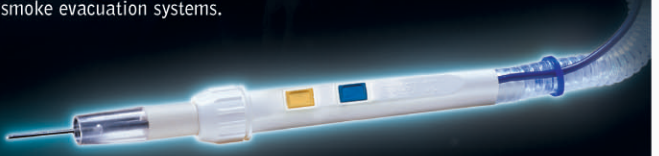

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23rd Atlantic Operating Room Nurses Conference

October 3 – 6, 2004 • Moncton, NB

PERIOPERATIVE NURSING – SOLID AS A ROCK

Author: NBORN President *Karen Frenette, RN, BN, CPN(c).*

New Brunswick Operating Room Nurses (NBORN) hosted the 23rd Atlantic OR Nurses Conference at the Delta Beauséjour in Moncton, New Brunswick. 178 delegates, from all four Atlantic Provinces, attended the 3-day conference entitled ***Perioperative Nursing – Solid as a Rock***.

ORNAC President, Marg Farley, was in attendance and brought greetings on behalf of *ORNAC*. The New Brunswick Nurses Association President, Beth Sparks, attended the opening ceremonies that were conducted by Mr. Paul LeBlanc, Master of Ceremonies, a former medical salesperson. Other dignitaries included the Honourable Joan McAlpine, representing the provincial government, and Kathryn Barnes, Deputy Mayor of Moncton.

Cathy Fenwick, keynote speaker, entertained the delegates with her energetic session entitled "Building Bridges: The Heart of Effective Communication". She helped those present understand the dynamics of interpersonal relationships, explore the vulnerability of emotions and, the importance of building trusting relationships. Cathy's presentation stressed that happiness is a vital component of being healthy.

OTHER TOPICS PRESENTED INCLUDED:

- Understanding prostate brachytherapy
- Career success

Courtesy K. Frenette

Delegates enjoying the banquet at the Memramcook Institute.

Courtesy K. Frenette

ORNAC President, Marg Farley, speaks with NBORN delegate, Corina Balcom.

- Acute Viral Hepatitis: Key problem pathogens for healthcare professionals
- Lung cancer: Past and present
- Dealing with CJD in the OR
- Evidence Based Practice
- Morbid obesity: Bariatric surgery
- Women and heart disease

The closing speaker, Brent Finnamore, kept the delegates entertained with his explosive, compelling, intense, and funny presentation entitled "Emotional Mastery" that motivated one and all.

The social events, both planned and unplanned, were enjoyed and well attended. A banquet at the Memramcook Institute, located in a small rural community approximately 20 minutes from Moncton, was truly delightful and offered a breathtaking setting. The chapel at the Institute has been transformed into a magnificent banquet facility and the food was outstanding. Perioperative nurses were able to network with old friends and new acquaintances.

38 exhibitors displayed the latest equipment and supplies. The exhibits permitted the delegates to explore what is available and return with new insight.

Julie Belliveau, Chair of the Planning Committee, and the numerous committee members must be commended on a job well done. Delegates returned to their homes rejuvenated and prepared to bring perioperative nursing to the next level!

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