CANADIAN
OPERATING ROOM
NURSING JOURNAL

Volume 22, Issue 2
June 2004

Infection Control

Leaders' Role
Reprocessing Methods
Custom Procedure Packs

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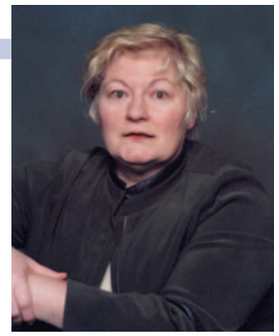
PM40951517

President's Message



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

Recently, at the *Association of periOperative Registered Nurses* (AORN) Congress, I had the opportunity to network with the *International Federation of Perioperative Nurses* (IFPN) Executive and members of the Canadian *Council of National Representatives* (CNR). It reminded me that there is a great deal of history, and energy, behind all the acronyms.

The *International Federation of Perioperative Nurses* (*IFPN*) is the result of the dreams, ideas, and hard work of forward thinking nurses around the globe. In 1997 a steering committee was formed to bring the dream to reality and in 1999 the *IFPN* was born.

IFPN's Constitution states its purpose "is to represent and be the voice of perioperative nurses worldwide and to promote quality patient care internationally." *IFPN* currently represents 12 member nations.

Many registered nurses in Canada are members of the Federation (represented by *ORNAC*). *ORNAC* is a founding member of *IFPN*.

The *IFPN* Constitution states "The *IFPN* is a federation of national perioperative nurses associations, or an equivalent perioperative nurses' group, which is affiliated to the official nursing organization of the member country, and which are in compliance with this Constitution and have been formally admitted into membership. *IFPN* functions under a policy of non-discrimination."

As a member of the *Canadian Nurses Association* (CNA) *ORNAC* was originally able to seek membership in *IFPN*, at the time of its founding, as the representative of Canadian perioperative nurses.

CNR meetings provide opportunities to network, collaborate, compare practices, exchange ideas, learn, and assist each other while performing the functions of *IFPN* as laid out in the constitution. My involvement has been both a pleasure and an honour — I can't begin to tell you about what I've learned and the people I have met!

IFPN also has an elected Executive Board, with members from around the world. The roles of *IFPN* President, Vice President, Treasurer, Secretary, and three Full Board Member positions are currently being handled by representatives from New Zealand, South Africa, Australia, Canada, the United Kingdom and the United States.

IFPN has worked very diligently to write educational modules/ standards in order to assist any global partners, in developing world countries, that have not yet been able to create their own versions. Kate Woodhead has worked tirelessly, as President of *IFPN*, to find industry partners that are able to provide financial assistance with the printing of these standards. The first set of Standards was released in the spring of 2003. Those nurses attending the 18th National Conference, held Winnipeg MB in June 2003, would have seen & heard Kate's lectures on *IFPN* and its goals (CORNJ, Sept03, pg 14-15)!

In November 1999 *IFPN* applied for, and was granted, affiliate status in the *International Council of Nurses* (ICN). This is of benefit to both *IFPN* and to *ORNAC*, as an *IFPN* member. *ICN* grants affiliate status to only one special interest group at any given time. As a result of this new status perioperative nurses around the globe are now affiliated with *ICN*. This allows for the global sharing of knowledge, technology, expertise, and best practices among all nurses, not just those in the perioperative specialty.

For more information visit www.ornac.ca and click on "links".

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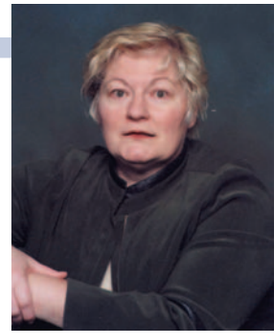
International Federation of Perioperative Nurses (IFPN) Constitution, Harrogate, UK: National Association of Theatre Nurses. www.ifpn.org.uk

***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)

Il n'y a pas longtemps, au congrès de *l'Association of periOperative Registered Nurses* (AORN), j'ai eu l'occasion de rencontrer le conseil d'administration de *l'International Federation of Perioperative Nurses* (IFPN) ainsi que des membres du Conseil des représentantes nationales (CRN). Cette rencontre m'a rappelé le fait qu'il y a toute une histoire, et beaucoup d'énergie, derrière ces acronymes.

L'International Federation of Perioperative Nurses (IFPN) est le résultat des rêves, des idées et du travail assidu d'infirmières et infirmiers à travers le monde qui sont tournés vers l'avenir. En 1997, un comité directeur a été établi dans le but de réaliser ce rêve et en 1999 l'IFPN a été fondée.

La constitution de l'IFPN précise que son objectif « est de représenter et de donner voix aux infirmières et infirmiers de salle d'opération à la largeur de la planète et de promouvoir sur l'échelle internationale les soins au patient de première qualité ». L'IFPN représente actuellement 12 pays membres.

Bon nombre d'infirmières autorisées et d'infirmiers autorisés au Canada sont membres de la fédération (représentée par L'Association des infirmières et infirmiers de salle d'opération du Canada – *l'AIISOC*). *L'AIISOC* est membre fondateur de l'IFPN.

La constitution de l'IFPN énonce que « l'IFPN est une fédération d'associations nationales d'infirmières et d'infirmiers de salle d'opération, ou de groupes d'infirmières et d'infirmiers de salle d'opération équivalents, associés à l'organisme officiel d'infirmières et d'infirmiers du pays membre se conformant à cette constitution et qui ont été officiellement admis à titre de membres. L'IFPN souscrit à une politique de non-discrimination.

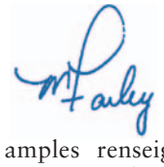
En tant que membre de l'Association des infirmières et infirmiers du Canada (AIIC), l'Association des infirmières et infirmiers de salle d'opération du Canada (*AIISOC*) a pu devenir membre de l'IFPN au moment de sa fondation à titre d'organisme représentant les infirmières et infirmiers de salle d'opération canadiens.

Les réunions du CRN fournissent des occasions de rencontre, d'échange, de collaboration, de comparaison de pratique, d'échange d'idées, d'apprentissage et d'entraide tout en permettant l'exécution des fonctions identifiées par l'IFPN dans sa constitution. Ma participation est à la fois un plaisir et un honneur – il me serait impossible de vous raconter tout ce que j'ai appris et toutes les personnes que j'ai rencontrées!

L'IFPN comprend aussi un conseil d'administration élu, et ses membres viennent de partout au monde. Les rôles de président, vice-président, trésorier, secrétaire et trois membres du conseil sont présentement remplis par des représentants de la Nouvelle-Zélande, l'Afrique du Sud, l'Australie, le Canada, le Royaume-Uni et les États-Unis.

L'IFPN a travaillé inlassablement à la création de modules/normes pédagogiques afin d'aider à tout partenaire global dans les pays en développement qui n'a pas encore été en mesure de créer sa propre version. Kate Woodhead a travaillé assidûment, en tant que présidente de l'IFPN, à la recherche de partenaires dans l'industrie qui pourront fournir de l'aide financière au niveau de la publication de ces normes. Le premier ensemble de normes a été publié au printemps, 2003. Les infirmières et infirmiers qui ont assisté au 18e congrès national à Winnipeg, Manitoba, en juin 2003 auraient vu et entendu les discours de Kate au sujet de l'IFPN et de ses objectifs (se reporter à CORNJ, sept 03, pp 14-15)!

En novembre 1999, l'IFPN a demandé, et a été accordé, le statut d'association affiliée au sein du Conseil international des infirmières (CII). Ce statut bénéficie à la fois l'IFPN et *l'AIISOC*, cette dernière étant membre de l'IFPN. Le CII n'accorde le statut d'organisme affilié qu'à un seul groupe d'intérêt spécial à la fois. En conséquence de ce nouveau statut, les infirmières et infirmiers de salle d'opération à travers le monde sont maintenant associés au CII. Cela permet un partage global de connaissances, de technologies, d'expertise et de meilleures pratiques parmi toutes les infirmières et infirmiers sans se limiter à la spécialité des soins périopératifs.



Pour de plus amples renseignements veuillez consulter www.ornac.ca et cliquer sur « liens ».

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Editorial Contents

Perioperative nurse, Barbara Eastveld in the scrub role
Cover photo by J. Porteous

ORNAC Executive

ORNAC Board Members

Tearing Down The Walls Between O.R. and S.P.D.

Author: *Sandra Stewart, RN, BA Health Sciences, is a Nurse Consultant with Cardinal Health, Canada.*

This article is a synopsis of a talk given at the Operating Room Nurses Association of Ontario 7th Biennial Provincial Conference. The author would like to thank all of the O.R. and S.P.D. staff that she has had the pleasure of working with and observing over the years.

Photo by L. Socha

SPD staff at work

ABSTRACT

The focus of this article is the relationship between the Operating Room (O.R.) and the Sterile Processing Department (S.P.D.). The goal is to help readers gain insights into the driving forces which impact on both departments and to help them establish realistic expectations for improving the performance and quality of this relationship. It is important to discuss ways to solve conflict and enhance teamwork between the O.R. and S.P.D. Both departments need to establish a common understanding and ensure that everyone "talks the same language" and "tears down the walls" between them.

For the purpose of this article the short form of S.P.D. will be used for Sterile Processing Department (sometimes known as Central Processing), the department where instrument processing takes place and the distribution center for the entire hospital's supplies.

TEARING DOWN THE WALLS BETWEEN O.R. and S.P.D.

The complexity of knowledge and skill that is required to care for our patients today is exceptional. The O.R. and S.P.D. are unique environments and they each have very unique staff. In order to create or restructure systems in these departments and produce solutions for conflict between departments, an innovative knowledge base is required. Both departments need to combine knowledge and skill. Every team member must take responsibility for, and be accountable for, his or her own practices.

In most hospitals the S.P.D. is located in the basement below the O.R. But there are also many hospitals where the S.P.D. is located at the furthest point from the O.R. In still other institutions the instruments are still decontaminated and sterilized in the O.R., not in the S.P.D. However, regardless of the facility's policies, and the location of the S.P.D., there are still conflicts shared by all Operating Rooms and Sterile Processing Departments.

Missing instruments and instrument damage are common conflict situations between the O.R. and S.P.D. But when are instruments disappearing and when is the damage occurring? The answers can be numerous. Incorrect dismantling of the instrument table in the O.R. can result in missing and damaged instruments. Misuse of the instruments during surgery can also result in damage. Examination of how instruments are transported from the O.R. to S.P.D. can uncover other problems. Finally, examining the decontamination and processing of instruments in S.P.D. will also result in the answers to many questions.

Outdated pick lists in S.P.D. will result in incorrect O.R. cases and the creation of a conflict situation. Who is responsible for updating the lists? Appropriate O.R. resources need to be assigned and management must allow the time for compliance. Technology can be utilized to facilitate the updating process.

Ask yourself if, as an O.R. nurse, you consciously or unconsciously invoke a servant/master relationship with the S.P.D. staff. Are your demands reasonable? According to Jesse Jackson, "You should never look down on anybody unless you are helping them up." Trying to resolve conflicts means organizing the

Tearing Down The Walls (cont.)

Photo by L. Socha

Clean scrubs for staff

problem solving effort and creating change. Recommendations for change should also contain provisions for ongoing improvement. An important strategy to help overcome resistance to change is to acknowledge past successes. What changes have impacted both departments and what was done to respond positively to those changes? It is also important to continually evaluate our practices rather than treating this process as a one-step solution.

Forming a workgroup to solve the conflicts between the O.R. and S.P.D. can help create other solutions. It is critical to choose the right workgroup members and to build a successful team. Key people, in both the O.R. and the S.P.D., must be identified and involved to obtain their support. The key members should include staff that are directly involved in the daily practices and stand to benefit the most from a solution, as well as the main decision makers who are responsible for implementing changes.

Staff need to identify the key issues that are causing conflict. Discussions should be focused on how to make the suggested solutions work instead of wasting energy discussing the negative. Aim for productive outcomes. Have an agenda and establish a definite time limit. Schedule meetings carefully to maximize staff member attendance. Identify and capitalize on each team member's strengths. Over time, as team members work through various problems and discuss how to approach them, they will learn about each other's abilities and goals and will benefit from each other's experience and knowledge.

Monthly meetings for ongoing evaluation should be scheduled and adhered to. To increase the likelihood of success every team member should be held accountable to the process and its deadlines. Avoid procrastination!

Teamwork will help to break down the walls between the two departments and to foster communication. We need to actively listen to one another. In this society of super sophisticated talkers we often suffer from a shortage of listeners. A lack of communication among staff members can lead to negative outcomes – so any change that occurs needs to be announced to all of the staff in the O.R. and the S.P.D. For this reason it is important to not rely on just one method of communication. Letters – both on paper and in electronic format – can be sent. Establishing a targeted electronic message list, just between the O.R. and S.P.D. staff, and putting priority ranking on messages will alert staff of the "must read" messages. Once the message has been opened it should register the staff member who has acknowledged receipt.

Another communication option is to create a poster display informing staff of any changes. These posters must be strategically placed in locations where they will catch they attention of the right people. Using interdepartmental group meetings to communicate change is also important as it allows for discussion. Workshops, to introduce change, allow for hands on learning. Many people find it is easier to learn something new when they actually try the new process instead of just hearing or reading about it.

Photo by L. Socha

Pans & basins drying after clean cycle in SPD

Tearing Down The Walls (cont.)

Photo by L. Socha

OR Aide cleaning (processing)

The primary purpose of communication is to deliver information from one person to another with minimal chance of distortion of the meaning. The O.R. and S.P.D. staff need to speak the same language. This can be challenging as we often do not even speak the same language within the O.R. – how often, as a scrub nurse, have you met a surgeon who likes to make up his/her own names for instruments? How can we expect the S.P.D. staff to know that "Dr. Jones" calls a Freer Elevator a "Red Cigar"?

We have to strive for an absence of these language barriers. A computerized list, or reference manual, grouping instruments according to their type of service could be beneficial. The instruments should be cross-referenced if they are known by more than one name.

Creating strong short-term communication is also important. Often, in the O.R., we need it "immediately"… but do both parties understand the real level of urgency? Is a 15-minute response time, to get an instrument from S.P.D. to the O.R., too long? How about 10 minutes? Or 5 minutes? If the need is not clear then the O.R. staff will often end up in unnecessary panic… and panic is not pretty!

As already mentioned, the S.P.D. is, in most institutions, located in the basement and the O.R. is often one floor, or more, above… sometimes the two departments are even at opposite ends of a hospital. As separate entities both departments are positioned to create complications and tension is inevitable.

A dedicated phone line from the O.R. to the S.P.D. can often be a simple, effective solution to a lot of problems simply by eliminating the chance of getting a busy signal. The key to success on both sides also lies in the personnel who handle both ends of that phone call. Systems fall apart when one party has no idea what is being requested or does not understand the real urgency of the requirement. Cross training of S.P.D. staff can make them more confident and lead to increased accountability and better job performance.

But how can the O.R. and S.P.D. understand each other's worlds when they often feel worlds apart – both physically and mentally? Most S.P.D. staff have never been in an Operating Room. They have no idea how the instruments they prepare and sterilize are used. The O.R. staff needs to show the S.P.D. staff how important their role is in overall patient care. This should lead to an understanding of the necessity for the high-standards in S.P.D. production. It is also important for O.R. staff to understand the complexity and diversity of S.P.D. responsibilities. In order to understand each other's worlds we have to understand each other's processes. How does it all work? A day taken by O.R. and S.P.D. staff to walk in each other's shoes could lead to a world of understanding and help "tear down the walls".

It is also important that the O.R. and S.P.D. staff get acquainted with each other. We have to aim for an absence of barriers in the Operating Room – a challenging task when we are already physically isolated. We have to work to establish interpersonal relationships in our own department and inter-departmentally. S.P.D. Managers with O.R. backgrounds must help to unite the team. An awareness of each other's

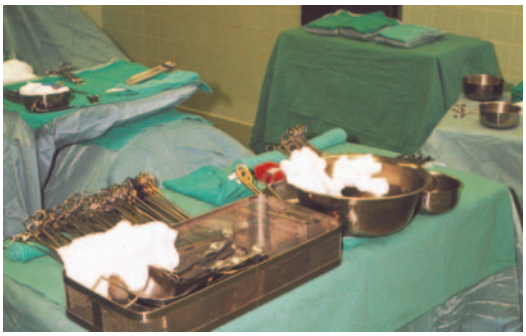

Photo by J. Porteous

Sterile fields prepared for a surgical procedure

Continued on Page 15

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.

NEED A smoke capture device that makes it easy to gain compliance of the surgical staff and will work with all smoke evacuation systems.

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BCORNG 2004 Conference

March 10 - 13, 2004

The Face of Change: Challenge, Competency, Commitment, Compassion

Submitted by: *Marcy McKay RN CPN(C), Immediate Past President BCORNG*

THE TOPICS AND THE SPEAKERS:

Carol Ann Fried addressed *Better than Money – How to Increase Employee Motivation, Productivity, and Self-esteem,* a funny, inventive look at making people feel valued. She encouraged us to work together to help meet other people's needs.

Dr. David Naysmith, Master of Ceremonies, presented the *Top ten things you need to know as a scrub nurse…* It was hilarious to get his perspective on the topic as he discussed things like "surgeon-ese" (i.e. the different names we have for instruments). He wrapped up with a video showing a 90 yr old woman setting the table. Her husband sits down and picks up the saltshaker… she smacks his hand and takes it away from him… and then she HANDS it back to him. In the final shot she is dressed as a scrub nurse. Helping us laugh a little at ourselves was a fabulous start to the conference.

Dr. Ken Smith, Plastic Surgeon presented *When Animals Attack* about a cougar attack that took place on Vancouver Island. The story had been

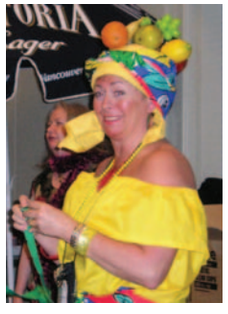

Photo by M. McKay

Janet Cochrane, as Carmen Miranda, for Tacky Tropical Tourist Party

Photo by M. McKay

Steve Makuch at Tacky Tropical Tourist Party

Photo by M. McKay

Russell East enjoying himself at the Tacky Tropical Tourist Party

featured in Readers Digest and the surgeon was able to update us with information about the patient's progress, additional surgeries, etc.

ROOM FOR IMPROVEMENT?

I wish we had taped Dr. David Naysmith's *"Top ten things you need to know as a scrub nurse…"*.

HIGHLIGHT OF THE SOCIAL ACTIVITIES:

The *Tacky Tropical Tourist Party* featuring *The Timebenders* band (4 1/2 hour show, 80 costume changes). Guys in grass skirts with flower bras… lots of Hawaiian shirts… inflatable palm trees, leis, a 10ft. tall paper machier Tiki… it was all a riot.

OPENINGS AND CLOSINGS:

Kick Off: An evening reception for delegates and exhibitors.

Ending: Potential for disaster when the laptop wouldn't work with the data projector… in the end our closing ceremonies became a very informal get-together with various people getting up to the microphone. Improvising worked!

Photo by M. McKay

Fran Gaudreau, Winner BCORNG Recognition Award for Outstanding Perioperative Nursing Care with Sandra Stewart, Membership Secretary and Awards Committee Chair

LIFE LESSONS…

Some of our speakers were quite controversial, in their views and in the way they conducted their research. They stirred up the crowd and got the delegates talking. We may not have always agreed with the speaker, but we loved the fact that the controversy was able to kick things up a notch.

We also had a speaker cancel 2 weeks before the conference (in order to attend another conference)! Despite our feelings we remained true to our own professional values in the way we handled this. And in the end our substitute speaker was really fabulous!

Photo by M. McKay

19th Biennial BCORNG Planning Committee

NURSES FIGHT TO MAINTAIN SURGICAL STANDARDS

Cindy E. Harnett
Times Colonist (Victoria)

Originally published Sunday, March 14, 2004

Sometimes it is brain surgery. And many times the actions of operating nurses are a matter of life and death.

So when operating room nurses say there must be a registered nurse present during each surgery, the provincial government should listen, says Marcy McKay, outgoing president of the B.C. Operating Room Nurses Group. The BCORNG ended its three-day 19th biennial conference — the Face of Change — in Victoria Saturday.

Sessions delivered by mostly doctors included a range of topics from O.R. efficiency, single-use medical devices and trends in breast health to mangled extremities and animal attacks. McKay said that operating nurses must maintain optimum levels of care, compassion and commitment — and continue their education. They must also face the mounting pressures in their profession as a team — head on with heads high, she said.

"We have to remain true to our standards," said McKay, of Victoria. "We feel every patient deserves a registered perioperative nurse caring for them."

McKay said there will be lots of talk in coming weeks and months "about replacing us with less qualified, less skilled staff. "And I have to be honest with you, I fear for our patients," said McKay, in an interview.

Like so many other health-care professionals, perioperative nurses say they are working with decreasing resources and increasing demands. Unlike other registered nurses, however, operating nurses spend their entire time in direct patient care and are part of a tight-knit team comprising surgeons, assistants, anesthetists, a circulating nurse and scrub nurse.

BCORNG 2004 Conference (cont.)

"We are there 100 per cent of the time to care for our patient," said McKay. But that could all change if registered nurses are taken out of the operating room, said McKay.

Currently, when a patient undergoes surgery there are two registered nurses present — a circulating nurse (who organizes the equipment and caters to the patient) and a scrub nurse (who hands the instrument to the surgeon).

But there is a move underfoot — with talks occurring in the Lower Mainland — to replace the registered nurse in the operating room with a licensed practical nurse.

There's a view if there's a registered nurse in the vicinity — who could be at the desk — that's good enough, said McKay.

Operating room technicians and LPNs play a part in the operating room but should be confined to the technical "scrub" roles leaving the circulating role to registered nurses, according to the Operating Room Nurses Association of Canada.

McKay said patients must ask: "Who is going to be looking after me. Am I going to have a registered nurse looking after me during my surgical procedure or am I going to be looked after by someone with less skills, paid less, with less education."

Until the public demands the highest standard of care "government and administrators in the hospital will do whatever it takes to get that budget under control," said McKay. "And that means kow-towing to the bottom line, the dollar line, at the expense of patients."

McKay left her two-term post Saturday handing over the reins to president-elect Bonnie McLeod.

UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL CONFERENCES

Alberta	Medicine Hat	October 20-23, 2004
Quebec	Quebec City	December 1-3, 2004
Atlantic Conference	Moncton, NB	October 3-6, 2004
Newfoundland & Labrador	Gander	October 28-30, 2004

ORNAC CONFERENCES
www.ornac.ca

19th National	Montreal, PQ	May 2-6, 2005

INTERNATIONAL CONFERENCES

NATN (www.natn.org)	Harrogate, UK	October 6-9, 2004
AORN (www.aorn.org)	New Orleans, USA	April 3-7, 2005

ANAESTHESIA CONFERENCES

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

ORNAC / Johnson & Johnson
Medical Products Bursary for OR Nurses

This bursary was established to financially assist *ORNAC* members in furthering their education in areas that will enhance the perioperative nursing practice.

Up to **$1,500** is awarded each year to one or more successful candidates. The name(s) of the recipient(s) is announced at the *ORNAC* National Conference or at the Provincial Conference of the recipient(s).

Funding is available for post-basic operating room nursing programs approved by *ORNAC* and also for Baccalaureate, Masters, and Ph.D. nursing programs that are considered an enhancement to existing perioperative employment.

ORNAC recognizes that the education of perioperative nurses plays a pivotal role in creating a successful national organization and appreciates the financial support of *Johnson & Johnson Medical Products*.

SUBMISSION DEADLINE IS JANUARY 15TH

For submission criteria, or a bursary application,
visit **www.ORNAC.ca** and click on **awards**
OR
Contact the President of your Provincial Association

Tearing Down The Walls (cont.)

roles, frustrations, problems, and needs will lead to greater understanding and create a bridge to cooperation. Social activities, such as an introductory lunch, can be more effective than waiting until there is a conflict in order to schedule a meeting with each other. In this way the departments interact and get to know each other when there is no conflict resolution required. How many O.R. staff, especially in the large institutions, can name the staff members in S.P.D. (outside of the individuals who are in charge)? And how many S.P.D. staff could name the O.R. nurses (again with the exception of those who are in charge)?

We should not have the attitude that there is an 'US' and a 'THEM'. Taking each other's ideas seriously, accepting each other's opinions, and being able to explain our needs will open up the lines of communication and effective interaction. Knowledge and understanding will create a cooperative work environment where O.R. and S.P.D. staff work together and share their knowledge and expertise.

Building trust will reduce tension, disagreement, backbiting, and criticism. We all have expectations of each other but when expectation levels are realistic and very clear they are much easier to achieve. Our expectation should be for a seamless team between the O.R. and the S.P.D.

So let's go **TEAR DOWN THOSE WALLS!**

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Pearls of Wisdom

LEADERS' ROLE IN INFECTION PREVENTION AND CONTROL

FIGHTING THE INVISIBLE AND INVINCIBLE… IF ONLY…

INTRODUCTION

If only we could enlarge the microbes to a sharp, clearly visible image and give it character, perhaps then we could terrorize people into a new respect for infection prevention, control, and practice compliance. It would remind us there is no safe place to run and hide – they are inside you, all over you and on everything you touch! Microbes falling over each other to get to you and to everyone around you. Scary thought!

Imagine the fat, ugly pseudomonas glaring at you in defiance – from every drop of water you touch, drink or use – shouting, "Show me the way to ICU!" Methicillin-Resistant Straphylococcus Aureus (MRSA) with hands on hips and an impenetrable suit of armour, taunting you with,

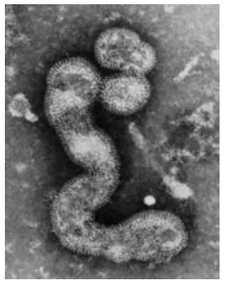

Photo by Provincial Lab of SK

Influenza virus

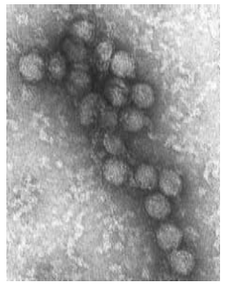

Photo by Provincial Lab of SK

West Nile Virus

Photo by L. Socha

Dr. Lawlor scrubbing his hands

"Just try me!" Or the SARS corona virus flying though the air, on vehicles of aerosols, passing through an ill-fitting mask to land in your mouth and eyes. Killer clostridium from someone's bowel, picked up from the door handle because someone before you skipped the hand washing, is now sitting on your fingers just waiting for you to touch your lips. Old faithful, staphylococcus aureus, dancing about like a king, singing, "After hundreds of years I still rule the world of surgical wounds." Legionella lurking in the biofilm of hot water tanks, pipelines, faucet aerators, and dead-end plumbing, crying, "Just let me out… it is time for a pneumonia attack." A new guest at the party produces shudders of fear – everyone welcome Anthrax. West Nile arrives at the party to contaminate our blood and provide meningitis in the process. All together they shout, over and over again, "Let's mutate! Let's mutate!"

Trying to fight the invisible dangers of the historical, current, and emerging pathogens is not unlike fighting ghosts. Most human beings believe more in what we see than it what we cannot see… and this attitude drives our practices. Why, with all we know, do healthcare workers still have a hand-washing rate that is estimated at 40%[1] … but may be even lower. We know that mucous membrane is a common route for microbes that can make us sick or even kill us… and yet health care providers too often defy the aseptic protocols of dress code, masks, glove usage, and even hand washing with its over 200 years of proven efficacy? Are we being independent and thinking we're invincible? Where can we start to change this?

Continued on Page 21

Isabelle Adams Award For Excellence In Perioperative Nursing

This award was established, in 1987, on the initiative of the Operating Room Nurses Association of Quebec. Ms. Isabelle Adams was a perioperative nursing leader who was instrumental in initiating the first national Operating Room Nurses conference in 1970 in Montreal. She also participated in the OR Nurses Standards Committee of the Canadian Standards Association. Ms. Adams was an inspiration to young nurses considering the Perioperative specialty and she promoted excellence in practice throughout the specialty.

The Isabelle Adams Award is presented to an outstanding Perioperative Nurse, who has made a significant contribution to operating room nursing in Canada. The award is presented at the biennial ORNAC national conference to an OR nurse whose professional life reflects the practices and ideals of Ms. Adams.

Application forms may be obtained from the chairperson of the ORNAC awards committee or through the ORNAC website at:

www.ORNAC.ca
(*click on awards*)

CORL CORRAL (cont.)

Leadership Roles, Responsibility and Accountability

Don't let the death of a colleague be the trigger that spurs you to be an infection prevention monitor and crusader. Delegating this responsibility to others does not mean you do not have a major role and influence in this area. The sobering reality of SARS is that it offers a prelude to what lies before us. It is important to integrate yet another responsibility (infection prevention) into our often all-consuming jobs.

Be a Role model – Demonstrate consistent patterns of practice, attitudes and behavior towards infection prevention and risks in your work place, home and community. Don't underestimate your impact – you set the tone and the expectations. Never cut corners that violate principles and remember you are the nurse – one of Florence's protégés**.**

Obtain Knowledge – Science is ever changing. Sacred cows may have been slaughtered, only to later gallop back into favour. Overwhelming volumes are available both in print and through on-line web sites. The international community of the World Health Organization (WHO) is playing a very large role in setting standards and recommending practices. It is closely integrated with governments and other designated organizations. Your local and provincial Medical Officer's of Health (MOH) have also likely established web sites. Health Canada (HC) and the USA Centers for Disease Control (CDC) are vast resources of current information in user-friendly formats. Locate credible sources such as these, "bookmark" their web sites for ease of access on an ongoing basis, and visit them regularly. You can skim or, when time allows or need dictates, you can delve deeply into these sites to obtain extensive detail. Spend a little time each week surfing the web for new, current, information. Learn and use the "new language" of infection control – including terms such as *Respiratory Etiquette*. Share tidbits of new information with your team on an ongoing basis.

Create a Learning Environment – ensure that you establish and maintain a learning, teaching, and mentoring environment that is focused on patient and staff safety as well as risk management.

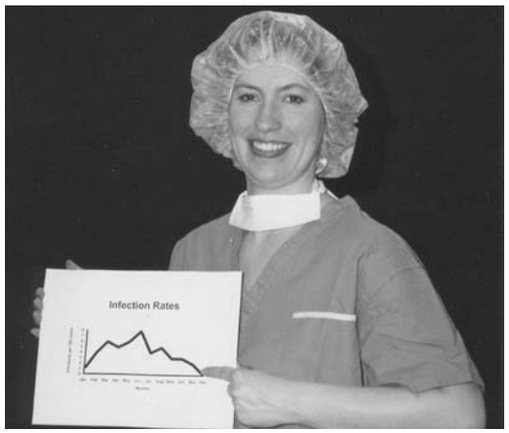

Photo by by J. Porteous

Infection rates on the decline (held by OR Nurse Melodie Kurys)

Teach both the reasons and the principles – people respond better to the implementation of new practices if they understand the "why". Use innovative and creative ways to share information. Too much familiarity with a topic may cause some team members to "tune out" especially when the traditional format of a one-hour long, repetitive, lecture is used. A rapid "fast food approach" providing the key facts in a brief format is most effective. Be sure to change posters and warning signs often, to continue to draw attention, and to keep them simple. Keep them brief and to the point to allow for a fast read. Integrate infection prevention into your orientation and your annual education updates. Place articles in lounges and theatres and update them frequently so others can read, and share, the information they contain.

Monitor and Supervise Practices – Tasks that are considered more important, or tasks that command immediate attention, will always threaten to take the lead role in your scheduling. As the leader you must work to keep this life and death issue at the top of the list of daily practice priorities through continuous monitoring and corrective practice. Make people accountable for the risks that their defiance or lack of awareness, brings to others.

Practices to prevent high-risk infection:

Hand Washing – the age-old problem of non-compliance, when it comes to hand washing

Photo by L. Socha

Incorrect wearing of mask

practices, still continues… and now it is combined with the misuse of gloves. It is not uncommon to observe individuals touching many objects in the room with potentially highly contaminated gloves, spreading pathogens to unsuspecting colleagues. Establish the protocols based on principles, and then enforce them. Circulators need remove the gloves, unless there is a high priority reason not to. Personnel are much more attentive to what they touch with bare hands than they are when gloved. A large number of people continue to bypass the sink after using the washrooms. As a result it is highly advisable to place the paper towel waste bin near the door, use paper towel to turn the door handle, and then dispose of the paper once the door is open. Remember, whatever is on the doorknob could soon be on your fingers… that will soon be near your face and your mouth.

Active vigorous hand washing using soap, and placing extra emphasis on the spaces between the fingers, will remove the vast majority of organisms. Keeping fingernails short and clean is essential. The wearing of artificial or gel nails must not be permitted, as they will harbour fungus that, while it may not affect staff, can be lethal for compromised patients. Many Canadian hospitals are beginning to introduce alcohol hand rubs or gels. These products have been used in Europe for over 30 years.

While they have been reported to be a good as, or perhaps better than, traditional hand washing excess use of alcohol gel may cause drying, especially if skin is subject to irritation. In addition, their use does not preclude serious soap and water washing at the beginning of each day and whenever significant contamination may have occurred (i.e. upon removal of surgical gloves, after inadvertent handling of body fluids, and following use of the rest room).

The availability of alcohol rubs at workstations, or in staff pockets, should, however, increase the effectiveness of hand decontamination. However, while to this date there have not been any reported fires caused by the hand alcohol products concerns about the risk of fire do exist. At this time the rules of use seem to vary from one fire department to another. Leaders should ensure the Infection Control Committee approves all products and work with the designated fire marshall to determine an acceptable location for the products.

Masks – Used masks are highly contaminated by the organisms from the wearer's own mouth and noses well as the organism laden aerosols that may have landed on the outside of the mask. The results of a cough, a sneeze, or the use of aerosols (i.e. for high speed drills and irrigators) are frequently within a full three-foot radius of the source. Is your respiratory system protected? The organisms will live where they land for several days – what are you carrying around?

Handling of a used mask with bare hands, rolling it up in to a pocket for future use, hanging it around your neck, or pushing it up on to your forehead is a high risk practice that encourages the spread of organisms… not a status symbol. Masks should only be handled by the strings. Careful tying of masks at the back of the neck

Photo by L. Socha

Mask being worn correctly

Continued on Page 36

Choosing A Reprocessing Method

Author: *Barbara Bolding RN, BSN, MBA. Barbara Bolding is a Sterile Processing educator and consultant based in British Columbia. She currently works as a clinical educator for Johnson & Johnson Medical Products.*

WHICH INSTRUMENT REPROCESSING METHOD IS BEST FOR YOUR PATIENT?

The short answer to this question is that there is no single best method. There are many reprocessing methods available to hospitals and to Operating Rooms so any choice will depend on the particular situation at your facility and with your patients. The purpose of this article is to outline the factors to be considered when assessing or comparing reprocessing methods.

Spaulding's Classification

In the mid-1960s Dr. Earl Spaulding developed a framework to guide reprocessing decision-making. The system is based on the patient's risk for infection that various types of instrument or equipment contact can create. The following table summarizes his system.[1]

Critical Contact – The normally sterile parts of the body that are covered by intact skin have no contact with the external environment or with the microorganisms that abound there. If, through inadequate or inappropriate instrument reprocessing, some of those external microorganisms are introduced into this normally sterile tissue, a patient's risk for infection is high. A sterilization procedure, or use of a chemical germicide formulated as a sterilant, is recommended for reprocessing of instruments in order to keep patients safe.

Semi-Critical Contact — While there is still a risk for infection with mucous membrane contact, it is not as high as with trans-parenteral contact. Consequently, a high-level disinfection procedure is recommended for reprocessing semi critical instruments. Although chemical germicides formulated as high-level disinfectants do not kill high numbers of bacterial spores, they are active against all bacterial and viral pathogens and, as a result, they will still keep patients safe.

Non-Critical Contact – In a situation where a patient's intact skin comes in contact with a reusable item (e.g. a blood pressure cuff on the arm), or does not come in direct contact with the item at all (e.g. lying on a bed covered by a fresh sheet), the risk of infection is very low. The safe level of reprocessing is also low. At this point it is important to note that intermediate and low level disinfectants have been designed for use on environmental surfaces and not on invasive medical devices.

Available Methods

Taking Spaulding's system one-step further, the next table categorizes the reprocessing methods currently in use in Canada.

How to choose?

To choose a reprocessing method, the first step is to assess the type of contact the item will make with the patient. Use Spaulding's classification in Table 1.

Table 1

TYPE OF CONTACT	DEFINITION	EXAMPLE	MINIMUM REPROCESSING LEVEL REQUIRED
CRITICAL	Contact with a normally sterile body part	Major Orthopaedic instrument set	Sterilization
SEMI-CRITICAL	Contact with mucous membrane or broken skin	Oral Airway, Flexible Gastroscope	High Level Disinfection
NON-CRITICAL	Contact with intact skin or no direct contact	OR bed, Blood Pressure Cuff	Intermediate or Low Level Disinfection

Continued on Page 35

Zofran®

(ondansetron)

4 mg and 8 mg ondansetron tablets
(as hydrochloride dihydrate)

4 mg/5mL ondansetron oral solution
(as hydrochloride dihydrate)

4 mg and 8mg ondansetron orally disintegrating tablets

2 mg/mL ondansetron for injection
(as hydrochloride dihydrate)

THERAPEUTIC CLASSIFICATION

Antiemetic
(5-HT_3 receptor antagonist)

INDICATIONS AND CLINICAL USE:

ZOFRAN® (ondansetron hydrochloride; and ondansetron) is indicated for the prevention of nausea and vomiting associated with emetogenic chemotherapy, including high dose cisplatin, and radiotherapy.
ZOFRAN® is also indicated for the prevention and treatment of post-operative nausea and vomiting.

CONTRAINDICATIONS:

ZOFRAN® (ondansetron hydrochloride; and ondansetron) is contraindicated in patients with a history of hypersensitivity to the drug or any components of its formulations

WARNINGS:

Cross-reactive hypersensitivity has been reported between different 5-HT_3 antagonists. Patients who have experienced hypersensitivity reactions to one 5-HT_3 antagonist have experienced more severe reactions upon being challenged with another drug of the same class. The use of a different 5-HT_3 receptor antagonist is not recommended as a replacement in cases in which a patient has experienced even a mild hypersensitivity type reaction to another 5-HT_3 antagonist. ZOFRAN® ODT (ondansetron) contains aspartame and therefore should be taken with caution in patients with phenylketonuria.

PRECAUTIONS:

ZOFRAN® (ondansetron hydrochloride; and ondansetron) is not effective in preventing motion-induced nausea and vomiting. There is no experience in patients who are clinically jaundiced. The clearance of an 8 mg intravenous dose of ZOFRAN® was significantly reduced and the serum half-life significantly prolonged in subjects with severe impairment of hepatic function. In patients with moderate to severe hepatic function, reductions in dosage are therefore recommended and a total daily dose of 8 mg should not be exceeded. This may be given as a single intravenous or oral dose.
As ondansetron is known to increase large bowel transit time, patients with signs of subacute intestinal obstruction should be monitored following administration.

Ondansetron does not itself appear to induce or inhibit the cytochrome P450 drug-metabolizing enzyme system of the liver. Because ondansetron is metabolized by hepatic cytochrome P450 drug metabolizing enzymes, inducers or inhibitors of these enzymes may change the clearance and, hence, the half-life of ondansetron. on the basis of available data, no dosage adjustment is recommended for patients on these drugs.

Use in Pregnancy:
The safety of ondansetron for use in human pregnancy has not been established. Ondansetron is not teratogenic in animals. However, as animal studies are not always predictive of human response, the use of ondansetron in pregnancy is not recommended.

Nursing Mothers:
Ondansetron is excreted in the milk of lactating rats. It is not known if it is excreted in human milk, however, nursing is not recommended during treatment with ondansetron.

Use in Paediatrics:
Insufficient information is available to provide dosage recommendations for children 3 years of age or younger.

Interactions
Specific studies have shown that there are no pharmacokinetic interactions when ondansetron is administered with alcohol, temazepam, frusemide, tramadol or propofol.

Ondansetron is metabolised by multiple hepatic cytochrome P-450 enzymes: CYP3A4, CYP2D6 and CYP1A2. Due to the multiplicity of metabolic enzymes capable of metabolising ondansetron, enzyme inhibition or reduced activity of one enzyme (e.g. CYP2D6 genetic deficiency) is normally compensated by other enzymes and should result in little or no significant change in overall ondansetron clearance or dose requirement. In patients treated with potent inducers of CYP3A4 (i.e. phenytoin, carbamazepine, and rifampicin), the oral clearance of ondansetron was increased and ondansetron blood concentrations were decreased.

Data from small studies indicate that ondansetron may reduce the analgesic effect of tramadol.

ADVERSE REACTIONS:

ZOFRAN® has been administered to over 2500 patients worldwide in controlled clinical trials and has been well tolerated. The most frequent adverse events reported in controlled clinical trials were headache (11%) and constipation (4%). Other adverse events include sensations of flushing or warmth (<1%).

Metabolic:
There were transient increases of SGOT and SGPT of over twice the upper limit of normal in approximately 5% of patients. These increases did not appear to be related to dose or duration of therapy. There have been reports of liver failure and death in patients with cancer receiving concurrentmedications including potentially hepatotoxic cytotoxic chemotherapy and antibiotics. The etiology of the liver failure is unclear. There have been rare reports of hypokalemia.

Central Nervous System:
There have been rare reports of seizures.

Hypersensitivity:
Rare cases of immediate hypersensitivity reactions sometimes severe, including anaphylaxis, bronchospasm, urticaria and angioedema have been reported.

Cardiovascular:
There have been rare reports of tachycardia, angina (chest pain), bradycardia, hypotension, syncope and electrocardiographic alterations.

Dermatological:
Rash has occurred in approximately 1% of patients receiving ondansetron.

Special Senses:
Rare cases of transient visual disturbances (e.g. blurred vision) have been reported during or shortly after intravenous administration of ondansetron, particularly at rates equal to or greater than 30 mg in 15 minutes.

Local Reactions:
Pain, redness and burning at the site of injection have been reported.

Other:
There have been reports of abdominal pain, weakness and xerostomia.

Post-Market Experience:
Over 128 million patient treatment days of ZOFRAN® have been supplied since the launch of the product worldwide. The following events have been spontaneously reported during post-approval use of ZOFRAN®, although the link to ondansetron cannot always be clearly established.

Transient episodes of dizziness (<0.01%) have been reported during or upon completion of iv infusion of ondansetron. Rare reports (<0.01%) suggestive of extrapyramidal reactions such as oculogyric crisis/dystonic reactions (e.g. orofacial dyskinesia, opisthotonos, tremor, etc.) have been reported without definitive evidence of persistent clinical sequelae.

There have been rare reports (<0.01%) of myocardial infarction, myocardial ischemia, angina, chest pain with or without ST segment depression, arrythmias (including ventricular, supraventricular tachycardia, premature ventricular contractions, and atrial fibrillation), electrocardiographicalterations (including second degree heart block), palpitations and syncope. There have also been rare reports of hiccups.

Occasional asymptomatic increases in liver function tests have been reported.

Rare cases of hypersensitivity reactions, such as, laryngeal edema, stridor, laryngospasm and cardiopulmonary arrest have also been reported.

SYMPTOMS AND TREATMENT OF OVERDOSAGE:

At present there is little information concerning overdosage with ondansetron. Individual doses of 84 mg and 145 mg and total daily doses as large as 252 mg have been administered with only mild side effects. There is no specific antidote for ondansetron, therefore, in cases of suspected overdosage, symptomatic and supportive therapy should be given as appropriate.
The use of Ipecac to treat overdosage with ondansetron is not recommended as patients are unlikely to respond due to the antiemetic action of ondansetron itself.
"Sudden blindness" (amaurosis) of 2 to 3 minutes duration plus severe constipation occurred in one patient who was administered 72 mg of ondansetron intravenously as a single dose. Hypotension (and faintness) occurred in another patient who took 48 mg of oral ondansetron. Following infusion of 32 mg over only a 4-minute period, a vasovagal episode with transient second degree heart block was observed. In all instances, the events resolved completely.

DOSAGE AND ADMINISTRATION
CHEMOTHERAPY INDUCED NAUSEA AND VOMITING:

ZOFRAN® (ondansetron hydrochloride; and ondansetron) should be given as an initial dose prior to chemotherapy, followed by a dosage regimen tailored to the anticipated severity of emetic response caused by different cancer treatments. The route of administration and dose of ZOFRAN® should be flexible in the range of 8-32 mg a day. The selection of dose regimen should be determined by the severity of the emetogenic challenge as shown below.

Use in Adults:

***HIGHLY EMETOGENIC CHEMOTHERAPY* (e.g. regimens containing cisplatin):**
ZOFRAN® has been shown to be effective in the following dose schedules for the prevention of emesis during the first 24 hours following chemotherapy:

Initial Dose: ZOFRAN® 8 mg infused intravenously over 15 minutes given 30 minutes prior to chemotherapy. OR ZOFRAN® 8 mg infused intravenously over 15 minutes, given 30 minutes prior to chemotherapy, followed by 1 mg/h by continuous infusion for up to 24 hours. OR ZOFRAN® 32 mg diluted in 50-100 mL of saline or other compatible infusion fluid and infused over not less than 15 minutes [i], given 30 minutes prior to chemotherapy.

Post-chemotherapy: After the first 24 hours, ZOFRAN® 8 mg orally every 8 hours[ii] for up to 5 days. No significant differences in terms of emesis control or grade of nausea have been demonstrated between the 32 mg single dose, the 8 mg single dose, or the 8 mg dose followed by the 24 hour 1 mg/h continuous infusion. However, in some studies conducted in patients receiving medium or high doses of cisplatin chemotherapy, the 32 mg single dose has demonstrated a statistically significant superiority over the 8 mg single dose with regard to control of emesis.
The efficacy of ZOFRAN® in highly emetogenic chemotherapy may be enhanced by the addition of a single intravenous dose of dexamethasone sodium phosphate, 20 mg administered prior to chemotherapy.

***LESS EMETOGENIC CHEMOTHERAPY* (e.g. regimens containing cyclophosphamide, doxorubicin, epirubicin, fluorouracil and carboplatin)**

Initial Dose:
ZOFRAN® 8 mg infused intravenously over 15 minutes, given 30 minutes prior to chemotherapy; or ZOFRAN® 8 mg orally 1 to 2 hours prior to chemotherapy.

Post-chemotherapy:
ZOFRAN® 8 mg orally twice daily for up to 5 days.

Use in Children:
Clinical experience of ZOFRAN® in children is currently limited; however, ZOFRAN® was effective and well tolerated when given to children 4-12 years of age. ZOFRAN® injection should be given intravenously at a dose of 3-5 mg/m^2 over 15 minutes immediately before chemotherapy. After therapy, ZOFRAN® 4 mg should be given orally every 8 hours[ii] for up to 5 days.

Use in Elderly:
Efficacy and tolerance in patients aged over 65 years were similar to that seen in younger adults indicating no need to alter dosage schedules in this population.

RADIOTHERAPY INDUCED NAUSEA AND VOMITING:

Use in Adults:

Initial Dose:
ZOFRAN® 8 mg orally 1 to 2 hours before radiotherapy.

Post-radiotherapy:
ZOFRAN® 8 mg orally every 8 hours[ii] for up to 5 days after a course of treatment.

Use in Children:

There is no experience in clinical studies in this population.

Use in Elderly:

Efficacy and tolerance in patients aged over 65 years were similar to that seen in younger adultsindicating no need to alter dosage schedules in this population.

POST-OPERATIVE NAUSEA AND VOMITING:

Use in Adults:
For prevention of post-operative nausea and vomiting ZOFRAN® may be administered as a single dose of 16 mg given orally one hour prior to anaesthesia. Alternatively, a single dose of 4 mg may be given by slow intravenous injection at induction of anaesthesia. For the treatment of established post-operative nausea and vomiting, a single dose of 4 mg given by slow intravenous injection is recommended.

Use in Children:
There is no experience in the use of ZOFRAN® in the prevention and treatment of post-operative nausea and vomiting in children.

Use in Elderly:
There is limited experience in the use of ZOFRAN® in the prevention and treatment of post-operative nausea and vomiting in the elderly.

PATIENTS WITH RENAL/HEPATIC IMPAIRMENT:

Use in Patients with Impaired Renal Function:
No alteration of daily dosage, frequency of dosing, or route of administration is required.

Use in Patients with Impaired Hepatic Function:
The clearance of an 8 mg intravenous dose of ZOFRAN® was significantly reduced and the serum half-life significantly prolonged in subjects with severe impairment of hepatic function. In patients withmoderate to severe hepatic function, reductions in dosage are therefore recommended and a total daily dose of 8 mg should not be exceeded. This may be given as a single intravenous or oral dose. No studies have been conducted to date in patients with jaundice.

PATIENTS WITH POOR SPARTEINE/DEBRISOQUINE METABOLISM:

The elimination half-life and plasma levels of a single 8 mg intravenous dose of ondansetron did not differ between subjects classified as poor and extensive metabolisers of sparteine and debrisoquine. No alteration of daily dosage or frequency of dosing is recommended for patients known to be poor metabolisers of sparteine and debrisoquine.

ADMINISTRATION OF INTRAVENOUS INFUSION SOLUTIONS:

Compatibility with Intravenous Solutions: ZOFRAN® Injection is compatible with the following solutions:

For Ampoules
0.9% w/v Sodium Chloride Injection;
5% w/v Dextrose Injection;
10% w/v Mannitol Injection;
Ringers Injection;
0.3% w/v Potassium Chloride and 0.9% w/v Sodium Chloride Injection;
0.3% w/v Potassium Chloride and 5% w/v Dextrose Injection.

For Vials
5% w/v Dextrose Injection;
0.9% w/v Sodium Chloride Injection;
5% w/v Dextrose and 0.9% w/v Sodium Chloride Injection;
5% w/v Dextrose and 0.45% w/v Sodium Chloride Injection;
3% w/v Sodium Chloride Injection.

Compatibility with Other Drugs:
ZOFRAN® Injection should not be administered in the same syringe or infusion with any other medication with the exception of dexamethasone (see below). ZOFRAN® may be administered by intravenous infusion at 1 mg/hour, e.g. from an infusion bag or syringe pump.
The following drugs may be administered via the Y-site of the administration set, for ondansetron concentrations of 16 to 160 µg/mL. If the concentrations of cytotoxic drugs required are higher than indicated below, they should be administered through a separate intravenous line.

For Ampoules and Vials:

Cisplatin — concentrations up to 0.48 mg/mL administered over 1 to 8 hours.

Dexamethasone — admixtures containing 8 mg of ondansetron and 20 mg of dexamethasone phosphate, in 50 mL of 5% dextrose infusion fluid stored in 50 mL polyvinyl chloride infusion bags, have been shown to be physically and chemically stable for up to two days at room temperature or up to seven days at 2° C–8° C. In addition, these same admixtures have demonstrated compatibility with Continu-Flo® administration sets.
In a clinical study (Cunningham *et al*, 1989) ondansetron (standard dosing regimen) was given to patients receiving cisplatin or non-cisplatin chemotherapy. Eight patients who continued to experience nausea and vomiting were given dexamethasone in addition to ondansetron. In every case there was an improvement in the control of emesis and all patients preferred the combination of ondansetron and dexamethasone.

For Ampoules:

5-Fluorouracil — concentrations up to 0.8 mg/mL, administered at rates of at least 20 mL/hour. Higher concentrations of 5-fluorouracil may cause precipitation of ondansetron. The 5-fluorouracil infusion may contain up to 0.045% w/v magnesium chloride.

Carboplatin — concentrations of 0.18 mg/mL–9.9 mg/mL, administered over 10–60 minutes.

Ceftazidime — bolus i.v. doses, over approximately 5 minutes, of 250–2000 mg reconstituted with Water for Injections BP.

Cyclophosphamide — bolus i.v. doses over approximately 5 minutes, of 100–1000 mg, reconstituted with Water for Injections BP 5 mL per 100 mg cyclophosphamide.

Doxorubicin and Epirubicin — bolus i.v. doses, over approximately 5 minutes, of 10–100 mg as a 2 mg/mL solution. Lyophilized powder presentations can be reconstituted with 0.9% Sodium Chloride Injection USP.

Etoposide — concentrations of 0.144 mg/mL–0.25 mg/mL, administered over 30–60 minutes.

STABILITY AND STORAGE RECOMMENDATIONS:

ZOFRAN® Tablets, Oral Solution, Injection and ODT orally disintegrating tablets should be stored below 30°C.
ZOFRAN® Oral Solution should be stored upright and should not be refrigerated.
ZOFRAN® Injection should not be frozen and should be protected from light.
ZOFRAN® Injection must not be autoclaved.

Stability and Storage of Diluted Solutions:
Compatibility studies have been undertaken in polyvinyl chloride infusion bags, polyvinyl chloride administration sets and polypropylene syringes. Dilutions of ondansetron in sodium chloride 0.9% w/v or in glucose 5% w/v have been demonstrated to be stable in polypropylene syringes. It is considered that ondansetron injection diluted with other compatible infusion fluids would be stable in polypropylene syringes.
Intravenous solutions should be prepared at the time of infusion. ZOFRAN® Injection, in ampoules and vials, when diluted with the recommended intravenous solutions, should be used within 24 hours if stored at room temperature or used within 72 hours if stored in a refrigerator, due to possible microbial contamination during preparation.
Hospitals and institutions that have recognized admixture programs and use validated aseptic techniques for preparation of intravenous solutions, may extend the storage time for ZOFRAN® Injection in admixture with 5% Dextrose Injection and dexamethasone phosphate Injection (concentration of 0.34 mg/mL) in Viaflex bags, at a concentration of 0.14 mg/mL, to 7 days when stored under refrigeration at 2° to 8°C.[iii]

DOSAGE FORMS:

AVAILABILITY

ZOFRAN® Tablets 8 mg:
Oval shaped, yellow, film-coated tablets, engraved '8' on one face and 'GLAXO' on the other. Each tablet contains 8 mg ondansetron (as hydrochloride dihydrate). Available in a tamper-evident polypropylene container of 100 tablets and a unit dosed blister pack of 10 tablets.

ZOFRAN® Tablets 4 mg:
Oval shaped, yellow, film-coated tablets, engraved '4' on one face and 'GLAXO' on the other. Each tablet contains 4 mg ondansetron (as hydrochloride dihydrate). Available in a tamper-evident polypropylene container of 100 tablets and a unit dosed blister pack of 10 tablets.

ZOFRAN® Oral Solution:
Ondansetron 4 mg/5 mL (as hydrochloride dihydrate) is supplied in 50 mL bottles.

ZOFRAN® ODT 4 mg and 8 mg orally disintegrating tablets:
White, round, plano-convex orally disintegrating tablets with no markings on either side, packaged in double-foil blister packs with a peelable, aluminum foil laminate lidding, in paperboard carton with 2 x 5 orally disintegrating tablets per blister. Each 4 mg tablet contains 4 mg ondansetron (base) and each 8 mg tablet contains 8 mg ondansetron (base).

ZOFRAN® Injection:
Ondansetron 2 mg/mL (as hydrochloride dihydrate) for intravenous use is supplied in 2 mL (4 mg) and 4 mL (8 mg) ampoules, in boxes of 5 ampoules and 20 mL (40 mg) vials, packed in individual cartons.
Ondansetron hydrochloride is a SCHEDULE "F" drug.

Full prescribing information available to healthcare professionals upon request.

Revised September 16, 2003.

i Infusion of 32 mg ZOFRAN® for injection should take place over a period of not less than 15 minutes, because of increased risk of blurred vision.
ii The efficacy of twice daily dosage regimens for the treatment of post-chemotherapy emesis has been established only in adult patients receiving less emetogenic chemotherapy. The appropriateness of twice versus three times daily dosage regimens for other patient groups should be based on an assessment of the needs and responsiveness of the individual patient.
iii As with all parenteral drug products, intravenous admixtures should be inspected visually for clarity, particulate matter, precipitate, discoloration and leakage prior to administration, whenever solution and container permit. Solutions showing haziness, particulate matter, precipitate, or discoloration or leakage should not be used.

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Custom Procedure Packs - The Regina Experience

Author: *Darlene Boyd, Processing Manager, Regina Qu'Appelle Health Region*

A custom procedure pack is a pre-packed bundle containing disposable drapes, gowns, and other items such as suctions, cauteries etc.

Regina Qu'Appelle Health Region's custom procedure pack (custom pack) experience began in Regina in 1997. The first pack made for cardiovascular surgery – specifically for coronary artery bypass grafts (CABG). The reason we needed this pack was initially required for reasons not related to budgets. Our linen quality was poor and, as a result, our open-heart patients were cold and wet when they were transported to intensive care. They also had to be defibrillated in the Operating Room because of low body temperatures. Once we started using the disposable drapes, in the custom pack, the patients stayed both warm and dry and the need to defibrillate was reduced. An additional benefit was that the length of stay in intensive care was shortened by an average of two days for a normal patient. With the cost for an Intensive Care patient at $700 a day, and assuming ten cases per week, the annual savings would be approximately $728,000.

Photo by J. Porteous

Open custom pack

The Issues

After implementing the CABG pack we decided to expand on our pack program as a way to resolve some issues in other areas. In addition to improved patient comfort and recovery we had challenges in the areas of linen supply, the amalgamation of three hospitals, standardization, and time-management/cost effectiveness.

Linen Supply

We had been experiencing several problems with our linen supply. One of the biggest problems was a lack of supply. The linen for our hospitals came from an off-site, hospital–owned, central laundry. We were constantly falling short of our daily OR quota for linen bundles. When assembling our bundles we often discovered we were missing the main drapes. This led to assembly delays.

The quality of linen was an issue of equal concern to the pack room staff, the OR nurses, and the surgeons. Some linen drapes are designed for a limited number of uses. The laundry had no system for monitoring and controlling the number of uses and, as a result ,the drapes were often used too often, became thin and began to lack water repellency. The OR often reported strikethrough – a big concern as it can mean result in contamination of the operative area.

Another linen problem was that there were no specialty drapes available. The operating room staff were trying to adjust the basic drapes to fit different patient positions. Consequently drapes were being cut and ruined and needed regular replacement.

The OR staff and surgeons also found the cloth gowns to be heavy and hot. For long procedures they were very uncomfortable. For operations involving a lot of blood loss the surgeons were finding their scrubs soaked in blood and fluid under the gown proving that the gowns had no water repellency.

Ongoing linen shortages had also led to a poor relationship between the processing staff and the laundry. The laundry staff suspected that hospitals were over ordering, and hoarding, linen and the processing staff felt the laundry was deliberately short-changing them on linen supply.

Amalgamation

As a region we were fortunate to already have custom packs in production when the

Custom Procedure Packs (cont.)

amalgamation of three hospitals (Plains, Pasqua, and Regina General) began. The closure of the Plains hospital, and the transferring of its services to the remaining two hospitals was extremely stressful for the OR and the processing staff. The other two sites were not prepared for the volume of work that resulted from the move of additional procedures in to the central processing area. If the preparation of custom packs had not already been implemented then two additional full-time equivalents (FTEs) would have been required at a cost of approximately $48,000 per year.

Standardization:

Standardization was an issue even before amalgamation. Surgeons were working at all three sites. And, in some cases, using different instrument sets and different draping procedures in each location. To minimize confusion and streamline preparation, we began to prepare packs that were the same for all surgeons at all sites. The surgeons accepted it, it worked very well during the teaching process, and it was generally considered a successful change.

Cost-Effectiveness/Time Management:

Prior to the implementation of custom packs our pack room required one full-time supervisor and two other full time staff, every day, for the folding of linen and preparation of bundles. At the end of a busy, hectic day additional time was required to put away items that had not been used or had been picked in error by the OR staff. Usually the equivalent of a full supply cart was sent back to processing from the OR. It could take as long as an hour to put these items away. The annual cost for this task was approximately $3,000 - $4,000. The extra handling of these items also increased the chance of contamination.

The Implementation Process

A custom pack contains all of the sterile, single-use, items required for a specific procedure. The packs are built specifically for our hospitals and for each procedure.

The contents of a basic pack are:

1) the back table cover (used as the pack's outer wrap);
2) the drapes suitable for the position of the patient;
3) the prep dish and components;
4) gowns for the nurse, surgeon, and assistant;
5) and a variety of other items such as dressings, needle board, cautery, and scalpel blades.

After we created our first pack (for CABG) other services began to request them. Neurosurgery now has a pack for craniotomies and a disc pack for back surgery. When orthopaedics requested a pack, standardization came into effect (unlike some procedures, orthopaedic surgery is done at all three of our region's hospitals). Minor and major orthopaedic packs standardized for all three hospitals and general surgery packs soon followed.

Life After Packs

After the custom packs, with single use drapes, were implemented the region's linen supply issues were resolved. For a large variety of procedures we now have specific drapes that fit perfectly without gaps, leaks, or strike-through. The gowns light, cool, and totally water-repellent.

The staff requirements in our linen room have been reduced from three FTEs to one FTE (the additional staff were relocated to other areas in

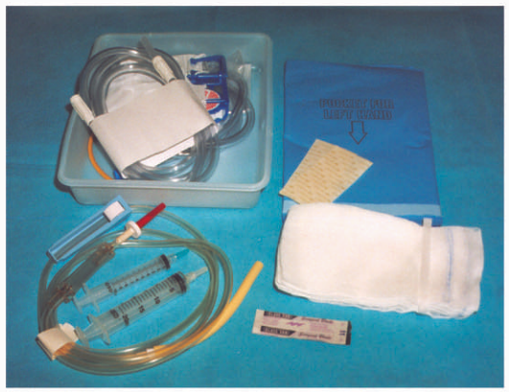

Photo by J. Porteous

Custom pack contents

Custom Procedure Packs (cont.)

processing). And the remaining individual actually has time available to assist in other areas. The annual savings in the linen department have been estimated at $48,000.

The task of returning and restocking unused or incorrect items has been eliminated – for an annual savings of $3,000 to $4,000 in HR costs.

Custom packs have changed the processing departments cart preparation process for the operating room schedule. This function is now completed by the two night processing aides. For an average operating room slate for the next day it would take the staff about three hours.

The frustration and stress level for everyone involved has also been lowered – processing staff no longer have to search for individual items to pack for each case and the OR staff do not have to deal with the frustration of receiving incorrect items.

Custom packs have also really helped with standardization and, as a result, with cost issues. Many items are now standardized throughout all packs – for example, we now use the same cautery in all our packs throughout the region. Once we selected a standardized component that met with the surgeons' and coordinators' approval it was placed on our regional purchasing list. By ordering a large volume of one item, instead of small quantities of many items, we benefited from reduced volume pricing. Standardization was not an easy task because not only did the surgeons and coordinators have to agree on the components, but the surgeons also had to change some of their practices. However in the end it was actually less confusing for the OR staff as they became familiar with the standard components.

Impact in the OR

The impact of custom packs in the operating room was just as positive as it was in the Processing Department. Changes to custom packs are controlled by the specialty coordinators. The coordinators in our region consider service needs, remove or change items to avoid wastage, and look for new opportunities to reduce component costs.

Comments from interviews with three specialty coordinators say it all!

Lori Stricker, the Neurosurgery Specialty Coordinator at the Regina General Hospital, finds the packs convenient and quick. Her department has been using the packs for about five years. Stricker estimates that her nurses save as much as 10 to 15 minutes in set up time for each procedure. In some situations time saved allows for an extra short case being added at the end of the slate. With hospitals dealing with long waiting lists the time saving is quite an asset.

Stricker also noted that the packs have resolved strike-through issues. And she likes the fact that each pack is only used on a single patient, and is then discarded, thus eliminating the risk of transferring organisms from one patient to another.

Stricker also values the fact that our region's packs are latex free – which means more safety for the patient and less stress for the OR staff.

Myrna Pugh, the Gynaecology Specialty Coordinator, uses a large quantity of specialty packs because of their wide range of surgical patient positions and their laparoscopic procedures. Pugh feels that the packs work well as long as they are carefully monitored and controlled for waste. Gynaecology has been using custom packs for five years.

She also noted that student training is easier because the labeling on the drapes clearly shows how to unfold them. As a result there are fewer drapes being contaminated and no time lost due to mishandling of the drapes. The students also are not as intimidated as they were with linen draping.

Pugh also finds that patients draped for laparotomy procedures now stay drier and during multi-procedures the patient is no longer over draped. Pugh also noted that the standard of drapes is more consistent and the integrity of the case is better.

Custom Procedure Packs (cont.)

Photo by J. Porteous

Custom pack

Brenda Zdunich, the Cardiovascular Specialty Coordinator, really sees the benefit of the patient being dry at the end of the operation. In the past, when taking the vein for the coronary bypasses, the drapes under the legs were saturated and had strike through when we used linen. Now, with the single-use drapes, the patients are dry.

Zdunich also finds that custom packs are efficient for emergencies. The circulating nurse can spend more time with the patient and the anaesthetist, instead of being back with the scrub nurse opening packages. In emergency situations, the room is now ready to go even before the patient even arrives.

Zdunich says she would never go back to linen. The Cardiovascular team looks forward to the day when all they have to open are their gloves!

In summary, since their introduction in 1996 custom packs have been very popular in both the OR and the processing department of the Regina Qu'Appelle Health Region. We now have forty different packs and have expanded from basic packs to more specialized ones. These include abilation packs, laparoscopic nephrectomy packs and paediatric packs. Nurses are happier; surgeons and patients are more comfortable. Some of our nurses have even claimed that they would quit if we ever stopped using custom packs!

For more information please contact the author at Darlene.boyd@rqhealth.ca.

BENEFITS IN REGINA:

PROCESSING

Case cart preparation was reduced to two night staff picking for about two hours.

Lower stress level & frustration

Save 1 hour/day returning incorrectly picked items – annual savings of $3,000 $4,000.

Eliminated 2 positions in Sterile Processing at approximately $48,000 per year

Dollar savings from standardizing to less expensive components – the packs drove the standardization.

Reliable drape supply

NURSING

No strike through

Reduced ICU stay for CABG – annual savings of $728,000.

Patients dry and warmer

Standardized components/draping

Specialty draping to fit needs

Surgeons now cool and comfortable

Saving set up time – 10 to 15 minutes per procedure

Easier teaching of new staff

Latex Free

Quick set up for emergencies

More time can be spent with the patient pre-op

Greater employee satisfaction

Choosing A Reprocessing Method (cont.)

Table 2

TYPE OF CONTACT	MINIMUM REPROCESSING LEVEL REQUIRED	REPROCESSING METHODS CURRENTLY AVAILABLE
CRITICAL	Sterilization	• Steam • Ethylene Oxide • Hydrogen Peroxide Gas Plasma (Sterrad) • Liquid Peracetic Acid (Steris System I) • Ozone (TSO3)
SEMI-CRITICAL	High-Level Disinfection	• Glutaraldehyde • *ortho*-phthalaldehyde (OPA) • Hydrogen Peroxide (apx. 7%) • Hot Water Pasteurization
NON-CRITICAL	Intermediate or Low-Level Disinfection	• Alcohol (70%) • Phenolics • Moist heat • Halogens (Chlorine & Iodine) • Hydrogen Peroxide (apx. 3%) • Quaternary Ammonium Compounds (QUATS)

The second step is to identify the alternatives that will provide the minimum reprocessing level necessary to keep patients safe. Use Table 2.

The third step is to compare the choices within a selected category. Use Table 3 to identify the issues for comparison of the selected reprocessing methods.

EFFICACY

In reviewing any reprocessing method, the first criterion to consider is efficacy. If the method is not effective against the spectrum of microorganisms of concern, patients will not be safe from infection. For example, during the reprocessing of anaesthetic equipment, tuberculosis is always a concern. Equipment must therefore receive high-level disinfection. The processing time for high-level disinfection is based on the time needed to kill *M. tuberculosis var. bovis*. Low-level disinfection procedures are not as potent as high-level disinfection and were not designed to be used on instruments.Following Spaulding's classification will ensure appropriate spectrum efficacy.

Once efficacy is confirmed, a short cycle/contact time is usually preferable. This will allow instrument inventory to be turned around quickly as possible.

The effectiveness of any sterilization or high-level disinfection process must be monitored.[2,3] Some monitoring requirements may be more onerous than others and this will have implications for ease of use.

SAFETY

Once it is determined that the efficacy of a system is appropriate, the next issue to address is safety. Staff using any system must be safe. Ideally, a reprocessing method will pose no occupational health or safety risks. If that is not possible, the risks associated with any process must be mitigated. Include the costs of mitigation when comparing systems or methods. Environmental safety is also a concern and the same considerations apply to it as to staff safety. Ideally, the method should cause no harm but, if it might, the costs of mitigation must be factored in to any comparison.

Confirm device compatibility with the reprocessing method(s) being considered. Contact the device or the reprocessing method

Table 3

CRITERIA	ISSUES FOR COMPARISON
EFFICACY	• Spectrum • Cycle/Contact time • Monitoring protocols
SAFETY	• Staff OH&S • Instrument & equipment compatibility • Environment
BENEFITS & LIMITATIONS	• Ease of use • Cost per use or per item processed • Total processing time

Choosing A Reprocessing Method (cont.)

manufacturer for written guidelines. Reprocessing instructions accompany all new reusable medical devices. Keep a copy on file.

BENEFITS AND LIMITATIONS

Once it has been determined that the processes being considered are both effective and safe, the in-use characteristics become relevant. Depending on the processes, there may be a wide variety of method-specific benefits or limitations to consider. The three listed in Table 3 are common to all reprocessing methods. Add any others that are relevant to your facility and to the specific methods being considered.

CONCLUSION/SUMMARY

The choice of a reprocessing method depends on many factors and there is no one perfect method that suits all situations. The needs of patients, staff and the healthcare facility, as well as the types of products available at any given time, will all influence the decision. And that decision will not be final. Products change as do consumer needs. As a result the reprocessing decision will need to be reviewed, on a regular basis, in order to ensure that it remains current.

For further information on this topic, or if you have any questions, please contact the author at bbolding@medca.jnj.com.

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2. Canadian Standards Association. *Z 314.3-01 Effective Sterilization in Health Facilities by the Steam Process*. CSA International. Toronto: 2001. pp 18-26.
3. Society of Gastroenterology Nurses and Associates, *Guideline for the Use of High-Level Disinfectants and Sterilants for Reprocessing of Flexible Gastrointestinal Endoscopes* p. 4. From the web www.sgna.org 30 August 2003.

CORL CORRAL (cont.)

and top of the head is very important to preclude any side vents. It is believed that staff members may have become infected with SARS due to improper wearing and handling of masks.

Use of the regulation *N95* masks, with proper fit testing by the Occupational Health department, has become standard for SARS and related viruses. Initially it was thought that surgical masks were sufficient to protect against SARS but that theory has been disproved. Refusal to modify facial hair to accommodate the proper fit of N95 masks presents risk of inadequate protection. In addition, fit testing needs to be redone every year or two. The developments in this field and changing information are not widely understood among team members.

Conclusion

It is of grave concern, in this age of mass media and easy access to information, advanced education and scientific evidence, that a lack of compliance to the fundamental basics of hand washing and the proper wearing of masks still pose an infection prevention risk. It is sometimes said, "The further ahead we are, the further behind we become." Key points for safe health care teams include having current knowledge, sharing the information, following protocols and ensuring your teammates comply. Be a role model for all! Our patients, friends and families may live because of two basics in health care – hand washing and the proper use of masks.

WASH YOUR HANDS!

References:

1. Source: www.handhygiene.org

Infection Prevention Source Web Sites:

www.hc-sc.gc.ca
www.health.gov.ab.ca
www.cdc.gov/ncidod/sars
www.cdc.gov/ncidid/hip.ARESIST/mrsawww.cdc.gov/flu/avian

Operating Room Open House

Submitted by: *Carleton Memorial Hospital Operating Room Nurses Jane Gaddas, Pat McLellan, Nancy Kilfoil, Grace Harris, Shirley Pickard, Sheri Kinney, and Bev King as well as OR Aide Carol Davenport.*

Photo by B. King

OR Nurse, Grace Harris, demonstrating video colonoscope to medical student, Emma Burns

On November 14, 2003, in recognition of Operating Room Nurses Day, the OR Staff at The Carleton Memorial Hospital (Woodstock, New Brunswick) hosted an open house for all hospital staff. The goal was to promote increased awareness of the surgical services the hospital provides.

Five displays were set up in the main corridor, in one OR suite, and in the recovery room. They showcased ophthalmology instruments and equipment, abdominal surgical instruments, tourniquet, pacemakers, lead aprons, a colonoscope, a gastroscope, a bronchoscope, and an endoscope washer. A nurse provided an oral explanation to visitors at each station.

One operating room was set up to feature a mock laparoscopic cholecystectomy. Two nurses demonstrated the camera equipment and the instruments used during this procedure.

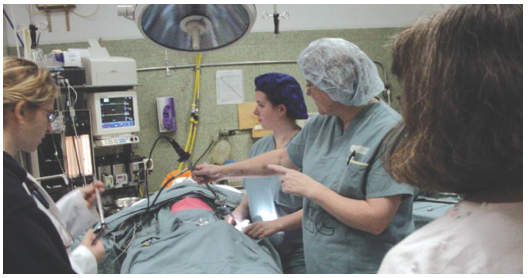

Photo by B. King

OR Nurses, Sheri Kinney and Nancy Kilfoil, demonstrate a laparoscopic procedure to visitors.

Photo by B. King

OR Aide, Carol Davenport, demonstrates endoscope washer/sterilizer

Homemade snacks were also provided, and the sale of fudge raised money in support of the upcoming 2004 Atlantic OR Nurses Conference (Moncton, Oct 3 to 6, 2004).

We received a lot of positive feedback from the many staff that attended the open house. It is our hope to host another event in the future and to expand it to include the general public.

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