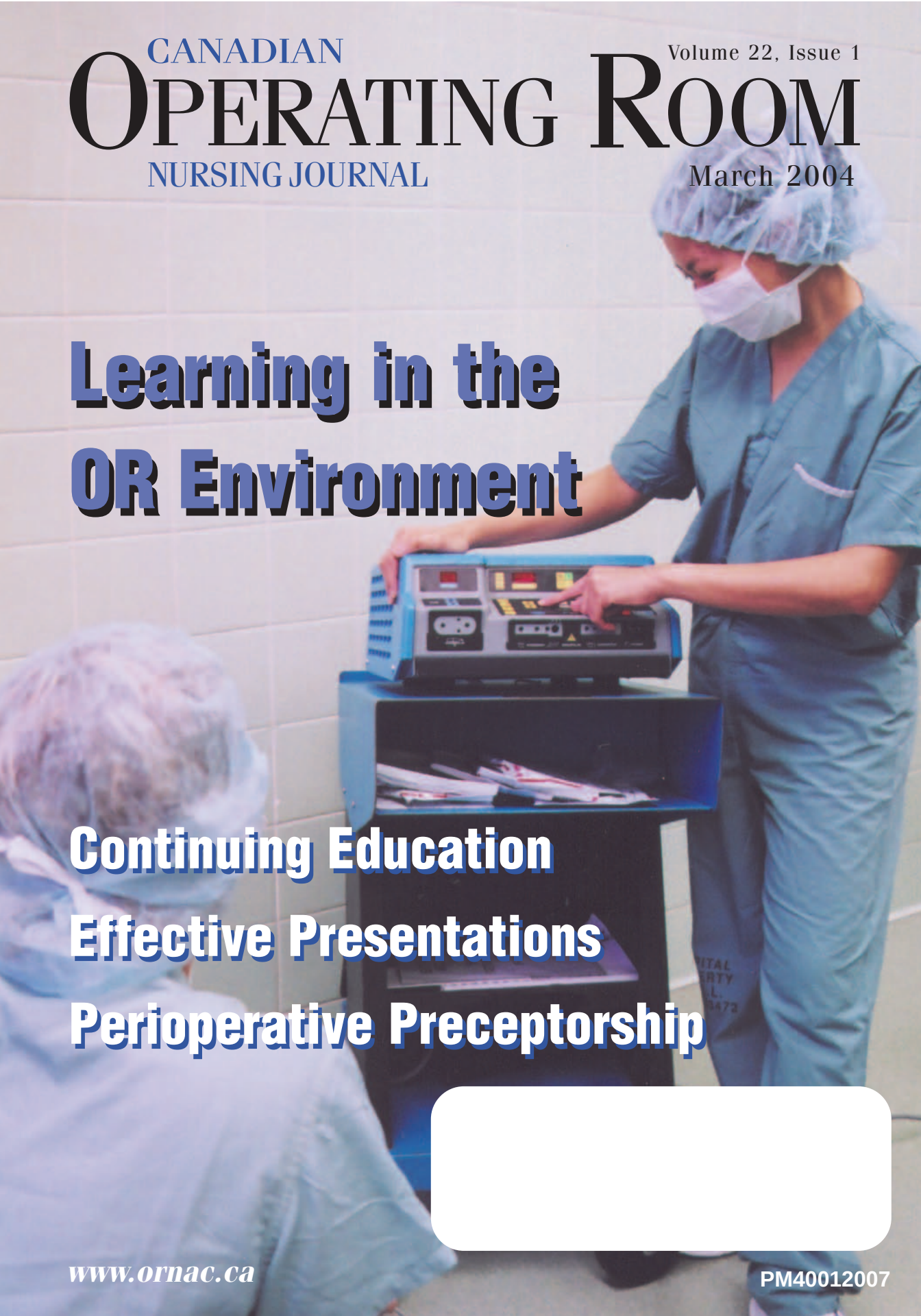
CANADIAN
OPERATING ROOM
NURSING JOURNAL
Volume 22, Issue 1
March 2004

Learning in the OR Environment



Continuing Education

Effective Presentations

Perioperative Preceptorship

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President's Message

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

Last year, as I traveled on *ORNAC* business, I found that I was coming across the same topics no matter where I was. At the 18th National *ORNAC* Conference, the *National Association of Theatre Nurses* (*NATN*) Annual Congress, the *Operating Room Nurses Association of Alberta* (*ORNAA*) conference or at meetings with the *Saskatchewan Operating Room Nurses Group* (*SORNG*) the topics and the themes were pretty consistent. Our world may be physically vast, but it seems we are all dealing with the same issues around the world.

In Harrogate, UK, Calgary, Alberta, Humboldt, Saskatchewan, and Winnipeg, Manitoba, speakers addressed similar topics – infectious diseases, recruitment, retention, leadership, and mentoring/preceptorship – all topics some of us may be tired of discussing! If so, be comforted by the fact that you do not suffer alone. No matter your location on the globe, it seems you will be dealing with these same issues.

In Harrogate, at our *Council of National Representatives* meeting for the *International Federation of Perioperative Nurses* (*IFPN*), President Kate Woodhead asked each of the attending countries to tell us the top three perioperative nursing issues in their home country. From A to Z (or Australia to Zambia) it was the same three issues being voiced – recruitment, retention, and staff shortages.

Leadership is often deemed to be somebody else's domain. Many feel they do not need to lead because they have not been placed in a leadership job or role. Leaders are not instantly created once they reach a certain career level or earn a certain title. They grow in to leaders throughout their career – often right before our very eyes! The leader within your perioperative setting is the person teaching, mentoring, encouraging colleagues, or acting as one of your unit's decision makers. This is not a title – it's an attitude.

ORNAC business has often taken me away from my own perioperative setting. However, I still find myself surrounded, in every different room in every different city or town, by perioperative leaders from every job offered in theatre nursing.

As the year advances, so do our leaders. Shortly after you receiving this journal we will witness the first ever IFPN Seminar Day! This event will take place in Adelaide, Australia, on Wednesday, April 28, 2004.

That venue will find an abundance of leaders forging the future and advancing our specialty. *ORNAC* will be well represented by Past-President Mary Knight. Mary has been asked by IFPN to speak and one of her topics will be *SARS – a Chinese & Canadian Perspective*. Once again, different venue, similar issues!

So what can we all learn from this? How can we be part of the global solution? There are many ways that each of us can help lead perioperative nurses, and our practice, toward solutions.

Get involved with a committee • Attend conferences to learn different perspectives on the problem and solutions • Keep in touch with ORNAC so that you know what others are doing • Share your knowledge and ideas for solutions - conduct research, write articles • Participate in job fairs • Attend high school career days • Always be positive about the field of nursing as you never know who may be listening • Be a mentor

As 2004 advances so can we all. I wish you all increased knowledge, new ideas, and continued growth this year and for many years to come.

***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)

L'an dernier, alors que je voyageais pour affaires pour *l'AIISOC*, j'ai découvert que les mêmes sujets étaient abordés dans toutes les régions. A la 18e conférence nationale annuelle de *l'AIISOC*, au congrès annuel du *National Association of Theatre Nurses (NATN)*, à la conférence *de l'Association des infirmières et infirmiers de salles d'opération de l'Alberta (ORNAA)*, ou aux rencontres de L'Association des infirmières et infirmiers de salles d'opération de *Saskatchewan (SORNG)*, les sujets et les thèmes étaient plutôt similaires. Notre monde peut être vaste physiquement, mais il semble bien que nous fassions face aux même enjeux.

A Harrogate (G.-B.), Calgary (Alberta), Humboldt, Saskatchewan et Winnipeg, les présentateurs ont traité des même sujets: maladies infectieuses, recrutement et rétention du personnel, leadership et mentorat. Vous en avez sans doute assez d'entendre parler de ces sujets, mais sachez que vous n'êtes pas seuls! Peu importe votre localisation sur la Terre, il semble que vous faites face aux mêmes enjeux.

À Harrogate, à la rencontre du *Council of National Representatives pour la Fédération internationale des infirmières et infirmiers en soins périopératoires (IFPN)*, la présidente, Kate Woodhead a demandé à tous les représentants des différents pays de nommer les trois enjeux-clé des soins périopératoires de notre pays. De A à Z, soit de l'Australie au Zambie, les mêmes trois enjeux ont été identifiés: recrutement, rétention et manque de personnel.

Le leadership est souvent reconnu comme l'affaire de quelqu'un d'autre. Plusieurs personnes croient que diriger n'est pas nécessaire puisqu'elles ne sont pas dans un rôle de gestion. Les leaders n'apparaissent pas instantanément parce qu'ils ont atteint un certain niveau ou un certain titre; ils le deviennent au cours de leur carrière, sous nos yeux! Le leader au sein des soins périopératoires est celui qui enseigne, encourage ses collègues, pratique le mentorat ou prend des décisions. Ce n'est pas un titre, c'est une attitude.

Les affaires de *l'AIISOC* m'ont souvent retenu hors des installations des soins périopératoires. Cependant, je me trouve entourée, dans toutes les salles de toutes les villes, par des leaders de tous les domaines des soins périopératoires.

L'année progresse et nos leaders également. Peu de temps après la parution de ce journal se tiendra le premier séminaire de l'IFPN. Cet événement se tiendra à Adélaide en Australie, le mercredi 28 avril 2004.

Cet événement réunira un nombre important de leaders qui forgent l'avenir de notre spécialisation. *L'AIISOC* sera représenté par l'ancienne présidente, Mary Knight. L'IFPN a demandé à Mary de présenter l'un des sujets: *Le SRAS: une perspective chinoise et canadienne*. Une fois de plus, un nouvel événement et des sujets semblables!

Que pouvons-nous apprendre d'un événement comme celui-ci? Comment pouvons-nous prendre part à une solution globale? Il y a de nombreuses manières pour nous tous de devenir leaders en soins périopératoires, dans nos pratiques:

S'impliquer dans un comité • Assister aux conférences pour apprendre les différentes perspectives d'un problème et ses solutions • Demeurer en contact avec l'AIISOC pour savoir ce que les autres font • Partager vos connaissances et vos idées pour trouver des solutions: faire de la recherche, écrire des articles • Participer aux foires d'emploi • Assister aux journées-carrière des écoles secondaires • Être toujours positif à propos du domaine des soins infirmiers en sachant que vous ne savez pas toujours qui est à l'écoute • Être un mentor

Je vous souhaite d'accroître vos connaissances et de continuer votre développement au cours de la nouvelle année et des années à venir.

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Published Quarterly ✦ Volume 22, Issue 1, March 2004

A peer-reviewed Journal published quarterly for the Operating Room Nurses' Association of Canada by Clockwork Communications.

Editor: Deborah Murphy
Art Director: Sherri Keenan

Canadian Operating Room Nursing Journal

c/o **Clockwork Communications**
Quinpool RPO #33145
Halifax, NS B3L 4T6
Tel: 902.497.1598
Fax: 902.444.0694
E-Mail: Contact@ClockworkCanada.com

Non-Member Subscription Rates

Canada	$30 *plus GST/HST*
United States	$48
Other Countries	$50
Single Copy Orders	$10 *+ tax in Canada*
	$15 *outside Canada*

HST# 886-118-926-RT001
I.S.S.N. No. 0712-6778

Publications Mail Agreement No. 40012007
Return Undeliverable Canadian Addresses to PO Box 33145
Halifax NS B3L 4T6
subscriptions@ClockworkCanada.com

EDITORIAL CONTENTS

Judy Vnabia, RN, instructs student nurse Jennifer Leach on safe use of electrosurgery unit
Cover photo by Joan Porteous

INDUSTRY HAPPENINGS

In the December 2003 issue we printed an incorrect e-mail address for Greg Samson of Operation Smile. He can be reached at gregorysamson@hotmail.com. Our apologies for any inconvenience caused.

ORNAC Executive

ORNAC Board Members

Continuing Education

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

ABSTRACT

Advances in medicine and technology are demanding increased, and more diverse, education and learning. To provide quality patient care perioperative nurses need to be up to date. Is it possible to accomplish this task in our era of healthcare staff shortages and budget cuts? Step outside the traditional classroom and see where it leads. Continuing education, or mandatory education hours are also requirements for a growing number of professional bodies. Can we continue to meet this demand?

Photo by J. Porteous

Educational Videos

Continuing Education – What is all the Fuss About?

Education is one of the most important aspects of perioperative nursing practice. All perioperative team members, regardless of their position – manager, general duty, educator, team leader, charge nurse, director – have multiple demands on their time. Family, religion, personal commitments, and professional obligations are just a few examples. How, and when, will continuing education fit in to all our lives?

While not all regulating bodies are currently demanding a minimum number of continuing education hours, many are in the process of adding this criteria. Still others are in the planning phase for future implementation. In the very near future continuing education will be a necessary reality throughout perioperative nursing practice.

How will perioperative nurses meet the demand? Budget cuts and the decreasing numbers of nursing personnel create educational challenges. Who will work while we learn? Who can take the time to attend an education session or conference? Where will the resources be found to fund ongoing education?

To meet these challenges we need to put aside our concept of the classic, or traditional, ideas of learning and find new solutions.

The classic, old-fashioned, classroom and lecture mode have been virtually replaced by modern technology and techniques. With a decrease in our available time and resources, the traditional classroom setting is often rejected. While this educational format is not completely gone, it is more difficult to access. We are learning to take our learning moments when, and where, we can. Today's issues demand that we invent ways to learn and to remain competent at our practice.

The reality is that we now do more with less… and we do it faster! Education needs to be consumed in the time we have available, offered in varied forms of delivery, and made use of all available resources. The classroom has moved out to meet the student and our ongoing educational opportunities are beginning to focus on "tidbits" of learning.

The burden of the education solution falls to the education team at each medical facility. Providing appropriate and flexible learning opportunities is a very tall order for the education team to fill – and even more challenging for those hospitals that do not have

Continuing Education (cont.)

an education team. Those at facilities with dedicated education time and resources are very fortunate. More often than not our restricted resources can leave the theatre staff functioning as their own educational resource.

Here are some examples of innovative learning/teaching possibilities available in a "bits and bites" format. You may be surprised at the options available as far as the location and mode of learning opportunities.

- **Video and Audio Tapes** – sign them out to use at home
- **Meetings** – professional, committee, staff
- Post-it-cards – stick on the bathroom door or a locker
- **Read** – journal, article, textbook
- Online – view websites and read articles
- **CD's** – either general medical, surgical, or product related
- **Display** – a bulletin board or booth
- **Tours** – be shown around other departments
- **Self Study Modules** – participate in or run a mini training course
- **Posters** – stop and read them
- Hospital intranet – access training and information resources
- **Lecture** – give one or attend one
- **Demonstration** – attend to learn about new equipment
- **Information Card** – send one to a peer

While not all of us have home access to a computer, we can often access internet connections at work, at the library, through a friend, or at an internet café. The world wide web offers phenomenal resources. Or try faxing another department with news from your area. If your department has a "Fact Sheet", on topics such as MRSA, read it and be sure to pass it on to a colleague. That sheet of paper may be the only learning opportunity there is this week!

Every "bit" of education helps and there is no such thing as wasted knowledge. An often untapped source of new knowledge is the coffee break. Invite a colleague to join you and spend fifteen minutes discussing your burning issues. This "bite" of education offers you social company, private instruction, and a break, all at the same time! *Lunch and Learn* sessions are cropping up in many workplaces. They allow participants to bring lunch and learn while they eat. Individuals can also put on earphones any day and munch their lunch while listening to a discussion of a new procedure that might be required next week.

Workplace posters should be scanned for educational opportunities such as lectures or product demonstartions. By jotting down the details, and keeping a calendar of events on our workplace lockers, we will be ready to attend if the time becomes available. Handing out a fact sheet, about any subject, while listening to the morning report can provide all of your co-workers with a learning opportunity – it is probably the only time of day when everyone is in the same room.

Mail slots are also fast and effective means of mass communication.

The telephone is also a wonderful communication tool. It can be used to find out health information from a local library or on-site health sciences library. Conference calls have been used, for many years, as a tool for nurses to consult regarding patients, epidemics, treatments or medication use. Telenursing has been present in rural and remote communities for decades. It has enhanced patient care, furthered treatment and assisted in the delivery of services.

Digital video communication allows for teledelivery, almost anywhere in the world, of health promotion, education, disease prevention and treatment, robotic or remote surgeries, and classroom lectures. I recently viewed the new minimally invasive suite, at Mount Sinai Hospital in Toronto, through the internet. I also "attended" a lecture on SARS where the speakers were in Toronto, Geneva and Atlanta… and I was in Regina!

Continued on Page 12

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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Continuing Education (cont.)

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The Staff Lounge Provides Learning Opportunities

We also have seen the rise of telephone health hotlines used to provide information, education and instruction to patients. Technology and telecommunications continue to advance and we continue to use these resources in our practice. Find out if these resources are available in your community and if they are then access this mode of learning.

This list displays more alternative ways of learning. Some have been discussed in this article, while others are designed to get you, the reader, thinking about alternative learning opportunities that you see every day.

- Fax-
- Coffee break -
- Internal memo -
- Department Newsletter -
- Professional Newsletter -
- Word match sheets -
- Fill in the blanks sheets -
- Fact Sheet -
- Lunch & Learn -
- Facility newsletter -
- Library visit -
- Health chat room -
- Bulletin board -
- Workbooks -

We can learn from others in our workplace by assisting in a research project or asking a physician if you, and your perioperative colleagues, would be welcome at rounds or at a medical presentation. Facilities with intranet capabilities often have their own educational presentations available online.

Finding moments for ongoing education is difficult. The poster you saw and read as you left to go home may be the only educational opportunity you have time for this week. Grab the opportunities while you can – scan a journal in the staff room or keep a professional journal by your bathtub.

An often forgotten resource is your professional body. Get involved or tap in to the educational options it provides. This also applies to special interest groups. Specialized groups offer a wealth of information geared to the specialty they support. At the very least these perioperative groups will provide a network of contacts for your use. Invite other members in to your OR for coffee, a chat, to sit in on "Question and Answer Time" or an information session, or to conduct a presentation.

Our industry partners or sales representatives, and their companies, will often have information pamphlets, CDs, videos, or even qualified educational consultants available for perioperative nurses. Other companies have continuing education available on-line as well as inbooklet form. Contact your sales or customer service representatives and find out what is available.

Last, but not least, attend conferences and workshops whenever the venue, topics, and dates are suitable. The benefit of these events is they offer a large number of learning hours, in one location, over a short period of time.

Photo by L. Socha

Sales rep Brian Balliant works with OR Educator Marla Ewen

Continuing Education (cont.)

Photo by J. Porteous

Educational CDs

Remember to take the power of learning and teaching to your theatre with you daily. Take advantage of continuing education in any manner that it is offered to you and you will continue to grow, learn, and meet all of the professional challenges put before you.

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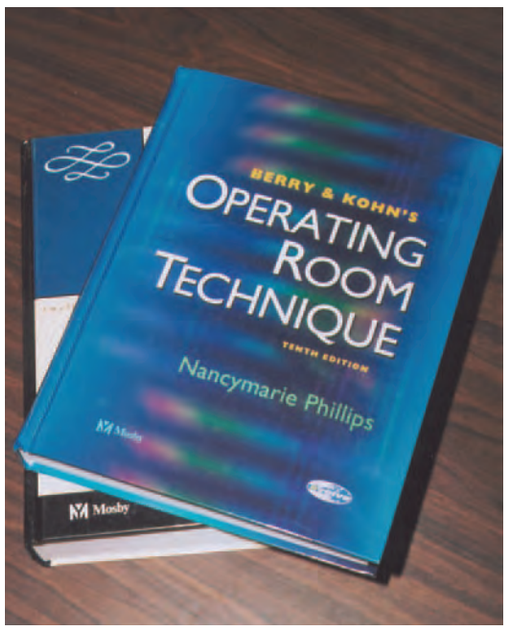

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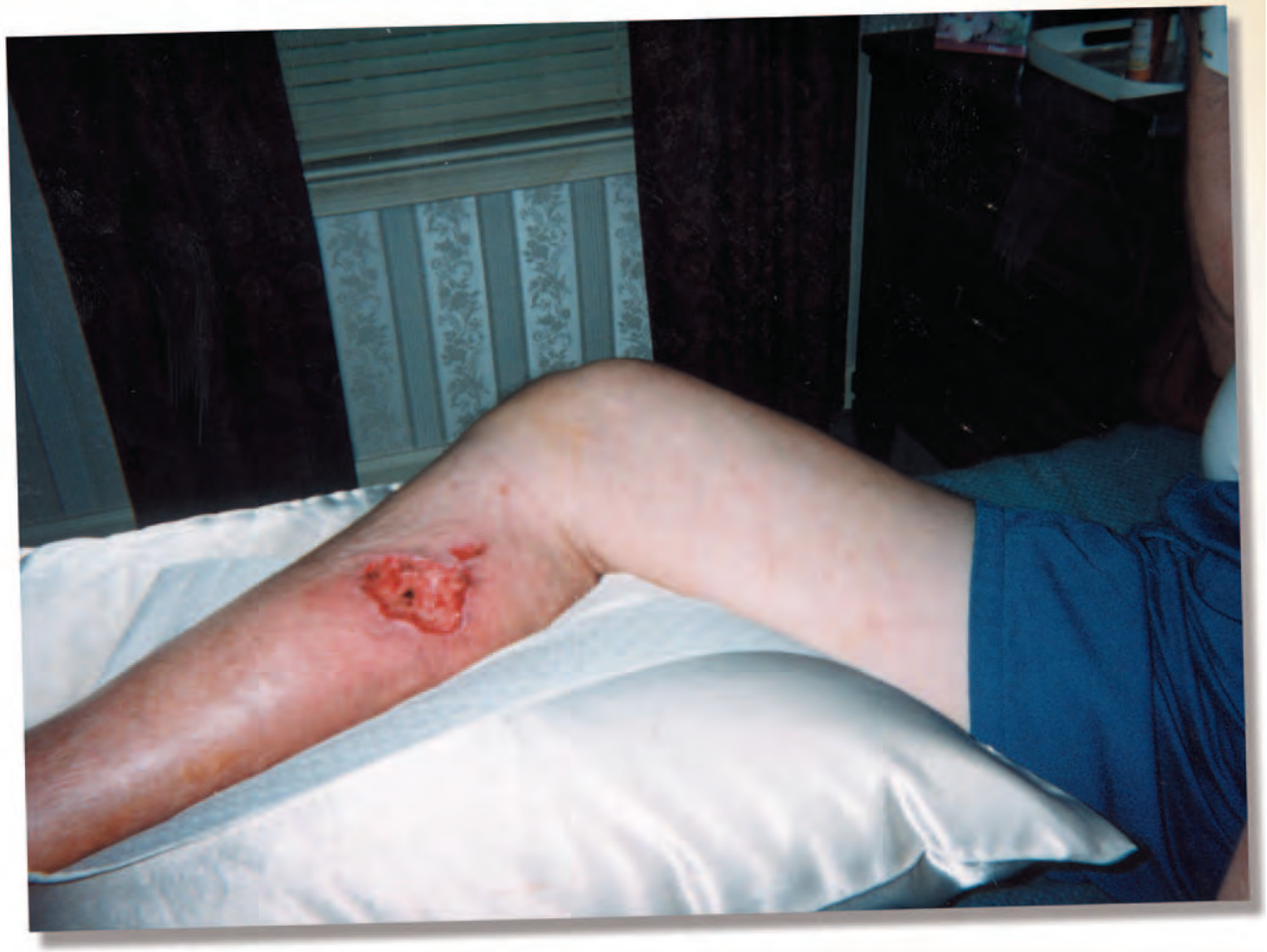

This patient was admitted to the hospital for surgery. While in surgery, the patient had a forced-air warming hose placed between his legs for more than four hours without it being attached to an inflatable warming blanket. As a result, the patient received third degree burns that required months of 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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Leadership and Mentoring

Author: *Brenda Huff, RN, MN. Ms. Huff is Patient Care Manager PARR at Peter Lougheed Centre in Calgary, Alberta.*

In today's working environment a leader has to demonstrate qualities of honesty, integrity, loyalty, trustworthiness, principled behaviour and understanding).[1] Leadership begins with practicing personal accountability; identifying how you can make a difference; and never under-estimating the power of one person to make a difference. A means to do this is by being a mentor and being mentored.

Mentoring is a facet of leadership in nursing that, since it has occurred since the time of Florence Nightingale, we too often take for granted.[2] Mentoring is not only practicing personal but also professional accountability. It also offers a chance for growth and development within the practice of nursing. Mentoring can offer professional replenishment to expert nurses, thus contributing to the retention of experienced nurses and producing nursing leaders with the skill and passion to make a lifelong commitment to professional development and nursing growth.

A leader needs to have a strong sense of self and awareness of his/her own leadership style. A leader needs to understand the personal characteristics that impact on their leadership method. It is important to seek feedback from those they guide, to endeavor to advance their own personal knowledge, and to develop a network that will help advance both themselves and others. A leader who mentors is a leader who is understands and respects these complex systems. The mentor believes in empowering his or her followers and facilitating learning in others. The mentor is a role model, and actively advises, guides, and promotes other careers. Mentors use open communication, inspirational motivation and celebrate the accomplishments of the individuals they encourage in the development of their role. The relationships they develop encourage and support life-long learning.[1]

Mentors provide insider information on how the system they work in operates. They support, encourage and develop the protégé's confidence so that they are able to establish goals that might even surpass the mentor's own achievements!

Leaders and mentors give the glory up for their protégé and allow the protégé to share the limelight. It is a selfless act that can only be accomplished by an experienced and confident leader.[3]

Support from within the workplace is necessary for mentorship to flourish and succeed. While mentorship is essential for recruitment and retention, it should not be mandated as a work requirement. Mentoring relationships can best be encouraged providing an environment of openness and interpersonal support and where continuing education is supported.

When nurses support mentor/protégé relationships they become part of our everyday practice and a natural part of our career process. Whether it is part of a formal or a casual relationship, the connection is a shared contract with both parties experiencing reciprocity through trust and shared experiences.[4] Mentorship lets protégés develop leadership skills that can only enhance the nursing profession.

Strategies that professional nurses may use to become effective mentors include:

- recognize what you can do to make a difference;
- always work for individual growth;
- perform in ways that affirm your professional identity;
- take a chance on another person;
- seize new learning opportunities; and
- engage, engage, engage [5] – connect emotionally, intellectually, and professionally with other nurses.

Mentoring is a facet of leadership that is too often overlooked – to the detriment of our profession and everyone practicing it. Fostering mentoring relationships is a powerful strategy that can enhance productivity, increase retention, and improve recruitment. It offers

Photo by L. Socha

Marla Ewen precepting a student

experienced nurses the chance to engage in a professional relationship that helps develop new learning opportunities. Take the opportunity to become a mentor and you will not be disappointed. You will become a professional role model, you will make a difference… and you will be better for the experience.

The author would like to thank her inspiration mentors: Muriel Shewchuk and Lynn McCabe.

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Giving Effective Presentations

Author: *Nadine Englehart RN, BN, CPN(C), Instructor, Staff Development, Operating Room at Foothills Medical Centre in Calgary, Alberta.*

Apprehension about oral communication, or public speaking is rated as the number one fear among most individuals.[1] Developing skill in, and comfort with, public speaking is important whether we are presenting oral reports and proposals, responding to questions, or training co-workers. Effective speakers are able to communicate information in a way that stimulates interest, helps the audience to understand and remember, and influences attitudes and behaviours.

Many of us think that effective speakers are born rather than made. In truth most successful speakers work hard and invest a great deal of time and effort in to improving their speaking capabilities. Effective public speaking is a learned skill and activity that requires lots of practice. Like other learned skills, having a strategy with clear action steps can help you achieve your goal.

DETERMINE YOUR SPECIFIC SPEECH GOAL AND ADAPT IT TO YOUR AUDIENCE

When planning your speech, select a subject that is important to you, and that you are knowledgeable about, and brainstorm to generate as many ideas as possible. Analyze your audience by considering their age, education level, gender, knowledge, culture, geographic uniqueness, and group affiliation. From this you can predict their interest in, knowledge of, and attitude toward both you and your topic.

By conducting an audience analysis, you can collect demographic data on your audience and determine their similar characteristics, predict their level of interest and knowledge of the topic, and their perceived attitude toward you as a credible source of information. This information and knowing the location or setting for your presentation will provide guidelines on how to meet the audience expectations and determine the tone of the speech. What is the size of the audience and venue? What time of day will it be scheduled? Where in the program does the speech occur? What is the time limit? Will the necessary equipment be available?

After choosing your topic, and analyzing the audience and the setting, you will want to identify both your **general goal** and your **specific speech goal.** The **general goal** is the intent of your speech – *if you want to entertain, inform, or persuade your audience.* The **specific speech goal** is a single statement specifying the exact audience response you are looking for [2] such as *I want my audience to understand the importance of correct site surgery.*

A thesis statement, or sub-goal, outlines the specific elements of the speech that will support the specific goal statement – i.e. *the three criteria for correct site surgery will be to develop a policy, provide education for healthcare workers, and follow the seven absolutes for surgical site verification.*

GATHER AND EVALUATE MATERIAL

Reviewing all available resources will provide you with high quality information and help support your specific speech goal. Draw on your own knowledge and experience and utilize books, periodicals, encyclopaedias and other electronic databases. Use examples, illustrations, anecdotes, narratives, or statistics for comparisons and contrasts. Interesting and vivid research and resources will bring your topic to life.

ORGANIZE AND PLAN THE MATERIAL

Write an outline of the body of the speech, prepare the introduction and the conclusion, list the resources, and then review and revise.

The introduction (7 to 50% of the total speech) should grab the attention of the audience. Arouse their interest by asking a question, making a startling remark, or providing an illustration. Let them know what the speech is about. Set an appropriate tone for the topic – a humorous opening for a serious issue will confuse the audience. If you are enthusiastic, warm, friendly, and display passion you will establish a bond of goodwill.

In the body (45 to 88% of the speech) identify the main points, or building blocks, of your speech. These are the ideas that you want to be remembered. They should be clear, follow the same structural pattern, meaningful, and limited in number (usually to five or fewer). They should be organized according to time, topic, or logical sequence. Be sure to provide clear transition between sections of the speech.

In the conclusion (5% of total) focus on two goals:

- Wrapping up the speech by reminding the audience what you said; and
- hammering home a memorable message.

Four types of conclusions are summary, story, appeal to action, and emotional impact. An effective conclusion can make the entire speech more effective.

HOW TO USE VISUAL AIDS

Use the KISS principle (Keep It Simple Silly). Don't overload the audience with irrelevant or in-appropriate material. Keep cartoons to a minimum.

Use key words or phrases. For overheads and power point, keep to the 6X6 rule – up to 6 words per line, no more than 6 lines. Avoid printing in yellow or in red as they are both difficult to read. Use a 24 to 36 point font for headings and an 18 point font for the text. Refrain from using more than two styles of font.

Talk to the audience, not to the visual aid. Stand to the side and don't turn your back to the audience. **Place yourself at center stage.** Use yourself as a visual aid. Dress appropriately. Don't chew gum or eat food. Your posture, gestures and movements can provide descriptive motions.

Use pointers sparingly. Point at the screen, not the projector as you often block the view. Don't play with the pointer when not using it and keep your shoulders orientated toward the audience.

TIPS FOR REDUCING ANXIETY

1 - **Be well prepared.** Plan ahead, rehearse your speech and know your visual aids. Arrive early to check the room set-up, chair placement, lighting and the temperature. Start on time.
2 - **Be organized.** Organized thoughts will give you confidence to focus your energy on your presentation.
3 - **Practice.** You will gain confidence by practicing out loud to the pillows on the sofa, the cat, the dog, or the mirror. Learn to pause. Be aware of your rate of speech and tone of voice. Audio taping a practice session using your visual aids can help determine an accurate speed as well as evaluate your fluency, enthusiasm, and voice expressiveness.
4 - **Visualize yourself doing well.** Do not underestimate the importance of self-visualization in gaining a higher level of self-esteem.
5 - **Maintain eye contact.** Pick out friendly faces and make eye contact for four to six seconds. Moving your eyes in a 'Z' pattern across the room is an effective way to engage everyone.
6 - **Concentrate on your message** and you will forget about yourself. Confidence, conviction, and enthusiasm portray professional qualities.
7 - **Don't apologize.** Negative thinking will bring negative results.
8 - **Move around naturally.** This releases nervous energy and restores calm. Avoid moving in a strategic pattern. Use gestures to support your message.
9 - **Breathe, breathe, and breathe.** This increases blood flow and helps you relax.
10 - **Dress in comfortable clothes.** Clothes that you like and feel good in will increase your confidence.

Giving Effective Presentations (cont.)

Preparing a speech is similar to writing a research paper. Plan, research, organize and prepare an introduction, body and conclusion. The memorable public speaker enhances a presentation by using a variety of strategies involving and engaging the audience, and by effectively preparing through practice, practice, and more practice. Through vocal expressions, eye contact, spontaneity, fluency, and enthusiasm, the speaker can achieve a conversational quality and connection with the listeners.

Simply:
Tell them what you're going to tell them; tell them; and then tell them what you told them.

For more information on this topic please contact the author by e-mail at nadine.englehart@calgaryhealthregion.ca.

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2003 Operating Room Nurses Association of Alberta Conference

October 15-18, 2003

Author: *Nadine Englehart, RN, BN, CPN(C) and Editor, ORNAA Newsletter.*

Pulse of Perioperative Nursing was the theme of the 2003 *ORNAA* provincial conference hosted, in Calgary, Alberta, by the South Central Operating Room Nurses Association (*SCORNA*). One hundred and sixty seven delegates, four nursing students, and 50 exhibitor booths filled the halls of the Coast Plaza Hotel for 3 wonderful and exciting days of education, camaraderie, and fun.

ORNAA Annual General Meeting

The *ORNAA* Awards Committee was hard at work this year. Snips and Snaps Writing Awards e were presented to **Cheryl Doucet** *Seeing Through a Clagett Window* ($250), **Colleen Pedersen** *Laser Safety* ($250), **Cindy Laukkanen** *Capitalizing on Strengths* ($250), **Carol Rolfe** *ORNAA: 25 Years in the Making* ($250), **Teresa Vollob** *T-Max Made Easy* ($250), and **Nadine Englehart** *Giving Effective Presentations* ($500). Two bursary awards were also presented to Calgarians **Cathy Rankin** and **Nadine Englehart.**

This year *ORNAA* also had a poster presentation. Three of the posters had been displayed at the *ORNAC* National Conference in Winnipeg (one was the winner of *The People's Choice Award)* and the fourth was the *ORNAA* provincial conference poster.

Photo by D. Van Nieuwkerk

ORNAA Conference Planning Committee
Back row L to R: Jennifer Janostin, Jenny Levitt, Elaine Redfern-Hlady, Sheila Tomlinson, Katherine Kelly, Errin St Thomas, Noreen Hansen
Front row L to R: Kris Rollins, Marg Hill, Tracy Villeneuve

ORNAA has a presence on the *ORNAC* website – our thanks to Jennifer Jonasten for keeping it updated.

ORNAA President Peggy Zeigler gave a moving tribute to Dahlia (D.) Robinson, former *ORNAA* President, our friend and our colleague, who passed away suddenly in 2003. The Alberta Exhibitor's Advisory Committee held its second annual jewellery raffle with proceeds being donated to the Stollery Children's Centre, University of Alberta, Edmonton, in honour of D. Lucky winners were Ann Mayer of Calgary, Veronica Blocksage of Medicine Hat, Lisa Frost of Calgary, and Marjorie Phillips of Edmonton.

Educational Sessions

The 2003 *ORNAA* educational program included concurrent sessions, presented by nurses, in *Perioperative Nursing Expanded Roles, Deciphering the New Acronyms of Infectious Disease, Post Anaesthetic Complications, Perioperative Nursing Care of*

Photo by M. Ensminger

Keynote speaker Herbert Stuemer "Dare to Dream"

2003 *ORNAA* Conference (cont.)

the Endovascular Stent Patient, Intraoperative Chemotherapy, and Ventricular Remodeling – Surgical Treatment for a Medical Condition. Other presentations discussed Advances in Treatment for Patient with Primary Malignant Brain Tumor, Endovascular Stenting of the Aorta, Regional Approach to Metastatic Disease, Nuss Repair for Pediatric Pectus Excavation, Forensic Investigation in Kosovo, and *Preserving Forensic Evidence in the Operating Room.*

Several general sessions brought all the delegates together. For 90 minutes we sailed around the world with keynote speaker Herbert Steumer. In 1997, Steumer, his wife, and their 3 boys (all under 12) set off to sea on a voyage around the world that would change them forever. Thirty-four countries, and four years, later they had battled deadly storms, evaded pirates, dodged a tornado at sea, swum with sea lions, visited endangered primates in Borneo, and gained compassion for Kenya children who are unable to attend school. The *Voyage of The Northern Magic* was spellbinding and inspirational. Steumer reminded us that "Life is so glorious. There is so much to do and no time to waste."

Noreen Linton spoke about *Nurses: Making the Dream Real* addressing the fact that we all have dreams, hopes, and aspirations and that we made a difference to every person we touch. She reminded us we should leave our work a better place at the end of each shift and at the end of our career. Sometimes there are barriers that get in the way of achieving our dreams. How we view these barriers can determine their power or effect. She believes that life is 10% what happens and 90% how we react. While the only person we can change is our self, we should be aware of how much energy we spend trying to change others.

The ***Pat Ferguson Memorial Lecture*** focused on *Preceptorship: A Quintessential Component of Nursing* by Dr. Florence Myrick. She spoke about recent studies showing that preceptor behaviour, role modeling, and feedback all contribute significantly to the quality of student learning. It proves to us that it is important that students feel safe in the learning environment and that it should always be about the ideas, not the person.

Debra deWaal, a former Calgary Police Officer, entertained, enlightened, and sometimes frightened us on the topic of personal safety. She offered techniques for staying safe, dealing with potentially dangerous situations, utilizing simple defense moves that could save your life, and making a plan for your safety.

The closing speaker, Linda Edgecombe, energized everyone on the last day of the conference with *Batteries Included – Lessons to Energize and Balance Your Life*. As a "Life Perspective Specialist" Linda says that if she makes her audience "giggle, reflect and get teary", then she has done her job. She focused on two ultimate goals in life:

1 - **Happiness** – we all have our own recipe for happiness. There may be only 5-12 of those moments per year when we can say "It doesn't get any better that this."
2 - **Have few regrets** – try things just for the sake of trying them. Don't worry about the results.

Energizing tips she shared:

- **Life is a physics equation.** Energy Out = Energy In… so move your body!
- **Lighten up… over and out!** Laugh! We all have a different sense of humour – use it!! Make it OK to laugh at work.
- **Get quiet with yourself.** Hear yourself think…silence is power.
- **Do what you have to do.** What do you do outside of work that motivates you to keep going? If you were given two extra hours a day, what would you do with them?
- **Purpose = Your Recipe for Happiness.** What do you do well that you don't remember learning? Where do you hang your soul when stressed out?

Remember, people may forget what you said, or did, but they will not forget how you made them feel. Always plan ahead – it wasn't raining when Noah built the ark.

Photo by M. Ensminger

Alberta Exhibitors' Advisory Committee L to R Rob McKitterick, Jason Brown, Lenore Byers, Brian Hill, Sheila Tomlinson, Bryce Taylor, Jerry Walrath.

Social Events

Hats off to the Social Committee, Alberta Exhibitors Advisory Committee (AEAC), and the Coast Plaza hotel for the great entertainment and scrumptious food. The *"Wear What You Dare" Casino Night* was a huge success and many delegates and exhibitors changed places with the casino dealers to try their hand on the other side of the table. Tables laden with donated gifts were auctioned off for the play money delegates had won at the casino tables.

Night at the Improv brought three individuals from the Loose Moose Theatre to entertain the delegates with innovative hospital scenarios.

During the closing ceremonies, Conference Chair Marg Hill offered a special tribute to Muriel Shewchuk. Here is an excerpt from that tribute.

"Muriel Shewchuk is an experienced health care manager and educator, with a vast background in Surgical Suite Management and perioperative nursing. Muriel's 40 years of education and leadership contribution to perioperative nursing have had a positive impact on the nursing profession. She has spoken at 6 World OR Conferences, and at Provincial and National levels, and her vision and leadership has enhanced perioperative nursing for some 22 years.

Whether it was chairing the first ORNAC conference in 1984, or helping to develop the professional standards and technical standards for OR nurses, helping set nursing practice standards with the AARN in 1991 and being involved with recommended standards of practice for perioperative nursing, her awards and distinctions are many.

She encourages nurses to support the perioperative specialty locally, provincially, and nationally and provides huge support for nurses to attend. She negotiates relentlessly with medical staff and administration to close theatres when conferences are held. When the National OR conference was hosted by Alberta and held in Banff, approximately 20 theatres were closed in the region so nurses could attend.

Muriel is recognized as one who makes a difference to perioperative nursing. Her work is her passion and she lives it every day. It is my privilege and honour on behalf of your home district, SCORNA, to say thank you for your dedication and efforts for nursing."

Thank you to everyone who attended our conference and we look forward to seeing you in Medicine Hat in 2004.

Photo by M. Ensminger

Casino Night 'Wear What You Dare' Jennifer Janostin and Errin St. Thomas.

Thinking Outside the Box: Perioperative Preceptorship

Author: *Jackee Higgins RN, BScN, MEd, CPN(C), is a Nurse Clinician for Perioperative Services at Mount Sinai Hospital, Toronto, Ontario.*

One of the more important transitions of adult life occurs when facing the challenges of a new job in a new setting. This experience is stressful in both positive and negative ways. Yet we know very little about the process. As the months turn into years the new employees become as comfortable as an old pair of PJs and we forget about those awkward first few months.

It is not new for perioperative education specialists to be facing challenges when orienting new staff to the perioperative unit. These challenges result from diversity in language and culture, skill mixes (such as RN's, RPN's and non-licensed scrub techs), diversity in language and cultures, varied work values, and the rapid advancement of technology in surgery. In recent times, it has become almost impossible to meet the needs of newcomers in the old orientation structure. There is constant change in nursing – and perioperative nursing is no exception. Some examples of these changes are increased patient acuity, shortened length of surgical stays, and increased role responsibilities due to the flattening of the nursing hierarchy. These changes, although very positive in some cases, have caused a destabilization and disruption to the traditional perioperative nursing orientation models. In light of these changes, Mount Sinai Hospital's Perioperative Unit has begun to research and experiment with alternate ways of envisioning orientation.

In the context of learning, this new preceptorship model provides enhanced availability of support for the newcomer. The orientation model's goal is the integration of new staff in to any department at a pace that is specific to the newcomer's needs (refer to figure 1). Mount Sinai's perioperative preceptorship model mixes the realities of both the clinical and the theoretical components of perioperative nursing experiences. In addition, this model uses the adult learning principles (andragogy) as well as nursing organizational and development

Figure 1

Continued on Page 37

ORNAC in a Nutshell — Fall 2003

Author: *Lynn Anderson, ORNAC Secretary*

The Fall Executive & Board Meeting was held in Toronto Nov 6, 7 & 8, 2003.

- v President Margaret Farley welcomed Dotty Connor (PE), Alicia Oucharek Mattheis (SK) and Chris Downey (ON) to the Board. Thank you & farewell to Tina Kennah (NB) and Claire Tremblay (QC). Observers/visitors to the Board meeting included Kim Reese (NB), Sue Styles (AB), and Donna Gramigna (BC). Kathy Bruce, Chair of the Standards Revision Committee, attended for the release of the *ORNAC* Standards 5th Edition. Stephane Delorme, Accountant/Auditor, attended to discuss our financial status. Pat Pocock and Val Zellermyer attended as CORL representatives. CORL's annual Meeting will be held May 3&4, 2004 after the *ORNAC* Spring Board Meeting (May 1 & 2, 2004).

- v President Margaret Farley announced IFPN's first Seminar Day will be held in conjunction with an Australian College of OR Nurses (*ACORN*) meeting in April 2004. This Seminar will have an international flavour and address global issues. *ORNAC* Past President Mary Knight has been invited to present a session.

- v *ORNAC* President Margaret Farley's travels have included attending a NATN Congress (and representing Canada/*ORNAC* as CNR/IFPN delegate), attending Canadian Anesthesiologists' Society (CAS) annual meeting in Ottawa, attending Provincial conferences in AB and SK and sending greetings to the NL conference.

- v Several of our Provincial Associations have been involved in International projects. NS has purchased 50 copies of International Standards to be distributed to developing countries and AB has provided financial assistance to be distributed where needed in developing countries.

- v CORNJ continues to be a success under Editorial Chair Linda Socha. Please check the website for criteria for submission of articles.

- v The Awards Committee has been reviewing the criteria for *ORNAC* awards, see **www.*ORNAC*.ca** and click on awards for information, deadlines and application/ nomination details.

- v The Perioperative Education Committee has granted approval of Post Graduate Programs to Providence Health Care at St Paul's Hospital in Vancouver, BC, and QE II Health Sciences Center in Halifax NS.

- v As we move toward more advanced technology and communication we will be exploring the idea of a Virtual Office for *ORNAC*.

- v *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice, 5th Edition* has been released. See **www.*ORNAC*.ca** for information on how to order your copy.

Our thanks to everyone who has been involved in the above activities. *ORNAC* welcomes all comments and concerns at **www.*ORNAC*.ca**.

AIISOC en Bref — Automne 2003

La réunion du conseil exécutif et du conseil d'administration de l'automne s'est tenue les 6, 7 et 8 novembre 2003 à Toronto.

- v La présidente, Margaret Farley, a souhaité la bienvenue au conseil d'administration à Dotty Connor (I.P.-É.), Alicia Oucharek Mattheis (Saskatchewan) et Chris Downey (Ont.). Des remerciements et au revoirs ont été adressés à Tira Kennédie (N.B.) et Claire Tremblay (Que.). Jim Rase (N.B.), Sue Styles (Halbe.) et Donna Graminacée (C.B.) ont assisté à la rencontre en tant qu'observateurs. Kathy Bruce, présidente du Comité de révision des normes, a assisté à la rencontre pour le lancement de la 5e édition des normes de *l'AIISOC*. Stephane Delorme, comptable-vérificateur, a assisté à la rencontre pour discuter de notre état financier. Pat Pocock et Val Zellermeyer ont assisté en tant que représentants du CORL La rencontre annuelle du CORL se tiendra les 3 et 4 mai 2004, après la rencontre printanière du conseil d'administration de *l'AIISOC* prévue les 1er et 2 mai 2004.

- v Margaret Farley a annoncé la tenue d'un premier séminaire du IFPN qui sera organisé en collaboration avec l'ACORN (*Australian College of OR Nurses*), en avril 2004. Ce séminaire international mettra l'accent sur des inquiétudes globales. Mary Knight, l'ancienne présidente de *l'AIISOC*, sera invitée à faire une présentation à l'une de ces séances.

- v Les voyages de la présidente, Margaret Farley, ont compris sa présence au congrès de NATN ainsi que sa représentation du Canada et de *l'AIISOC*, en tant que déléguée du CNR/IFPN, lors de la rencontre annuelle de la *Canadian Anaesthesia Society* en juin, à Ottawa, et lors des conférences provinciales en Alberta et en Saskatchewan. Elle a dû décliner et envoyer ses regrets à la conférence de Terre-Neuve.

- v De nombreuses associations provinciales ont été impliquées dans des projets internationaux. La Nouvelle-Écosse a fait l'acquisition de 50 copies des normes internationales pour fin de distribution dans des pays en voie de développement et l'Alberta a fourni un soutien financier à des pays en voie de développement.

- v Le CORNJ continue à être une réussite sous la présidence éditoriale de Linda Socha. Veuillez SVP consulter le site web pour vous renseigner quant aux critères et échéanciers reliés à la soumission des articles.

- v Le Comité des distinctions honorifiques a révisé les critères des prix de *l'AIISOC*, veuillez SVP consulter le **www.*ORNAC*.ca** pour obtenir de l'information et les échéanciers pour les applications aux prix.

- v Le Comité sur l'éducation en soins périopératoires a grandement approuvé les programmes post-scolaires du Providence Health Care, St Paul's Hospital, Vancouver et du QE II Health Sciences Center, Halifax, Nouvelle-Ecosse.

- v Alors que nous nous dirigeons vers une ère de technologie et de communication avancées, nous envisagerons l'idée d'avoir un bureau virtuel pour *l'AIISOC*.

- v La 5e édition des normes, lignes directrices et énoncés de position recommandés pour les soins infirmiers périopératoires sont maintenant disponibles. Veuillez consulter le **www.*ORNAC*.ca** pour voir les directives.

Merci au grand nombre de personnes qui ont été impliquées dans le processus. *L'AIISOC* apprécierait les questions et commentaires.

theories to support the design. The proposed model consists of six phases:

1 - **Organizational Entry**: Welcome Aboard
2 - **Bureaucratic Role Conceptions:** The New Reality
3 - **Professional Role Conceptions:** Finding a Good Fit
4 - **Achieving Role Competency:** Pre-Consolidation
5 - **Role Transition:** Consolidation
6 - **Mutual Acceptance:** Post-Consolidation

The following excerpt is an example of one staff member's initial experience.

"The hospital hired seven of us from our graduating class. We all started roughly around the same time, perhaps a few weeks apart. We were so glad that we had finally retained a perioperative nursing position and sequentially we were going to be earning a salary. We were so ecstatic. The orientation was vigorous and perhaps too fast for our learning needs. We all suffered high levels of anxiety and returned home after work with huge stress migraines. It was perhaps worth it in the end. We are all perioperative nurses and have contributed to the perioperative team for about eight years now. Hinds sight, I do wish things could have been done differently. I can only remember the feeling of being stressed more times than I care to remember. I found learning perioperative nursing was just different. In the last year, we have hired a bunch of new staff. I wonder how they are feeling?"

This story may ring true to you. What is disconcerting is that the story raises a question about the successes and failures of our workplace socialization.

As a start, healthcare employers must look beyond immediate recruitment and retention challenges to view the needs of the current healthcare workforce as a long-term investment. From this perspective equal attention must be given to the development and utilization of the existing human resources and to filling immediate staff shortages and engaging in succession planning. *American Review of Sociology* (1999) states that "nursing studies consistently report that autonomy, improved communication and respect are positively associated with job satisfaction, recruitment and positive assessments of the work environments" [1]

For the purpose of clarification and defining the domain of organizational socialization this article uses the definition of socialization by Feldman as the "process by which outsiders of organizations become transformed into effective and fully participating members" [2]. While socialization is often an ongoing and lengthy process, I have focussed my attention on the socialization processes that occur within the first year of the newcomer's entry, when the impact and salience of socialization activities are the greatest [2].

ORGANIZATIONAL ENTRY

Welcome Aboard

The first stage in the model is the *Organization Entry*. This stage encompasses all of the learning that occurs prior to the newcomer's first day on the job. For example, newcomers would be exposed to varied personnel, such as the manager and the educators, and a range of specialties and staffing skill mixes within the department. The basic idea is that socialization begins even before newcomers arrive into the organization. By this time, newcomers have formed expectations of the new organization, the department and subsequently the new job. They arrive with a heightened sense of curiosity, excitement and a readiness to learn the ropes.

Before the enthusiastic newcomers take hold of the new work environment, (and in order to provide the structure within which learning takes place for each newcomer - commonly known as the learning plan) they must understand the organization itself. There are

several sources of insider knowledge within the employing organization. These include:

the tenured staff;

managerial discussions;

human resources;

and public relations.

These resources are the key to harnessing newcomers' enthusiasm and their quest to embrace the new organization.

BUREAUCRATIC ROLE CONCEPTIONS

The New Reality

The second period, is the *Bureaucratic Role Conceptions*. This phase exposes newcomers to the organizational structure and their roles within that organization. Newcomers begin to understand the long-term view of the organization and the new job. The organization shares its values, history and expectations of their staff (within the context of the organization). It is where the reality of the new organization meets the reality of newcomers.

At any stage of professional socialization newcomers can choose to leave the organization for numerous reasons. In this model, one reason would be *'reality shock'*. Reality shock, coined by Schein, is a phenomenon that may occur due to the disparities between the lofty expectations of the newly hired and the realities of everyday organizational life [3]. Both newcomers and the organization have a large role to play in decreasing the level of stressors newcomers may experience. It is imperative that the organization and the subsequent employing department approach newcomers honestly, without over selling or over inflating the organization, department and its members. The length of this stage is still unknown, but research done by Davis suggests it lasts for the first 6-9 months on the new job [4].

PROFESSIONAL ROLE CONCEPTIONS

Finding A Good Fit

Professional Role Conceptions begins with newcomers learning their role within the employing department. At this stage, the individual determines whether there is a professional and organizational fit. This fit is not judged solely on the newcomer's work abilities and roles, but also in terms of the culture and climate of the organization. Once again, if there are disparities between the expectations and the realities of the organizational life, coupled with a high level of newcomer stress and anxiety, then resignations may occur. During this period, newcomers are most receptive to insider's influence. A concerted effort to maintain open lines of communication is imperative because communication minimizes the effects of "reality shock".

ACHIEVING ROLE COMPETENCY

Pre Consolidation

The first step in achieving role competency is referred to as the *Pre-Consolidation* stage. This stage begins within the employing department. During this phase newcomers begin to define their role within the department. Newcomers start to identify the necessary activities for successful role socialization. It is during this period that newcomers meet their preceptor and the tenured staff. At this time, there is a heightened exchange of information. Newly hired nurses arrive with several questions specific to understanding their role within the new department. Such questions can be related to policies, procedures, ordinary daily routines, historical events, or rumors about the department and organization. Newcomers are *making sense* of this new knowledge, and in doing so, increasing their own understanding of the department/working cultures, their role as newcomers and the organization itself. Pre-consolidation continues until full saturation of the new working environment, job roles and expectations are competently achieved.

The intense contact with newcomers in the new working environment (such as the perioperative unit) serve to strengthen the morale of all involved staff. It is during this crucial stage that clarification of values is revealed. The similarity of attitudes and behaviors among the working staff may become more salient, thereby increasing the frequency and positiveness of the interactions. During the pre- consolidation stage the staffing ratio is 1:2 (newcomer: tenured staff). This period provides newcomers with an opportunity for planning and reflection, which promotes self-directed learning opportunities. It is also seen as an integral component to 'learning the ropes' within the organization and the employing department.

Flexibility is, of course, the key to success, both in meeting the needs of new staff and the needs of the organization. The newcomer's learning needs can be met by providing appropriate learning resources suited to a variety of learning styles. Additionally, to enhance learning and decrease possible high levels of stress/anxieties, newly hired nurses will rotate into surgical services that they themselves have identified as areas where they require the most experience. This process moves newcomers from the most comfortable surgeries to the least familiar.

During pre consolidation, newcomers may be temporarily performing important job functions considerably less often than their colleagues. Therefore regular progress evaluations, feedback from preceptors/professional colleagues, and needs assessments are fundamental to a newcomer's success.

ROLE TRANSITION

Consolidation

Consolidation is the most important stage to achieving successful socialization of newcomers. During this stage both the newcomers and the organization experience a *'trial run'*. The trial run allows newcomers to 'consolidate', or apply, their new and existing knowledge and responsibilities to the new role while under minimal supervision. Newcomers are allowed to function as participants on their own terms. At this stage, perioperative nurses are given an opportunity to work in surgical ORs, where they have already been successfully rotated. This grants them the opportunity to be supported in services where they are the most comfortable. At this stage newcomers would have rotated through only 50% of all clinical specialties.

The rules for consolidation are as follows:

Newcomers will:

- work day shifts;
- not float or be utilized as swing/pod personnel;
- work with competent and expert nurses (by Benner's definition);
- work in the surgical services where they have rotated successfully;
- be required to function fully within those successfully rotated areas;
- and receive regular feedback.

As newcomers consolidate, they are expected to function as contributing team members alongside preceptor/veteran staff. The ratio of staff is now 1:1 (veteran: newcomer) and this arrangement forms the new staffing mix. There is limited direct supervision. This phase provides a *'win-win'* situation for both the department and its members. Newcomers are given the opportunity to expand their knowledge base, and apply it to real life, as well as expanding their new roles and responsibilities. Newcomers develop a gradual sense of 'insidership', increased self-esteem and the ability to feel that they are participating in achieving their goals. The basic principle behind this period is to ensure that newcomers can successfully demonstrate early successes in areas that are small enough to be achieved, but significant enough to excite enthusiasm. This fosters newcomers' development and transition into the new working group. The length of time an individual spends in the consolidation phase varies depending on their needs.

The consolidation period holds shared responsibilities for both newcomers and the organization. The employing department evaluates newcomers' performances, growth, and development during the first 2-6 weeks

of their consolidation. Newcomers must demonstrate to the employing department that the new position is a good fit and that the department has made a good hiring decision.

REFINEMENT OF ROLES & VALUES: MUTUAL ACCEPTANCE

Post Consolidation

The final stage in this model is the *Post Consolidation* phase. During this phase, newcomers are placed back into the intense learning mode where unfinished role functions and remaining responsibilities and experiences are assumed. The newcomers now make the transition to fully understanding and functioning in their new roles. They are aware of the need to be committed to their jobs. During this phase newcomers are slowly validating both their new roles and their previous work experiences. They take advantage of opportunities to analyze the strengths and weaknesses within the department. During this phase newcomers can provide valuable and unfiltered feedback about departmental functions. Likewise, newcomers have a better understanding of the new working group and may be able to unfreeze old behavioral routines. This final period is complete once 100% of the roles and responsibilities in the new position are successfully achieved.

Since the first year of employment is the most crucial for both newcomers and the organization, regular informal debriefings are recommended. These debriefings (held once every 2-3 months) should include departmental management representatives and all other discipline related newcomers. Debriefings should serve as forums for follow-up/feedback, job clarification, and workplace enhancement opportunities.

The Mount Sinai Perioperative Preceptorship model is an innovative approach to socializing newcomers, such as newly hired perioperative nurses, into a work environment that is more tailored to the individual's learning needs. Through the newcomer's progression and successive steps, successful socialization of the newcomer is achieved. Moreover, at a conceptual level, this socialization gained by the newcomer provides additional long-term benefits such as self-efficacy, control over the working environment, flexible behaviour, innovativeness, and organizational citizenship.

For more information please contact the author at jhiggins@mtsinai.on.ca.

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SURGICAL SMOKE

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ORNAC Update: What's New on the Educational Front?

Courtesy L. Socha

Submitted by:
Linda Socha, Chair, ORNAC Education Committee

Several of the *ORNAC* board members serve on the Education Committee. This working committee assembled at the 2003 Fall *ORNAC* board meeting to discuss the objectives for 2004. Decisions affect the Research, Scope of Perioperative Practice, Standards, and Perioperative Education groups.

Research

The research grant is now titled the "Cardinal Health Research Grant" to reflect the new name of the sponsoring company. This grant was established to promote perioperative nursing research activities. The call for grant sub-missions is forwarded to universities/ educators, the website, and the *CORNJ*. The deadline is March 15th, of each year and the next set of winners will be determined at the May 2004 *ORNAC* Board meetin. Guidelines for applicants and application forms are available from Karen Frenette, Chair of the *ORNAC* Research Committee, at kfrenett@health.nb.ca or at **www.ORNAC.ca** click on Awards.

Scope of Perioperative Practice Canadian Anesthesiologists' Society (CAS)

The focus, at this time, for this group is two-fold. They are involved with the Registered Nurse First Assist (RNFA) Network of Canada and participate in an ad hoc committee formed by the Canadian Anesthesiologists' Society (CAS) that is looking at the anesthesia assistant role.

The RNFA Network of Canada has submitted an application for recognition as an *ORNAC* affiliate member. If previous *ORNAC* Board recommendations are addressed before the May 2004 *ORNAC* Board meeting then the Board will vote on granting affiliate status.

ORNAC continues to maintain representation on the CAS ad hoc committee that has, for the past few years, been investigating the feasibility of the anesthesia assistant role. Serious consideration was given to *ORNAC*s involvement and the Education Committee has decided to continue its involvement. *ORNAC* will remain able to provide input and to lobby for perioperative nurses, with the appropriate skills and experience, to extend their practice into this role.

Standards

As everyone knows, the 2003 "Recommended Standards, Guidelines, and Position Statements For Perioperative Registered Nursing Practice" (English version) is now available for purchase. The French version will be available shortly (visit **www.ORNAC.ca** for the status). The Standards committee, and the independent reviewers, should be commended for the tireless efforts involved in producing this document. The group's work will now focus on reviewing individual modules on a regular rotating basis and developing Position Statements and/or Competencies for the expanding role of the perioperative nurse.

Perioperative Education

Two perioperative postgraduate programs have been awarded full *ORNAC* approval. Another previously approved program is due to re-apply. For further information, access **www.ornac.ca** and click on the Executive or Education links.

For more information about Education Committee activities contact Linda Socha at lsocha@shaw.ca.

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