CANADIAN
# Operating Room
Nursing Journal

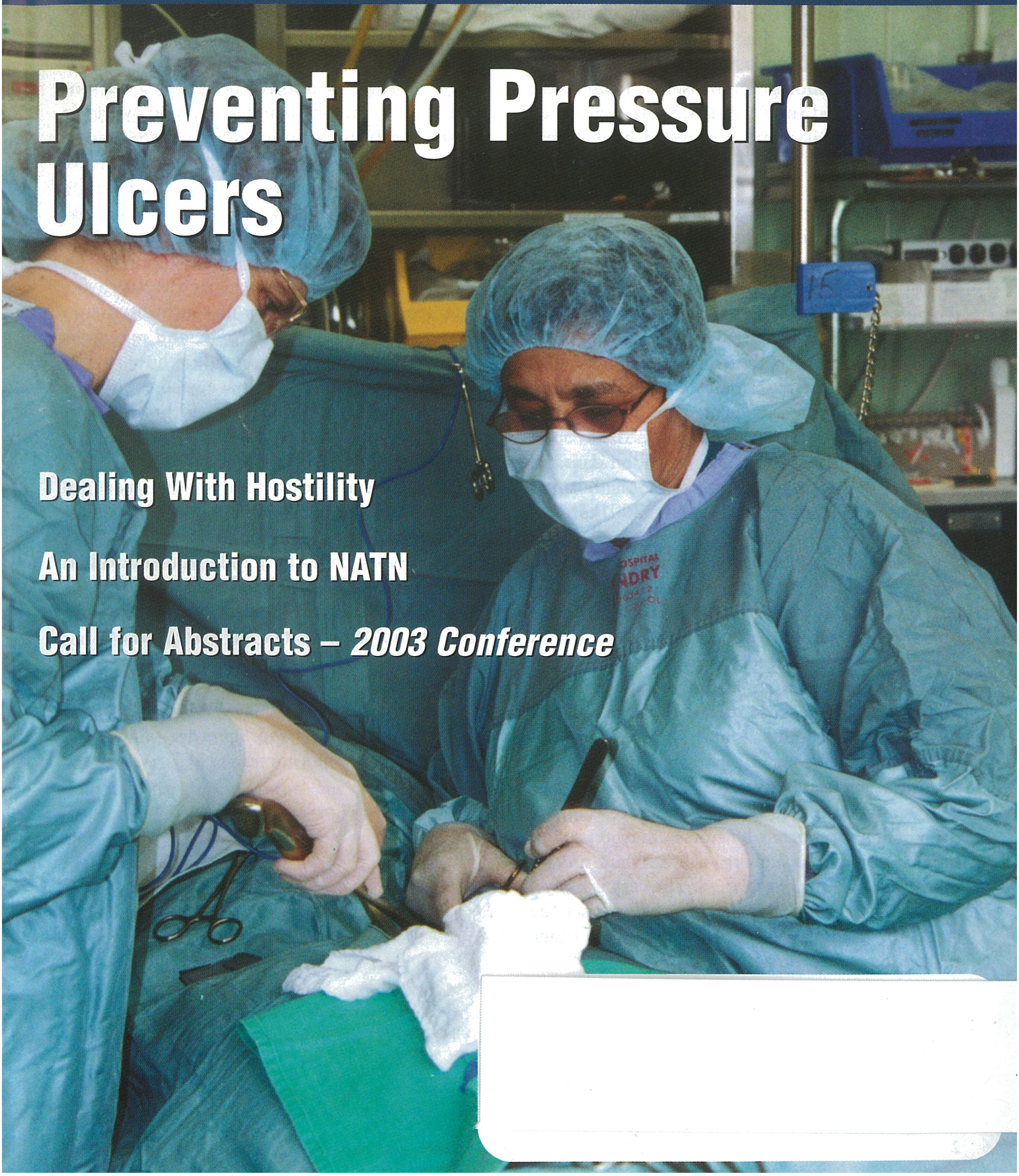
June 2002

## Preventing Pressure Ulcers

Dealing With Hostility

An Introduction to NATN

Call for Abstracts – *2003 Conference*



# President's Message

## "Just Say No" to Abuse in the Workplace

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

A recurring theme in recent publications, conferences and in the news is the presence of abuse or violence in the healthcare environment. Several sessions at the *World Conference on Surgical Patient Care* last September addressed this topic, including submissions from New Zealand, Finland and Australia. Sadly, workplace violence or harassment appears to be a global phenomenon.

When I use the phrase workplace abuse, I am not referring to direct physical attacks, although those happen as well. I remain optimistic enough to hope that those are isolated incidents, and that they are reported and dealt with either by facility, union or professional association processes. However rare, these incidents do occur in Canada – for example, an incident last September was reported when a protest ensued after a surgeon lost his temper, and grabbed an operating room nurse's arm, causing tendon damage. The goal of the protest was to force the hospital to take the incident seriously (*Daly, 2001*).

The abuse that concerns me the most is the type that is insidious – it may be present every day, and is condoned either by silence or by the lack of any visible action to address it. Often excuses develop for the unacceptable behaviours, such as saying it is "because things are going so badly" or "it's because of the pressure". These behaviours can be horizontal, directed within a peer group, or occur in a perceived hierarchical situation, such as between professional groups (physicians : nurses). The biggest concern is that the incidents reported by nurses may represent only the tip of the iceberg – fewer than half of abusive incidents are reported. The very isolation of the perioperative setting may help to set the stage for workplace abuse, which may range from rudeness to physical abuse.

However, there is no acceptable reason or excuse for violent or abusive behaviour within the perioperative environment in a civilized society.

What can we do about such behaviours in the workplace? The first thing is to create an environment in which the message is clear – violence or abusive behaviours will not be tolerated. All staff and personnel working within the O.R. should have a clear understanding that there is zero tolerance. New recruits to perioperative nursing need to be supported. Policies or guidelines should be developed for the process to be followed and the individuals to be contacted when reporting an incident. These should be clearly displayed for all to see. Education programs and discussion forums should address the topic, and managers and leaders should be instructed on how to deal with these issues.Most of all, we need to support our colleagues and co-workers through our actions, words and behaviours!

Perioperative nurses already work in a potentially stressful environment, and that stress is compounded by a severe nursing shortage. Allowing workplace abuse to be added into that equation may cause qualified nurses to leave, or deter new recruits. ***We must be diligent and "just say no" to abuse in the workplace!***

***Reference:***


Daly, R. (December 7, 2001). *The great hospital divide: Guelph inquest spotlights age-old conflict between doctors and nurses.* The Toronto Star.



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# Message de la présidente

## Dire 'non' à l'abus en milieu de travail

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

Un thème récurrent dans les récentes publications et conférences ainsi que dans l'actualité est la présence de l'abus ou de la violence dans l'environnement des soins de santé. Lors de *la conférence mondiale* de septembre dernier portant sur les soins du patient en chirurgie, plusieurs présentations avaient pour thème ce sujet, incluant des présentations de la Nouvelle-Zélande, de la Finlande et de l'Australie. Malheureusement, la violence en milieu de travail et l'harcèlement semblent être un phénomène généralisé.

Quand j'utilise l'expression 'abus en milieu de travail', je ne fais pas référence aux attaques physiques directes, bien que celles-ci se produisent également. Je demeure suffisamment optimiste pour souhaiter que ce sont des événements isolés et qui sont rapportés et traités, soit par le service, par le syndicat ou par les mécanismes des associations professionnelles. Bien que rares, ces incidents surviennent au Canada. Par exemple, un incident a été rapporté en septembre dernier à la suite d'un mouvement de protestation qui a suivi la perte de contrôle d'un chirurgien qui a saisi le bras d'une infirmière de la salle d'opération, lui causant des dommages au tendon. Le but de la protestation était d'obliger l'hôpital à considérer sérieusement l'incident. (*Daly, 2001*).

Le genre d'abus qui m'intéresse davantage est un type insidieux pouvant se produire tous les jours, et qui est condamné au silence ou par l'absence d'action tangible pour le corriger. Des excuses sont souvent formulées pour ces comportements inacceptables, telles que dire : 'c'est parce que les choses vont tellement mal' ou 'c'est à cause de la pression'. Les comportements peuvent être horizontaux, c'est-à-dire dirigés vers un groupe de pairs, ou ils peuvent se produire dans une situation hiérarchique, telle qu'entre des groupes professionnels (médecins VS infirmières). La plus grande inquiétude est que les incidents rapportés par les infirmières peuvent seulement représenter la pointe de l'iceberg : moins de la moitié des comportements abusifs sont rapportés. Le très grand isolement lié à l'environnement périopératoire peut contribuer à mettre en oeuvre un climat favorable à l'abus en milieu de travail, le-quel peut varier de l'impolitesse à l'abus physique.

Cependant, il n'y a pas de motif acceptable ou d'excuse valable pour un comportement violent ou abusif dans un environnement périopératoire dans une société civilisée.

Que pouvons-nous faire à propos de tels comportements en milieu de travail ? La première chose à faire est de créer un environnement dans lequel le message suivant est clair: les comportements violents et abusifs ne seront pas tolérés. Tous les individus travaillant dans la salle d'opération doivent savoir qu'il y a tolérance zéro. Les nouvelles recrues en soins périopératoires ont besoin d'être soutenues. Des politiques et lignes directrices devraient être développées afin que les individus connaissent la marche à suivre et qui contacter lorsqu'ils doivent rapporter un incident. Celles-ci devraient être affichées clairement à la vue de tous. Des programmes d'éducation et des forums de discussions devraient porter sur le sujet, et les gestionnaires et les leaders devraient être formés sur la manière de traiter ces questions. ***Plus que tout, nous avons besoin de soutenir nos collègues et travailleurs d'équipe dans nos actions, dans nos paroles et dans nos comportements*** !

Les infirmières en soins périopératoires travaillent d'ores et déjà dans un environnement potentiellement stressant, et ce stress est combiné à un manque sévère d'infirmières. Permettre que l'abus au travail soit ajouté à cette équation peut conduire des infirmières à quitter ou à décourager les nouvelles recrues. Nous devons être vigilants et dire 'non' à l'abus en milieu de travail !

***Référence:***


Daly, R. (December 7, 2001). *The great hospital divide: Guelph inquest spotlights age-old conflict between doctors and nurses.* The Toronto Star.

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| **Saskatchewan** | Sept 13-15, 2002 | Moose Jaw |
| **Quebec** | Nov 20-22, 2002 | Montreal |
| **Atlantic Conference** | Sept 25-28, 2002 | Charlottetown |
| **Newfoundland** | Oct 17-19, 2002 | Goose Bay, Labrador |

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| **National 2003** | June 8-12, 2003 | Winnipeg, MB |
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## INTERNATIONAL CONFERENCES
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| | | |
|---|---|---|
| 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 |

## INFORMATIONAL WEBSITES

Heart and Stroke Foundation of Canada www.heartandstroke.ca
Caregivers and Nannies On-line www.caregivers.ca
Canadian Association for Community Living www.cacl.ca
Alzheimer Society of Canada www.alzheimer.ca
Registered Nurses Association of Ontario www.rnao.org
Tommy Douglas Research Institute www.tommydouglas.ca
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# OH MY, THE PRESSURE!

*ABSTRACT*

*The intraoperative phase of a surgical patient's hospital stay has been overlooked as a major contributor of pressure ulcers that may arise postoperatively. Pressure ulcers are defined and then the hazards, underlying knowledge, and prevention tactics are reviewed. Bed sore, decubitous ulcer, pressure sore, and pressure ulcer are different terms describing the same problem encountered by medical and surgical patients. The common denominator is pressure — sustained pressure.*

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*Patient's arm, on the armboard, receives pressure*

***OH MY, THE PRESSURE!***

Effective patient positioning to avoid intraoperative injury has become a major issue for surgical suites worldwide. It is especially challenging in prolonged surgical procedures. As we increase our knowledge and our ability to do more complex surgeries, so do we increase the risk of perioperative surgical complications. Although we cannot alter the length of surgery or the position required for our patients, we can continually assess, monitor, and search for better ways to protect our patients.

What is a pressure ulcer? It is an area of local damage to skin and underlying structures caused by constant pressure, shearing, or friction. Increased amounts of pressure, shearing forces caused by movement, and increased amounts of friction combine to cause pressure ulcers intraoperatively. One of the greatest risk factors is unrelieved pressure points.

What do pressure ulcers look like? They may be reddened, warm areas; blistered areas; abrasions; boggy or soft areas; areas where the skin is gone. Table 1 documents the four stages of pressure ulcers. Surgical patients may not display a pressure ulcer until three to five days post-operatively. Therefore, intraoperative factors are often for-gotten. We have all taken patients to the Post Anaesthesia Care Unit [PACU] and noticed a slightly reddened area. We generally give it a rub and often think no more of it. It is not normally documented in the operative record or in the nurse's notes, and may not be mentioned to the PACU admitting staff. Is this the beginning of a pressure ulcer? Perhaps it is. Documentation of the suspicious site — including its appearance and any actions taken — is very important. If no portion of the operative record is available for this, use the Nurse's Notes and be sure to pass these findings on to the PACU staff. Research shows a variety of statistics surrounding pressure ulcer formation with figures ranging from 7-66% in surgical patients (3-32% of hospitalized

*Continued on Page 11*

patients). This means that over half of our patients could be at risk! Documentation also shows that tissue damage may occur after 1-6 hours of sustained pressure.

Assessing patient risk for skin breakdown is routinely done on wards as well as in long-term care facilities. Unfortunately, the perioperative setting doesn't offer the luxury of time needed to review and apply these tools. Fortunately others have incorporated this process into the patient care plan. Awareness of the tools arms us with useful knowledge that can be applied in our theatres.

| Table 1 | CLASSIFICATION OF PRESSURE ULCERS |
|---|---|
| Stage I | - Visible Alteration of intact skin<br>- Considered superficial |
| Stage II | - Partial thickness skin loss<br>- Can be seen as blisters or an abrasion<br>- Considered superficial |
| Stage III | - Involves full thickness of skin and deeper tissue |
| Stage IV | - Involves full thickness of skin<br>- Extensive underlying tissue damage<br>- May involve muscle and / or bone |

*(Barrett, 1996)*

There are five notable risk assessment formulas: Norton and Waterlow (two distinguished European scales) and Knoll, Gosnell, and Braden (respected North American creators). The American Braden Scale is regularly used upon patient admission and at regular intervals throughout the hospitalization. Braden (*Ayello & Braden, 2001*) has six categories of assessment tools. They are sensory perception (including level of consciousness and cutaneous sensation); moisture; an evaluation of continence of bladder and bowel; mobility (whether or not the patient can move independently); activity (is the patient very mobile in day to day life, or does he/she sit the majority of the time); nutrition (quantity, frequency, and quality

| Table 2 | AREAS AT RISK FOR DEVELOPMENT OF PRESSURE ULCERS |
|---|---|
| **OR Position** | **Areas at Risk** |
| Supine | Scapula, occiput, sacrum, elbow, shoulder, heels |
| Lateral | Ear, shoulder, trochanter, medial portion of the knee, malleolus, edge of foot, elbow |
| Prone | Nose, forehead, chin, chest, breasts, genitalia, iliac crest, toe, patella, edge of foot |
| Lithotomy | Scapula, shoulder, occiput, sacrum, lateral knee, elbow, ankle |
| Sitting | Buttocks, sacrum, genitalia, heels, elbow, bottom of foot |

*(Fortunato & McCullough, 1998)*

including hydration); and the friction/shearing factor (which goes along with mobility). These tools, along with the intensity and duration of pressure, accurately assess the risk of ulcer development. High-risk patients are then ranked in the clinical evaluation process. The result is an increase in prediction, awareness, and prevention. All models help you identify which patients are at the most risk of ulcers – perioperatively, it is a matter of managing the risks.

Table 2 shows the body areas frequently affected in five common intraoperative positions. Reviewing the risk factors will keep us aware of potentially high-risk patients. Diabetes, low preoperative haemoglobin (contributes to the amount of oxygen available to tissue under pressure), age, nutritional status, preoperative mobility, obesity, continence, hydration, preoperative skin care, friction, shearing, and underlying medical conditions all contribute to the creation of pressure ulcers.

Perioperative risks include things we do to our patients all day, every day. How we position the patient and the positioning devices we use (such

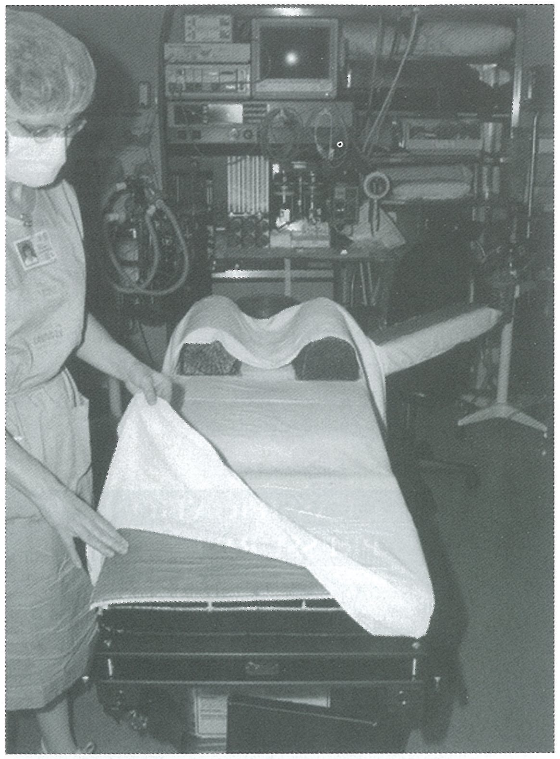
*Continued on Page 12*

as gel pads, gel bolsters, pillows, and soft flannel linens) come with risks. Smooth surfaces are important, as pressure over a tiny wrinkle in linen can still cause skin and tissue damage. The choice of position and the duration of the surgery are factors we must work with. Care must be taken during surgical site skin preparation as both the pooling of chemical prep solutions and the exposure time to a chemical increase the risk. If necessary, tuck spare linen around the prep area to catch the "drips", then remove upon completion of the prep. Skin friction and shearing when the patient is moved, lifted and turned creates stress and exerts pressure on the skin. This is a major risk factor. There are many moving devices available, at a range of prices, to reduce this risk. One important way to decrease risk factors is to ensure that there is enough assistance available to achieve smooth, efficient turning or positioning of the patient. Many hands make for easier, safer and more effective positioning.

The next important step is to maintain body temperature during long surgeries or when cavity organs will be exposed for extended periods of time. Fluid warmers are a proven source of steady heat. Fluid warming blankets have been proven to have only limited success with maintaining normal thermia and may contribute to pressure ulcer formation. The hot air style warming blankets are considered to be a better option. Controlled hemodynamics, along with relatively unaltered circulation, helps in the prevention of ulcerations.

During the time it takes to move the patient to the operating table, and during positioning, catheterization, prepping and draping, note the status of your patient's skin. Document the integrity of your patient's skin in order to provide a baseline should a concern be noted post-operatively.

Intraoperatively the constant pressure exerted by the holding of retractors can contribute to skin breakdown and the creation of ulcers. Another often-unseen factor in tissue damage is a surgical team member leaning on the patient during surgery or allowing the patient to be used as a mayo tray. The patient is unable to



*OR bed with gel positioning devices*

express discomfort or shift to relieve the pressure. Avoid leaning on an anaesthetized patient and remember that heavy instrumentation belongs on a table or mayo tray, not on a motionless patient.

Until recently, the operating table mattress has been a well used but ignored piece of equipment. A standard O.R. mattress is usually 1-2 inches of foam covered in a thick, durable, easily cleaned, non-allergenic, radiopaque, firm, fluid resistant material. It is difficult to have all these properties and to maintain an even pressure distribution without the mattress flattening, compressing or allowing the patient to "bottom out" or sink. Numerous layers of linen between the mattress and patient are also discouraged. Proven alternatives – air, various foams, gel, and water – have made mattresses more effective in the prevention of ulcers. Surgical suites need to review what is offered in today's marketplace. Research has been conducted on various theatre table mattresses.



One mattress study (*Defloor & De Schuijmer, 2000*) made several conclusions:

1. Patients in the lateral position have the highest pressure exerted on portions of the body
2. Foam is a poor contributor to the prevention / relief of pressure ulcers
3. When doing research on perioperative pressure ulcer formation, patient positioning should be considered
4. Gel mattresses prevent pressure ulcer formation in a limited capacity
5. Visco-elastic polyether foam and visco-elastic polyurethane offer the best resistance to ulcer prevention

Some alternates, such as circulating air or circulating water, are difficult to use in surgical suites, as the necessary pumps and cords are cumbersome and inconvenient in tight quarters. They also increase the danger of patient movement intraoperatively.

Solutions are neither easy to find nor inexpensive. Gel-filled mattresses have been used in many palliative and long-term care situations with positive results (*Defloor & De Schuijmer, 2000*). Gel mattresses are now available for use with operating tables. A recent clinical evaluation of one gel mattress indicated that although the mattress was heavy, it was "worth its weight in gold" {Farley, 2002, equipment trial}. Resistance was encountered when it was time to return the trial unit! Columns of gel that distributed patient weight evenly made it a joy to recline on and equally as comfortable in the prone position - I tried it myself as a guinea pig and felt it was definitely comfortable! Purchasing new mattresses for O.R. tables is a costly proposition, but the initial expense would prove cost effective if one incident of pressure ulcers (as described in Table 1) was prevented. The Case Study below demonstrates this.

### *CASE STUDY*

A healthy young man underwent eighteen hours of surgery in the lateral position. Upon removal of the surgical drapes, it was noted there were several areas of altered skin on the scapula, hip, knee, elbow and ankle. Recovery from the surgery was not as prolonged as the recovery from the intraoperatively acquired pressure ulcers! The scapula region needed draining and primary closure of the area. The process took six months of physician visits, dressing changes, medications, and further surgery. The cost to the healthcare facility was significant, and to the patient, intangible. Not the outcome you would want, choose, or expect.

The increased cost factor for a facility is measurable but the cost to our patients is not. Perioperative time spent diligently considering all the mentioned risks could improve your patient's outcome. Patients agree to the direct risks of a surgical intervention, but don't expect the added complications of a pressure ulcer. The resulting pain, increased possibility of infection, altered lifestyle, emotional stress, physical limitations, disfigurement, additional surgery, continued dressing changes in areas other than the surgical site, and perhaps months of continued care and treatment are not an expected outcome of surgery.

Understanding the causes of skin breakdown and how to prevent it is a crucial component of the perioperative nursing practice. Skin is a layered, multifunctional covering that aids in the activities of daily living and keeps a body's contents in the correct area. This first line of defence deserves the best care possible. The surgical suite is no longer "the great unknown" in the pressure ulcer equation. We cannot underestimate the risk of pressure ulcers in a surgical patient who is immobilized for extended periods of time. High intensity pressure in the short term or low intensity pressure over an extended period of time will result in tissue damage. No one in the surgical suite intentionally increases a patient's chances of morbidity and mortality, or would knowingly contributes to pressure ulcer formation. If we watch for new and improved products, ask for and share product information, and lobby for the evaluation or purchase of equipment we can help keep our patient's skin intact and healthy during their time in the O.R. theatre.

*Continued on Page 20*

***Pearls of Wisdom***

# MANAGING THE ANGRY, HOSTILE, FINGER POINTING INDIVIDUAL WITH SUCCESS

As a leader, you will encounter a number of hostile, angry, red-faced, finger pointing, obstinate colleagues or team members. It may be a one-time explosion or it may be a frequent event. Depending on the situation, surrounding events and people, the relationship you have with the individual, and your prior methods of dealing with this person, the CORL Corral offers some tools and techniques you might consider.

- Try to temporarily diffuse the situation with a promise that you will speak with them in a more appropriate place once they have the chance to calm down. Don't make it worse by "telling them off" or telling them to "just smarten up". Better to have them walk away than to get pulled into their problem. Do not continue the discussion since that can add fuel to their fire. Be sure to follow up as soon as you can – if they leave without explaining their inappropriate behavior and taking responsibility, the behaviour will only continue and be used as a "get what I want" strategy.

- If they are accusing you of some action that is really their own issue, and are personally blaming you for their mistakes or a situation, try to detach yourself from the personal attack and the hurt. Take a deep breath or two before you respond. Apologize in such a way that you do not accept the blame but recognize the distress the individual is under. Focus the apology on your concern that they are distressed. The majority of people will cool off and think they have succeeded in getting an apology. Remember if they are really angry they will not rationally hear all the words you say.

- Use a tone of voice that calmly and quietly identifies that you are very sorry for their frustration. Speaking quietly and calmly forces them to calm down in order to hear you. Remember, "anger begets anger". Also remember that an angry, yelling person only hears loud responses – they have to calm down to hear quietly spoken words.

- Although it will be extremely difficult, try to be very charming and say something positive about the person. It is very hard to continue to be angry when someone is saying something positive about you. Use the terms committed, concerned, interested, dedicated or whatever fits the situation. Give the person an understanding that you perceive what their anger is about.

- Inappropriate conduct needs to be referred to the next level of authority so that responsibility, accountability and the impact of the behavior are acknowledged. Remember to DOCUMENT, DOCUMENT, DOCUMENT. Note the time, date, circumstances, and precise statements STICKING TO JUST THE FACTS -- no personal opinions. Be sure that YOU take an active part by stating "We will review this situation together with Ms/Mr person-in-authority in order to clarify the situation and find a resolution." Emphasize that this will be a chance for the individual to make it better. Do not say "I'm reporting you to Ms/Mr person-in-authority" as this sounds like a threat similar to sending them to the Principals office and will only make them more angry or fearful or give the impression you are "passing the buck". You need to stay involved so that the angry person knows you are committed to dealing with the issues. That way they will likely think twice before they blow up at you again.

- When you're being attacked ask yourself "Will this matter in 2 years?". If the answer is no then LET IT GO! Do not hold on to the baggage resulting from personal attacks! Try to see the humour in the situation, even if it's black humour it can help you survive. Laughter increases your survival odds!

- Once the heat is off, remember that everyone comes to work believing they are doing a good job. You may not feel that this individual is doing a good job, but in their mind they are!

- Try to reframe the situation after the fact and look at what can be learned from this and how you can reduce the negative factors that push this person's buttons instead of taking the easy way out by labeling this individual as a constant problem.

- In the days following the incident, ask the individual if the situation is better. Hard as it may be, this will ensure that they know you have not forgotten and that you are concerned about what happened.

Good luck! And remember, live and learn! ✦

*By: Muriel Shewchuk*

*The Association of Perioperative Registered Nurses is mourning* ***Dr. Jean M. Reeder****, RN, PhD, FAAN who passed away May 1st, 2002. Dr. Reeder served as President of AORN from 1991 to 1992, and was a well-respected perioperative nursing scholar, author, presenter, and recipient of many honours. She worked in Canada from 1995 to 2000, and was a member of ORNAO. The ORNAC Executive and Board wish to express our sincere condolences to Dr. Reeder's family and friends.*

*She will be greatly missed.*

## SCOPE OF PERIOPERATIVE NURSING PRACTICE

The Scope of Perioperative Nursing Practice is an Ad Hoc committee of the ***Operating Room Nurses Association of Canada*** (*ORNAC*) whose purpose is to act as a liaison for groups affiliated with *ORNAC* and to maintain a registry of these affiliated groups. At the present time this committee is focusing on two sig-nificant areas of perioperative nursing practice that expand the practice beyond its conventional role. Once organized, these practitioners may apply for affiliate status with *ORNAC*. Their roles are:

1 Registered Nurse First Assist (RNFA)

2 **Anaesthesia Assistant**

The more familiar area of these expanded practices is the **Registered Nurse First Assist (RNFA)** role. The basic definition of an RNFA is a perioperative nurse who assists in surgery and functions under the direction of a surgeon. In addition to the intraoperative activities, the RNFA may also be responsible for performing preoperative and postoperative assessments to enhance continuity of care throughout a patient's surgical experience. There has been an enormous amount of work being done across the country in an effort to introduce and implement the RNFA role in various health districts.

The majority of practicing RNFAs in Canada have completed their curriculum though one of the three formalized RNFA programs that are being offered in Canada – in British Columbia, in Newfoundland, or in Quebec. There are also some RNFAs who took their coursework through programs in the U.S.

Several provinces are now introducing the RNFA role through pilot projects as a means of testing to see if it is a viable option. Other provinces have already permanently established the role in their health districts. As a result of the RNFA pioneers, a committee entitled The RNFA Network of Canada has been formed. Its mandate is to create an official organization that will develop national RNFA competencies, create a registry of all RNFAs, and offering net-working oppor-tunities. It is anticipated that the group will be submitting its formal application for affiliate membership in *ORNAC* before the 2003 National Conference.

The second area that the Scope of Perioperative Practice has been monitoring over the past several years is that of the **Anaesthesia Assistant.** At present, there is no one standardized title that is being utilized nationally – *ORNAC* is currently using the interim title Registered Nurse Anaesthesia Assistant. It is hoped that if this role becomes more prevalent in the O.R. envir-onment, it will not suffer the same title confusion that has plagued many other nursing roles.

ORNAC is maintaining ongoing involvement with a special interest task force organized through the Canadian Anaesthesia Society. The first meeting of this task force took place in 1994 and at that time it was agreed that the Ana-esthesia Assistant role has merit in today's health care arena and that the fundamentals of the role needed to be further outlined. Since that time the task force, which also involves participation by Respiratory Therapists, has met annually.

In 1997 the task force submitted an application to *Human Resources Development Canada* (*HRDC*) for funding for the development of national competencies for the Anaesthesia Assistant role. The request was rejected on the basis that they felt the group was proposing to develop yet another category of O.R. worker at a time when health care funding is being reduced. In actual fact, *ORNAC*'s position is O.R. nurses are already performing the Anaesthesia Assistant's tasks – performing the preoperative assessments, assisting with anaesthesia induction, and fulfilling any other needs the anaesthetist may have. As a result, the role of the Anaesthesia Assistant is simply an extension of the role that the O.R. nurse already performs and the development of national competencies would only require an enhanced educational component.

At the time of this writing, the task force was planning to meet again in June 2002. Their intention was to reapply for funding based on a clarification of the task force's position. *ORNAC* will continue to have representation at these meetings. One concern of the task force is that many O.R. nurses are unaware of the existing programs in Canada that offer the Anaesthesia Assistant curriculum. One program is offered at *Cariboo College* in British Columbia and the other is offered at the *Michener Institute* in Ontario.

One of the projects the Scope of Perioperative Practice has in the works is the creation of an information sheet outlining these programs and publicizing this information. To date it appears that the role has not been widely implemented as an extension of the O.R. nurses' practice. Instead, there are a few variations of the role that have taken root within various health districts. The job descriptions seem to have been to suit each hospital's own needs and functions and Respiratory Therapists appear to be filling most of these positions. This may be related to the lack of information available to perioperative nurses regarding the existing programs.

If you have any questions or comments, or are just interested in learning more about the Scope of *Perioperative Nursing Practice Committee* ***visit www.ornac.ca*** and click on *Executive.*

*By Linda Socha, Chair, Scope of Perioperative Nursing Practice Committee*

## DID YOU KNOW?

By the time Alzheimer's has been diagnosed, irreversible damage has occurred? Research is giving us hope – no, not necessarily a cure, but the medications to slow, stop, or perhaps reverse the process. There are about 19 drugs under investigation at the moment.

## ENDEARING THOUGHTS

*An elderly gent was invited to his old friend's home for dinner one evening. He was impressed by the way his buddy preceded every request to his wife with endearing terms – "Honey," "My Love," "Darling," "Sweetheart," "Pumpkin," etc. The couple had been married almost 70 years and, clearly, they were still very much in love. While the wife was in the kitchen, the man leaned over and said to his host, "I think it's wonderful that, after all these years, you still call your wife those loving pet names." The old man hung his head. "I have to tell you the truth," he said.*

*"I forgot her name about 10 years ago."*

## CALL FOR ABSTRACTS

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***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 infirmiéres et infirmiers en salles d'opération du Canada

### 18iéme Conférence nationale

Winnipeg, Manitoba • *8 au 12 juin 2003*

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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 :**
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# OH MY, THE PRESSURE! *(cont.)*


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# ORNAC in a Nutshell — Spring 2002 Update

- Our spring *2002 Executive & Board meeting* was held in Windsor ON in May. We were fortunate to be invited by *ORNAO* to join them at "*The Impact Zone*", their 7th biannual Provincial Conference, chaired by President **Kathy Bruce**. Approximately 18 *ORNAC* Board members remained for the conference.

- **Lynn Anderson** of NF, **Ray Larkins** of MB & **Kim McLennan-Robbins** of AB have completed *ORNAC* Board terms. We bid them farewell and thank them fortheir hard work!

- **Susan Bell**, ON President Elect has resigned her position to continue her studies. We thank her for her time and effort and we wish her well in the future.

- Welcome to Alberta (*ORNAA*), as they join the increasing number of provincial associations with pages on **www.ornac.ca.** Visit and find out what is going on in Alberta.

- **Peggy Ziegler**, President Elect of *ORNAA*, is the new Chair of the Awards Committee.

- There were many busy committee workers in Windsor! They created the *ORNAC Education Committee* – a blend of the *Research, Translation, Scope of Perioperative Practice, Public Awareness, Perioperative Nursing Education, and the Editorial Advisory Committees.* **Linda Socha** of SK is the Chair of this new committee. Our goal is to be more productive with a smaller number of committees. We will continue trying to "right size" our Board at the meeting this fall!

- **Marla Ewen**, *ORNAC* Research Chair, & **Vafa Jamali**, Vice President & General Manager, *Allegiance Healthcare*, presented **Deb Clendenning** of the *Children's Hospital Eastern Ontario* (*CHEO*) with this year's Allegiance Research Grant. Congratulations to Deb!

- President **Mary Knight** has been very busy as well, and recently attended *AORN* in Anaheim. *AORN* announced that the *International Planning Committee* has been renamed the *International Education Planning Committee* (*IEPPC*), to help clarify the purpose of the committee. The *International Federation of Perioperative Nurses* held a meeting during the conference, and reported that Uganda is now a member and that Zambia will join later the year.

- The theme of the *2003 Hong Kong World Conference* is **One World - Working Together.** A call for papers is forthcoming and the deadline will be June 28th, 2002. Stay tuned to **www.ornac.ca.**

- The 2007 *ORNAC National Conference* is going to be held in Victoria, BC rather than Vancouver!

- BC's new President Elect, and *ORNAC* Board member, is **Bonnie McLeod** from the *Royal Columbian Hospital.* Ontario has **Alaine Young** from the *Hamilton Health Sciences Centre* as its new President Elect and *ORNAC* Board member.

- The last week of April 2002 marked a "first" for *ORNAC*- the first issue of *CORNJ* published by Clockwork Communications on *ORNAC*'s behalf! *CORNJ* information can be found on **www.ornac.ca**

# AIISOC en Bref

- Notre *réunion de l'exécutif et du conseil d'administration* du printemps 2002 s'est tenue à Windsor, Ontario. Quelle chance ! Nous étions invités par l'Association des infirmières et infirmiers en salles d'opération de l'Ontario à joindre leur groupe pour leur 7ième Conférence provinciale bi-annuelle "*The Impact Zone*", sous la direction de la


*Continué a page 22*

présidente de l'Ontario, **Kathy Bruce**. Plusieurs membres du conseil d'administration sont restés pour la conférence.

- ❖ **Lynn Anderson** de Terre-Neuve, **Ray Larkins** du Manitoba et **Kim McLennan-Robbins** de l'Alberta ont complété leur mandat au conseil d'administration de *l'AIISOC*. Nous leur disons aurevoir en les remerciant chaleureusement pour leur important apport à l'association.

- ❖ **Susan Bell**, présidente élue de l'Ontario, a démissionné de son poste pour continuer ses études. Nous la remercions pour son temps et son travail pour l'association et lui souhaitons bonne chance dans son engagement académique.

- ❖ Bienvenue à l'Alberta qui joint les rangs des associations provinciales à avoir un site sur **www.ornac.ca** . Visitez leur site et découvrez ce qui se passe en Alberta.

- ❖ **Peggy Ziegler**, présidente adjointe de l'Association des infirmières et infirmiers de salles d'opération de l'Alberta, est la nouvelle présidente du comité des distinctions honorifiques.

- ❖ Plusieurs membres de comités furent très occupés à Windsor ! Nous avons créé le *comité, éducation*, de *l'AIISOC* qui regroupera les comités - *Recherche, Traduction, Champ de pratique en soins périopératoires, Relations publiques, Éducation en soins périopératoires et le Comité consultatif de rédaction.* **Linda Socha** de Saskatchewan est la présidente de ce nouveau comité. Nous espérons être plus productifs avec un plus petit nombre de comités : tous les comités antérieurs seront représentés dans cette nouvelle entreprise. Nous continuerons notre travail de restructuration à notre réunion de l'automne afin de mettre au point la meilleure façon de fonctionner pour notre conseil d'administration.

- ❖ **Marla Ewen**, présidente du comité de recherche, et **Vafa Jamali**, vice-présidente et directrice générale de Services de *santé Allégiance*, ont présenté **Deb Clendenning** du *Children's Hospital Eastern Ontario* (*CHEO*), récipiendaire de la bourse de recherche Allégiance 2002. Toutes nos félicitations !

- ❖ Notre présidente, **Mary Knight**, a également été fort occupée. Elle assistait récemment au congrès de *l'AORN* à Anaheim. Lors de la réunion de *la Fédération internationale des infirmières et infirmiers en soins périopératoires* (*IFPN*) , il était rapporté que l'Ouganda est maintenant membre et que la Zambie le deviendra plus tard en 2002. *International Planning Committee* (*IPC*) a été renommé *International Education Program Planning Committee* (*IEPPC*) ; le changement de nom a été fait pour clarifier, pour les membres de *l'AORN*, la fonction de ce comité.

- ❖ Le thème de *la Conférence mondiale de 2003* à Hong Kong est - **Un monde travaillant ensemble.** Un appel de résumé pour fin de présentation suivra prochainement, la date limite pour s'inscrire est le 28 juin 2002. Surveillez le site **www.ornac.ca.**

- ❖ La conférence nationale de *l'AIISOC 2007* se tiendra à Victoria, CB, plutôt qu'à Vancouver, CB.

- ❖ La nouvelle présidente adjointe de la Colombie-Britannique et nouveau membre du conseil d'administration de *l'AIISOC* est **Bonnie McLeod** du *Royal Colombian Hospital.* Pour l'Ontario, la nouvelle présidente adjointe et nouveau membre du conseil d'administration de *l'AIISOC* est *Alaine Young du Hamilton Health Sciences Centre.*

- ❖ La première semaine de mai 2002 représentait une première pour *l'AIISOC* : La sortie du premier numéro du *JAIISOC*, publié conjointement par **Clockwork Communications** et *l'AIISOC* ! Nous espérons que celui-ci soit prospère. Surveillez la sortie du second numéro! Vous trouverez l'information sur le *JAIISOC* sur le site **www.ornac.ca.** N'hésitez pas à faire vos commentaires.



# AN INTRODUCTION TO THE NATIONAL ASSOCIATION OF THEATRE NURSES

I am delighted to have been asked to write a short message from the *National Association of Theatre Nurses* (*NATN*) in the United Kingdom and would like to thank *ORNAC* President, **Mary Knight**, for this opportunity.

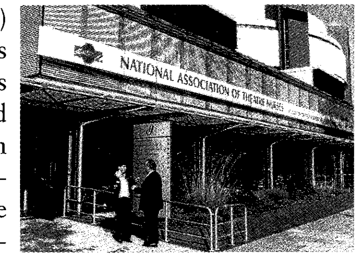
*NATN* represents over 8,000 operating room nurses throughout the four home countries of the UK, England, Scotland, Northern Ireland and Wales, as well as the Isle of Man and the Channel Islands. We also have almost 250 overseas members. Our membership comprises nurses working in a variety of settings in the operating room including anaesthetics, scrub, recovery, and pain management.

*NATN*'s role, as with perioperative nursing organisations in other countries, is to provide perioperative education, principles for good practice, and professional advice as well as to represent the voice of perioperative nursing at all levels within the healthcare arena. We run an annual education programme reflecting current issues affecting perioperative care in the United Kingdom. In addition, we publish documents that provide comprehensive guidance on 'hot' perioperative topics.

Our most widely recognised publication is the *British Journal of Perioperative Nursing* (*BJPN*), a monthly Association journal for *NATN* members. The journal is well respected and popular in the perioperative community and contains articles on a full range of topics from clinical subjects to nursing and product news, from opinion columns to Association updates.

We are very proud to have launched, in April 2002, the *Journal of Advanced Perioperative Care* (*JAPC*), designed to disseminate information about perioperative research in line with *NATN*'s Research Strategy – to promote excellence in perioperative care. *JAPC* will include research-based articles, literature reviews, ethical and philosophical discussion, research abstracts and reports, research methodology, information about the Research Strategy, and research resources.

*NATN*'s Research Strategy is also manifested in the form of a *Perioperative Nursing Research Network* (*PNRN*) for members. This network allows nurses involved or interested in perioperative research to exchange information or support on research projects. The network receives a quarterly newsletter with updates on research opportunities, *PNRN* activities, calls for papers and reports on relevant research sessions. Our annual Congress programme also includes research sessions and provides an opportunity for members of the *PNRN* community to meet and interact. As part of the medium – to long-term plans for the Research Strategy, we are collating a com-prehensive perioperative research database that will allow us to commission research work in areas of particular importance.



*NATN Office*

A few years ago *NATN* created a **'Managers Forum'** to respond to the specific needs of Operating Room Managers. This Forum has proven to be very popular and has led to the organisation of an annual Managers Conference and Exhibition. We plan to expand the concept this year to create an Anaesthetic and Recovery Nurses forum to ensure we fulfil the particular education requirements of, and provide support to, members who work in these areas.

From a strategic point of view we have developed our links with the Departments of Health in each of the four home countries and are determined to reflect the particular issues of devolution that affect our members. We receive frequent requests for representation at Department working parties, associated professional working parties and ad hoc groups, and find these opportunities of tremendous benefit to the enhancement of perioperative practice and patient care.

On an international level, *NATN* is proud of its status as a founding member of both the *European*

*Continued on Page 24*

## AN INTRODUCTION TO THE NATN (*cont.*)

*Operating Room Nurses Association* (EORNA) and the *International Federation of Perioperative Nurses (IFPN)*. We consider assisting with the globalisation of perioperative practice and standards of care to be critical work. The opportunity to share international educational experiences and professional networks is invaluable and the collaborations can only serve to strengthen the voice of perioperative nursing around the world.

On a related topic, visitors to the United Kingdom in the fall may be interested in attending the NATN Congress and Exhibition from October 8th – 10th in Harrogate, England. This is the premier event on the *NATN* calendar and it attracts nearly 3,000 perioperative practitioners, exhibitors, and other visitors every year.

Congress educational sessions are contained in three concurrent programmes at the Congress. They include clinical, professional, policy, and research sessions. In addition, there will be a series of industry workshops and numerous educational opportunities in the anaesthetic and surgical devices exhibition. *NATN* has a new service to support our first time attendees (attendees are linked up with a member who has been to a previous Congress and can act as a guide). In addition, international delegates will be provided with specific guidance as well as the opportunity to attend an international "meet and greet" evening. Attendance at this evening usually includes around 100 OR nurses from over 20 countries.

For more information about *NATN* visit **www.natn.org.uk**. We wish everyone at *ORNAC* continued success and hope that this article has provided useful insight in to another perioperative nursing organization. We all benefit when we stimulate our members' interest in international collaboration and co-operation.

Siobhan Rankin
Chairman, *NATN*

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*We sadly report that Ms Rankin passed away as a result of a sudden illness while attending the Annual AORN Congress in Anaheim, California.*

*In addition to her role as Chairman of NATN, Ms Rankin was also Directorate Manager, Directorate of Education, Research and Development, The Royal Hospitals, Belfast, Northern Ireland. The Executive and Board of ORNAC extend our sincere sympathy to Siobhan's family and friends and to our colleagues at NATN.*

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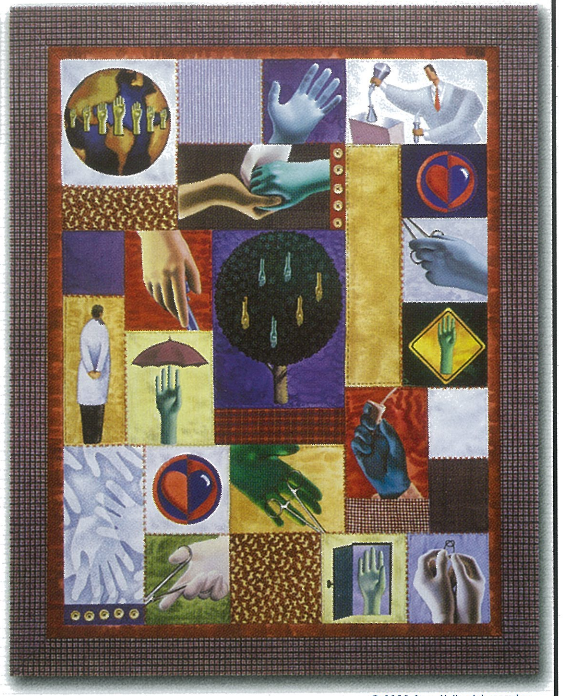

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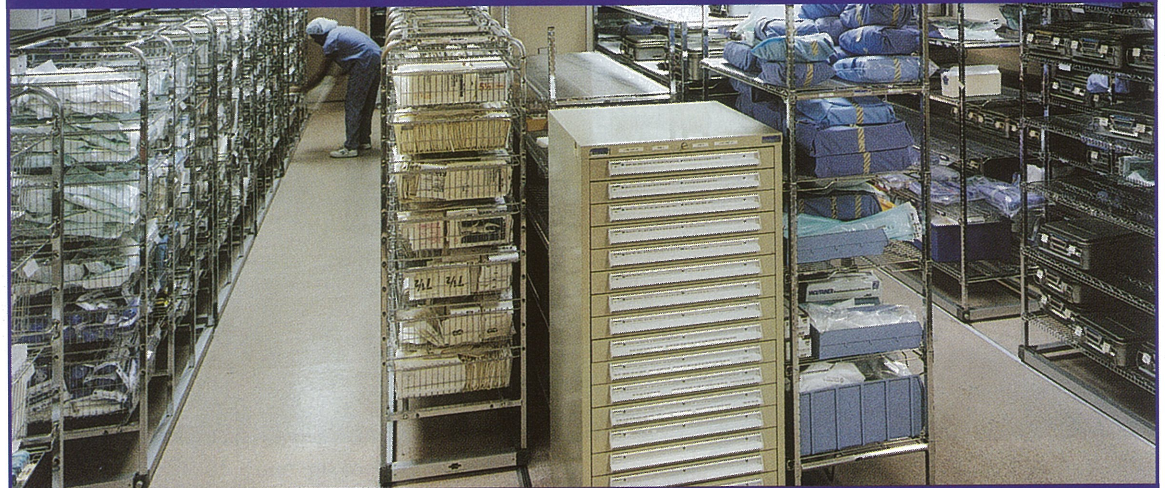

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