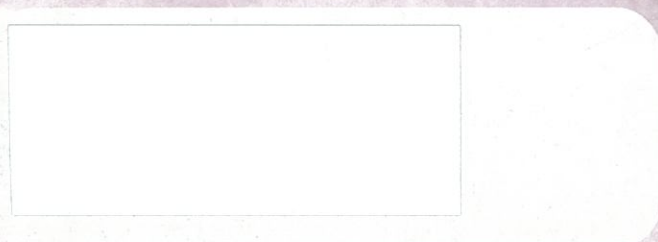
CANADIAN
Operating Room
Nursing Journal

June 2003

Oh, Those Baby Blues...
...dealing with children with PHPV

The Benefits of a RNFA

Upcoming Events



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President's Message

By Mary Knight, RN, BScN, MN, CPN(C)

Sometimes we are fortunate, and opportunities arise that take us down a career path that is rewarding and satisfying. However, making plans and strategic choices will place you in control, and nurture your perioperative nursing career.

Develop yourself - Assess your talents and skills and pursue personal development opportunities.
Utilise resources when needed – When you have successes, share them with those you are mentoring. When "character-shaping" experiences occur, consult your mentors for affirmation of your skills and strengths.
Become a futures thinker – Today's reality will not be that of tomorrow. Associate yourself with those who are succeeding. Place yourself to be part of decision-making opportunities for tomorrow's work world.
Navigate organisations – Know how organis-ations function, so you can successfully navigate them to achieve your goals. Develop leadership skills to influence people and situations to expand your sphere of influence.
Position yourself for recognition – Develop your communication and presentation skills so that your can express your thoughts and passion for perioperative nursing and patient care. Partner with a colleague to present an inservice, or educational session.
Retire actively – Consider how you can continue to participate in your life's profession – write articles, volunteer, or stay active within your provincial O.R. association.

As you are reading this, my term as *ORNAC* President has come to an end. *Marlene Hill*, Past President and *Sheila Billiard*, Treasurer both leave the Executive – thank you for your hard work and contributions! The collective wisdom of all the individuals with whom I have worked over the years at the *ORNAC* Board makes it challenging, stimulating and dynamic, and everyone is to be congratulated for their efforts to advance the perioperative nursing profession.

The accomplishments of the *ORNAC* Executive and Board during the past two years reflect the efforts of this dedicated group of volunteers. The *ORNAC* Board reviewed its structure and processes last November, and affirmed its commitment to the Standards, the *CORNJ*, *www.ornac.ca* and the National Conference as the foundations of our organisation. In the fall, the *ORNAC* Constitution and By-Laws will be revised to incorporate the outcomes of that review.

One of the most obvious successes is *ORNAC's* ownership of this Journal. Many individuals have worked diligently to make this a successful venture, and will continue to do so. Another venture has been to revise the *ORNAC* Recommended Standards, which will be published this fall. This edition will have a new format, so that revisions and new modules can be incorporated, with the intent of keeping the document current.

The website is undergoing revisions, and will continue to evolve. Plans are underway to develop mechanisms to utilise the website to facilitate the work of the *ORNAC* Board, as a "cyber national office". The 18th *ORNAC* National Conference is now over, thanks to the hardworking Conference Planning Committee from *MORNA* members. And of course, planning is already underway for National Conferences in Montreal (2005) and Victoria (2007).

I would like to say a special thank you to my family – Mike, Jamie and Mom, who have coped with my travels and extra workload. My employers, friends, and colleagues who supported me in many ways during my terms as President-Elect and President also deserve special recognition. Your unwavering support has enabled me to fulfill the mandate of the offices, and is truly appreciated.

Best wishes to *Margaret Farley*, your incoming *ORNAC* President, and the newly elected Executive. Leading a volunteer organisation is challenging, as everyone is busy in both our careers and personal lives! *ORNAC* is fortunate to continue to find capable individuals with a strong commitment to perioperative nursing to carry on its goal of "*Promoting Excellence*". ✤

***Mary Knight**, RN, BScN, MN, CPN(C), is President of the Operating Room Nurses' Association of Canada. She is the Director, Programs & Patient Services, Surgery & Women's Health Programs, at Victoria General Hospital in Winnipeg, MB.*

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Message de la présidente

Mary Knight, inf, BScN, MN, CSP(c)

Parfois, nous avons la chance que les occasions surviennent d'elles-mêmes, modifiant ainsi notre plan de carrière de manière positive et satisfaisante. Cependant, planifier et faire des choix stratégiques nous permettra d'être en contrôle, et alimentera notre carrière en soins périopératoires.

Développez-vous – Évaluez vos compétences et habiletés et profitez des occasions de développement personnel.
Au besoin, utilisez des ressources – Lorsque vous remportez des succès, partagez-les avec ceux qui apprennent auprès de vous. Quand des possibilités de développement personnel surviennent, consultez vos mentors pour confirmer vos forces et compétences.
Devenez un visionnaire – La réalité d'aujourd'hui ne sera pas celle de demain. Associez-vous avec ceux qui vous succèderont. Soyez en position pour prendre part aux prises de décision concernant le monde du travail de demain.
Connaissez les organisations – Sachez comment les organisations fonctionnent, ainsi vous pourrez les influencer pour atteindre vos buts. Développez vos habilités de leadership pour influencer les gens et les situations afin d'étendre votre sphère d'influence.
Positionnez-vous pour être reconnu – Développez vos habiletés de communication et de présentation, ainsi vous pourrez exprimer vos idées et votre passion pour les soins périopératoires et le soin des patients. Associez-vous à un collègue pour une formation dans votre milieu, ou une session éducative.
Restez actif lors de votre retraite – Considérez comment vous pouvez continuer de participer dans votre vie professionnelle – écrivez des articles, soyez bénévole, ou restez actif à l'intérieur de votre association professionnelle provinciale en soins périopératoires.

Au moment où vous lirez ce message, mon mandat comme présidente de *l'AIISOC* se terminera. *Marlene Hill*, présidente sortante et *Sheila Billiard*, trésorière finiront leur mandat au sein de l'exécutif – Merci pour vos contributions et l'énorme travail effectué ! L'ensemble des connaissances des personnes avec qui j'ai travaillé pendant toutes ces années au conseil d'administration de *l'AIISOC* en ont fait un défi stimulant et dynamique. Chacun doit être félicité pour ses efforts dans l'avancement de la profession en soins périopératoires.

Les réalisations de l'exécutif et du conseil d'administration de *l'AIISOC* reflètent les efforts de ce groupe dévoué de volontaires. Le conseil d'administration de *l'AIISOC* a révisé ses structures et ses procédures en novembre dernier, et a confirmé ses engagements face aux normes de pratiques, au journal canadien, au site *www.ornac.ca* et à la conférence nationale comme base de notre organisation. À l'automne, la constitution ainsi que les règles et procédures seront révisées pour inclure les résultats de cette révision.

L'un des succès évidents de *l'AIISOC* est le fait d'être devenu propriétaire de son journal. Plusieurs personnes ont travaillé assidûment pour réaliser un succès dans cette entreprise, et elles continueront de le faire. Une autre grande activité a été de réviser les normes recommandées de *l'AIISOC*, lesquelles seront publiées cet automne. Cette édition aura un nouveau format, ainsi des révisions et de nouveaux modules pourront être incorporés avec la possibilité de conserver le document courant.

Des révisions seront entreprises pour continuer à faire évoluer le site web. Des plans sont en cours pour développer des mécanismes pour l'utilisation du site web afin de faciliter le travail du conseil d'administration de *l'AIISOC*, tel qu'un réseau cybernétique national. La 18ième Conférence nationale de *l'AIISOC* est maintenant terminée, merci aux membres du comité organisateur de l'Association des infirmières et infirmiers de salles d'opération du Manitoba (*MORNA*) pour leur dur labeur. De plus, la planification des prochaines conférences nationales de Montréal (2005) et de Victoria (2007) sont déjà en cours.

J'aimerais dire un merci spécial à ma famille – Mike, Jamie et ma mère, qui ont su faire face à mes voyages et à ma grande charge de travail. Un grand merci à mes employeurs, amis et collègues qui m'ont apporté leur soutien de plusieurs façons pendant mon mandat de présidente élue et de présidente, méritant aussi ma reconnaissance. Votre soutien constant m'a permis de remplir mes obligations, et cela a été vraiment apprécié.

Mes meilleurs souhaits à Margaret Farley, votre nouvelle présidente de l'AIISOC, ainsi qu'au nouvel exécutif élu. Diriger une organisation de volontaires est un défi, comme chacun est aussi occupé dans sa carrière et sa vie personnelle ! L'AIISOC est chanceuse de pouvoir compter sur des personnes compétentes ayant un fort engagement dans la poursuite des objectifs de promotion de l'excellence en soins périopératoires.

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Jorja Wheddon, 6 months
Cover photo by Joan Porteous

Due to a production error the numbering of references were inadvertently erased in "Reuse of Single Use Medical Devices" by Ann Tapp (Volume 21, Issue 1). We apologize sincerely to readers and to Ms. Tapp for the error and for any inconvenience caused.

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Pearls of Wisdom

A Perioperative Work Environment Based on Values

Can it be so?

Current Status

The current perioperative work environment is often frustrated with many negative, daily occurrences. It is not uncommon to hear complaints of " *they just don't seem to care like they used to*"; "*late yet again*"; "*sick again – nothing wrong with her yesterday – oh by the way its Monday or Friday, what do you expect- I could have written the sick list names in advance*"; " *she never prepares for the surgery – doesn't know the anatomy, has not pre-read the pick list, isn't organized, table is a mess, count is mixed up, is not keeping up with the surgeon never mind anticipating with pride and efficiency*" and the interminable "*stays too long at breaks*". This list can go on and on, you have heard it all and uttered the same words. What can we do to turn it around, how do we change the environment to one of - "*Yeh, lets get to work!*"

The next five to ten years will be trying times. There will be three to four generations of workers in the perioperative environment ranging from the late sixties, retiring, to the keen twenty-something with a whole new vision. The young will get called generation X, Y and Z with a presumptive judgement that they don't have the values we had. I dare challenge you, very few have taken the time to find out what those values are, and how will they fit with the needs of the surgical patient. The values are different, the youth are our future. *How do we keep the passionate, professional flame burning and keep everyone working with enthusiasm?*

What is a Values Based Work Environment?

A value-based perioperative work environment is one that clearly exudes a professional passion where nurses excel in knowledge, skill, are quality minded and enjoy humor and create appropriate fun. The environment is founded on strong basic education and continuous learning, striving for continual advancement and excellence. The environment will be noted for being "the place to work", with potential employees clamoring to get hired, not unlike the "Magnet Hospitals" in the USA.

There must be a strong environment of caring that focuses on making each patient a special guest who is going to enjoy this visit. The patient's will remember the kindness, warm blanket, comforting hand, soft voice and caring eyes at a most vulnerable and anxious time.

Colleagues and associate workers will feel valued, appreciated, recognized, respected and fully understand the importance and impact of a job well done. Honest and frequent praise will be received and given freely with meaningful impact. Staff will take more responsibility in doing a job well and are likely to take on more roles, since value is recognized. Feedback will be current, appropriate, positive, and constructive. Deficiencies are dealt with in a manner that produces positive results. Employee's go home, each day, with a major sense of having contributed in a meaningful way, with keen anticipation of return the next day. You say this is utopia- what planet did I come from, or get a reality check!

What Impedes a Value Based Perioperative Environment?

Needless to say we have all the answers without solutions! Unless we know the root cause we cannot rebuild to create a value based perioperative environment. The reasons are

Continued on Page 24

OH, THOSE BABY BLUES:
When you are dealing with a child with PHPV

Author: Dawn Atwell RN, CPNC. Dawn is a staff nurse at North York General Hospital in Toronto and Resource Nurse in Ophthalmology as well as Co-Chair of the Paediatric Glaucoma and Cataract Family Association.

In 1995 a mother had concerns about her infant son. She thought she could see a white, crescent moon shape in the upper medial aspect of his left eye. This shape could only be seen when the lights were low and the pupils were dilated. Unfortunately, no one else could see it. She also noticed that her son behaved as if he could not see if she covered his right eye. Instinct told this mother to get answers to her questions. Her family doctor referred her to an ophthalmologist. The ophthalmologist examined the left eye and told the mom that her son has ***PHPV****.*

Why does *PHPV* concern the author of this article? Two reasons. First, is the uniqueness of the condition. Second, is the fact that I was the mother in the introductory story… and the child is my son. As parents we need to be informed and ready to advocate on behalf of our child. As OR nurses we can become advocates for our clients.

Parents also need to know where to find support, information and resources in dealing with *PHPV* (and related conditions such as glaucoma and cataracts). As OR nurses we can help point parents in the right direction. In 1993, a group of concerned parents formed the Paediatric Glaucoma Family Association (now titled the Paediatric Glaucoma and Cataract Family Association). Its goal is to improve the quality of life for children with glaucoma and cataracts as well as for their families. They do so by providing information, resources, education, and family support. They can be reached at *www.pgcfa.org*

How does *PHPV* relate to the practice of perioperative nursing? We can ease parental concerns about the OR experience when surgery is required. In addition, when a surgical patient is a child with compromised vision the emphasis on preventing intra-operative corneal abrasions is even stronger.

UNDERSTANDING PHPV

What is ***PHPV*****?** *PHPV* stands for "*persistent hyperplastic primary vitreous*". By the simplest definition, it is when remnants of the fetal vascular system have remained behind. During fetal development, the spaces within the eye are characterized by luxuriant, but transient, blood vessels. These vessels do not respect the specific chambers of the eye such as anterior chamber or vitreous. The vessels extend from the posterior poles of the eye to the anterior poles of the eye (*Goldberg, 1997*). This vessel is called the hyaloid artery. As this vessel approaches the lens, it branches out, not unlike the struts of an umbrella. The development of the hyaloid artery begins early in the gestational period. As the fetus approaches the end stages of gestation, the fetal vascular system in the eye has virtually disappeared.

PHPV affects both male and female children. Either eye can be affected but on occasion it can be bilateral. Bilateral *PHPV* should always be investigated further as it can be associated with various syndromes. From the point of view of this article, we will only look at unilateral *PHPV*.

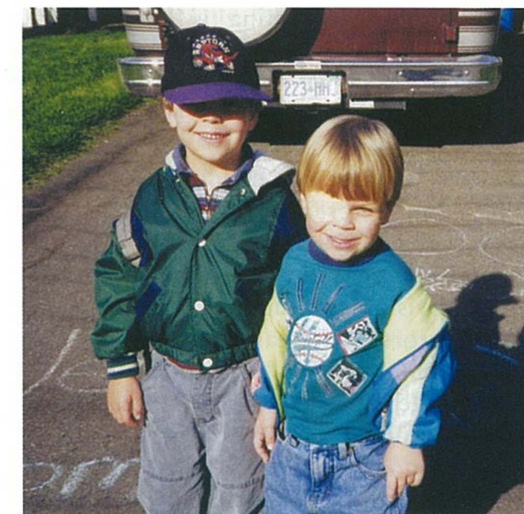


Photo by D. Atwell

Christopher (age 3) patched and his older brother

PHPV, as a unilateral condition, has no known cause other than a developmental "glitch". It is one of the most common congenital malformation syndromes affecting the eye (*Wagner, 1997*). It can be affect the anterior (lens), posterior (retina), or both. The affected eye is usually micro-ophthalmic meaning it is smaller than normal. Many children who are micro-ophthalmic require conformers to stimulate orbital growth to keep the face symmetrical.

Affected infants are usually full term and have not received supplemental oxygen (*Goldberg, 1997*). Many children affected by *PHPV* are also diagnosed with cataracts and/or glaucoma (*Moore, 1994*) The child at the beginning of the article has both. Other conditions associated with *PHPV* include cataracts, aphakia, amblyopia, and glaucoma.

CATARACTS

Infantile cataracts can be diagnosed at birth or up to 18 months of age. The incidence of infantile cataracts ranges from 1 in 1000 to 1 in every 10,000 live births. Cataracts have been historically, the leading cause of serious visual impairment in young children.

One of the easiest tests for cataracts is to check for a red reflex in the eyes – the reflex that causes red eye in photos. It is caused by light reflecting off of the retina (*Moore, 1994*). When no red reflex is seen, that indicates that something is blocking the light from getting through.

Treatment of cataracts in children differs from that of adult cataracts. With children, the longer the delay before treatment of congenital cataracts the more the amblyopia (dimness of vision not due to organic defect or refractive errors) is increased. The best rate of success is removal of the cataract before 3 months of age especially if it impedes vision. There is still some prospect of a good result up to about 6 months of age. Dense congenital cataracts, if left untreated until 9 months of age, are almost impossible to treat successfully.

A few cataracts are small enough not to block light from entering the eye and are treated with dilating drops to increase the amount of light that reaches the retina through the dilated pupil. Some cataracts are only monitored closely and if they do start to impede vision, then more aggressive action can be taken.

APHAKIA

Aphakia is the condition of being without a natural lens either from birth or as a result of cataract surgery or trauma.

For this condition, surgery is only the beginning. Follow up care is very important to visual development.

Once the lens has been removed, a new one must be provided. This involves three choices – glasses, intraocular lenses, and contact lenses (*Foster, Gilbert, Rahi, 1997*).

Contact lenses are the method of choice for correcting aphakia in children because the refractive power is easy to change as the child grows (*Moore, 1994, Morgan 1995*). Parents need to become skilled at inserting and removing contact lenses, and at the same time they also become skilled daily observers of their child's eye and can quickly note any changes that may occur.

Glasses work well with children with bilateral cataracts as the refractive power in each lens is very similar. Glasses also work as a back up system (should a contact lens be lost) or in cases where bifocals are needed to increase the focusing capabilities for the child. Glasses are also used with Plano lenses to offer protection to the eyes (*Moore, 1994*).

IOLs (intraocular lenses) are used routinely in adults but are not the first choice in young children, especially those under the age of 2. This is due to the fact that the eye is still growing and changing and it is difficult to predict what the final visual acuity will be in one so young. However, older children receive more of these lenses as their visual acuity is more stable because the eye is stopped growing. Due

to the fact that children with *PHPV* have a malformed eye, IOLs are usually not an option.

If a child has become intolerant to contact lenses then IOLs provide an alternative method of correcting amblyopia. There is no clear age at which the experts agree that IOLs can be used. One of the major issues concerning IOLs is their inability to change the refractive power as the child grows. As more and more children receive them, the long-term outcomes will be known (*Moore, 1994*).

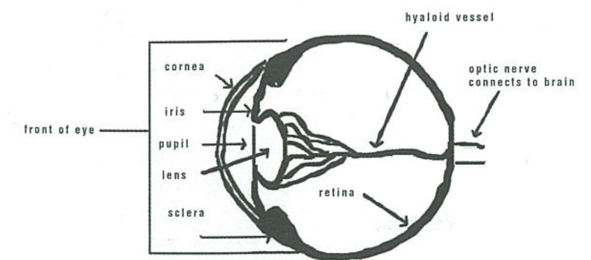
AMBLYOPIA

Amblyopia is when an individual has a "lazy eye". The most effective way to treat amblyopia is with occlusion therapy – blocking the vision in the stronger eye and forcing the weaker eye to work (*Moore, 1994*). This therapy may be required anywhere from a couple of hours every other day to all waking hours. Adhesive patches are the most common tools. If a child becomes intolerant of the patches, due to allergies or non-compliance, an occluding lens (black contact lens worn in the stronger eye) can be used instead. If the difference in acuity in both eyes is not too great, atropine drops can be used to blur the vision in the stronger eye. This process of occlusion therapy can continue until the child reaches 10 years of age by which age the visual pathways in the brain have become set.

GLAUCOMA

Glaucoma is a group of diseases of the eye characterized by increased intraocular pressure. The result is pathological changes in the optic disk, typical visual defects, and eventual blindness if treatment is not successful.

Primary infantile glaucoma occurs in the absence of any systemic disease or other ocular condition. It is an uncommon disease, 1 out of 10,000 live births, but its impact on visual development is extreme (*Wagner, 1993*). The goal of treatment is to stabilize the intraocular pressure (IOP) to preserve vision. Secondary glaucoma is associated with structural, metabolic, miotic or other diseases of the eye.



The optic nerve in infants and children is more vulnerable to increases in IOP than in adults.

If a child presents with excessive tearing, hypersensitivity to light, and squeezing of the eyelids, glaucoma is suspected. Corneal clouding, bulging eyes and "red eyes" that mimic conjunctivitis are also symptoms. Ocular enlargement occurs because the infant globe, unlike the adult one, is distensible. Pain is unusual with primary developmental glaucoma. A corneal diameter of more than 12 mm in an infant is suggestive of infantile glaucoma. In order to make a proper diagnosis, an E.U.A. (examination under anesthesia) is needed as most young children will not cooperate fully (*Wagner, 1993*).

If left untreated, infantile glaucoma is progressive, eventually resulting in blindness. Spontaneous remission has been reported but it is extremely rare (*Wagner, 1993*). The earlier the onset of glaucoma, the poorer the visual prognosis. Despite the ability of being able to control IOP (intraocular pressure) in 85% of cases, only 35% of patients have visual acuity better than 20/50 (being able to see at 20 feet what a person with normal vision can see at 50 feet). Although the disease is uncommon, successful management to prevent blindness depends on early recognition by the paediatrician.

There are medications on the market today to aid in the management of glaucoma. Some of these medications slow down the production of the aqueous humor, constrict the pupil, and/or increase aqueous outflow. Medications are added and removed until a combination that works is obtained (*Wallace, Steinkuller, 1998*).

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In addition, these surgical procedures work very well in the paediatric population:

1. Goniotomy is an operation for glaucoma that consists of opening the canal of Schlemm under direct vision. This procedure is very effective when glaucoma has been recognized early.
2. Trabeculectomy/trabeculotomy are surgical procedures that remove or break up part of the trabeculum in the eye to relieve pressure caused by glaucoma. They involve removing a tiny piece of the eyeball right at the place where the cornea connects to the sclera and creating a flap to allow fluid to escape the anterior chamber without deflating the eye. Along with that tiny piece of cornea and sclera comes a piece of the iris. The whole area is called the trabeculum. Fluid can then flow out onto the surface of the eye and be absorbed by the conjunctiva. Sometimes, an additional piece is taken out of the iris so that anterior chamber fluid can also flow backward into the vitreous part of the eye. This procedure is called an iridectomy. The results of goniotomy and trabeculotomy are about the same.
3. Implants are tiny tubes connected to a roundish or oval plate that are used to direct the aqueous humor to a space just outside the eye. Some implants have small valves that regulate the flow. These implants help to lower the IOP and are used when adequate control has not been achieved with medication and other surgical techniques or in children who have had cataract surgery. They are usually made of polymethyl-methacrylate (*PMMA*) or silicone.
4. Cyclodestructive procedures are used when the ciliary body needs to be destroyed to decrease the amount of aqueous humor that is produced. This can be done with laser or cryotherapy.

Parents should be advised that more than one procedure might be required to control the IOP in many cases (*Wagner, 1993*). End stage glaucoma, in which a child may have a blind or painful eye, may require enucleation for management.

Why has information on cataracts, aphakia, amblyopia and glaucoma been included in a discussion of *PHPV*? In regards to the case first presented, it is and has been a daily routine to deal with each of these. When this child was an infant, the parents dealt with the concerns of anesthesia and cataract surgery on one so young. The parents dealt with the daily struggles of inserting a contact lens into the eye of a less than cooperative child. They dealt with occlusion therapy to build vision in the weaker eye. Monitoring the health of the weaker eye that has also developed glaucoma is a daily occurrence. Today, all these activities are routine. That is how they deal with a child with *PHPV*.

For more information about *PHPV*, or related conditions, please visit the Paediatric Glaucoma and Cataract Family Association's website at *www.pgcfa.org* or contact the author at *atwell@primus.ca*. ✤

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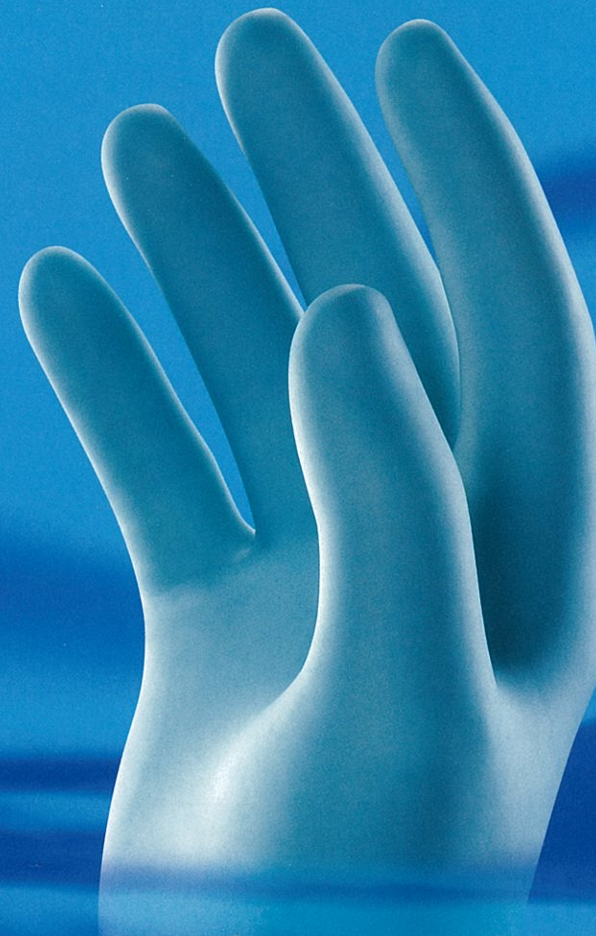

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1 Cooper Research Surgical Glove Focus Group, July 2001.

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CAS (www.cas.ca)	Ottawa, ON	June 20-24, 2003

ORNAC Welcomes New President

Margaret Farley began her nursing career as an ORT, graduating from the ORT program at the Winnipeg General Hospital in 1972. Looking for more of a challenge she decided to return to school and obtain her Registered Nurses' status and graduated from St. Boniface School of Nursing in 1978. She has been employed at various hospitals in Manitoba and Regina over the past 21 years. Most of those 20 years were spent in Cardiovascular/ Thoracic surgery at what was the Plains Health Center in Regina. She is currently the Clinical Nurse Educator for the Regina Quapple Health Region, a position she has held for the past two years. Margaret obtained her CPNC in 1995. Margaret has been a member of *Saskatchewan Operating Room Nurses Group* (*SORNG*) since it's inception in 1983. She has held the positions of president elect, president, past president, and is currently the newsletter editor. She has been an *ORNAC* board member representing *SORNG* from 1995 – 1999. She was the chair of the Public Awareness Committee in 1997 and was instrumental in launching the *ORNAC* website in December of that year. Margaret was elected to the *ORNAC* Executive in 1999 into the position of Secretary, which she has held up until her nomination and election into the position of President Elect in November of 2002.

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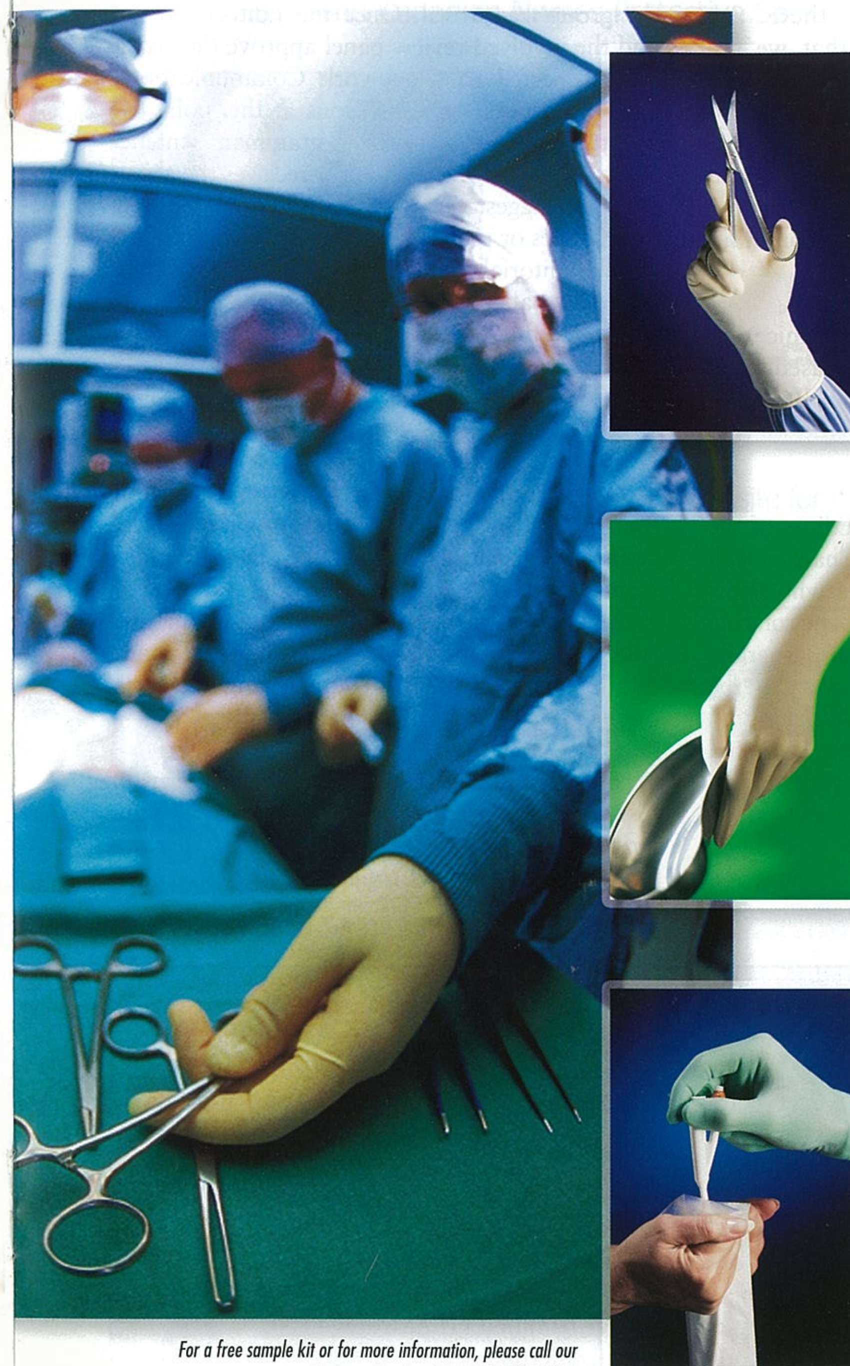

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Update from the Editorial Board

As you may be aware, *ORNAC* has recently gone through a board review to look at the general strategy and structure of the organization. While there are several achievements that we are proud of, we identified several structural concerns that required consideration. We also used the review to prioritize the existing activities of *ORNAC*. Using this information, the *ORNAC* board amalgamated all of the committees into three basic themes: communication, education, and corporate.

The journal now falls under the communication umbrella. The result has been an increased focus on the journal activities as well as a confirmation of the significance of the journal to perioperative nursing.

The Editorial Board comprises the Editor of the Journal and an *ORNAC* Editorial Chair as well as various *ORNAC* board members who assist with article reviews and an independent rotating panel of article reviewers. The Editor generally receives all articles and forwards them to the Editorial Chair. The Chair shares the articles with select reviewers depending on the related expertise of each reviewer. Reviewers respond with comments on relevancy, accuracy, references, thoroughness and overall suitability. A detailed list of criteria for reviewers has been developed in order to streamline this process. The article, along with the reviewers' comments, is returned to the Editor. If content changes are required, the article is sent to the author for revision prior to obtaining the group's approval. Once the Editorial Board and the involved review panel approve the article it is subjected to Clockwork Communications' editorial process. The revisions at this point are generally geared to length, grammar, sentence structure, and flow. The author receives the article with the suggested changes and can either accept the changes or refuse to publish. Clockwork relies on the editorial board for nursing expertise and the editorial board relies on Clockwork for writing/editing/publishing expertise.

We are proud of our accomplishments especially as the *Canadian Operating Room Nursing Journal* Editorial Board consists of a dedicated group of individuals who volunteer their time for this effort. We encourage everyone to consider submitting articles for publication – from the neophyte writer to the established author. The journal is meant to inform and educate perioperative nurses all across Canada in all types of operating room settings and it is only as good as we all can make it!!!!

If you should have any questions or concerns or just want to know how to get started with your writing career, contact either *lsocha@shaw.ca* or *Contact@ClockworkCanada.com*

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❖ We acquire fingerprints even before we enter the world. They develop at 3 months gestation while we're still in the womb.

❖ You can die of sleep deprivation before you'll die of starvation. Go without sleep for about 10 days and you'll die, but you can stop eating for weeks before dying.

❖ The fastest-growing hairs on the human body are those in a beard. It's been estimated that if the average man never trimmed his beard, it would grow to nearly 30 feet long during his lifetime.

From "*The Complete Home Health Advisor*" by Deborah Mitchell, 2001, Prentice Hall

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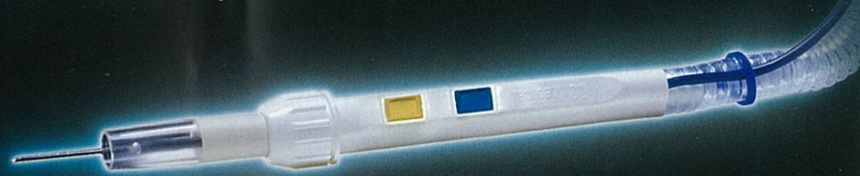

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WHY A RN FIRST ASSISTANT? *A Look at the Benefits....*

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

Can a Registered Nurse First Assistant (RNFA) work effectively as a first assistant to the surgeon and the patient? This article will examine the *RNFA* role and the benefits it provides to the healthcare system.

Most procedures performed within the operating room suite require a surgical assistant. Traditionally this function has been fulfilled by residents in teaching hospitals or by family physicians in community hospitals. Community-based hospitals are finding it increasingly challenging to acquire surgical assistants. This in turn is causing cases to be delayed or postponed. With the media reporting a shortage of physicians that is likely to increase in the future, it is not surprising that several Ontario hospitals and surgeons have begun to look to *Registered Nurse First Assistants* (*RNFAs*) to augment the available pool of surgical assistants.

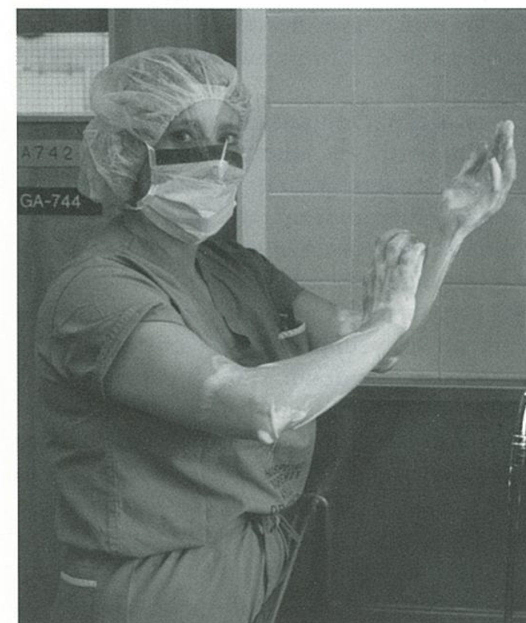

Photo by Joan Porteous

Karen Sagness, RNFA, scrubs preoperatively

RNFAs are experienced perioperative nurses who have been educated to function in this expanded role. Recognition of pertinent anatomy, coupled with knowledge of the operative sequence and its rationale, are requirements to effectively anticipate the surgeon's next move and assist rather than hinder the process. The *RNFA*, through a formalized educational process that includes a surgeon mentored clinical internship, is prepared to effectively fulfill the assistant's role.

Canadian hospitals for the most part do not reimburse physician assistants. Physicians bill the provincial government for their services so they are free to the hospital, although not to the global health system. Understandably, hospital administrators and heads of nursing and surgery balk at paying for a *RNFA* in these times of financial restraint. *Why then are those hospitals and/or surgeons who currently employ RNFAs willing to pay that extra price? What unique perspective does a RNFA bring to the operating room, surgical team and a patient's surgical outcome?*

Little qualitative data exists or is published on the benefits of the *RNFA*. *Suzin Ilton*, a *RNFA*, (2002) working with a paediatric neurosurgeon is positively influencing the patients and the practice. She reports that together she and the surgeon are able to see more patients. Case and turn over times are faster, patient satisfaction is improved, the surgeon is more efficient, and Ilton's job satisfaction is way up.

Holmes (1993) in a study from the UK, involving 1300 patients undergoing coronary bypass surgery, showed a significant difference in leg surgical site infections depending on who harvested the saphenous vein. Where the *RNFA* was involved the rate was 2.45% compared to an infection rate of 7.9% if a surgeon/physician was the vein harvester.

Quantitative or anecdotal data is much more readily available. Surgeons, perioperative nurses, anaesthesiologists, registered respiratory therapists, and perfusionists have been known to comment that things just seem to go smoother and quicker when a *RNFA* assists. Data generally

supports that a faster operation equals a better patient outcome (*Wysocki, 1989*).

But how does a *RNFA* contribute to this? By being available and present a *RNFA* is able to recognize what needs to be done, and has the skills and education to actually do it. A willingness to work hard is also a key attribute of a *RNFA*.

Within the operating room itself, *RNFAs* are motivated by what is in the best interest of the patient, rather than by advantageous billing practices. *RNFAs* are there to assist the entire health team – including nursing, anaesthesia, respiratory, and perfusion – not just the surgeon. *RNFAs* tend to be immediately available and very focused.

Assisting a surgeon intra-operatively is similar, in concept, to ballroom dancing. When the same partner is available for every dance, the partners become able to anticipate each other's moves and utilize their different sets of skills to function as one. The surgeon leads while the assistant follows. The result is a smooth and elegant "dance". When the assistant continually changes, it is more difficult to get the same results. If the assistant is not familiar with, or comfortable with, the environment, this will further detract from the outcome.

As a result of their perioperative background, *RNFAs* can assist a variety of surgeons equally well. Individuals who work with each other on a regular basis also come to understand each other's idiosyncrasies, moods and preferences. They begin to complement each other and achieve optimal outcomes for the patient in a safe and efficient manner.

As operating rooms become increasingly complex and dependent on ever changing technology, it is no longer possible to have just any assistant "pop in" to the OR. Daily ongoing experience and education build a comfort level and a skill set that short-term involvement cannot. The *RNFA*, with previous scrub and circulating experience, is intimately familiar with and at home in the perioperative environment.

Patient safety is integral to the practice of perioperative nursing. The *RNFA*, in collaboration with the OR team, helps to ensure that the patient remains free from harm. Experience and familiarity with the environment ensure that the RNFA, along with other nursing staff are quick to discern subtle clues and to intervene and prevent untoward events from occurring.

Ideally, *RNFAs* also maintain contact with the patient throughout their perioperative experience – pre-operatively, intra-operatively and post-operatively. Nurses tend to be holistically oriented and in general, have more time to spend with patients than surgeons. *RNFAs* not only understand the surgical process, but they also understand what the patient is about to face and, as a result, are able to prepare the patient and his/her family for what lies ahead. The unknown can be very frightening and confusing. A smiling friendly *RNFA* can help to alleviate fears and make the process more tolerable and manageable. Both pre- and post-operatively patients, and their families, appear less reluctant to ask questions of the *RNFA* than they would be with a surgeon. In the writer's experience, patients often have unanswered questions which increase their anxiety level but do not want to bother the surgeon as they feel he/she is too busy. Because the *RNFA* directly participates in the surgical procedure he/she is an excellent front-line source of information and comfort.

By assessing the patient pre-operatively, consulting with the surgeon, and having a thorough understanding of the operative sequence and equipment, the *RNFA* is able to personalize the plan of care and communicate that information to other team members. This often prevents the unnecessary opening of equipment and supplies thus contributing to keeping case costs down.

RNFAs can also be an integral part of the learning experience for staff, students, and even other assistants. The world of the operating room is one of mystery – few outsiders know what happens beyond that magical red line on the floor or pneumatic double doors. *RNFAs* are often among the most highly trained individuals who work with the surgeon on a

regular basis and have a 'bird's eye view' of the surgical intervention in addition to hands-on experience. When unplanned events occur, the *RNFA* is generally able to continue assisting effectively. As a result they have much to offer less experienced personnel.

When a surgery utilizes large amounts of instruments and equipment, as it does in orthopaedics, for example, the *RNFA* is able to help novice nurses understand and prepare for the sequence of events. This makes the situation less stressful for the scrub nurse, reduces the potential frustration of the surgeon, and helps to maintain the pace of surgery.

Previous scrub nurse experience allows the *RNFA* to help the surgeon in other small ways. Seemingly minor acts such as handing suture ends to the surgeon or cleaning tissue off forceps when the scrub nurse is busy helps to keep the operative flow constant and the pace of work steady. These tasks may be little factors on their own but, in combination, they facilitate a smoother and faster operation.

RNFAs, like other registered nurses, are becoming involved in research opportunities and best practice innovations. Both alone and in collaboration they help to identify practice problems, and seek answers and solutions through scientific investigation (*Elliott, 2002*).

As the predicted nursing shortage becomes more acute recruitment and retention are becoming increasingly important issues. The use of *RNFAs* is one way to help the system retain experienced registered nurses within the perioperative arena. The opportunity the role offers encourages nurses to expand their skills and helps to foster a positive work environment. *RNFAs* become mentors, role models, and informal educators. As *Ilton* (2002) states "*people making career choices are attracted to nursing for the opportunity of an autonomous role, with the opportunity for clinical growth*" (p. 26). The *RNFA* role exemplifies this statement.

The subspecialty of nurse anaesthetists (in the USA) was born because surgeons felt that nurses had the "*natural aptitude and intelligence to develop a high level of skill in providing the smooth anaesthesia and relaxation that the surgeon demanded*" (*Garde, 1946, p. 567*). Likewise, *RNFAs* are proving that they have the knowledge, skills, and professional judgment required to act as effective assistants in the OR. As a result they are being accepted by surgeons and by hospitals as a viable addition to the available pool of surgical assistants.

It seems the answer to this article's introductory question – '*Can a RNFA work effectively as a first assistant to the surgeon and patient?*' – is YES. ✤

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CORL CORRAL (*cont.*)

many, including stressed and inadequately prepared leaders. Leaders who are constantly pressured with short staff, staff with performance problems, efficiency and financial pressures, endless meetings, employee relations and physician demands find little time to care for themselves never mind the struggling staff. When pressures increase the first thing to go is the value of education, which flies in the face of one the key satisfiers for staff. The stressed leader cannot be the mentor and role model the staff so desperately need to thrive and keep the professional passion burning. The stressed, overworked leader often does not even know what the staff are feeling and need, much less improve the situation. The stressed leader can truly identify with the rat running on a spinning wheel that is ever increasing in speed.

Limiting factors that preclude a value-based environment include negative staff, that have limited interest in change, moving forward and striving for daily excellence. Staff, who set poor examples, are marginal performers, have minimal insight into deficiencies or simply choose to put in time, reduce the value, professional conduct and interest. Staff who "eat their young, their old and their peers", as a daily routine inversely effect a value based environment.

Physician behavior, attitude, demands, expectations and treatment of staff has a major impact on a value-based environment. The level of the cooperation, participation and respectful nature of physicians has a great deal of impact on the staff. Leadership actions, effectiveness, support and expectations related to managing physician behavior aberrance directly influences a "value based environment".

How to Create a Value Based Environment

The organization has to espouse to a value-based environment, where staff are a key resource to be valued in order to deliver service for our purpose of being – the patient! The values concept must be real, evident, and must be clearly a "walk-the talk", not just lip service. The platform is a learning/ teaching environment. A focus on values and culture is practiced.

The fundamental personal values must be identified for each group, especially considering different generations. The values and needs of different work groups and team structures then need to be assessed against the personal, individual and then assessed against the organizational values. The meshing of these three groups of values will be critical to make the utopian workplace where happy, loyal, cooperative and productive employees thrive. Professional passion will thrive once again.

Between Utopia and Now

Creating a truly value based environment requires a tremendous amount of time, focus, energy, commitment, skill, resources and effective leadership. Just like eating the elephant, small bites over an extended time are required.

We need to be passionate about our work and our career. Being visible and showing a caring concern for the staff, on a regular basis, is essential. We need to frequently acknowledge their accomplishments and contributions. Staff need to know "how they are doing", with descriptive, positive feedback loops. Nurturing positive values should help in reducing stress and tension. Celebrate small and big successes.

Today's leaders need to role models, that serve as mentors for staff to become engaged, passionate and remain in the system create a value based environment. Take time to stop and smell the roses – they are your staff – they are the leaders of tomorrow! Make it so! ♣

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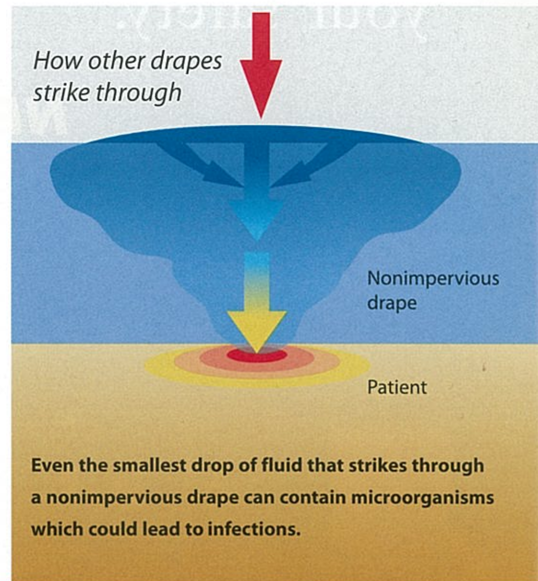

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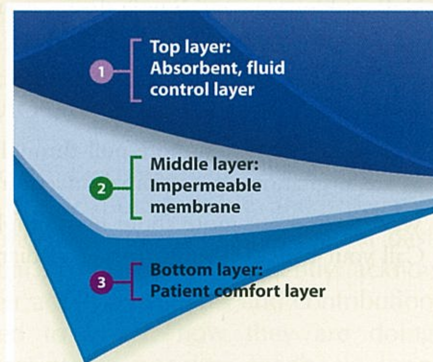

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*The Centers for Disease Control and Prevention's Guideline for Prevention of Surgical Site Infection, 1999.

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