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Volume 22, Issue 4
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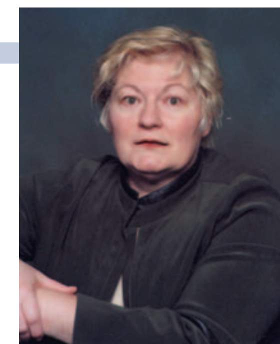
President's Message



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

As the season changes to winter, and this year is followed by a new year, I begin to reflect on the last year. *ORNAC* has had many changes in 2004 and our progress seems to be unstoppable.

One of the most noticeable changes is the revamped, updated website – www.ORNAC.ca. It is a marvel, thanks to the direction and dedication of Marcy McKay! To see what I mean you need only to visit the site – the changes are obvious and we welcome any and all comments. The *ORNAC* constitution has also undergone review and revision, as has our Board structure. Please stay tuned for more information regarding the *ORNAC* structure.

ORNAC activity on an international level has also changed. My last message dealt with an explanation of the relationship *ORNAC* has with the International Federation of Perioperative Nurses (IFPN), and the key benefits to *ORNAC* members that are the result of this liaison. The giving and sharing of this type of professional relationship results in increased knowledge, vision, friendship, and success. The combination of friendship with knowledge can be a powerful tool. In my opinion adding these two components to your professional arsenal makes one quite formidable in facing any task or challenge. When combined with the information outlined in the June 2004 CORNJ, regarding *ORNAC*'s continued relationship with IFPN, the following announcement takes on even more meaning.

The *ORNAC* Board voted, in June 2003, to allocate funds to support one nation in its goal of acquiring membership in the IFPN. Careful consideration was given to the idea. While helping our fellow team members occurs daily in theatres around the globe, we wanted to assist theatre staff as an organization as well and to support Cana-dians reputation as a caring and giving people. *ORNAC* has committed to the sponsorship of one nation – Kenya – over the course of the next three years.

We are pleased to welcome the theatre nurses chapter of the National Nurses Association of Kenya (NNAK) as the newest member of IFPN. *ORNAC* is proud to offer a fellow group of perioperative peers the opportunity to participate on an international level through this IFPN membership.

The Council of National Representatives (CNR) Kenyan delegate to IFPN is James Musela of Nairobi. Mr. Musela is a charge nurse in the Aga Khan Hospital and I recently had the pleasure of meeting him at the 40th National Association of Theatre Nurses (NATN) Congress in Harrogate, UK (see page 14)! He was attending his first NATN Congress and his inaugural IFPN Meeting. I was thrilled by the opportunity for this face-to-face meeting as colleagues and representatives of our respective perioperative nursing organizations. I look forward to having more to share with you about the Kenyan involvement in the future.

As 2004 draws to a close I wish each of you all the best in the coming year. Do not forget that 2005 brings *Today's Projects, Tomorrows Progress* the 19th National *ORNAC* Conference, May 1-6, 2005, in Montreal, QC. I look forward to working with you all in 2005 and to continuing the promotion and advancement of the excellence in perioperative patient care in Canada and around the world.

M Farley

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***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)

Le passage de l'automne à l'hiver et de cette année à la nouvelle me met à réfléchir sur celle qui s'achève. *L'AIISOC* a connu beaucoup de changement au cours de l'an 2004 et nous allons sans cesse de l'avant.

Un des changements les plus remarquables, c'est le site Web nouvellement réorganisé et mis à jour : www.ORNAC.ca. C'est une merveille, grâce à la direction et la volonté de Marcy McKay! Pour en faire témoin, vous n'avez qu'à visiter le site – la transformation est évidente et nous invitons vos commentaires. La constitution de *l'AIISOC* a également subi une révision, tout comme la structure du conseil d'administration. De plus amples renseignements sur la structure de *l'AIISOC* seront disponibles.

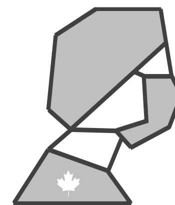
Les activités de *l'AIISOC* au niveau international se sont également développées. Mon dernier message a expliqué la relation entre *l'AIISOC* et l'*International Federation of Perioperative Nurses (IFPN)*, ainsi que les avantages de cette liaison pour les membres de *l'AIISOC*. L'échange d'idées qui se produit au sein de ce type de relation professionnelle a pour résultat l'épanouissement de la vision, des connaissances, des amitiés et des succès. La combinaison d'amitiés et de connaissances est un outil puissant. Il est de mon opinion que l'ajout de ces deux éléments à son coffre à outils professionnel assure davantage son succès face aux tâches et aux défis qui se présentent. Lorsque ce fait est combiné à l'information sur la relation entre *l'AIISOC* et de l'*IFPN*, détaillée dans le volume de juin 2004 du *CORNJ* (Journal des infirmières et infirmiers de salle d'opération du Canada), l'annonce suivante prend de l'ampleur.

Le conseil administratif de *l'AIISOC* a voté en juin 2003 d'allouer des fonds à un pays afin de l'aider à réussir son objectif de devenir membre de l'*IFPN*. L'idée a été soigneusement examinée. Quoique les membres d'équipes chirurgicales à travers le monde s'entraident quotidiennement, nous avons aussi voulu fournir de l'aide au personnel en salle d'opération au niveau organisationnel, tout en appuyant la réputation des Canadiens en tant que peuple sympathique et généreux. *L'AIISOC* s'est engagée à parrainer un pays – le Kenya – lors des trois prochaines années.

Il nous fait plaisir de souhaiter la bienvenue au chapitre des infirmières et infirmiers de salle d'opération de la *National Nurses Association of Kenya* (*NNAK*), le plus récent membre de l'*IFPN*. *L'AIISOC* est fière de pouvoir offrir à ce groupe de co-travailleurs en soins péri-opératoires l'occasion de participer à l'échelle internationalle grâce à son statut de membre de l'*IFPN*.

Le délégué kényan du *Council of National Representatives* (*CNR*) (conseil des représentants nationaux), James Musela, du Nairobi, est infirmier-chef au Aga Khan Hospital. J'ai récemment eu le plaisir de le rencontrer au 40e congrès de la *National Association of Theatre Nurses* (*NATN*) à Harrogate, Royaume-Uni! Il assistait à son premier congrès de la *NATN* et sa première réunion de l'*IFPN*. J'étais extrêmement contente de cette occasion de nous connaître en personne dans nos rôles de collègues et de représentants d'organisations d'infirmières et d'infirmiers de salle d'opération. J'attends avec plaisir l'occasion de partager plus de détails sur nos activités au Kenya.

En cette fin d'année 2004, je vous offre, tous et chacun, mes meilleurs vœux pour la nouvelle année. N'oubliez pas que l'an 2005 annonce le 19e congrès national de *l'AIISOC*, *Projets d'aujourd' hui, progrès de demain*, du 1 au 6 mai 2005 à Montréal, QC. Il me fera plaisir de travailler avec vous en 2005 et de continuer notre devoir de promouvoir l'excellence en soins péri-opératoires de nos patients au Canada et à travers le monde.



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Surgical Counts Can Be Risky Business!

COMPTE DES INSTRUMENTS CHIRURGICAUX, AFFAIRE RISQUÉE!

Auteure: *Joan Porteous, infirmière autorisée, baccalauréat en sciences infirmières, CPN(C), éducatrice clinique, salle d'opération, Health Services Centre, Winnipeg, Manitoba*

Le compte des instruments chirurgicaux joue un rôle vital dans l'habileté des infirmières à fournir aux patients un environnement sécuritaire. Les erreurs ne sont pas inévitables. Quoique les niveaux de diligence nationaux fournissent d'excellentes lignes directrices pour le développement d'un protocole de compte efficace, les procédures sont souvent modifiées selon les politiques individuelles des soins de santé. Cet article traitera des facteurs de risque reliés aux corps étrangers retenus, la fréquence, quels objets sont laissés dans les patients, le rôle des radiographies et les conséquences des corps étrangers retenus dans un patient. Les points à considérer lors de l'implantation de nouvelles procédures de compte seront également soulevés.

SURGICAL COUNTS CAN BE RISKY BUSINESS!

Author: *Joan Porteous, RN, BN,CPN(C), Clinical Educator, OR, Health Sciences Centre, Winnipeg, MB.*

ABSTRACT

The surgical count plays a vital role in enabling perioperative nurses to provide a safe environment to surgical patients. Counting errors are preventable. Although national standards of care provide excellent guidelines for developing effective count protocols, counting procedures are often modified according to individual health care policy. This article will discuss the risk factors for retained items, rate of occurrence, what objects are being left in patients, role of x-rays and consequences of leaving an object in a patient. It will also highlight points to be considered when implementing new count policies.

Introduction:

In November, 2002, AORN President, Donna Watson, stated that health care in the US is not as safe as it should be, and can be.[1] Ms. Watson referred to a 1999 Institute of Medicine report that stated that at least 44,000 to 98,000 patients die in hospitals each year as a result of preventable medical errors. Canadian statistics on medical errors are elusive. Retained surgical tools, such as instruments and sponges, have resulted in a large number of preventable major injuries and death.[2] Reports indicate that surgery tools are left in 1,500 people a year in the United States.[3,4] Several articles state that this number is likely underestimated.[4,5,6]

Risk Factors for Retained Items:

Gawande et al performed a case-control study of retained surgical items in order to identify risk factors for this type of medical error.[4] Malpractice and incident reports involving 54 patients, with a total of 61 retained items, were investigated. In 69% of the cases the retained items were sponges and in 31% of the cases they were instruments including clamps, retractors and electrodes. Surgery, to remove the retained items, was required for 37% of patients and one patient died during this surgery. The investigators found that items were retained more frequently in emergent surgical cases, in situations where there was an unexpected change in surgical procedure and in patients with a higher body-mass index.

Kaiser et al reports that sponge counts which were thought to be correct, but were actually incorrect have been attributed to team fatigue, difficult operations, sponges "sticking together", or a poor counting system.[7]

Butler et al studied factors that contribute to errors in counting.[8] They report that the most common error is one of documentation, that errors occur more commonly in cardiovascular and general surgery and that they often involve needles. Findings indicated that inexperienced staff, lengthy cases, the involvement of more than one scrub nurse, and two procedures being conducted simultaneously may also increase the likelihood of count errors.

Rate of Occurrence:

Lauwers and Van Hee report a prevalence ranging from 1/100 to 1/5000 cases.[9] Gawande et al report that items are left in surgical patients in at least one out of every 1,000 to 1,500 intra-abdominal procedures. This corresponds to 1 or more cases each year for a typical large hospital.[4] Because this incidence was calculated only on the basis of malpractice claims, the authors report that the above rate of occurrence is likely grossly underestimated.

What is Being Left Where?

Gawande et al's study found foreign bodies in the abdomen or pelvis (54%), vagina (29%), thorax (7.4%) and elsewhere including spinal canal, face, brain and extremities (17%). These investigators found no retained items in cases involving laparoscopic or endoscopic procedures.[6] They also reported that when objects were lost and a count was performed, the count was thought to be correct in 88% of the cases.

Kaiser et al reported that retained sponges were found more frequently in abdominal surgery (55%) and vaginal deliveries (16%). In cases with retained sponges, the sponge counts had been falsely correct in 76% of abdominal procedures.[7]

The Role of Radiographs to Detect Lost Items:

Studies have been undertaken to determine the effectiveness of identifying lost items by radiographs (x-rays). Kaiser et al state that in 3 of 29 cases in which intraoperative x-rays were used to detect radiopaque sponges, the radiograph was falsely negative.[7] False negative x-rays were reported as a factor contributing to incorrect diagnosis. Poor quality films, multiple radiographic opacities and the radiologist's lack of awareness of the surgical team's concerns were also factors involved.

Radiographic techniques such as scrutinizing the periphery of the image for partially imaged sponges, soft copy image manipulation and digital manipulation have proved to be effective in identifying sponges on radiographs.[10]

The literature contains few publications on the value of taking an x-ray to detect lost needles. Barrow published a paper in which the researcher was able to identify needles on sutures as small as 8-0 on anterior-posterior and lateral films.[11] Only the thread size was used to describe the needles. An acrylic torso with the approximate density and resistance of an average human body was utilized for the study.

Macilquham, et al published a study which identified the minimum needle size that can be visualized using a variety of common radiographic techniques.[12] An acrylic radiological teaching torso (phantom) was also used. Routine radiological chest exposures displayed all 12 needles. Needle size ranged from 65 mm to 6 mm (#1 to 8-0).

The researchers went further to attempt to view these needles using three most common radiographic techniques including departmental x-ray equipment, a portable x-ray machine and an image intensifier.

Resultant images were viewed by 10 individuals, including radiologists, surgeons, radiographers and perioperative nurses. All viewers correctly identified every needle larger than 19 mm (4-0) on at least one of the films presented. The smallest size needle identified by the observers was the 13mm needle (6-0). The smallest size needle identified by the majority of observers was 17mm (5-0).

The majority of the viewers (6 of 10) indicated that needle identification was easiest on the image intensifier, followed by the departmental equipment (3 of 10). Only one observer described the portable technique as the optimum radiographic technique.

Consequences of a Retained Object:

To the courts, a retained item is an open-and-shut case of negligence.[13] Under Canadian law both surgeons and nurses have been found negligent in cases involving retained items.[14]

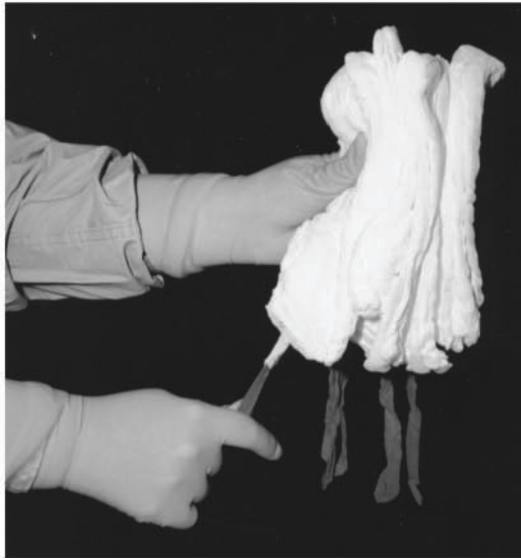


Photo by J. Porteous

Counting laparotomy sponges

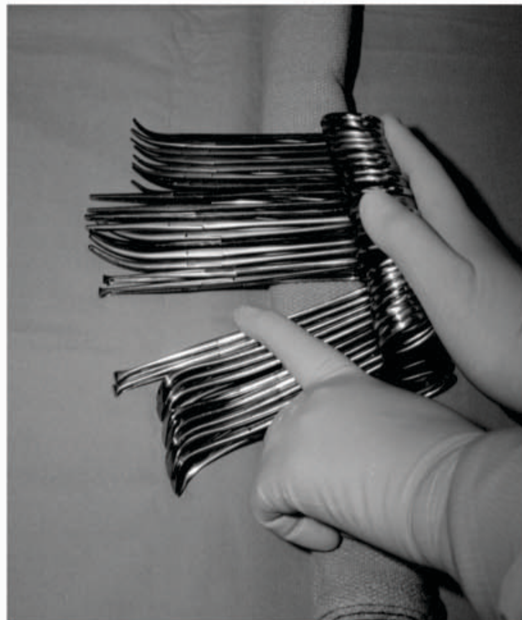
The consequences to patients can be much greater. Mortality rates resulting from retained items have been found to be as high as 11 to 35%.[9] In addition to the need for another surgical procedure (in order to remove the object) retained items have reportedly caused bowel perforations, organ damage, sepsis, and acute pain.

Developing Count Policies:

Clear, concise count policies and procedures are essential to ensure perioperative nurses count when appropriate, count in an effective manner, document appropriately, and take appropriate action in the event of an incorrect count outcome. Not only do these directives need to exist, but perioperative nurses also need to be familiar with the directives and practice them consistently. These care standards protect the patient, the surgical team, as well as the health care facility. Count policies and procedures that reflect established standards of care will lower patients' risk from harm associated with retained objects. They also lower the risk for malpractice lawsuits.

The Operating Room Nurses Association of Canada (ORNAC) provides excellent recommendations which should be included in count policies and procedures.[15] Each health care facility develops their own policies according to their unique resources. Some important elements to consider in the establishment of surgical count practices that reflect the ORNAC standards are:

1. The scrub shall be involved in **all aspects** of the count. Two circulators shall not count together without the scrub, or two scrubs without the circulator. This includes counting items off the field.
2. Count out loud and **together**. Each should hear the other's voice to confirm sightings. If you do not hear the other person, stop, and count that item again.
3. Let the **scrub nurse take the lead for the initial count**. Count systematically across the instrument table. There may be items on the table, which are not listed on the count sheet. The circulator should not call out instruments from the count sheet during the initial count.
4. Do not forget to count retractors. Large retractors are being left inside patients.[16,17]
5. **Do not disperse instruments** to another area of the surgical field (e.g. Mayo tray) **until the initial count is complete**. The risk of forgetting to count an item is increased when one type of instrument is in two locations.
6. The **circulating nurse shall take the lead for closing counts**, since during surgery items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Counting instruments

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Surgical Counts (cont.)

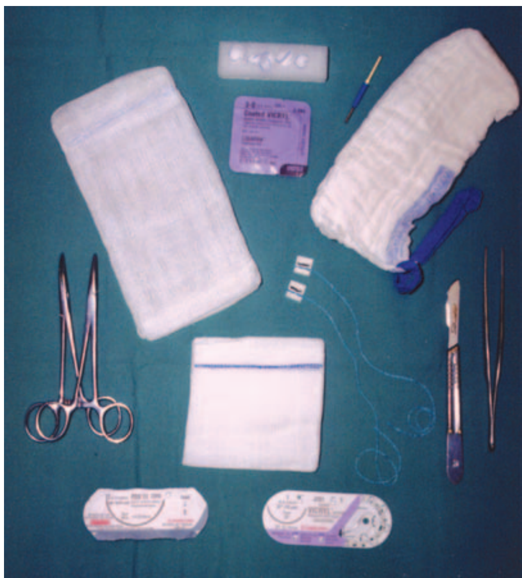

Photo by J. Porteous

An assortment of sponges, instruments, needles, and ligature reels that may require counting.

are distributed over the sterile field. The circulator calls out items from the “list” on the count sheet. There is less chance of forgetting to count an item.

7. Only **document what you have counted.** Never document for someone else. The risk of having an item documented twice, or not at all, is increased when people document for each other.
8. **Document** items that are added to the sterile field **immediately.** It is easy to become distracted, and forget to do so.
9. **Separate sponges completely** when counting. Each individual must be absolutely certain about the number of sponges in each package.
10. Both **too many and too few items are considered an incorrect count.**
11. If a count is incorrect **let the surgeon know immediately** and then start the search. The surgeon may not yet have completed the closure.
12. When staff are being permanently relieved during a case, the incoming scrub, **and/or** circulating nurse, shall complete a full count before assuming legal responsibility for that count. This should be accomplished before the departure of the outgoing nurse(s).

Conclusion:

The words of a 59-year-old man who suffered life-threatening complications involving a surgical clamp being left inside him *twice* (during 2 separate surgical procedures) gives us some insight into his experience: “It was a terrible ordeal that I wouldn’t want anybody else to go through”.[18]

Another man, who retained a foot-long malleable retractor, stated, “There were days when I would just roll up on the floor in the bathroom and sob, because I was in so much pain”.[17] We need to make every effort to protect our patients from the dangerous consequences of retained objects.

Photo by J. Porteous

Counting radiopaque gauze sponges

SURGICAL SMOKE

RISK Surgical smoke can carry dangerous bacteria and viruses, including HIV. It can produce upper respiratory irritation and may have mutagenic potential.

FACT An estimated 23,000 operating room professionals are exposed to electrosurgical smoke each year in Canada, including surgeons, nurses, anesthesiologists, and surgical technologists. Sadly, many existing operation room smoke evacuation systems are underutilized due to bulky handpieces that nobody likes to use.

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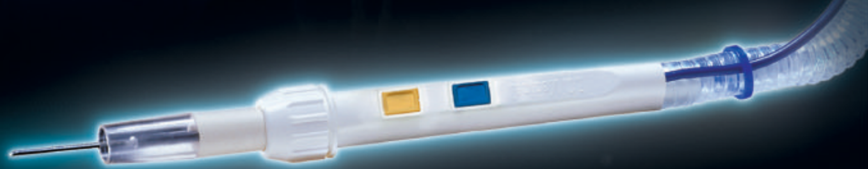

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Surgical Counts (cont.)

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Assortment of surgical sponges

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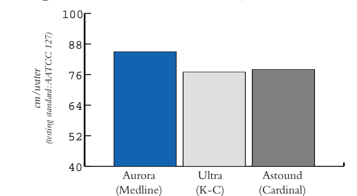
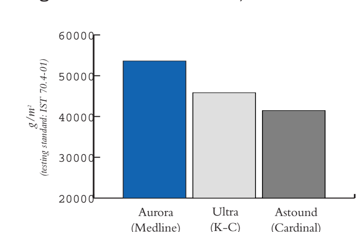
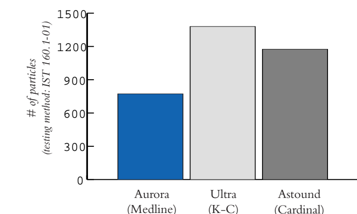
Hydrostatic Head
(A common method of testing protection. Higher numbers are better)



Moisture Vapor Transmission Rate
(A common method of testing breathablity. Higher numbers are better)



Linting
(Lower numbers are better)



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Duncan

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Report From NATN Congress

NATN celebrated it's 40th anniversary (Ruby) at it's annual Congress in October 2004. ORNAC was well represented by its President, Margaret Farley, and President Elect, Marcy McKay.

Promotion of the 2005 ORNAC National Conference was one of the key goals of our representatives. The Conference Planning committee provided lots of promotional material and by the end there were plenty of *"Montreal"* pins visible on international lapels. We look forward to possible poster submissions, presentation submissions and international delegates as a result of these efforts.

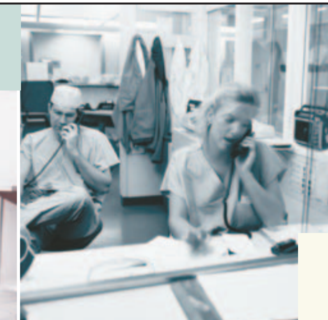
NATN is not only a very successful association but it is also a business. Several business/information gathering discussions were held with NATN staff and members during Congress. ORNAC and NATN share many of the same issues and therefore we welcome the same outlooks and therefore we welcome the opportunity to strengthen our relationship while learning from each other.

The other key focus at NATN was ORNAC representation to IFPN. The annual Council of National Representatives (CNR) meeting of IFPN was held during the Congress. ORNAC is represented by a voting delegate (Margaret Farley) and also by the Treasurer of IFPN (our Past-President Mary Knight). There were many networking and learning opportunities among the CNR group.

ORNAC will be sponsoring Kenya's membership in IFPN for the next three years. The Kenyan representative, James Musela, of National Nurses Association of Kenya (NNAK), met with ORNAC to discuss a relationship that we hope will continue grow over the years.

Photo by M. Knight

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



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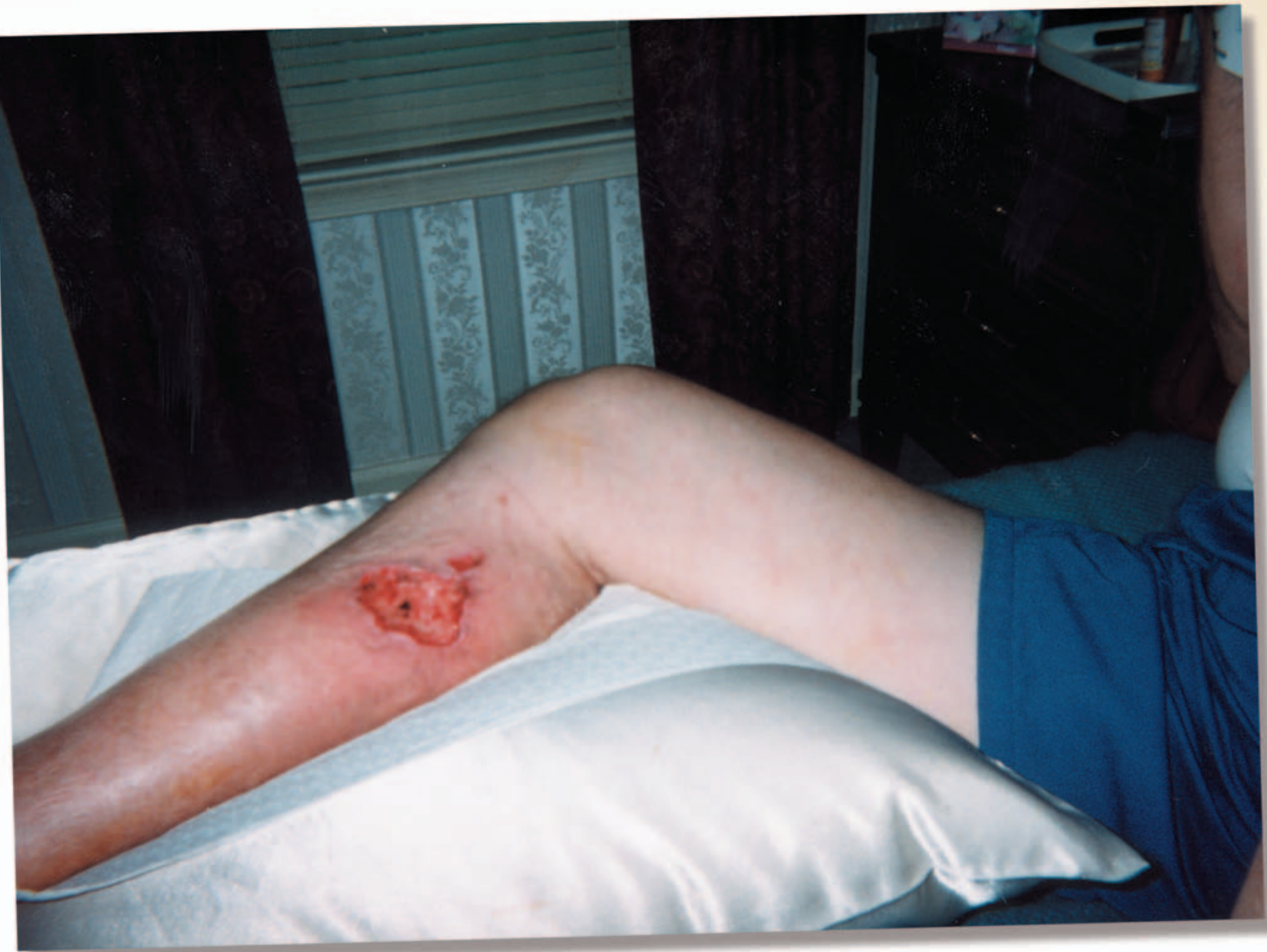

This patient was admitted to the hospital for surgery. While in surgery, the patient had a forced-air warming hose placed between his legs for more than four hours without it being attached to an inflatable warming blanket. As a result, the patient received third degree burns that required months of medical attention and two additional surgical procedures that resulted in scarring on both legs.

Every day patients are unintentionally and unnecessarily put at risk by a practice called "hosing" – using forced-air warming systems without their inflatable blankets. Forced-air warming, a safe and proven technology, improves patient outcomes dramatically. Hosing, however, has led to numerous reports of 1st, 2nd and 3rd degree burns, and injuries requiring plastic surgery and amputation. Ironically, practitioners of hosing may think they are saving money by not using an inflatable blanket. In actuality, inflatable blankets (most costing less than $10) are an integral part of these safe, reliable, time-tested systems.

Every instance of such hosing, regardless of the system used, invites potentially harmful consequences. For an educational packet on the prevention of hosing or a copy of an ECRI hazard report on the misuse of forced-air warming, please call 1-800-733-7775 or find materials at www.stophosing.com.

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ORNAC ANNOUNCES. . .

The 2005 CARDINAL HEALTH RESEARCH GRANT VALUE: up to $5,000

WHO Available to researchers who meet the criteria as outlined in the Cardinal Health Research Grant Guidelines for Applicants (see HOW).

WHAT An annual grant of up to $5,000 sponsored by Cardinal Health and administered by the ORNAC Research Committee.

WHY To promote perioperative nursing research activities and to encourage the integration of research findings into perioperative nursing practice, in order to improve perioperative patient care.

WHEN Application deadline is March 15, 2005. Grant recipients will be selected at the May 2005 ORNAC Board meeting.

HOW Guidelines for Applicants and Application Forms are available from Karen Frenette, Chair of ORNAC Research Committee, at *kfrenette@reg6.health.nb.ca* or through the ORNAC Website: *www.ornac.ca*

L'AIISOC ANNONCE. . .

LA BOURSE DE RECHERCHE CARDINAL HEALTH 2005 VALEUR: jusqu'à 5000 $

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QUOI Bourse annuelle pouvant atteindre 5000 $, parrainée par Cardinal Health et administrée par le comité de recherche de l'AIISOC.

POURQUOI Promouvoir des activités de recherche et intégrer leurs résultats dans nos pratiques de soins périopératoires dans le but d'améliorer ou de valider ces soins auprès des patients.

QUAND La date limite pour soumettre votre demande est le 15 mars 2005. La sélection des gagnant(es) de la bourse se fera lors de la réunion du conseil d'administration de l'AIISOC de mai 2005.

COMMENT Le guide d'admission et les formulaires d'application sont disponibles auprès de la présidente du comité de recherche, Karen Frenette, par *kfrenette@reg6.health.nb.ca*, ou par le biais du site web de l'AIISOC : *www.ornac.ca*

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We look forward to serving you in 2005.

Happy New Year!

Auteure : Muriel Shewchuk
muriel.shewchuk@shaw.ca

PERLES DE SAGESSE AU SUJET DES HABILET S DE LEADERSHIP

SE REGARDER DANS LE MIROIR ET POSER LA QUESTION : ˙ COMMENT JE ME TROUVE MAINTENANT? ¨

Leadership

Le leadership peut se définir comme l'art et l'habileté d'influencer les personnes dans leur performance, implication et capacité d'inciter le changement. Un titre et un poste autoritaires ne livrent pas nécessairement l'habileté de leadership. Il serait plus exact de dire que c'est le leader qui valorise le poste, et non le poste qui valorise le leader. Pour être leader il faut des suiveurs – sans eux, au pire, vous marchez seul; au mieux, vous ne faites que « gérer ».

Author: *Muriel Shewchuk*
muriel.shewchuk@shaw.ca

PEARLS OF WISDOM FOR LEADERSHIP SKILLS

LOOKING IN THE MIRROR AND ASKING HOW DO I LIKE ME NOW?

Leadership

Leadership can be defined as the art and skill of influencing how individuals perform, get involved, or create change. Leadership does not necessarily come hand in hand with title and position. It can be said that it is the leader who makes the position, not the position that makes the leader. To be a leader you must have followers – if you have none then you are, at worst, walking alone or at best just "managing".

Leadership is about influencing — not about doing all the work! Leaders need to find a balance between leading, delegating, communicating, creating, innovating and networking.

As you travel down the road of leadership, some questions you can ask yourself include, "Am I leading in the right direction, for the right purpose, and at the right rate?" and, "Do the people I am leading have the right background, the right energy, and the right commitment?" Ask, "Where do I want to get to as a leader? What is my success rate – am I achieving what was intended and what I wanted to do? What are my primary personal, work and career goals? Have I mapped out both short and long term goals? What are the "must do's and must have's", like to's and the dreams?" Don't forget to also ask yourself "What do I want to be when I grow up and what road will get me there on my terms?" as well as the very important reality check of "How do I like me now?"

Taking the time to analyse, and to reflect on, ones personal leadership status and choices is often forgotten due to the daily demands, conflict and energy drain of our daily career tasks. Some leadership *Pearls of Wisdom* are offered below to help enhance your ability and skills, and to provoke thought and to increase your success as a leader.

TEN PEARLS OF WISDOM

1. Leadership is Evolutionary and Progressive

The generalized statement that "leaders are born" is not entirely true. Personality, childhood experience, opportunity, self-esteem, and parental role models are strong influences that play a role in the development of leadership skills. Education, type of friends, exposure to successful leader role models, and growth opportunities during the youth and early adult years also have a tremendous impact on the development of leadership traits and skills.

Leaders in new positions often struggle with fear of anticipation because they face many new or unexpected decisions and challenges. Each challenge, especially first time occurrences, offer learning opportunities if the leader consciously analyses the events, reflects on the outcomes, and uses the opportunity to build new knowledge and skills. Even the ugliest challenges can teach you a lot. Keep a notebook of what you learned and what you would do next time – this will help make sure you take the time to reflect on your experience. Constant doing, without adequate thinking, is not leadership. Take a few focused minutes several times each day to reflect – if you give your mind some quiet time the ideas will flutter in.

2. Surround Yourself with Good People!

Hire good people and delegate away tasks that should not require your direct involvement. Be sure to delegate in a manner that is not seen as "dumping". Encourage the unhappy, poor performers. and "sad sacks with little energy" to find a place where they like to be and then help them shine. There is a right place, and role, for everyone. Unfortunately many people get stuck in a rut that they cannot see a way out from the place they are to the place they truly belong.

Every successful leader needs the inner support of advisors to help balance their work and share the load. This internal team should be a committed, energetic, innovative, and creative group that helps make the right decisions and follows through on implementation. The more they participate, the greater their ownership – at times you may feel like you are actually following because they have taken on such a major role. You must be able to trust your advisers! Remember, if you have to lead alone you are a dictator, not a leader. You will have to make tough decisions, when they're needed, but you won't have to make all the decisions.

Jupiter Images

Surround yourself with good people!

3. Eliminate the Fluff, Fog, Uncertainty and Anticipatory Fear

Lack of clarity, emotional stress, and cluttered thinking prevent us from following a clear direction. You must take the time to think, and make a realistic plan. Without a well-defined plan, massive amounts of tasks, duties and "stuff" will consume your schedule, overwhelm you, and lead to frustration and exhaustion. Be very clear about what you want where you need to go, and how you are going to get there.

4. Organization and Time Management Dealing with Time Wasters

If you don't control your time then everyone else will. A key in leadership is to share your time between thinking, creating, innovating, networking and communicating. There are many courses and books written that offer excellent tips on this subject. Watch for the time wasters and eliminate them – by doing so you really can find more hours in a day.

5. Keep Current and Maintain Knowledge

You must be current and credible in the eyes of your followers. If you get behind the times then the followers will naturally begin to take over. In this age of mega media and constantly changing information it is hard to know where to start updating your knowledge. Take a few minutes every day to read short sections on leadership or motivation . Learn to scan the dozens of leadership books (read the index for a quick scan) to look for "hot tips". Take notes in the margins of the books and articles. Find the Internet sources that tweak your interest (look for human resource sections) and bookmark them so you can easily read them several times a week or more. Once you start you can

CORL CORRAL (cont.)

increase your knowledge base tremendously… and increase your confidence. A journal club can increase your exposure to more varied information and schools of thought.

6. Control the Meetings Bloody Meetings

Meetings can be all consuming and disrupt the necessary balance of your role. (For more detail see *Meetings Bloody Meetings*, by Muriel Shewchuk, Canadian Operating Room Nursing Journal, Volume 21, Issue 1).

7. Seek New Opportunities and Facilitate Networking

Seize new opportunities as part of self-development. Be out there! Identify who has influence in the decision-making world and be a part of the political arena. Many times it is whom you know, not what you know, that affects influence. That may sound unfair, but that's life. It is important to learn from your role models but also important to keep your followers in close proximity – if your leave them behind you will be walking alone.

8. Timing is Everything

Weigh the pros and cons of when to act. Many important projects have been scuttled due to poor timing. Monitor your environment for its readiness. Have well thought out plans and prepare your followers with progressive information. When the time is right ensure everyone is ready.

Jupiter Images

Timing is everything

9. Care for Your Team

Be there for everyone on your team, in good times and tough times. Stand by your followers. Show compassion, caring, respect and always be honest! It's the little things that count. Recognition, small notes of acknowledgment, and providing opportunities for people to shine are just a few of the key ways to maintain team loyalty. Sensitivity, professionalism, and humility balanced with friendliness and wisdom, create a strong leader.

10. Keep Humour in the Workplace

Humour helps us keep our sanity and offers a release so we can move on to the next challenge with renewed vigour. Be sure to use the right humour at the right time. Humour provides energy and helps release the stress in difficult situations. Be sure to laugh both at yourself and with your followers. Don't take yourself too seriously!

CONCLUSION

Maintaining the correct balance between leading, creating, innovating, communicating, networking, and being there for your followers needs to be the primary goal of any leader. There are many pressures and demands to take you off track – often without you even realizing it – so keep focused on controlling your balance and staying off the "tread mill of doing".

Have the confidence to say, "I have it my way! Because I am the kind of leader I want to be I can make it happen my way!" Be able to look in the mirror and say, "Damn, I'm a Good Leader." But don't forget to put your arrogance away. ❧

SHOW ME THE $$$!

***Auteure :** Grace Groetzsch, infirmière autorisée, baccalauréat en sciences infirmières, maîtrise en éducation, CPN(C), CRFNA, est une infirmière immatriculé première assistante au service de chirurgie cardiaque au Trillium Health Centre à Mississauga, Ontario, et infirmière-monitrice des assistants chirurgicaux au British Columbia Institute of Technology.*

MONTREZ-MOI L'ARGENT!

Facteurs à considérer lors du financement d'un poste d'infirmière immatriculée première assistante (IIPA)

De plus en plus, les hôpitaux voient dans le poste d'infirmière immatriculée première assistante une manière d'assurer la disponibilité d'une assistance rapide et qualifiée lors d'une intervention chirurgicale. Au Canada, le nombre d'IIPA augmente à chaque année. L'intérêt que suscite le poste accroît avec chaque individu qui se familiarise, soit par expérience directe, soit par les documents publiés, avec les avantages de ce rôle. Ce fait, de pair avec la réalité de la pénurie de médecins, mettent en relief l'importance du rôle de l'IIPA dans plusieurs hôpitaux à travers le pays. Le financement du poste est un des plus grands défis auquels les hôpitaux, ainsi que les IIPA, font face lors de la transformation d'un besoin reconnu dans un poste d'IIPA salarié.

SHOW ME THE $$$!

Factors to Consider When Looking to Finance a RNFA Position

***Author:** Grace Groetzsch RN, BScN, MEd, CPN(C), CRNFA, is a RNFA in the Cardiac Surgery department at Trillium Health Centre in Mississauga, Ontario, and a RNFA tutor for the British Columbia Institute of Technology.*

ABSTRACT

Increasingly hospitals are looking to the Registered Nurse First Assistant (RNFA) position as a means to ensure readily available, qualified assistance for a patient's surgical intervention. Each year, in Canada, the number of RNFAs grows. As more individuals learn about the benefits of the position, through either direct experience or published reports, interest in the role increases. This, coupled with the reality of physician shortages, is bringing the RNFA role to the forefront in numerous hospitals across the country. Funding the position is one of the largest challenges that hospitals, and RNFAs, face in converting a recognized need into the reality of a paid RNFA position.

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Why have hospitals with RNFA positions been successful? The reasons vary – not an answer that those struggling with the realities of implementing this position like to hear. Unfortunately it is not like a package of instant chicken soup – add hot water, stir, and voila! There are, however, common threads that should be considered by anyone investigating the RNFA position.

Firstly, the RNFA position is currently not a requirement in all hospitals. If surgical assistants (physicians or residents) are readily available the RNFA position has not been implemented. The RNFA has, however, had success in situations where physician/resident assistants are not available or where there is a shortage of available qualified assistants. The RNFA position is not intended as a replacement for all physician/resident assistants.

Secondly, hospital administration do not always appreciate that patient services and outcomes are being negatively impacted by a shortage of surgical assistants. It is not enough for operating

room personnel to understand that additional surgical assistants are needed. Given that hospitals are generally the ones that finance the RNFA position it is of paramount importance that they understand the issues involved. Education is key to successfully implementing the RNFA position.

Beware of assumptions. Individuals working within the perioperative environment often assume that other healthcare workers understand what happens within the confines of the operating room environment. In the author's experience those outside of the OR environment, including other nurses and physicians, often have very little understanding of what is involved in successfully completing a patient's surgical experience.

Thus the challenges begin. Many healthcare providers do not understand that it takes a team of individuals to successfully complete an operation. The surgeon, in most cases, does not perform a procedure single-handedly. The team includes numerous personnel from nursing, anaesthesiology, and, in some specialty areas, registered respiratory therapy and perfusion. For the vast majority of operative procedures, the team includes a minimum of one surgical assistant. If a surgical assistant is unavailable procedures may be delayed or cancelled. Without a skilled surgical assistant, procedures can also take longer. It is well documented that a shorter operative procedure results in better patient outcomes.[1,2] It is therefore imperative that everyone understands the significant role that a surgical assistant plays in a patient's perioperative experience.

In Canada most surgical programs and hospitals do not pay directly for their surgical assistants — traditionally surgical assistants are physicians (often family doctors) who bill the provincial healthcare plan for their assisting services. Some provincial health departments, like British Columbia's, calculate precisely how much public money is paid out for surgical assistants.[3] Most provinces, however, do not track this information.

Surgical residents also assist as part of their medical training, generally in teaching hospitals. Neither category of assistant, family physician or resident, is a hospital employee. Hospitals, therefore, do not have funds designated for surgical assistants. Being asked to fund a RNFA position is therefore something new – and something that there is no budget for.

It is relatively easy to do a side-by-side cost comparison between a full-time physician assistant and a RNFA. In unionized Ontario hospitals the bargaining unit for registered nurses (Ontario Nurses Association) has acknowledged the job classification of *RNFA and RN/RNFA* and a corresponding pay grid exists. For physician assistants access to the provincial fee schedule outlines remuneration for this position. A cost-effective analysis[4] demonstrates that RNFAs provide cost effective care based on monetary reward alone. Additional benefits that a RNFA brings to the environment have been described in a previous article (See CORNJ – June 2003 *'Why A RN First Assistant? A Look at the Benefits….'*). But for a hospital that has never had to budget for surgical assistants the $60,000 to $75,000, plus benefits, annual cost for each RNFA is significant. Ensuring that hospital administrators and finance personnel understand the importance of the assistant position, and the impact it has on delivery of care, is paramount to justifying this budget increase.

Thirdly, assumptions are often made about the quality of assistants available. Many individuals assume that the physician or resident assistant has the ability to complete surgery if something untoward should happen to the surgeon. In some rare instances a surgical assistant could complete the surgery. In most cases, however, this would not be true. The surgical assistant plays a complementary role to the surgeon – not an identical one. If something should happen to the surgeon intraoperatively then another surgeon would be called in.

Unbeknownst to most family physicians do not receive any special training to act as surgical assistants. Physicians may, or may not, have some experience depending on the electives they chose in medical school. Representatives of the Ontario Medical Association (OMA) and the Ontario College of Family Physicians acknowledge that

Continued on Page 38

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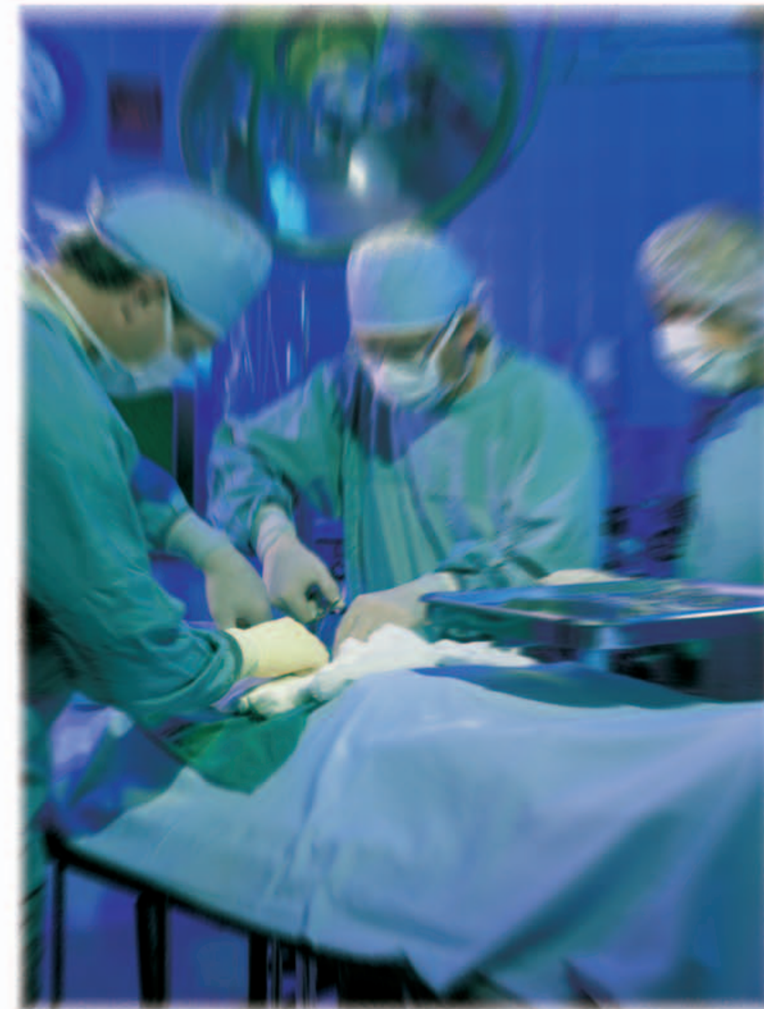

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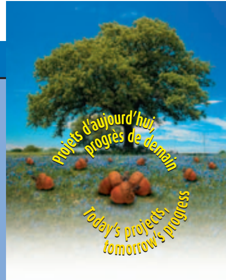

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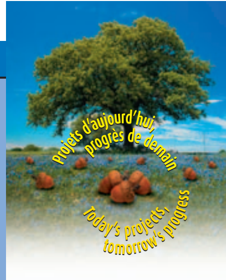

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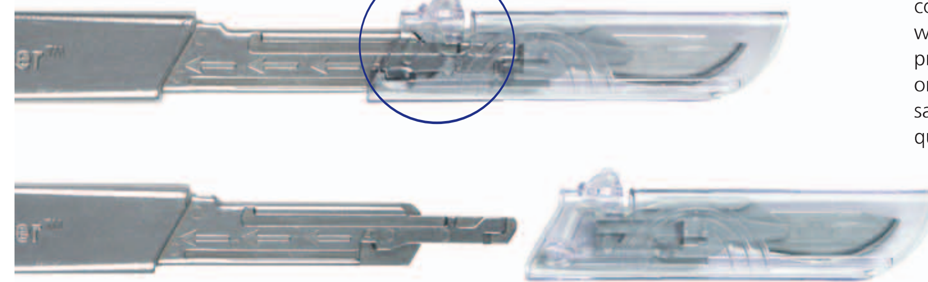

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We Enjoyed the View in Waskesiu!

Submitted by Linda Socha, SORNG President.

The Saskatchewan Operating Room Nurses Group had the pleasure of hosting its biennial conference in June 2004 in Waskesiu, SK - the beautiful north woods of Prince Albert National Park. The event was well attended by both S.O.R.N.G. members and industry representatives as well as a couple of special guests from Manitoba. A golf tournament and a welcome social kicked off the weekend in style.

Courtesy SORNG

Delegates take part in a bit of casino action

Conference highlights included guest speaker Richard Elson, a lawyer from Saskatoon, who presented "Legalities in the OR" employing some of the delegates to hold a mock court session. Dr. Arsiradam, an anaesthetist, covered the basics in patient monitoring in his presentation "What Are We Measuring?"

We were also fortunate to have Francis Loos, Clinical Development Educator of Post Anaesthesia Care Unit (PACU) and Day Surgery from Regina, SK, present "Care of the Morbidly Obese Patient (Bariatric Care)". Not only was it a relevant topic but it was also fantastic to have one of our own nurse colleagues presenting at our conference!

Courtesy SORNG

Left to right: Donna Sanders, Sandra Newhouse, Susan Macknak and Linda McCann the reigning queens of tacky tropical costumes.....

Courtesy SORNG

Meg Soper - keynote speaker

Keynote speaker Meg Soper, an OR nurse from Ontario and renowned comedian, presented "Humor is One Size Fits All'. She had everyone howling with laughter and effectively demonstrated how laughter can be good medicine for OR nurses working in the trenches.

The social highlight of the Conference was also the talk of Waskesiu. Our Tacky Tropical Casino Night truly was tacky!! There was a pig roast followed by indoor surfing and volleyball and an evening of blackjack. The Regina nurses reigned superior in the area of tackiest costumes! A special thank you goes out to BCORNG for sending us the six-foot tall palm trees!

Courtesy SORNG

Left to right: Marla Ewen, Linda Socha, and David Mantyka (ACMI representative) enjoying "Tacky Tropical Casino Night"

How about We were successful in living up to the theme, *Nurturing Knowledge & Nature* – we nurtured knowledge despite the typical Saskatchewan weather that attempted to dampen the festivities. In the end, we all learned new things, we chatted with old friends, and we partied like only prairie nurses can! We may be a small group, but our commitment to continuing education and improving perioperative practice is considerable.

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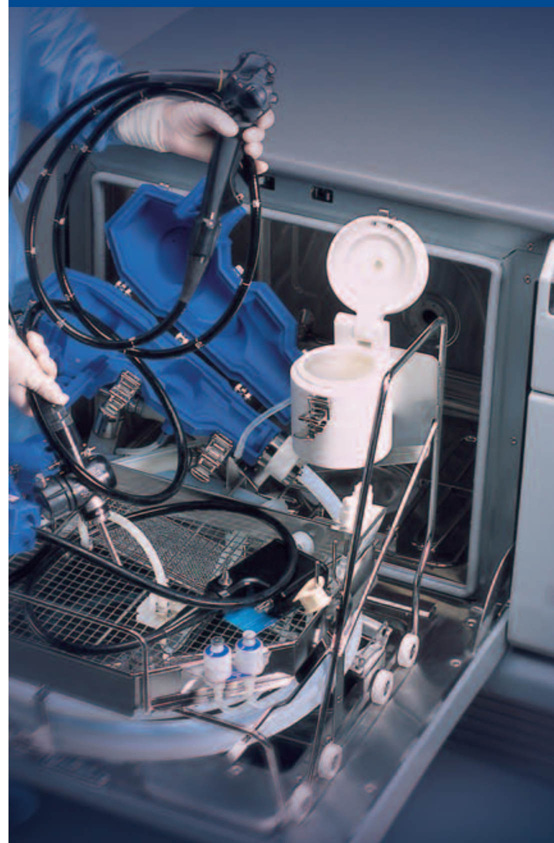

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Nurse Physician Communication – Discourse Analysis

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

LA COMMUNICATION ENTRE INFIRMIÈRE ET MÉDECIN – ANALYSE DU DISCOURS

La communication sous toutes ses formes fait partie intégrale de la vie quotidienne; dans le domaine des soins de la santé, elle peut faire la différence entre la vie et la mort. La communication inter-professionnelle peut avoir un effet négatif ou positif sur le partenariat critique qui existe entre les professionnels de la santé et les patients. La communication entre les infirmières et les médecins est d'une importance particulière ainsi que l'objet de beaucoup d'attention depuis plusieurs années. Dans cet article, le discours au sujet de cette communication en situation de soins actifs est présenté et analysé en suivant les principes de l'analyse critique du discours[1] afin de déterminer la façon dont ce sujet est discuté et compris par la société ainsi que le rôle que joue ce discours dans la reproduction de la dominance des médecins sur les infirmières.

1 van Dijk, T. (1993). *Principles of critical discourse analysis. Discourse & Society*, 4(2), pages 249-283.

NURSE PHYSICIAN COMMUNICATION – DISCOURSE ANALYSIS

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

ABSTRACT

Communication in any form is an integral part of daily life and within the realm of health care can mean the difference between life and death. A vital partnership exists between health care professionals and patients that can be either negatively or positively affected by inter-professional communication. Of particular importance, and the focus of much attention over the years, is the communication between physicians and nurses. The discourse regarding this communication within acute care settings is presented and analyzed in this article following principles of critical discourse analysis (CDA)[1] to determine the way the topic is discussed and understood in society and how this plays a role in the reproduction of the dominance of nurses by physicians.

THE DISCOURSE OF NURSE PHYSICIAN COMMUNICATION

Discourse simply refers to expressing oneself using verbal and/or written words.[2] Discourse analysis is not unlike reading between the lines to determine the meaning behind what is actually said/written. Take, for example, conversation within a relationship when one partner asks the other how they are and the response is a curt 'fine'. Usually this means the person is not really fine and it is left up to the partner to figure out what is really going on. To take this a step further in discourse analysis one not only tries to figure out what is really going on, but also why the partner is saying 'fine' rather than using direct open communication.

Studying and analyzing such communication patterns is done to reveal the underlying sources of power, dominance, inequality, and bias and how these sources are initiated, maintained, reproduced, and transformed within certain social, economic, political, and historical contexts.[1] The foundation for nurse physician communication is rooted in the historical origins of the two professions and is layered with gender issues and inequity in regard to socioeconomic status, employment status, education preparation, and work practice.[3,4] The roots are strong in that conversations with health professionals today result in reflection on these very themes when offering rationale for ineffective communication patterns.

Much of the discourse comes from the nursing community outlining faulty nurse physician communication patterns and providing

resources for nurses to become more effective communicators.[5,6] Despite the emergence of available resources, often nurses continue to use the passive voice and utilize deflective patterns when dealing with communication issues.[7,8] Little discourse specifically regarding nurse physician communication comes from the medical community and when it does the focus is often on legal aspects and what physicians expect in regard to communication in terms of transfer of patient data.[9,10]

Paradigms (Models) Present in and Dominating the Discourse

Not everyone will see nurse physician communication in the same light, as individuals do not view the world in identical fashion. Personal values, beliefs and life experiences form what is often referred to as individual worldviews. While there are many individual worldviews, dominant categories can be formed by grouping together common views and creating models or paradigms. Three such paradigms in the realm of social science include **empirical/analytical, interpretive,** and **critical**, with the primary tenets of each being objective control, understanding, and free unconstrained discourse respectively.[11]

Much of the discourse on nurse physician communication originates in formal research from the **empirical/analytical perspective** (experience and observation) with a large focus on communication as an aspect of collaboration that, when effective, correlates with positive patient outcomes in acute care settings.[12,13,14,15] Other empirical research regarding nurse physician communication explores physician verbal abuse (particularly in operating rooms) of nurses and the resulting effects on patient care and the job satisfaction of nurses.[16,17,18,19] Throughout the empirical literature the common theme arises that although it is recognized that nurse physician communication impacts patient care, communication patterns are not always effective and are sometimes destructive.

From an **interpretive** standpoint the focus is gaining understanding of the nurse physician relationship and communication patterns.[20,21,22,23] The theme remains regarding ineffective communication patterns, however, strategies for change based on the understanding of the patterns is the focal point.

While attempts to understand the communication patterns provide hope in moving towards a **critical** perspective, true unconstrained discourse – laying all cards on the table – is lacking. Traditional ties to empirical research and the focus on the negative aspects of nurse physician relationships are maintained and dominate the discourse, reducing the potential for the development of truly new approaches that will lead towards understanding and enhancing nurse physician communication.

Cultural Factors Influencing the Discourse

Many cultural factors influence nurse physician communication along the lines of socioeconomic status and gender, and awareness of these is present in the discourse. Such factors cited include role conflict, status difference, education differences, and goal conflict.[5,21]

"As the role of the nurse continues to expand, the boundaries between what is considered to be medical care and what is deemed nursing care become less obvious".[5] Physicians may find role blending threatening to their power stance thus negatively impacting their communication with nurses. Specific communication patterns may be interpreted as the sole method of maintaining power.

The status difference between physicians and nurses, developed as a result of both social and gender perspectives, has an influence on communication patterns. By virtue of both their relative position of power and their income most physicians run in different social circles than nurses.[24] This lessens the chance of similar communication patterns. The result is the development of communication patterns and mutual understanding primarily within, and limited to, the context of workplace situations. Gender stereotypes, that for years have generally shaped how women and men are expected to communicate, further limit the development of shared patterns of communication. Traditionally the expected communication patterns of women and men are complaisance and assertiveness respectively. It is common for women who are assertive to be labeled, unfavourably, as aggressive. Communication patterns of women are often not easily changed, even with increased education, due to the lasting influence of the gender expectations on which they were raised.

Education does, however, lead to more nurse responsibility for patient care and nursing autonomy, which may, in turn, further strain nurse physician communication patterns. While nurses and doctors require different education, it is the different types of education that may be a more important determinant of subsequent nurse physician communication patterns. "Physicians are taught to be decisive, independent problem-solvers, whereas collaboration and advise-seeking are encouraged in nursing education."[5]

Goal conflict may result due to the influence of different education backgrounds on determining the priorities for patient care. Discourse from the medical community indicates that extensive patient chart documentation and nursing time spent with patients is seen as an attempt to document nursing independence from physicians and that this view, along with poor communication, results in a power struggle leading to the polarization of patient care.[25]

Depiction of Power Relations in the Discourse

While both the medical and the nursing communities present a power struggle between nurses and physicians each group depicts the power relationships somewhat differently. The medical community sees nurses' struggle for independence and revised communication patterns as a possible detriment to patient care and does not recognize the need for a power shift in order to enhance communication. In the nursing community desired communication pattern changes are seen as essential for quality patient care, however, an interesting point to note is the lack of focus on power shifts in that the elevated status of physicians has come to be the accepted norm. The medical community, for the most part, sees no need for new communication patterns and wants to keep the status quo. The nursing community wants to improve communication and seems to feel this can be done while accepting the power status of the physicians.

What are depicted equally in both camps are the existence of the power differences and the bearing of cultural factors. Within the discourse the social status of physicians is reproduced time and time again without truly being challenged. For example, strategies are suggested for ways nurses can understand and enhance nurse physician communication through recognition of role differences and communication patterns.[20,21,22,23] However, it would seem the dominance that goes with the elevated social status of physicians is accepted. The concept of doctors' orders remains a predominant underlying point in formal communication between nurses and physicians.

Interests Served

Despite the reproduction of physician dominance over nurses – perhaps serving the interests of some physicians – the interests of nurses are served in the discourse. Through research, and the sharing of examples of both effective and ineffective nurse physician communication patterns, awareness of the discourse surrounding the issue is generated. This will in turn prompt further consideration of an important issue and perhaps eventually lead to critical discourse analysis.

Interests of acute care facilities are also served by the discourse. Facilities that recognize the benefit of collaborative work environments in cost savings, through positive patient outcomes and in increased staff retention rates, can direct conscious effort toward policies and programs that enhance nurse physician communication.

Absent Views and Voices

For a population reportedly dramatically affected by nurse physician communication patterns, the views and voices of patients are noticeably absent. Much of the discourse is presented amongst professionals and in literature sources not readily accessible to the general public. Therefore, knowledge of how nurse physician communication can potentially impact patient outcomes is likely not widespread

with exceptions being legal cases directly related to faulty nurse physician communication.

While physicians who are interviewed and included in studies provide feedback on nurse physician communication, much of the interest and research on this topic comes from the nursing community. In this respect the voices of physicians are absent perhaps presenting an underlying discourse regarding their interest and concern in regard to nurse physician communication.

The views of acute care centers in regard to nurse physician communication are also absent. Administrative structures could have a huge impact on the development of nurse physician communication and, given the research on patient outcomes, one may wonder why facilities are not more vocal and proactive in regard to nurse physician communication.

Discourses of Resistance

Further studies could potentially challenge current research by demonstrating lack of conclusive evidence that nurse physician communication impacts patient outcomes. It is reported that the question has been raised regarding the ability of studies to adequately support the link between positive nurse physician communication and patient outcome due to lack of scientific rigour.[26] Organizations that choose to function in a hierarchal manner could pick up on such potentially inadequate research and use it in support of maintaining strict lines of command and control between doctors and nurses.

Resistance from physicians, who are fearful of losing actual or perceived power, could challenge the discourse surrounding the importance of nurse physician collaboratively driven inter-professional communication patterns. Evidence of this resistance already exists indirectly in regard to the lack of input in the discourse by physicians regarding what can be done to enhance nurse physician communication. Perhaps more directly it exists when physicians place emphasis on the importance of understanding physician directed communication.[9,10,25] Nurses who are accustomed to, and prefer working 'under', physicians' authority and are not comfortable in, or not willing to learn, new roles in collaborative working relationships may also resist the discourse surrounding changed nurse physician communication patterns. Any confusion on behalf of patients in regard to who is responsible for their care could lead to resistance of changes to the hierarchal nature of the nurse physician relationship.

CONCLUSION

The result of continuing the current discourse regarding nurse/physician communication is beneficial in many regards in that it encourages people to pay attention to communication patterns. Discourse analysis must also be utilized to look beyond the current patterns to the underlying reasons that the patterns remain the same. Doing so will prevent the current discourse from being used to conceal, and reproduce, the dominance of nurses by physicians. This is especially the case in acute care areas – such as the perioperative environment – where communication patterns can be particularly poor and verbal abuse is often prevalent. When it is understood what shapes discourse and its role in the reproduction of dominance, the role of discourse in the challenge of that dominance can be better explored. This then allows for suggested action to transform health care delivery, which will be the focus of a future article in regard to nurse physician communication discourse in the perioperative acute care setting.

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

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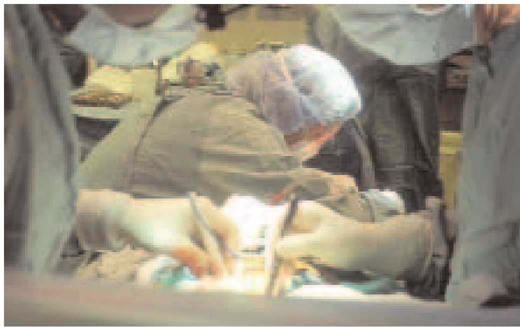

Courtesy G. Groetzsch

RNFA Grace Groetzsch assists in the OR

most physician assistants do not have the ability to complete an operation should something happen to the operating surgeon.[5] The role of a surgical assistant is, by definition, **to assist**. By virtue of their perioperative nursing background and formalized education RNFAs are well suited to act as surgical assistants.

Obtaining Funding:

There **are** ways for hospitals to fund RNFA positions. If the need is recognized, and patient care is being negatively impacted, hospitals, such as several in Ontario, are finding money within their budgets to fund RNFA positions. Both clinical (nursing and surgical) **and** administrative support are key to this method.

Some hospitals have chosen to assess the RNFA program via a pilot study. In this way funding is provided for a specific time period. Toward the conclusion of the study an evaluation determines the need for RNFA positions. Where there is a recognized need positions have often become permanent.

When a surgical program is implemented or expanded healthcare facilities submit funding proposals to the provincial government. At that time, the cost of RNFA positions can be factored into the cost of implementing/expanding the program. The case for including RNFAs must document a lack of surgical assistants or a quality initiative. In community hospitals this includes documentation that residents are not available and the difficulty of getting family physicians to assist, particularly during the day. The proposal should include the human resources aspect (i.e. number cases to be done, personnel required to do this, number of RNFAs to be utilized, outline of a job description) coupled with a financial impact statement. If the program/expansion is approved then the monies are available, and allotted, for RNFA positions. "Ask and ye shall receive!"

In an effort to retain experienced registered nurses some provincial nursing bodies are developing nursing initiatives that may be related to the RNFA position. For example, the Registered Nurses Association of Ontario is offering clinical fellowships that one hospital, and several RNFAs, are starting to take advantage of. This provides funding, for a short period of time, to evaluate the effectiveness of the RNFA position.

Thinking outside the box, coupled with a recognized need within the healthcare industry for surgical assistants, is the key to the financing of RNFA positions. By sharing their knowledge and resources employed RNFAs can help create additional RNFA positions. Information is key!

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Additional Resources

Ontario Nurses Association. **www.ona.org**
Registered Nurses Association of Ontario. **www.rnao.org**

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