


CANADIAN

September 2002

# Operating Room

Nursing Journal



## False Nails... Very Real Risks

**Positioning and Pain  
in Gynaecological Surgeries**

**Call for Abstracts – 2003 Conference**

**Provincial Conference Reports**



# Lac-Mac LIMITED



## Improve your protection Improve your comfort

### InnerBloc® Surgical Gowns and Drapes



Lac-Mac Limited  
425 Rectory St., London, Ontario, Canada N5W 3W5  
519.432.2616 www.lac-mac.com

InnerBloc is a registered trademark of Lac-Mac Limited  
GORE is a registered trademark of W.L. Gore & Associates, Inc.

## President's Message

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

Fall is upon us - a busy time for all, with another round of activities starting. I hope you will take time to participate in your local perioperative nursing association meetings and events. I look forward to meeting many of you at provincial conferences this fall.

It has been said that nothing is certain except change, and that undoubtedly is true for ORNAC. In June, Gloria Nemecek (AB), *President Elect*, submitted her resignation. She is leaving to assume a position with one of our industry partners and ORNAC wishes her well in her new career. Gloria has made significant contributions to ORNAC, not least being Co-Chair of the very successful 2001 National Conference. According to its By-Laws, the ORNAC Board will elect a President Elect during the next Board meeting in November. That individual will assume the ORNAC Presidency in June 2003, after the National Conference in Winnipeg.

The ORNAC Board is also embarking on a review of its structure and functions at the November Board meeting. The Board has identified four pillars of our organization: the *Recommended Practices for Perioperative Nursing* (often referred to as standards); the *Canadian Operating Room Nursing Journal*, or CORNJ; the *National Conference*; and, the ORNAC website, [www.ornac.ca](http://www.ornac.ca). The continued success of ORNAC rests squarely upon the strength of this foundation.

Our professional credibility as perioperative nurses rests on our Recommended Practices for Perioperative Nursing, a document widely used across our country. The five year cycle between editions has long been a concern, although the huge amount of work by volunteers to produce this document must also be appreciated and recognized. The fifth edition is due for publication in 2003.

The CORNJ is our professional face to our members and to our nursing colleagues. Assuming ownership of the Journal has provided a wonderful opportunity, but with it

comes an increased workload. Appropriate supports for this endeavour must be built into ORNAC's structure if we want to have a successful enterprise!



The National Conferences are the most important perioperative nursing educational event in Canada. Held every two years, the conference provides the ideal forum for Canadian perioperative nurses to meet face to face, network, get updated on the latest our industry partners have to offer, and find time to rejuvenate!

The website is ORNAC's future as we communicate with the world and especially with our members who more and more expect to communicate via computer.

At the November meeting, the ORNAC Board will deliberate on the best way to ensure these four pillars are firmly grounded and supported. ORNAC's committee structure has become cumbersome and will be streamlined. The Board has already taken the first steps to accomplish this, and will continue the discussion in November.

It is an exciting time to be active in ORNAC! ✨

*Mary Knight, RN, BScN, MN, CPN(C), is President of the Operating Room Nurses' Association of Canada. She is the Project/Systems Coordinator, Adult OR, at the Health Sciences Centre, in Winnipeg, MB.*

*Mary Knight, inf., BScN, MN, CPN(C), est la présidente de l'Association des infirmières et infirmiers de salles d'opération du Canada. Elle est coordonnatrice de projet du bloc opératoire de chirurgie adulte, au Health Sciences Centre, à Winnipeg, Manitoba*

## Message de la présidente

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

L'automne est à nos portes – un temps occupé pour tous, une autre période d'activités débute. J'espère que vous prendrez le temps de participer aux rencontres de votre association locale. J'attends avec intérêt de rencontrer bon nombre d'entre vous lors des conférences provinciales cet automne.

Il est dit que rien n'est certain sauf le changement, et c'est incontestablement vrai pour l'AIISOC. En juin, Gloria Nemecek (AB), *présidente adjointe*, a remis sa démission. Elle quitte pour occuper un poste chez l'un de nos partenaires de l'industrie et l'AIISOC lui souhaite du succès dans sa nouvelle carrière. Gloria a contribué de façon significative à l'AIISOC, entre autres comme co-présidente de la Conférence nationale 2001, laquelle fut couronnée de succès. Selon sa loi, le conseil d'administration de l'AIISOC élira une présidente adjointe lors de sa réunion de novembre. Cette personne assumera la présidence de l'AIISOC en juin 2003, après la conférence nationale de Winnipeg.

Le conseil d'administration de l'AIISOC amorcera aussi une révision de ses structures et fonctions à sa réunion de novembre. Le conseil d'administration a identifié quatre points principaux ou piliers de notre organisation : les *pratiques recommandées en soins périopératoires* (se réfèrent souvent aux normes) ; le *Journal des soins périopératoires canadien* ou CORNJ ; la *Conférence nationale* ; et le site web de l'AIISOC [www.ornac.ca](http://www.ornac.ca). Le succès continu de l'AIISOC repose vraiment sur la solidité de sa fondation.

Notre crédibilité professionnelle en tant qu'infirmières en soins périopératoires repose sur nos pratiques recommandées en soins périopératoires, un document largement employé dans tout le pays. La période de cinq ans entre chaque édition a toujours été un questionnement, bien que la quantité considérable de travail des volontaires pour produire ce document doive aussi être appréciée et reconnue. La cinquième édition est prévue pour 2003.



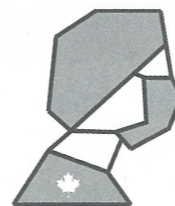
Le journal canadien CORNJ reflète notre professionnalisme face à nos membres et à nos collègues en soins infirmiers. La prise en charge du journal nous a fourni une opportunité fantastique, mais avec une charge de travail accrue. Les soutiens appropriés pour cette initiative doivent être mis en place à l'intérieur de la structure de l'AIISOC pour en faire une entreprise réussie !

Les conférences nationales sont les événements éducationnels en soins périopératoires les plus importants au Canada. La conférence, tenue tous les deux ans, offre un forum idéal aux infirmières canadiennes en soins périopératoires pour se rencontrer face à face, se bâtir un réseau d'échanges, s'actualiser sur les derniers développements que nos partenaires de l'industrie ont à offrir et aussi prendre le temps pour se remotiver ou refaire ses énergies!

Le site web est l'avenir de l'AIISOC, du fait que nous communiquons avec le monde et spécialement avec nos membres, qui de plus en plus s'attendent à communiquer via l'ordinateur.

Lors de sa réunion de novembre, le conseil d'administration de l'AIISOC discutera de la meilleure façon d'assurer une base et un soutien solides pour ces quatre piliers. La structure des comités de l'AIISOC est devenue trop chargée et dépassée, et sera rationalisée. Le conseil d'administration a déjà fait un premier pas dans cette direction et continuera la discussion en novembre.

C'est une période passionnante pour être actif dans l'AIISOC ! Alors, profitons-en et soyons actifs dans l'AIISOC ! ✨



# CANADIAN Operating Room Nursing Journal

Published Quarterly ✨ Volume 20, Issue 3, September 2002

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

**Editor:** Deborah Murphy  
**Art Director:** Sherri Cleveland

### Canadian Operating Room Nursing Journal

c/o Clockwork Communications  
3700 Kempt Road, Suite 255  
Halifax, NS B3K 4X8  
Tel: 902.497.1598  
Fax: 902.423.1961  
E-Mail: [Contact@ClockworkCanada.com](mailto:Contact@ClockworkCanada.com)

#### Editorial Board:

**Chair:** Linda Socha  
Saskatchewan

**Committee:** Tina Kennah  
New Brunswick

Marcy McKay  
British Columbia

Lucette McLean  
Manitoba

Claire Tremblay  
Quebec

#### 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

Canadian Publications Mail Product Sales  
Agreement No. 40012007

## Editorial Contents

7 Patient Positioning  
Outcomes for  
Women Undergoing  
Gynaecological Surgeries  
By: Hilda Power



Cover photo by  
Joan Porteous

15 Update From  
Public Awareness  
By: Margaret Farley  
and Tina Kennah

16 Artificial Nails...  
Very Real Risks  
By: Joan Porteous

18 The Time is Ripe —  
BCORNG 18th Conference

23 The Impact Zone —  
ORNAO's 7th Conference

24 Survival Tips in Organizational  
Chaos and Change  
Canadian OR Leaders  
*Pearls of Wisdom*  
By: Muriel Shewchuk

#### INDUSTRY HAPPENINGS

7 CALL FOR ABSTRACTS  
ORNAC's 2003 Conference  
APPEL DE RÉSUMÉ  
18ième Conférence Nationales

25 Upcoming Events

*In the June issue of CORNJ we incorrectly credited the author of Oh My, The Pressure in our Table of Contents. The author of this article was Margaret Farley. We sincerely apologize to Ms. Farley for the error.*

## CALL FOR ABSTRACTS



### Operating Room Nurses Association of Canada **18th National Conference** Winnipeg, Manitoba • June 8-12, 2003

Share your accomplishments in the fields of perioperative clinical practice, education, professional development, research and administration!

The 2003 Conference Program Committee invites you to submit an abstract for presentation or poster at our **18th ORNAC National Conference** *Planting Ideas, Reaping Rewards*.

Abstracts will be considered for presentation in one of the following forums:

- Paper:** A 20-minute presentation by the author plus 5 minutes for questions.  
**Poster:** A visual display. Posters will be displayed for the entire conference.

Abstract submissions should have a maximum of 150 words on a single-spaced page, typed with a minimum of 12 characters per inch. Abstract heading should include title, author's name, institution name, city and province. Please indicate your specific field of focus.



Please send three (3) copies of the abstract by November 1, 2002 to:  
Joan Porteous, RN, BN, CPN(C), Co-Chair, Program Committee  
Box 144, Woodlands, MB R0C 3H0  
Fax: (204) 787-3095 Email: jporteous@hsc.mb.ca

## APPEL DE RÉSUMÉ



### Association des infirmières et infirmiers en salles d'opération du Canada **18ième Conférence nationale** Winnipeg, Manitoba • 8 au 12 juin 2003

Partagez vos réalisations dans le domaine de la pratique clinique, de l'éducation, du développement professionnel, de la recherche et de l'administration en soins périopératoires!

Le comité responsable du programme de la Conférence 2003 vous invite à soumettre un résumé pour une présentation ou un affichage pour la **18ième Conférence nationale de l'AIISOC dont le thème est Semons nos idées, récoltons des récompenses**.

Les résumés seront considérés pour une présentation à l'un des forums suivants :

- Papier:** une présentation de 20 minutes par l'auteur avec une période de questions de 5 minutes.  
**Affiche:** une affiche disponible durant toute la conférence.

Les résumés soumis devraient inclure un maximum de 150 mots dactylographiés à simple interligne, et un minimum de 12 caractères par pouce. L'entête du résumé devrait inclure le titre, le nom de l'auteur, le nom de l'institution, la ville et la province. Veuillez également indiquer votre domaine d'intérêt spécifique.



Veuillez faire parvenir 3 copies de votre résumé avant le 1er novembre 2002 à :  
Joan Porteous, RN, BN, CPN(C), Co-Chair, Program Committee  
Box 144, Woodlands, MB R0C 3H0  
Fax: (204) 787-3095 Email: jporteous@hsc.mb.ca

## PATIENT POSITIONING OUTCOMES FOR WOMEN UNDERGOING GYNAECOLOGICAL SURGERIES

### AUTHOR:

Hilda Power, RN, BScN, MN, CPN(C). Hilda Power is the Perioperative Coordinator of the Women's Health Program at the IWK Health Centre in Halifax, Nova Scotia. The initial funds for this study were provided in two grants by the Dalhousie School of Nursing Research and Development Fund and the completion of this study was made possible by the ORNAC Allegiance Research Award.

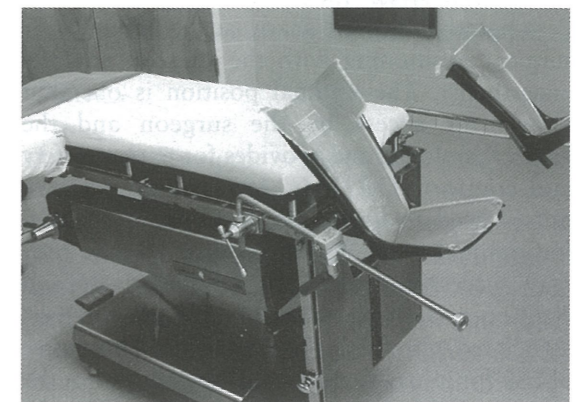
### ACKNOWLEDGMENTS

The author wishes to thank Dr. Lorna Butler and Mary Lee-Hebert, RN, for their contribution during the initial development of the study, and Lois Sutton, RN and Sheila Guile, RN who identified surgical positioning as an area of practice that required further investigation. I wish to extend a sincere thank you to all of the registered nurses who offered suggestions as to the appropriate process for collecting the data, to the nurses who participated as research assistants and to Colleen O'Connell for providing statistical support. The study was carried out between November 1996 and January 2000. Photographs are courtesy of Joan Porteous.

### ABSTRACT

The purpose of this study was to determine if women undergoing gynecological surgery experienced post-operative pain, separate from surgical site pain, in the lower extremities. The study used a quasi-experimental, comparative, exploratory design. A convenience sample of 153 women, mostly day surgery patients, comprised the study sample. The women were divided into two groups; Group I consisted of women for specific procedures requiring the lithotomy position and Group II consisted of women for specific procedures requiring the supine position. Descriptive statistics were used in the data analysis of the positioning guidelines and pain scale scores. Pearson's Moment Correlations were used to determine relationships among the variables and T-test analysis was used to compare the differences between the two groups.

The study found that 41% (n=63) of the women (N=153) had pain in the lower extremities, separate from incisional site pain, post surgery. Women who were in position for more than 60 minutes had significantly more pain than those who were in position for less than 60 minutes. Of those who reported pain (41%) there was no difference between the supine and lithotomy groups as to the incidence and severity of the pain. Of those in the lithotomy group who reported pain, there was no difference in the reporting of pain based on the type of stirrup used.



Allen Stirrup

## DEFINITION OF TERMS

Body Mass Index (BMI), calculated by dividing weight in kilograms by height in metres squared, is a helpful indicator of obesity and underweight in adults. According to the Statistical Report on the Health of Canadians (1999) a BMI of 20-24.9 is defined as a healthy weight. A BMI between 25 and 26.9 confers a "possible health risk" and a BMI of 27 or greater confers a "probable health risk".

**Pain:** "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (*International Association for the Study of Pain, 1986, P. S217*).

**Lower Extremities:** Include the lower back and lower abdomen from the umbilical level, the hips, thighs, legs, ankles, and feet (*Gregory Daws & Sileo, 1999*).

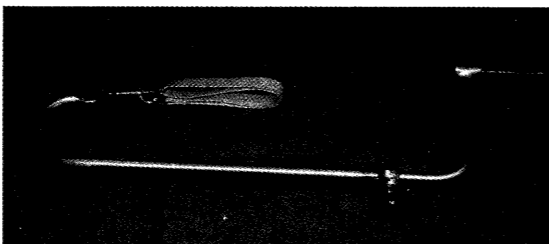
## PATIENT POSITIONING OUTCOMES FOR WOMEN UNDERGOING GYNAECOLOGICAL SURGERIES

Perioperative nurses share accountability for surgical positioning with the surgeon and the anaesthetist. The optimal position is one that allows for access by the surgeon and the anaesthesiologist and provides for patient safety and comfort (*ORNAC, 1998*). Perioperative nurses need to know the appropriate position for optimal physiological effects so that they may successfully intervene preoperatively and intra-operatively to reduce or eliminate the risks associated with the surgical position. The degree of risk for injury is relative to whether or not the patient receives general or regional anaesthesia, the type and length of surgery, the required

position, and the patient's overall condition at the time of surgery. Specific nursing diagnoses that may be applicable to surgical positioning include high risk for impaired skin integrity, high risk for altered tissue perfusion, high risk for musculo-skeletal injury and high risk for ineffective breathing pattern. Although desired outcomes are patient specific, the desired outcome relative to positioning is that the patient should have sustained no injury as a result of positioning (*Spry, 1997, p. 119*). One of the first indicators that an injury has occurred is the patient's post-op report of pain that is unrelated to the surgical site.

Pain is the body's first defense to indicate actual or potential tissue damage (*International Association for the Study of Pain, 1986*). "Acute pain is associated with tissue damage that begins to decrease as the tissues heal. It is generally of short duration, that is, days to weeks." (*McGuire, 1996, p. 335*). The anaesthetized patient is at increased risk related to positional injury because a general or regional anaesthetic prevents the body's normal defense of pain from warning of exaggerated stretching, twisting, and compression of body parts. As a result subsequent damage to nerves and vascular structure can occur without patient awareness. Muscle relaxants further exacerbate the potential for injury by inducing loss of muscle tone and exaggerated muscle relaxation, which interferes with normal defense mechanisms against unnatural or excessive range of motion (*Spry, 1997; McEwen, 1996*).

Surgical positioning may result in postoperative musculo-skeletal pain, joint dislocation, peripheral nerve damage, skin breakdown and cardiovascular and respiratory compromise (*Heizenroth, 1999*). In the supine position areas of the lower extremities exposed to risk include, but are not limited to, the lumbosacral nerve, the sciatic



Sims Stirrup

nerve, the common peroneal nerve and the deep peroneal nerve, the skin over the sacrum and the Achilles tendon. In the lithotomy position areas of lower extremities exposed to risk include, but are not limited to, the lumbosacral nerve, the sciatic nerve, the sacro-iliac joints, the skin over the sacrum, the femoral and obturator nerves, the common peroneal nerve, the tibial nerve, and direct pressure to the anterior and lateral compartments of the leg can result in "compartment syndrome"

The surgical position poses a risk of injury for the patient but so too does the current health status of the patient. Patients with certain diseases such as diabetes and cardiovascular disease (*McGuire, 1995; Graling & Colvin, 1992*) and of a certain weight are at greater risk of injury (*Heizenroth, 1999*). Hence, a preoperative health history to determine the patient's health status and the existence of diseases and conditions is required to ensure the best possible position and support devices necessary to optimize patient outcomes relating to surgical position (*McEwen, 1996*).

## PURPOSE AND RESEARCH QUESTIONS

The purpose of this study was to determine if women undergoing gynaecological surgery under general anaesthesia experienced post-operative pain, separate from surgical site pain, in the lower extremities. The supine and lithotomy positions were chosen because those are the positions most frequently used during gynaecological surgeries. There were four questions that the study was to answer. They were:

1. Do women experience lower extremity pain, separate from surgical site pain, post surgery?
2. Is the incidence and severity of pain related to the length of time in position:
  - a) 60 minutes or less or b) more than 60 minutes?
3. Is the incidence and severity of pain related to the
  - a) supine position or b) lithotomy position?
4. Is the incidence and severity of pain related to the type of stirrup:
  - a) Allen, or b) Sims?

## ETHICAL CONSIDERATIONS

Ethical approval was received at the health centres in which the research was conducted. All participants were informed that their participation was voluntary and their decision whether or not to participate would not affect the quality of health care they received. They were informed that there were no anticipated physical or emotional risks related to participation in the study and that they could withdraw from the study at any time. Confidentiality of the participants was ensured by the coding of all data collection forms. Any publications or presentations would use grouped data.

## STUDY DESIGN

In 1996 there were 2500 women per year who underwent general gynaecological surgeries at a large tertiary care centre. Women scheduled for gynaecological surgery comprised the study sample. The intended sample size was 134 women in each position: Group I = lithotomy, Group II = supine. [This sample size would provide a confidence level of 95%, which means that the significance level would be .05 or less, and a power of 80%.] The participants would be female between 20 and 50 years of age, speak fluent English, and have a body mass index (BMI) between 21 and 27. Women with prior physical or anatomical injuries to their lower back or legs such as hip pinning, hip replacement, arthritis, plus those with a history of pain in the lower extremities, cardiovascular disease and diabetes were excluded. To facilitate post-op access only women who were having day surgery or short stays (1-2 days) were included.

## TOOLS

A verbal descriptor scale (VDS) using a pain rating scale of 0 = no pain, to 5 = excruciating pain was used to measure pain intensity. This was chosen because it had the advantages of brevity, ease of administration and completion, and applicability to the type of pain being measured -- acute pain post-op. The VDS has been validated for construct validity and reliability (*McGuire, 1996*). The VDS scale was combined with the various locations (hips,

## POSITIONING (cont.)

knees, etc.) to allow each location to be rated for incidence and severity of pain. Researcher-developed scales based on perioperative positioning guidelines for supine and lithotomy positions were also constructed (*see end of article*). These scales were validated for content validity by OR nurse clinicians and educators. Reliability was not tested.

### DATA ANALYSIS

Descriptive statistics were used for the positioning guidelines and pain scale scores. Pearson's Moment Correlations were used to determine relationships among the variables and T-Test analysis was used to compare the differences between the two groups. Continuous variables were analyzed using the T-test and categorical variables were analyzed using a Chi-square. Fisher's exact test was used for small numbers where Chi-Square was not a valid test (i.e. positioning guidelines).

### ACCESSING PARTICIPANTS

The research assistant accompanied each woman to the OR and observed her being positioned on the OR table. The assistant documented the positioning at the start of, during, and at the end of surgery. The total table time was calculated from the time the woman was placed on the table to the time she was taken off the table. The supine time was recorded as the time the woman was induced for anaesthesia (all patients received a general anaesthetic) to when she was moved off the table. The lithotomy time included time up in stirrups to time of removal from stirrups.

On the third postoperative day the woman was contacted by phone to determine if she had lower extremity pain. If the response was no pain then only that information was recorded. If the response was yes to pain then the woman was asked to complete the rest of the post-test relating to pain location and rating.

### RESULTS

One hundred fifty-three women scheduled for gynaecological surgeries comprised the study

sample, 103 (67%) of these were day surgery patients. The age range was from 23 - 49 years (average age 35 years), and the Body Mass Index (BMI) range was 20 - 43 (average 25). The top three procedures for the supine position were tubal ligation, abdominal hysterectomy and salpingo-oophorectomy, unilateral. The top three procedures for the lithotomy position were diagnostic laparotomy, laser laparoscopy and vaginal hysterectomy. Of the 153 women involved in the study 63 (41%) women indicated they had pain in the lower extremities, separate from surgical site pain, 90 (59%) women indicated no pain. [*see Figure 1*] Of the 63 who had pain, almost three-quarters of them, 44 (70%), experienced pain on the first day post-op, 16 (25%) women experienced pain on the second day, and 3 (5%) women experienced pain on the third day. [*see Figure 2*] Women who reported pain stated they had pain in the lower back, hips, groins, thighs, knees, or calves. No one complained of pain in the ankles or feet.

Figure 1: Women reporting pain

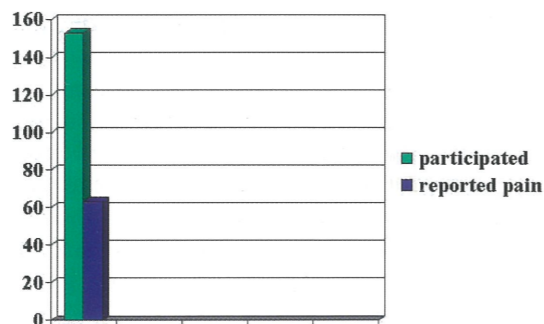
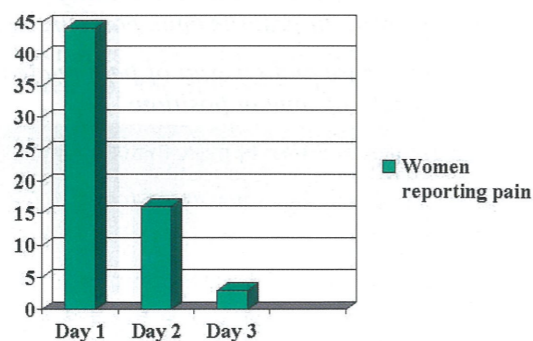


Figure 2: Days post-op & women reporting pain



Continued on Page 27

## PROTECTION



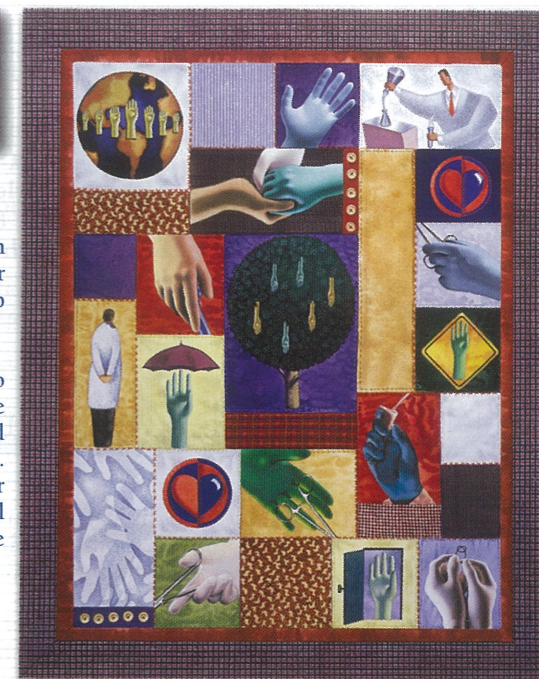
without question.

Ansell medical gloves provide the hand barrier protection you demand. As the world leader in medical gloves with over 97 years of history, we have a heritage of fine craftsmanship and a reputation for detail.

An expertise in what we do. Like being the first company to develop disposable, ready-to-autoclave surgical gloves, the first to offer orthopaedic and microsurgical latex gloves, and the first to offer a complete line of powder-free gloves. They're all part of the tapestry of products that reflect our commitment to excellence. From exam gloves to surgical gloves, synthetic to latex, and powder to powder-free, all the pieces come together perfectly.

105, Lauder, Cowansville, Quebec, Canada J2K 2K8  
Phone (450) 266-1850 Toll Free 800-363-8340 Fax (450) 266-6150 [ansellhealthcare.com](http://ansellhealthcare.com)

©2002 Ansell Healthcare Inc.



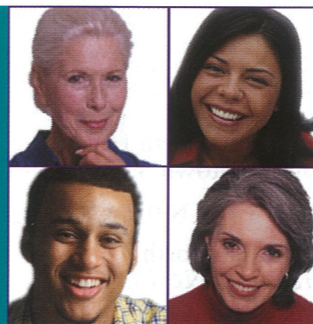
## Can Nurses Be Sued? Yes.

The Canadian Nurses Protective Society is here for you!

Visit the new CNPS website

- learn how to manage your legal risks
- read informative articles on nursing and the law
- download popular legal bulletins and much more . . .

[www.cnps.ca](http://www.cnps.ca)



CNPS is for You!

A website for nurses by nurses, and it's FREE

1-800-267-3390

## ORNAC Executive 2002

### PRESIDENT

**Mary Knight**  
Project / Systems Coordinator  
Adult OR  
Health Sciences Centre  
Winnipeg, MB

### PAST PRESIDENT

**Marlene Hill**  
Staff Nurse  
Queen Elizabeth Hospital  
Charlottetown, PEI

### PRESIDENT ELECT

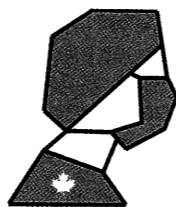
Vacant – Election to be held  
November 2002

### SECRETARY

**Margaret Farley**  
Perioperative Educator  
Regina Health District  
Regina, SK

### TREASURER

**Sheila Billiard**  
Staff Nurse, OR  
Western Memorial Hospital  
Cornerbrook, NF



## ORNAC Board Members 2002

### BRITISH COLUMBIA

**Marcy McKay**  
President, BCORNG  
Staff RN  
Victoria General Hospital,  
Victoria, BC

**Bonnie McLeod**  
President Elect, BCORNG  
Clinical Nurse Educator  
Royal Columbian Hospital  
Westminster, BC

### ALBERTA

**Peggy Ziegler**  
President, ORNAA  
Team Leader, Paediatric  
ORStollery Childrens  
Hospital, Edmonton, AB

**Diane Johnson**  
President Elect, ORNAA  
Staff RN  
Grey Nuns Community  
Hospital, Edmonton, AB

### SASKATCHEWAN

**Marla Ewen**  
President SORNG  
RNFA  
Royal University Hospital,  
Saskatoon, SK

**Linda Socha**  
President Elect, SORNG  
RNFA  
Royal University Hospital,  
Saskatoon, SK

### MANITOBA

**Lucette McLean**  
President, MORNA

Clinical Resource Nurse ENT  
St. Boniface Hospital,  
Winnipeg, MB

**Brenda Badger**  
President Elect, MORNA  
Staff RN  
Seven Oaks Hospital,  
Winnipeg, MB

### ONTARIO

**Kathy Bruce**  
President, ORNAO  
Program Leader,  
Surgical & Maternal/Child  
Lakeridge Health,  
Bowmanville, ON

**Alaine Young**  
President Elect, ORNAO  
Education Development  
Clinician  
Hamilton Health  
Sciences Centre,  
Hamilton, ON

### QUEBEC

**Claire Tremblay**  
President, CHSOQ/CORNQ  
Nurse Educator  
Laval Hospital  
Ste-Foy, PQ

**Liné Boucher**  
President Elect,  
CHIOQ/CORNQ,  
Staff RN  
Pierre Boucher Hospital,  
Longueuil, PQ

### NEW BRUNSWICK

**Tina Kennah**  
President, NBORN

OR Nurse Manager  
Region 3 Corp.  
Fredericton, NB

**Charlotte Roach**  
President Elect, NBORN  
OR Nurse Manager  
Hotel Dieu of St. Joseph,  
Perth-Andover, NB

### NOVA SCOTIA

**Diana Mabbett**  
President, ORNANS  
Staff RN  
QE II Infirmary Site  
Halifax, NS

**Lyn Thorne**  
Past President, ORNANS  
Staff RN  
QE II Infirmary Site  
Halifax, NS

### PRINCE EDWARD ISLAND

**Theresa Thomas**  
President ORNPEI  
Staff RN  
Queen Elizabeth Hospital  
Charlottetown, PEI

### NEW FOUNDLAND

**Laura Ellsworth**  
President, N&LORNA  
Staff RN  
St. Clare's Mercy Hospital  
St. John's, NF

**Angi Patten**  
President Elect, N&LORNA  
Clinical OR Nurse,  
Neurosurgery  
Health Sciences Complex, St.  
John's, NF

## Are You Moving?

To ensure that you continue to receive your copy of the Canadian Operating Room Nursing Journal please contact us before you move in one of the following ways:

- ◆ FAX this form to 902.423.1961
- ◆ MAIL this form to Subscription Department, Clockwork Communications 3700 Kempt Rd., Halifax, Nova Scotia B3K 4X8 Canada
- ◆ E-MAIL us the information below at [subscriptions@ClockworkCanada.com](mailto:subscriptions@ClockworkCanada.com)
- ◆ or, TELEPHONE us with the below information at 902.497.1598

Members of ORNAC and Provincial Associations are asked to provide their Association with change of address information for use next year.

Name: \_\_\_\_\_

Previous Address: \_\_\_\_\_

New Address: \_\_\_\_\_

Previous Telephone Number: \_\_\_\_\_ New Telephone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Date of your move: \_\_\_\_\_

(where we can contact you to confirm details)



We regret that there will be a surcharge of \$10.00 per copy to re-issue Journals to subscribers who have not notified us of an address change or where address information provided was incomplete. Additional charges will apply for US and international subscribers.

## Déménagez-vous?

Pour vous assurer de recevoir votre copie du journal canadien des soins infirmiers en soins périopératoires, s'il vous plaît contactez-nous avant votre déménagement selon les choix suivants :

- ◆ TÉLÉCOPIEZ ce formulaire à : 902.423.1961
- ◆ POSTEZ ce formulaire à : Subscription Department, Clockwork Communications 3700 Kempt Rd., Halifax, Nova Scotia B3K 4X8 Canada
- ◆ ENVOYEZ l'information par courrier électronique à : [subscriptions@ClockworkCanada.com](mailto:subscriptions@ClockworkCanada.com)
- ◆ ou, TÉLÉPHONEZ-NOUS avec l'information ci-dessous à : 902.497.1598

Les membres de l'AIISOC et des associations provinciales sont priés d'informer leur association de tout changement d'adresse pour une meilleure communication dans l'année à venir.

Nom : \_\_\_\_\_

Adresse antérieure : \_\_\_\_\_

Nouvelle adresse : \_\_\_\_\_

Ancien numéro de téléphone : \_\_\_\_\_ Nouveau numéro de téléphone : \_\_\_\_\_

Adresse de courrier électronique : \_\_\_\_\_ Date de votre déménagement : \_\_\_\_\_

(ou nous pourrions vous contacter pour confirmation)



Des frais de \$10,00 seront chargés par copie pour réexpédier le journal aux abonnés qui ne nous ont pas informés de leur changement d'adresse ou si l'adresse fournie est incomplète. Des frais additionnels s'appliqueront pour les abonnés des États-Unis ou internationaux.

 **Allegiance**

a Cardinal Health company

Convertors®

Medi-Vac®

Custom Sterile™



Protegrity Gloves™

Jackson-Pratt®

V. Mueller®

**We Operate With You...**

Proud Sponsor of the ORNAC Research Grant

For more information, contact Allegiance Healthcare Canada Inc. at 1-888-871-5950 or visit our web site at [www.allegiance.net](http://www.allegiance.net)

© Copyright 2001. Allegiance Healthcare Canada Inc. All rights reserved

## Update from ORNAC's Public Awareness Committee

Through the mid-1980s, the Public Awareness Committee was formed to fulfill the mandate of raising awareness of our specialty, Perioperative Nursing. ORNAC Recommended Practices for Perioperative Nursing Practice, or "standards", were written & published. Pamphlets defining practice, position statements, & providing information were developed. Each November Operating Room Nurses Day is promoted with a Proclamation from our President. In the late 1980's the need had been met and the Committee was disbanded.

In 1992, a demand for educational promotional items arose again and a need to lobby for the return of perioperative nursing to the basic nursing core curriculum caused this Committee to be re-established.

Since the late 1990s, ORNAC has realized the need to use technology to quickly and efficiently reach the maximum number of people. The spotlight has been on [www.ornac.ca](http://www.ornac.ca) since it was launched on the "World Wide Web" in December 1997. The ORNAC motto "Promoting Excellence" has been used to build and promote our website. Our quest to raise the profile of Perioperative Nursing as well as the knowledge within our specialty has been successful.

Once again this committee has fulfilled its mandate and has disbanded. As the needs change, so does the structure of ORNAC. The

last decade has seen many changes not only with ORNAC, but with advances in technology, changes in healthcare, nursing shortages and changes in the medical industry.

ORNAC feels the website is a large part of our future. It is an easily accessed area of information, and offers an array of information. It is regularly up-dated and is well monitored. Activities related to public awareness will continue to be part of the Education Committee.

[www.ornac.ca](http://www.ornac.ca) contains links, educational opportunities, information, provincial O.R. associations, a guestbook, discussion forum, French content, promotional material, position statements & a section on the CORNJ. Visitors and comments are welcomed!

*Margaret Farley,*  
Executive Secretary & Webmonitor

*Tina Kennah,*  
Public Awareness Committee Chair



[www.ornac.ca](http://www.ornac.ca)

## 2002 ALLEGIANCE RESEARCH AWARD

Shown Left to Right:

*Vafa Jamali, Allegiance Healthcare Canada Inc., Debra Clendenning, 2002 Allegiance Research Grant recipient, Marla Ewen, Chair, ORNAC Research Committee*



ORNAC and Allegiance Healthcare would like to congratulate *Debra Clendenning, Principal Investigator*, who received the 2002 Allegiance Research Award. Her research project titled "What are parent's information needs prior to their child's day surgery?" was awarded the \$5000.00 Award at the Ontario Provincial OR Nurses Conference in Windsor, Ontario on May 6, 2002.

## ARTIFICIAL NAILS... VERY REAL RISKS

### ABSTRACT

The current social trend towards personal esthetics has come into conflict with safe perioperative care practices. While artificial nails have become very popular they pose a significant risk to patients. Surgical personnel who scrub while wearing artificial nails are putting their patients at higher risk for post-surgical wound infection. Artificial nails harbour microbes and cannot be cleaned as effectively as short, natural nails. We cannot rely on surgical gloves to always contain these hand organisms. There are reported cases where artificial nails have been the cause of post-surgical infections and even death. OR personnel who scrub should not wear artificial nails.

### Author and Photographer:

Joan Porteous RN, BN, CPN(C).  
Joan Porteous is the Clinical Educator in the General Hospital Operating Room Department at The Health Sciences Centre in Winnipeg, Manitoba

### INTRODUCTION

Should OR personnel scrub while wearing artificial nails? This question is currently being discussed in many operating room departments.

This article will discuss the types of artificial nails available, and how they are applied.

Effects of hand cleaning on artificial nails and barrier properties of surgical gloves will also be investigated. Documented transmissions of infection related to artificial nails will also be discussed.

### TYPES OF ARTIFICIAL NAILS:

Nail extensions or tips enhance the nail's appearance and cover misshapen or bitten nails. Many are made of fiberglass or acrylic. Nail tips are glued into place on the nail plate. Gel or acrylic overlays are then brushed on top of the fingernail and the tip. Gels are thought to be stronger than acrylics and easier to apply because of they do not emit the strong fumes associated with the liquid acrylic coating. Both types of overlay require maintenance every 2 to 3 weeks.

Acrylic nails are applied using a sable brush to apply a mixture of powder and liquid to the natural or tipped nail. Acrylic nails require maintenance approximately every 2 to 3 weeks. There are two main types of acrylic nails; sculptured or tipped. Sculptured nails are formed

with acrylic liquid and powder that is layered to achieve desired nail form. A nail tip is a solid plastic tip that is applied with a resin and then sealed with an acrylic overlay for strength and bonding. Gel and acrylic nails can become chipped or lift from the nail plate if moisture seeps under the overlay. Moisture can seep under the nails if the overlay has been applied on top of the cuticle instead of just on top of the nail. The risk for chips or lifting varies according to the tasks each wearer performs with her hands. It is recommended that wearers wear gloves for tasks that may damage the artificial nails (Hollywood Nails, 2002).

Natural nails can also be strengthened with a fiberglass mesh that is bonded with a resin. This process, also known as a fiberglass wrap, is used to repair broken nail tips or split nails. Fiberglass can also be applied over an artificial nail tip in order to form a nail extension. The nail is then buffed to achieve a natural appearance. Maintenance is usually required after 2 to 3 weeks (Artificial Nails, 2002).

False nails are sometimes also referred to as artificial fingernails. False nails are shaped like a complete nail and are applied over the natural nails with special glue or a double-sided adhesive. They can be cut, filed, or varnished in the same manner as real fingernails and can be removed relatively easily when desired (False Nails, 2002).

Artificial nails can be applied by licensed estheticians or individuals can purchase equipment and attempt to apply their own.

### ARTIFICIAL NAILS AND MICROORGANISMS:

It is a well-known fact that bacteria adhere more easily to artificial surfaces than to natural ones (McNeil, Foster, Hedderwick and Kauffman, 2001). In addition, artificial nails are almost always longer than natural nails which makes them harder to keep clean. Artificial nails are also known to promote the growth of Staphylococcus aureus, gram-negative bacilli and yeast (McNeil, Foster, Hedderwick and Kauffman, 2001). Fungal



Artificial Nails Can't Be Cleaned As Well

growth occurs frequently under artificial nails as a result of moisture becoming trapped between the natural nail and the artificial nail (AORN, 2001).

Dermatologists report secondary infections associated with Pseudomonas and Candida when reactions to nail lacquers and hardeners cause onycholysis (Scher, 1990).

### EFFECTS OF HAND CLEANING ON ARTIFICIAL NAILS:

The subungual regions harbour a greater number of microbes than any other area of the hand. McNeil et al (2001) reports that their study concurs with others by determining that health care workers (HCW) wearing artificial nails had more pathogens isolated from their nails, after hand washing, than those with natural nails. Parry, Grant, Yukna, Adler-Klein, McLeod, Taddonio & Rosenstein (2001) state that artificial nails are known to promote the growth of gram-negative bacilli and yeast.

A 1998 study by Edel, Houston and Kennedy found OR personnel with artificial nails harboured more gram-negative rods before and after a five-minute scrub and had higher bacterial loads compared with natural or polished nails.

Larson (1995) reports that in two instances

Continued on Page 20

## THE TIME IS RIPE

BCORNG 18th Conference April 17 – 20, 2002



2000-2002 BCORNG Provincial Executive  
(L to R) Marcy McKay, Christina Hunter,  
Susan Wynne, Sandra Stewart

Our BCORNG 18th Biennial Conference was held in Kelowna, B.C. from April 17 to 20, 2002 at the Grand Hotel and Convention Centre situated on Okanagan Lake. We had three fun filled days and began the conference with a welcoming Wine and Cheese on the Wednesday evening. Our weather cooperated with Okanagan sunshine and we used "apples" as our theme.

On Thursday, at our Opening Ceremonies, Dr. Ball piped the processional party into the Kelowna Community Theatre. Ceremonies continued with short addresses by Marlene Boback, the Chair of the planning committee; Marcy McKay, BCORNG Executive President; the Mayor of Kelowna, Walter Gray; Bonnie Lanz, RNABC President; Debra McPherson, BCNU President; Carol Little, BCORNG Thompson Okanagan Regional chair; and Robert Seppala, BC Exhibitor's Advisory Committee President. Then we all enjoyed jazz performed by some talented high school students.

Following this performance the recipient of the BCORNG recognition award was announced. The winner this year was a very deserving nurse from Vernon – Sharon Dawe. Sharon has enjoyed her extensive nursing career in Canada and abroad, still finds time to enjoy golfing and skiing, and has been active in BCORNG for several years.

The conference's opening speaker was Dr. Denis Brown. His inspiring talk, "Touching the Sky", challenged us to go out in to the world and climb our own mountains. Dr. Brown has made several attempts to climb Mt. Everest and he succeeded in 1999 in spite of adverse weather conditions and his exercise induced asthma.

After the opening ceremonies the event moved to the official Opening of Exhibits. Over 60 sixty exhibitors participated this year.

The rest of the conference was focused around the educational sessions. These sessions varied in content from retirement information to filling out WBC claims and from caring for yourself to balancing life and work. Other topics included herbal medicines, spinal surgery, thoracic surgery, surgical management of urinary incontinence, allograft transplantation in knees, and hormone replacement therapy.

Our conference memories would not be complete without mention of the entertainment. These were great chances to have fun and network with other delegates. On the Thursday evening we had an outdoor experience at 8 Mile Ranch with a big tent barbeque. Later in the evening there was line dancing and a good old Western hoedown. Friday evening wrapped up with the music of "Girl's Night Out".

Saturday at the Closing Ceremonies we had a few more laughs as Linda Edgcombe enlightened us all on laughter, lightening up, and getting energized for the days ahead. The conference came to a close with a stroll down memory lane as we watched a video of events from the first couple of days of the conference.

**Author:**  
Archie Bunn, Publicity Chair of BCORNG  
Conference Planning Committee 🍁



Sandra Stewart presents Sharon Dawe with  
the Provincial Recognition Award



### Hibiclens® keeps working even when you're not.

**The instant and long-lasting cleanser that's easy on your skin.**

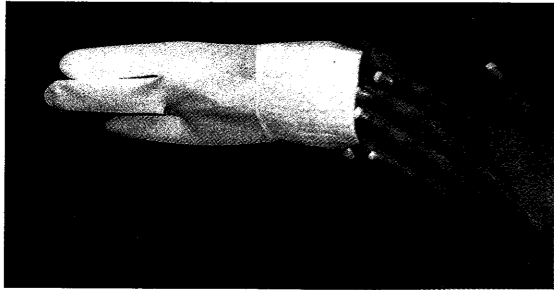
Hibiclens®, a trusted leader in antimicrobial cleansers, bonds with your skin to create a germ-killing field. One that begins working immediately and continues working, even when you're not. The active antiseptic agent, chlorhexidine gluconate (CHG), is effective against gram-positive and gram-negative bacteria, and many other pathogenic microorganisms you come in contact with every day. And, with frequent use, Hibiclens® maintains its antimicrobial activity without irritating your hands, giving you the peace of mind you can depend on. To find out more, call 905-669-6877 today.

**HIBICLENS®**  
Antiseptic / Antimicrobial Skin Cleanser



From the makers of Biogel® The World's Finest Surgical Gloves™  
[www.regentmedical.com](http://www.regentmedical.com) Regent, Biogel, Hibiclens, Regent logo, Biogel logo, and Hibiclens logo are trade marks of the SSL group.  
Distributed by Regent Medical and Durex Canada, divisions of SSL CANADA, Inc. 100 Courtland Ave., Concord, Ontario L4K 3T6, Canada.  
©2002 Regent Medical. All rights reserved.

## ARTIFICIAL NAILS... VERY REAL RISKS (cont.)



Artificial Nails Harbour Organisms

when prosthetic nails were broken or had separated from the natural nails, high colony counts were found despite a 30-second wash with povidone iodine.

Artificial nails may also interfere with hand cleaning because of a desire to protect the nail gloss.

### BARRIER PROPERTIES OF SURGICAL GLOVES:

*Are scrubbed personnel relying too heavily on the barrier properties of their surgical gloves to isolate organisms on their hands and nails?*

According to one study involving surgeons and first assistants, the overall glove failure rate was 51% when a single pair of gloves was worn. The longer the gloves were worn, the greater the failure rate. In this study, glove failure was defined as blood contamination to the fingers (AORN, 2000).

Alrawi (2001) reports on their study to detect unrecognized perforations involving 206 pairs of surgical gloves from 3 different manufacturers. Fourteen percent of the gloves demonstrated perforations after surgery. The authors conclude that surgical gloves are inefficient at resisting punctures.

This is only a small selection. There are other publications available that demonstrate less than optimal barrier properties of surgical gloves. It is for this reason that double gloving is recommended in specific situations. There is also an increased risk for glove perforations with long artificial and natural nails.

### NOSOCOMIAL INFECTIONS RELATED TO ARTIFICIAL NAILS:

The literature reports a significant number of hospital-acquired infections related to artificial nails. A February report from the *Center for Disease Control (CDC)* linked nurses' long and artificial nails to the deaths of 16 infants in a neonatal intensive care unit in Oklahoma City, following an outbreak of *Pseudomonas aeruginosa* (Moolenaar, Crutcher & San Joaquin, 2000).

Parry, et al (2001) reported 3 patients who were confirmed to have post-laminectomy deep wound infections due to identical *Candida albicans* isolates. These infections were linked to an operating room technician with artificial nails who had *C. albicans* isolated from her throat. The authors stated that "hospitals should enforce policies to prevent operating room personnel from wearing artificial nails" (p. 352).

Winslow (2001) reports on an incident that occurred in 1994 where seven patients at a California hospital acquired postoperative *Serratia marcescens* infections during a one-month period. One of them died. Infection control experts identified a scrub nurse with artificial nails as the likely source of the outbreak.



Gloves Cannot Always Contain Organisms

### RECOMMENDATIONS AGAINST ARTIFICIAL NAILS:

AORN (2001) states "Artificial nails shall not be worn" (p.177). ORNAC (1989) states "Acrylic or artificial nails shall not be worn" (p.72). The CDC (1999) states "Keep nails short and do not wear artificial nails" (p. 267). Phippen & Wells, (2000) and Berry & Kohn (2000), both recommend against artificial nails.

### CONCLUSION:

*Should OR personnel scrub while wearing artificial nails?*

The answer to the question seems simple. Scrubbed personnel should not wear artificial nails. Indeed by doing so, they are putting their patients at a significant and unnecessary risk. The current social trend towards personal esthetics has come into conflict with safe health care. Scrubbed personnel are legally and ethically accountable for their actions. In this extremely vulnerable time in their life, our surgical patients are depending on us to act in their best interest and protect them from harm.

### REFERENCES

Winskow, E. (2001). *The case against artificial nails*. Nursing 2001, 31(10), 30.

McNeil, S., Foster, C., Hedderwick, S., & Kauffman, C. (2001). *Effect of hand cleansing with antimicrobial soap or alcohol-based gel on microbial colonization of artificial fingernails worn by health care workers*. Clinical Infectious Diseases, 32 (February), 369-372.

AORN (2001). *Standards, recommended practices and guidelines*. Denver, CO: AORN.

ORNAC (1998). *Recommended standards for perioperative nursing practice*. ORNAC.

CDC (1999). *Guideline for prevention of surgical site infection, 1999*. Infection Control and Hospital Epidemiology, 20(4), 247-278.

Parry, M., Grant, B., Yukna, M., Adler-Klein, D., McLeod, G., Taddonio, R. & Rosenstein, C. (2001). *Candida osteomyelitis and diskitis after spinal surgery: An outbreak that implicates artificial nail use*. Clinical Infectious Diseases, 32 (February), 352-357.

*Hollywood Nails*, (personal communication, April, 2002).

Phippen, M. & Wells, M. (2000). *Patient care during operative and invasive procedures*. WB Saunders: Toronto.

Fortunato, N. (2000). *Berry & Kohn's operating room technique* (9th ed). Mosby: Toronto.

Scher, R., & Daniel, C. (1990). *Nails: therapy, diagnosis, surgery*. Philadelphia: WB Saunders.

Larson, E. (1995). *AIPC guideline for hand washing and hand antisepsis in health care settings*. AIPC.

AORN (2000). *Clinical Issues*. AORN Journal, 71(2) 398-403.

Alrawi, S, Houshan, I & Satheesan, R. (2001). *Glove reinforcement: An alternative to double gloving*. Infection Control Hospital Epidemiology, 22(8), 526-527.

Moolenaar, R., Crutcher, M. & San Joaquin, V. (2000). *A prolonged outbreak of Pseudomonas aeruginosa in a neonatal intensive care unit: Did staff fingernails play a role in disease transmission?* Infection Control and Hospital Epidemiology, 21 February, 2000, 80-85.

*Artificial Nails*. Retrieved April 30, 2002, from <http://www.justnails.demon.co.uk/artif.htm>

*False Nails*. Retrieved April 30, 2002, from <http://www.wave.co.nz/~comital/artifi.htm> \*

# THE DONNING OF A NEW DAY IN THE O.R.



Maxxim Medical's SensiCare® Surgical gloves offer the fit and feel of latex gloves, without the latex. This powder-free glove is part of the next generation of surgical gloves that Maxxim Medical is creating for sterile procedures.

Maxxim Medical also offers a complete line of latex and non-latex surgical gloves for general, micro and orthopedic surgery, with our new damp-hand donning technology. Call (800) 345-8849, or in Canada (800) 396-6996.

## MAXXIM MEDICAL

Setting the Standard in Glove Safety

www.maxximmedical.com

SensiCare is a registered trademark of Maxxim Medical, Inc.

## THE IMPACT ZONE

7th Provincial Conference of the Operating Room Nurses Association of Ontario

Author: Kathy Bruce, Photography: Jan Fitchett

Windsor, the city of Roses, was the site of the 7th Ontario Provincial Conference from May 5-8, 2002. The theme was the "Impact Zone". The impact of new technology, the impact of new bacterium, and the impact of shrinking human resources in a healthcare environment of fiscal restraint.

The conference got off to a stylish start with a fashion show featuring fashions from "Anne's of the Avenue", a store in the Windsor area. Perioperative nurses from the Windsor area modeled clothing.

Terry Evanshen, "The Man Who Lost Himself", gave the keynote address. Terry is a member of the Canadian Football Hall of Fame, twice voted outstanding Canadian in the CFL and a Grey Cup champion. On July 4, 1988, in a single second Terry Evanshen nearly lost it all in a devastating car accident. He now has no recollection of the first 44 years of his life. He gave a moving account of how he re-establishes his identity on a daily basis by rebuilding his confidence and purpose one step at a time. Terry's motto is "Seize each Day". Terry's words touched many in the audience and served to put our daily challenges into perspective.

Utilizing humour, our closing speaker Diane Miller helped us look at ourselves and the messages we are sending to others in our day to



ORNAO/Johnson & Johnson Bursary presentation:  
Left to Right:  
Ian Lawson, Johnson & Johnson Medical Products,  
Ann Bartlett, Bursary recipient  
Genevieve Micallef, Bursary recipient  
Kathy Bruce, ORNAO President

day lives. Diane taught us how to get back the zip in our lives and sent us away from the conference on a high note.

On an educational front, the conference also addressed many career related subjects:

- Risk management topics were "Impairment in Health Professionals: Risk, Recognition and Management", "Don't breathe in the OR: The hazards of surgical smoke", "Communication and Conflict resolution", and "Risk Management for the Perioperative Nurse: Avoiding Perils & Pitfalls".
- Clinical topics covered Herbal safety in the OR, Bladder Control, CJD Perioperative Implications, Informatics, Clinical Teaching plant and communication issues with the SPD. We also attempted to gaze into the future of "Perioperative Nursing & Anaesthesia".

Once again our vendor partners came through with flying colours in their support of our conference. The exhibit hall was sold out and delegates were able to educate themselves about the latest technology & tools available to care for our patients.

Of course the social events were a welcome break after a long day of learning. Thanks to the volunteers on the planning committee who donated many hours of their personal time to achieve such an outstanding conference. For information on future conferences visit [www.ornao-conference.org](http://www.ornao-conference.org)



2002 Conference Planning Committee  
Members - ORNAO

Left to Right, Back Row:

Rosemary Lemmon, Pat Busteed, Darlene Beaudet,  
Henrietta Thurston, Kathy Bruce. Front Row:  
Theresa Tremblay, Kathy Radcliffe, Elaine Young,  
Sandi Peterson, Teresa Taylor, Juliette Beaudet,  
Helen Friend, Missing from photo Susan Bell

*Pearls of Wisdom*

## Survival Tips in Organizational Chaos and Change

*"What is now will not be in the future -- the future is now"*

Right-sizing, integration, merger, consolidation, reorganization, "outside the box" (who decided there is a box?), re-engineering, position name change, expanded scope of supervisory breadth, non-nurses directing nurses – these are realities in the current state of the healthcare system. The new terms, intent, mandates and behaviours can have a deep impact on the hearts and souls of many people. The resulting anger, apathy, insomnia, loss of self-confidence and self-esteem, insecurity, and other emotional, mental and physical responses are all part of the resulting stresses. Job loss, being fired, being let go, and hearing "you don't fit anymore" are all part of a new world of nursing. The personal and professional trauma can be great – don't let it happen to you!

Develop some strategies and techniques now that will help you be an agent of change rather than a resistor of change. The "heat-in the kitchen" has been turned up – we have to learn to deal with it or get out of the kitchen. The "heat" may be fired by personal, political or financial issues; new time lines; or altered outcomes, benchmarking, or agendas. If you accept the challenge then stay and help create the recipe for the future.

- Accept that "What is today cannot be; what was in the past must stay there; the future is ours to create." Do not waste your time and energy longing for supposed good old days. Remember, they were not always so good – we only remember the good things while forgetting the bad! Take a short time to grieve for the past and then get on with life!

- Look for new creations – accept that there is zero tolerance for inertia and develop new ideas for change.
- Concentrate on something you have always believed could be changed and bring it forth in a new format as a new creation. Keep some ideas in your back pocket for the right moment. Remember timing is everything!
- What is and what was seem to only stand in the way of new leaders and are believed to be the reason for many of our current problems. The responsibility for this situation rests on some staff and leaders, particularly the negative, apathetic individuals who are stuck in the past.
- Embrace the rapid and exponential growth of technology, knowledge and driving forces. Accept that we are in permanent white water and that even more skills will be required to meet the challenges of tomorrow.
- Accept that planning in complete detail, along with firm and final conclusions, is a thing of the past. They are obsolete before they are completed. Fast-track planning, fast-track thinking, filling in the details later, and dealing with problems as they arise are common traits among the new leaders. If you are obsessive about detail you will not survive as a leader today. Remember though, you need detailed people to handle the detailed elements of the work or serious errors will occur.
- Don't expect emotional hand-holding – it is ruthless out there. Learn to manage the stress of this type of environment by creating your own support system outside of work. Do not let it eat you up! Toughen-up, blow it off, and learn to let things go – if it won't matter in two years then don't burden yourself with the baggage.
- Develop a personal tool to assess which battles you will fight – and be selective. Determine where the "war front" really is – it may not be the most obvious battle that is in front of you. Remember "war" always takes a massive toll, even on those who survive it.

- Develop a sense of "black humour" so that you laugh heartily when the going gets really tough. But be sure you only use it with safe people. Occasionally looking at the "dark side" can be good stress relief!
- Embrace the future; nobody has been there, so nobody has all the answers, contrary to the rhetoric. Looking ahead for clues, instead of behind you, will serve to minimize trauma and reduce negative impact.
- Determine who are the real players in the game. Who is writing the rule book and where is the game really being played? Do not be naive! Ask yourself "can I play this game, enjoy it, and survive it?" If not, find a game that you are comfortable with.
- Become political at all levels. Be aware of where and when information or contacts can be leveraged. Be sure you are involved in the "real discussions" or at least be cognizant that there are other arenas of strategy. Make sure you know who is in the decision-making rooms and who the power brokers are, and then ensure they have the information you want them to have. Information is power!
- Accept that there are very few low stress work environments that will still exist a few years from now. Determine how you will be a part of the future and the creation of the new world.

Treat the "New World" as Florence Nightingale did in 1867 when she said *"This is the beginning; we shall get what we want in time."* ✦

By: Muriel Shewchuk

# UPCOMING EVENTS

## PROVINCIAL & REGIONAL CONFERENCES

British Columbia	March 10-13, 2004	Victoria
Alberta	Oct 16-19, 2002	Edmonton
Ontario	June 20-23, 2004	Toronto
Hamilton and District	October 19, 2002	Niagara-on-the-Lake
Quebec	Nov 20-22, 2002	Montreal
New Brunswick	April 25 - 26, 2003	Saint John
Newfoundland	Oct 17-19, 2002	Goose Bay, Labrador

## ORNAC CONFERENCES

National 2003	June 8-12, 2003	Winnipeg, MB
National 2005	May 2-6, 2005	Montreal, PQ

## INTERNATIONAL CONFERENCES

NATN (www.natn.org)	Oct 7-10, 2002	Harrogate, UK
AORN (www.aorn.org)	March 23-27, 2003	Chicago, Illinois
EORNA (www.eorna.org)	April 10-13, 2003	Island of Crete, Greece
World Conference on Surgical Patient Care	August 17-22, 2003	Hong Kong

## ANAESTHESIA CONFERENCES

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

For details visit [www.ornac.ca](http://www.ornac.ca)



At Sutter Health, which serves more than a hundred communities throughout Northern California and beyond, you'll find an environment that reflects this philosophy. Our values and mission support healthy living, and our vast network of resources, employees and facilities presents boundless opportunities.

Our specialties include cardiology, heart surgery, high-risk obstetrics, neurology, neurosurgery, oncology, pediatric subspecialties, advanced endoscopy, transplantation, trauma and psychiatry.

Join our team of fulfilled professionals at Sutter Auburn Faith Hospital in Auburn, Sutter Davis Hospital, Davis, Sutter Medical Center in Sacramento, and Sutter Roseville Medical Center—and see just how wonderful living well can be.

We currently have the following excellent opportunities available.

**ASSISTANT NURSE MANAGER—SURGERY**

**CLINICAL EDUCATOR—SURGERY**

**PACU RNs**

**SPECIALTY SERVICES COORDINATOR—UROLOGY**

**SURGERY RNs**

You may forward your resume, indicating the Sutter Health affiliate and event code #570, to Sutter Health, Recruitment Dept., 5151 F St., Sacramento, CA 95819, USA, or fax to (916) 733-7038.

[WWW.SUTTERHEALTH.ORG](http://WWW.SUTTERHEALTH.ORG)

**APPLY ONLINE ANYTIME.**

Equal Opportunity Employer

Grey Bruce Health Services is a 297 bed hospital corporation with facilities in seven communities in northern Grey and Bruce counties providing a range of primary and secondary inpatient and ambulatory care. The corporation was formed through a unique voluntary amalgamation in April of 1998.

Patient Care Manager for Operating Room, Post Anaesthetic Care Unit, Preadmission Unit, and Day Surgery Unit

Position Summary:

The Full Time Patient Care Manager is a program-based position, reporting to the Manager of Medical Surgical Services. In accordance with the Grey Bruce Health Services Mission and Values, you will be responsible for the leadership and operations of the assigned areas. While demonstrating exemplary communication skills the Patient Care Manager will collaborate with the Medical and Nursing Program Leaders, the management team, and the Chiefs of each surgical service. The Patient Care Manager will provide program and services leadership and create an environment for innovation and excellence in patient focused care within available resources.

Qualifications:

A Baccalaureate Degree in Nursing • Registration with the College of Nurses • Minimum 3 years recent management experience • Clinical experience in Peri operative nursing • Peri-operative certification • Member of ORNAC

Qualified applicants are invited to submit a resume by October 11, 2002 to:

Human Resources, Grey Bruce Health Services  
Box 1800, 1800 1/2 St. East • Owen Sound, ON N4K 6M9  
Fax: 519 372 3949  
Email: sgrmstead@owensound.healthserv.org



**Operating Room Nursing Opportunities**

The Chinook Health Region has exciting nursing opportunities in our Operating Room. Our regional referral hospital in Lethbridge, Alberta offers seven OR specialties and performs more than 10,000 adult and pediatric procedures annually.

We are a fast paced, progressive department with cutting edge technology including automation of preference cards and documentation. With a strong emphasis on education and training, we provide generous custom designed orientations.

Registered Nurses (full-time and relief) must be graduates of an approved school of nursing, eligible for registration in the Province of Alberta, with current OR experience in scrubbing and circulating, or a post graduate Perioperative Program Certificate. Perioperative certification is preferred.

We also have an opportunity for a Clinical Coordinator. You will be responsible for the daily operation of the department utilizing your leadership skills to organize, facilitate and coordinate multidisciplinary teams and foster a team approach to program change and growth. This position requires perioperative management experience and clinical expertise, accompanied by theoretical knowledge of current perioperative nursing and the CQI process. Strong computer skills are an asset. BN and perioperative certification preferred.

If you are interested in either of these positions, please submit your resume, quoting the job title, to:

Ms. J. Tamayose  
Chinook Health Region, Human Resources Department  
960 - 19 Street South  
Lethbridge, AB T1J 1W5  
Fax: (403) 382-6016  
Tel: 1-877-333-3431 or (403) 382-6100  
Email: humanres@mail.chr.ab.ca

For additional information on this and other opportunities, please visit our website.

Your Link to Good Health



**POSITIONING (cont.)**

Figure 3: Location & severity of pain & women reporting pain

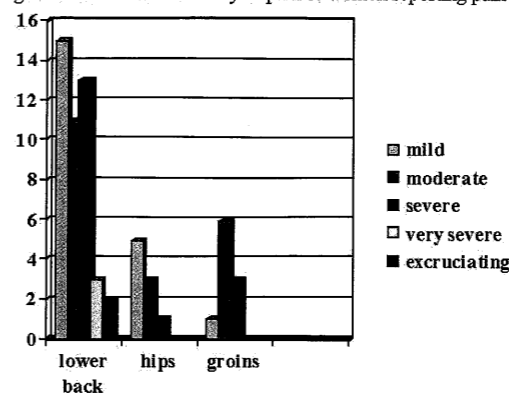
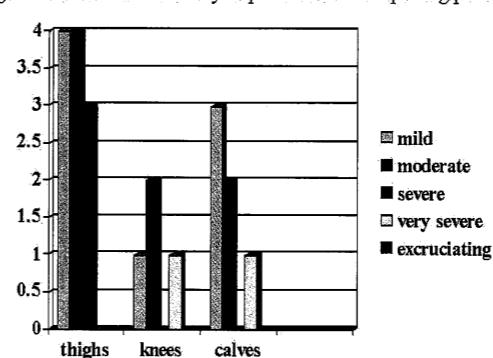


Figure 4: Location & severity of pain & women reporting pain



The women rated the pain for each location on a scale from mild to excruciating [see Figures 3 & 4]. The results show that as age increases the severity of pain in the lower back increases and the severity of pain in the hips increases. This is not a surprising finding since we know that the older surgical patient is at a higher risk for injuries (McEwen, 1996).

There was a significant difference between those who were on the table for 60 minutes or less and those who were on the table for more than 60 minutes (P = 0.01). Women who were on the table for more than 60 minutes were more likely to experience pain. This was the same for women in both the supine and lithotomy positions. There was no correlation between table times and ratings of pain. The severity of pain was not related to the length of time on the table.

In addition the results show as age increases there is a corresponding increase in table time (P = .003) and as BMI increases table time increases (P = 0.03). The results indicating an increase in

table time with the older and heavier patients results will come as no surprise to OR nurses who have noted this occurrence anecdotally. However the researcher is not aware of these results being documented elsewhere in the literature.

Of the 63 women who reported pain there was no significant difference between the incidence and the rating of pain for those who were in the supine position as compared to those in the lithotomy position. There was no significant difference in the number of women reporting pain (P = 0.8) after use of the two different types of stirrups. The severity of pain in the various locations had no relationship to the type of stirrup used.

**SUMMARY**

This study demonstrated that 63 (41%) of the 153 women having gynaecological surgery experienced lower extremity pain, separate from surgical site pain, even though these women had no preexisting conditions that predisposed them to pain. This finding is consistent with that of Clarke, Stillwell, Paterson and Getty (1993) who found that patients reported pain whether or not they had a condition that predisposed them to pain.

The women reported pain in the lower back, hips, groin, thighs, knees or calves; no one reported pain in the ankles or feet. The ratings for pain ranged from mild to severe for the hips, groins and thighs, to very severe for the knees and calves. Only two participants reported excruciating pain and this related to the lower back (one woman was in the lithotomy position and one woman was in the supine position.) This finding is similar to that of Graling and Colvin (1992) who found that patients who were in the lithotomy position reported pain in the lower back, leg and hip pain on the second day post-op and the pain in the lower back and hip increased on the fourth day post-op. Whereas in this study a majority of the women who reported pain experienced it on the first day post-op and fewer women reported pain on the second and third post-op days.

Women who were on the table for more than 60 minutes were more likely to experience pain

## POSITIONING (cont.)

than women who were on the table for less than 60 minutes. This finding is consistent with that of *Groom and Frisch (1989)* who found that patients having surgery lasting more than one hour had significantly more pain on day one. They also found that 28% of patients reported lower back pain regardless of position. This study found there was no relationship between type of position and the incidence or the severity of pain. There was no significant difference between the two types of stirrups and the number of women reporting pain. The severity of pain in the various locations had no relationship to the type of stirrup used.

Evaluation of use of the positioning guidelines shows that for the supine position a majority of the guidelines were followed. However, even when the guidelines are not followed, as in the lithotomy position, there appears to be little impact on patient outcome relative to pain in the lower extremities. The only aspect of positioning that directly influences whether or not women experienced pain was when their buttocks were over the table break. This may be explained by the fact that the lower back and buttocks would be exposed to risk of injury from not being supported or having inadequate support.

### LIMITATIONS OF THE STUDY

1. It would have been helpful to outline specific procedures that could result in referred pain to the lower extremities. However each patient's response is varied in relation to positioning, as is the case with specific surgeries. It was not possible to discriminate between the type of surgery and the referred pain.
2. The positioning guidelines were not validated for inter-rater reliability (*the strength of agreement made by two or more observers*). Inter-rater reliability would have demonstrated that the guidelines would obtain consistent results when reused.
3. The post-test for assessment of pain did not specify if the pain was continuous or intermittent. This information would have been beneficial in determining the possible cause of the pain.

4. The post-test for assessment of pain did not determine if the patient had taken any analgesia prior to reporting the pain. This information could have had an impact on the actual numbers of patients reporting pain.
5. The confidence level of 95% was set as the level of significance. However the small number of participants (supine = 25, and lithotomy = 128) shows that the study power was 30% not the 80% that was intended. Therefore the ability to detect a difference when one actually exists is limited i.e. difference between the supine and lithotomy positions. This is an important weakness as it is difficult to determine if there is a true difference between groups.

### SIGNIFICANCE FOR NURSING

1. The fact that patients with no previous history report lower extremity pain post-op indicates a need for redirecting our focus to following up with patients post-operatively to determine how many do report lower extremity pain. Patient outcomes need to be evaluated for a longer period than several hours post-op as is the situation now with most day surgery patients.
2. Even when positioning guidelines are followed by perioperative nurses, patients may experience negative outcomes such as lower extremity pain. There is a need for a refocus on education relating to positioning and further research is required to isolate the factors that impact on positioning.
3. There is a need for nurses who work in preoperative, recovery, and surgical units to be informed about patients' complaints of pain could relate to their position during surgery. This would enable nurses to inform patients that they may experience lower extremity pain that is related to positioning, not to the actual surgery.
4. There is a need for perioperative nurses to refocus on accurate and ongoing documentation before, during, and after surgery as it relates to assessments and relevant findings. This is important from a patient care perspective in order to accurately reflect

Increase Storage Capacity 40% or more in the same space –  
or hold your current inventory in *much less space* with Par Stor®.  
Contact us for a Free Space Use Analysis of your current storage areas!



## ACART – The Space Planners

Ph: 800-551-0560 • 905-625-5540 • Fax: 905-625-0151  
www.acart.ca • E-mail: dick@acart.ca

### SUBMIT AN ARTICLE TO THE

## CANADIAN OPERATING ROOM NURSING JOURNAL AND YOU COULD WIN \$3,000

Since 1983 Johnson & Johnson Medical Products has provided an annual \$3,000 award to the author of the best article of the calendar year. The Award is designed to recognize Canadian nurses who contribute to the advancement of the perioperative nursing industry and to the education of their colleagues through the creation of informative, relevant articles.

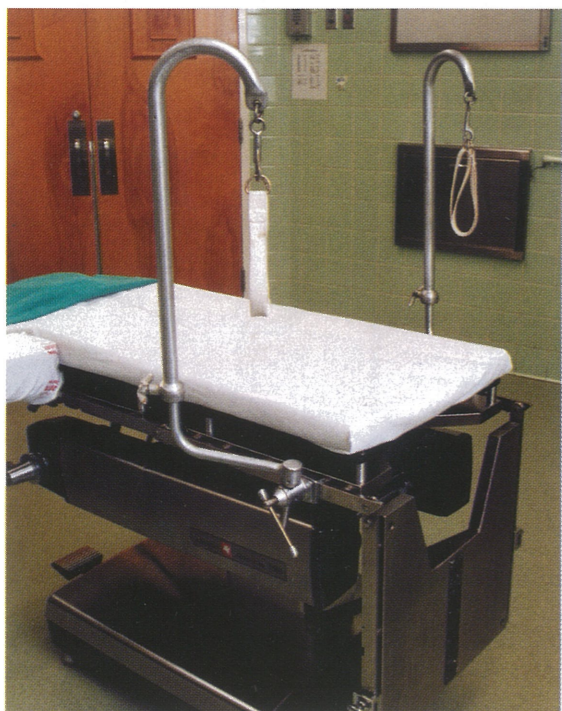
The *Canadian Operating Room Nursing Journal* is your Journal – it is written by you and your peers, for the benefit of your profession – and your contribution is what ensures its future success. Share your knowledge on new surgical procedures, nursing care issues, new technologies, new programs, educational material, and any other industry issue that is important to you and the people you work with.

*So get writing!*  
Johnson & Johnson

For Details and Submission Criteria  
visit [www.ORNAC.ca](http://www.ORNAC.ca) and click on Education

## POSITIONING (cont.)

how the patient was positioned, especially if there are negative outcomes and litigation relating to the outcomes.



Surgical Table with Sims Stirrups

### CONCLUSION

Positioning the patient for surgery is part of the perioperative nurse's everyday practice. Therefore it is surprising that so little evidence exists to validate the effectiveness of positioning guidelines and outcomes related to positioning. This study provides relevant information that helps address these two important issues. Hopefully it will serve as a building block for future research on positioning relating to women undergoing surgery.

For more information or for a copy of the Simple Descriptive Pain Intensity Scale Post-test, Supine Position Guidelines Data Collection Form, or Lithotomy Position Guidelines Data Collection Form please contact the author at [Hilda.Power@iwk.nshealth.ca](mailto:Hilda.Power@iwk.nshealth.ca)

### REFERENCES

Clarke, A. M., Stillwell, S., Paterson, M. E. L., & Getty, C. J. M. (1993). *Role of the surgical position in the development of postoperative low back pain*. *Journal of Spinal Disorders*, 6 (3), 238-241.

Federal, Provincial and Territorial Advisory Committee on Population Health. (1999). *Statistical Report on the Health of Canadians* (pp. 264-265). Ottawa: Health Canada.

Gregory Dawes, B. & Sileo D. M. (1999). Orthopedic surgery. In M. H. Meeker & J. C. Rothrock (Eds.), *Alexander's care of the patient in surgery* (pp. 730-854). Toronto: Mosby.

Groom, L. E., & Frisch, S. R. (1989). *Sequelae of the Intraoperative Lithotomy Position*. *AORN Journal*, 50 (4), 826-830.

Graling, P. R. & Colvin, D. B. (1992). *The lithotomy position in colon surgery*. *AORN Journal*, 55 (4), 1029-1039.

Heizenroth, P. A. (1999). *Positioning the patient for surgery*. In M. H. Meeker & J. C. Rothrock (Eds.), *Alexander's care of the patient in surgery* (pp. 153-172). Toronto: Mosby.

International Association for the Study of Pain. 1986. *Pain terms: A current list with definitions and notes on usage*. Pain [suppl], 1986. 3:S216.

McEwen, D. R., (1996). *Intraoperative positioning of surgical patients*. *AORN Journal*, 63 (6), 1059-1082.

McGuire, D. B. (1996). *Measuring pain*. In M. Frank-Stromborg (Ed.), *Instruments for Clinical Nursing Research* (pp. 333-356). Boston, MA.: Jones and Bartlett.

Operating Room Nurses Association of Canada. (1998). *Recommended standards for perioperative nursing practice*. 4th Edition.

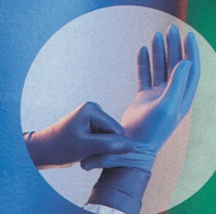
Spry, C. (1997). *Essentials of perioperative nursing*. Gaithersburg, Md.: Aspen. ★

## Double Gloving. Why take a chance when you have a choice?

Biogel® Indicator™ is our patented puncture indication system that alerts the user of outer glove puncture in the presence of fluid.



Biogel® Skinsense™ N Universal provides a non-latex double-gloving alternative that allows non-latex glove users an option they can feel safe with.



With the increased incidences of clinical issues within the medical environment, double gloving has become a viable protective tool available to you. Studies have demonstrated that single glove failure during surgery is a common occurrence: *over 50% of the single gloves used in surgery.*<sup>1,2</sup>

Regent Medical offers 2 underglove options. The **Biogel® Indicator™** patented puncture indication system that blossoms the moment fluid penetrates your outer glove, if punctured. And the **Biogel® Skinsense™ N Universal** that facilitates double gloving non-latex gloves. Both are powder-free, 100% air inflation and visually inspected, and provide added protection for peace of mind during potentially high-risk procedures. When it's a decision between risk and added protection, think double gloving.

For more information, or to order, call 905-669-6877 or visit [www.regentmedical.com](http://www.regentmedical.com).

**Caution:** Regent latex gloves contain natural rubber latex which may cause allergic reaction. Safe use of latex gloves by or on latex sensitive individuals has not been established.

Regent, Biogel, Indicator, Super-Sensitive, Biogel Sensor, Skinsense, Hibiclens, Hibistat, Hands Device, Regent logo, and Biogel logo are trade marks of the SSL group. Distributed by Regent Medical and Durex Canada, divisions of SSL CANADA, Inc. 100 Courtland Ave., Concord, Ontario L4K 3T6, Canada. ©2002 Regent Medical. All rights reserved.

\* Each Biogel® glove undergoes multiple checks for quality and user confidence.

1. Quebbeman EJ, Telford GL, Wadsworth K, Hubbard S, Goodman H, Gottlieb MS. Double Gloving. Protecting Surgeons from Blood Contamination in the Operating Room. *Arch. of Surgery* 1992; 127: 213-217.

2. Wright JG, McGreer AJ, Chyatte D, Ransohoff DF. Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel. *JAMA* 1991; 266: 1668-1671.

### CUSTOMER-DRIVEN GLOVING SOLUTION™

Our complete line is designed to meet your personal needs and preferences.

- BIOGEL®
- BIOGEL® M
- BIOGEL® SUPER-SENSITIVE™
- BIOGEL® INDICATOR™
- BIOGEL® ORTHOPAEDIC
- BIOGEL® SENSOR®
- BIOGEL® SKINSENSE™ N
- BIOGEL® SKINSENSE™ N UNIVERSAL

### ALSO AVAILABLE

- HIBICLENS® SKIN ANTISEPTIC
- HIBISTAT® SKIN ANTISEPTIC



REGENT MEDICAL

# CUSTOM-PAK®

## Just what you ordered!



### Look to the Leader™ in Ophthalmic Custom Paks

- Increases OR Efficiency
- Saves You Time
- Personalized to Your Surgical Needs
- Controls Hospital Inventory and Procedure Costs

**Alcon**<sup>MD</sup>  
CANADA  
[www.alcon.ca](http://www.alcon.ca)