Canadian Operating Room Nursing Journal

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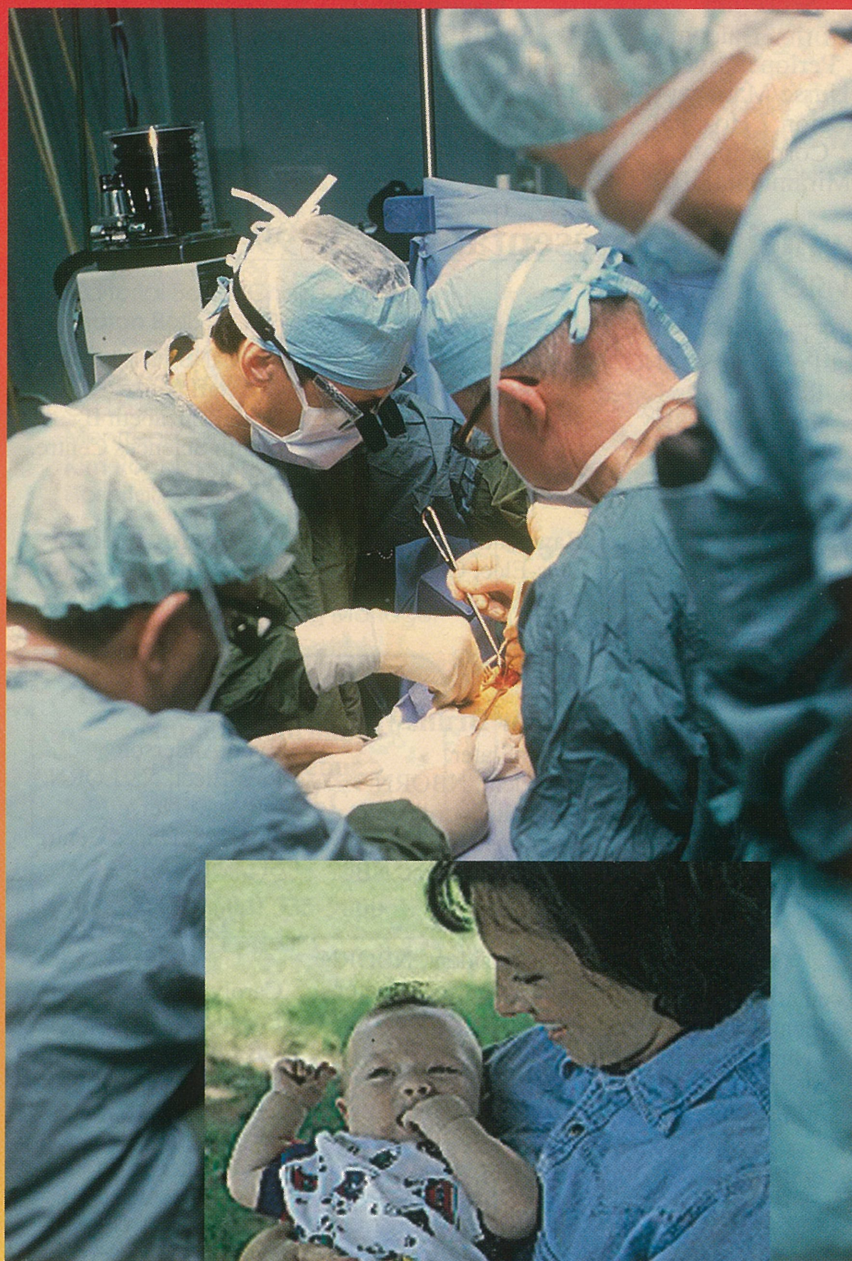

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Support Your OR Colleagues

By Donna Farid, RN, PGOR, CPN(C)

When I reminisce about my career in Perioperative Nursing, I have to admit my first few days/weeks of orientation (that's not what they called it in those days) do not conjure up fond memories. The staff nurse who was assigned to teach me the ropes, took vicarious pleasure in rearranging the instruments on my Mayo Tray with a lifting forcep while making disparaging remarks about my organizational skills in front of the whole surgical team, much to my humiliation and embarrassment.

Having survived, I gained some experience of my own, and moved on to live and work in other provinces. During one of these moves, and having just secured a job in the O.R. of a small general hospital, I was introduced to the staff as a nurse with lots of O.R. experience. A few days later, I offered to pick the bundles for the next case and asked a colleague what was needed. Her statement to me was "you have so much experience, figure it out for yourself".

Another perioperative nursing colleague shared with me an experience she had when starting out in a surgical specialty. The Team Leader in that specialty was reluctant to share information, and one morning when she arrived late for work, my colleague had done the best she could to set up for the first case. The Team Leader tore a strip off her for missing a couple of minor aspects of the setup, again in front of others.

These are all perfect examples of perioperative nurses ***eating their young***. We've come a long way since then. Today much more consideration is shown to new staff entering the O.R. setting. Preceptorship workshops are offered to experienced perioperative nurses, orientation packages have been developed and the learning experience is certainly much more positive than in the "old days". However, there still is some evidence that cannibalism is alive and well, and I will venture to expand on the theory that some perioperative nurses ***eat their own.***

How many of you have heard remarks made about nurses who go on to seek higher education? Comments like "she thinks she is better than the rest of us" or "who does she think she is" ?

On the other side of that coin, how many of you have seen examples of nurses who have achieved higher educational credentials, expressing their feelings of superiority over less educated Registered Nursing colleagues? Registered Nurses are employed in many levels of the health care spectrum, from Vice President of Nursing, Administrator, Manager, Educator, Clinical Coordinator, RN First Assistant, to Staff Nurse. We sometimes work in isolation, within our own spheres of influence, independent of each other. Yet we profess to be working to achieve the same goals: safe, quality patient care. I would like to see us doing a better job of supporting each other, of applauding each others' accomplishments, of acknowledging each others' contributions and of standing together to promote the role of the Perioperative Registered Nurse.

You may have surmised that I get rather passionate about this topic since I've "mentioned" promoting awareness of the role of the perioperative RN in ever President's Message since I began. Someone once told me in a derogatory tone that I was on a soap box. Well I'm proud to be on this soap box but I'd like some more company!

Perioperative Nursing is very attractive to many other health care workers and there have been several attempts to take over aspects of our role. If we truly believe in delivering the best, safest perioperative patient care possible, based on a strong, proven foundation of knowledge and skills, and if we believe in ORNAC's motto ***"Promoting Excellence"***, we must first work with each other in a supportive way at all levels and then unite to ensure that we continue to be there to provide that care. ■

Donna Farid is President of the Operating Room Nurses Association of Canada. She is Staff RN, Cardiovascular Surgery, Queen Elizabeth II Health Science Centre, Halifax, Nova Scotia.

Standards' Mailbox

By Marlene Hill
Chair, ORNAC Standards Committee

The Standards Committee have voted to periodically include a section of "Questions and Answers" in the *Canadian Operating Room Journal, CORNJ,* as long as the demand is there. This decision was made due to several phone calls received for clarification of certain sections in the 1998 Standards document, and by the return of some Evaluation Forms which are included as an insert in the Standards. In future, the Evaluation Form will be included as the final section of the publication.

We wish to stress that the Standards document is a guide only. There may be several good methods of performing procedures that achieve the same results and the final decision is dependent on the health care facility's policy.

Thanks to those who have returned the Evaluation Form. Our committee is attempting to reach a greater number of ORNAC members for input into the next printing of Standards due in 2003. Revision will begin approximately two years prior to that date and all suggestions and comments are important to us and will be considered. Thank you in advance for your effort in this endeavour.

Marlene Hill, RN, CPN(C) is President-Elect of ORNAC and Chair, ORNAC Standards Committee. She is an operating room staff nurse, Queen Elizabeth Hospital, Charlottetown, PEI.

Note: As previously published in the *CORNJ*, there is an error in the 1998 Standards on page 167 on positioning. The correct wording is:

Lateral Left: patient lying on the left side.
Lateral Right: patient lying on the right side.

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Question #1: Will the format change for the next revision?

Answer #1: No. The present format is quite distinctive to ORNAC and it was felt that the expense of changing it would be too great.

Question #2: Could the Standards be published on a more frequent basis?

Answer #2: No, not at the present time. The ORNAC Standards are published every five years. The review process takes approximately two years to complete. All members on the Standards Committee are volunteers and spend many hours on this project. It is not feasible nor cost effective to have a more frequent review.

Question #3: Could a binder type of book be used so that pages may be added or deleted as required?

Answer #3: No. It was felt that it would be too difficult to ensure the accurate pages were added or deleted. The CNA Perioperative Certification Examination is partly based on the information found in the Standards and the document must be the same for all readers.

Question #4: Why is the section on labeling of medication and solutions "buried at the back of the book"? (page 148, section 9.7)

Answer #4: We agree that labeling of medications and solutions on the sterile field is necessary. The section will be moved to a more prominent section in future and will read "all medications and solution on the sterile field shall be clearly labeled using a sterile marking pen or labels."

Question #5: Will there be a section on computerization in the 2003 edition of the Standards?

Answer #5: Yes, this will be included in the next edition.

Question #6: The Role of the Scrub Nurse is not as well defined as the Circulating Nurse (under Competencies page 38). Should a registered Nurse scrub in (in addition to the scheduled scrub nurse) to act as an assistant to the surgeon when the assistant is absent?

Answer #6: The role of the Registered Nurse is guided by the scope of practice as determined by each provincial territorial licensing body and health care facility's job description. The requirement of medical assistants for each category of surgical procedure should be outlined in each facility's policy, including the procedure to follow in the event a medical assistant is absent.

Question #7: About the wrapping of linens - Where did we get the information for the 1998 Standards and what happens when processes change?

Answer #7: ORNAC Standards and Recommended Practices are based on literature review and the opinions of experts. In the event a process changes significantly, an addendum will be published in the CORNJ and the CNA Certification Board will be notified.

One of the references listed in ORNAC Standards review was the Canadian Standards Association Standard Z314.10 *"Selection, Use, Maintenance, and Laundering of reusable Textile Wrappers, Surgical Gowns, and Drapes for Health Facilities".* Some sections of this standard are out of date. ORNAC's representative to CSA inform us that CSA's Technical Committee is currently determining what amendments are needed to the current edition and what needs to be considered for the next edition. Any amendments will be circulated to those who have purchased the Z314.10.97 Standard.

There have been several questions about wrapping, specifically about double and sequential wrapping. When wrapping with reusable textiles, <u>the class of textile and aseptic presentation</u> must be considered. Although double thickness sequential wrapping has been the traditional method, it is acceptable to wrap with double thickness without sequential wrapping or double thickness that is bonded together. Each facility should establish policies and procedures based on principles of sterilization.

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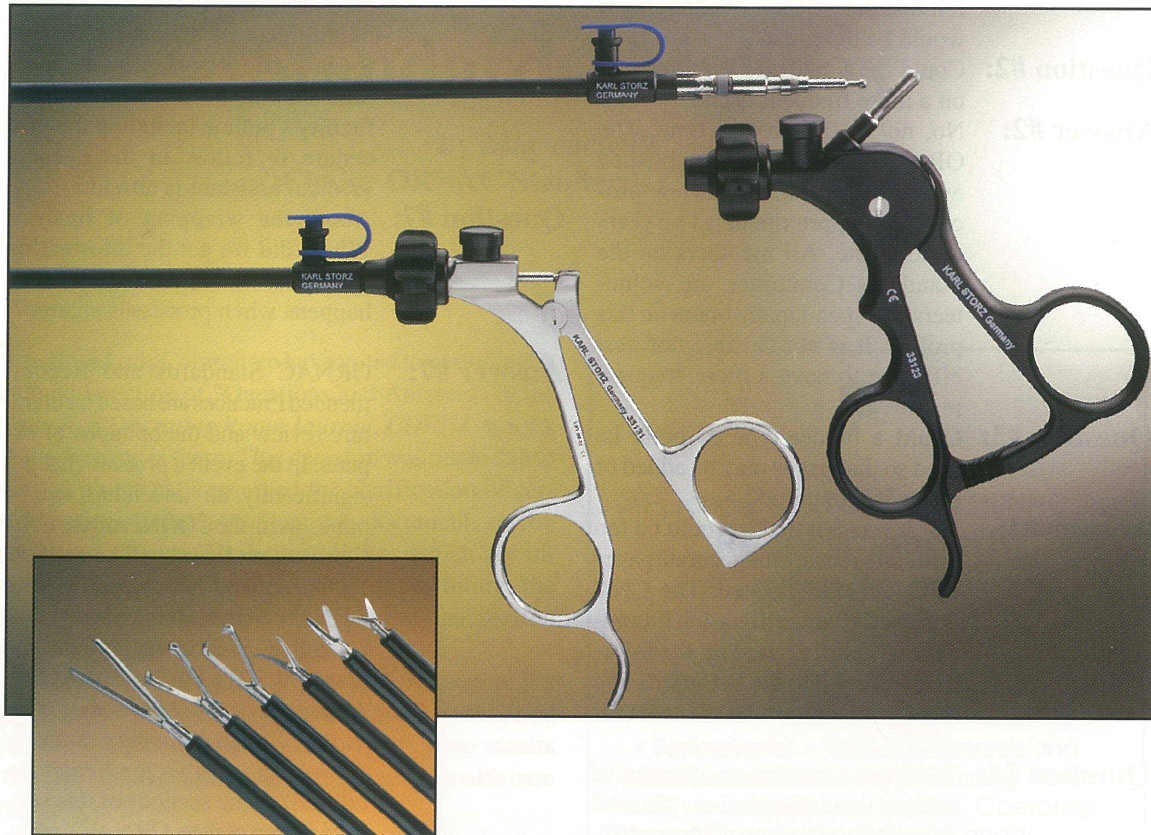

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Parental Presence During Induction: The Role Parents Play Is It Valid ?

By Josephine A. McGann, RN, CPN(C)

Pediatric patients preparing for surgery are exposed to a totally unfamiliar environment. The hospital is a very busy, noisy place. People are continuously coming and going, dressed in unconventional clothing, wearing funny hats and even covering their faces with masks. This creates anxiety and stress for both the pediatric patient and his/her parents. The perioperative nurse has ten to fifteen minutes to assess her patient to determine their stage of development, their emotional and psychological state, their physical needs and lastly their level of anxiety. At the same time she is analyzing how the parent is coping with the fact that their child is headed for surgery and must find some way of reducing their anxiety. Parental presence during induction (PPI) in the operating room can help decrease the stress and anxiety of both the patient and parents. An analysis of the four points mentioned above during the assessment stage, stresses the role parents can play during induction. Is this role a valid one?

A basic understanding of a child's growth and development is necessary to provide care and a safe environment. Noble, Jenks Micheli, Hensley and McKay (1997) define that growth implies changes in size of body as a whole of separate parts. Development describes the differentiation in changes in body function including structural, emotional and social interactions. Personality development is also an added component to the above and seems to be the most widely accepted tool used in pediatric care. Erik Erickson (1950) describes key concepts that an individual strives to master during critical periods of personality development. They are as follows.

Trust versus Mistrust (Birth to one year)

The mother is the primary caregiver and the infant's whole world. As familiarity with mother and other family members strengthens, separation anxiety and stranger anxiety becomes evident and a screaming, clinging infant is usually what a perioperative nurse might expect to encounter (Noble et al, 1997).

Autonomy versus Shame and Doubt (One to three years)

Children are striving to maintain autonomy and increase their ability to control themselves and their environment. Fears of abandonment and separation anxiety are normal. It is important to allow children time to express their concerns and feelings. Parental presence during induction eliminates their fear because there is no separation of parent and child. Instead the parent provides support and encourages co-operation from the child.

Initiative verses Guilt (3 to 5 years)

Children are striving for a sense of independence. Body integrity, with fears of bodily harm and mutilation can become magnified, especially when a child is facing surgery. Information given to the child must be simple, concise and stated in a simple manner.

Industry versus Inferiority (6 to 12 yrs)

Skill acquisition is part of this developmental stage. Making choices is important to this age group.

Author

Josephine A. McGann, RN, CPN(C) is a perioperative nurse at the Oakville-Trafalger Memorial Hospital, Oakville, Ontario.

The perioperative nurse can allow the child to decide such things as walking or riding to the OR. Children in this stage also need to feel that they can complete tasks and the perioperative nurse can support their need to do well. By allowing the child to participate in their OR experience by helping to take off their EMLA creme for example, gives them control. This reduces stress and anxiety levels.

Identity versus Role Confusion (12 to 18 years)

Adolescents are seeking their identity plus coping with emotional and physical changes. Self-consciousness and modesty are evident as the perioperative nurse interacts with the adolescent. Ensuring their sense of privacy as well as conversing in an easy friendly manner, whether answering questions or providing information, will reduce their anxiety markedly.

Emotional state and anxiety seem to go hand in hand. What type is a child displaying? Are they happy, carefree, or quiet and shy? How do the parents seem? Are they interacting in a calm manner with their child or do they seem anxious and stressed? Children are able to sense whether there is tension or calmness in a parent and will react accordingly. Parents, when they send their children off to the OR with the nurse, must be given reassurance that the nurse will take good care of their child and keep them safe. The child must be reassured in the same manner. She must also emphasize that mommy and daddy will be waiting for them once their surgery is complete. This in most cases satisfies both the child and the parents and allows a smoother transition to the operating room. However, remember one of the greatest fears of children undergoing surgery is separation from their parents (LaRosa-Nash, Murphy, Wade, Clasby, 1995).

Physical needs must also be assessed. The nurse must determine if the patient can walk. Obviously, an infant will have to be carried, but a toddler and older child can be given the choice of either walk or ride. A quick visual head-to-toe assessment of the patient is necessary. Special needs should be addressed accordingly. For example, do they have problems with hearing, sight or movement? Can the child speak English or is an interpreter necessary? Do they have something familiar like a favourite toy or special quilt to bring into the operating room?

Once the perioperative nurse completes her full assessment, her plan of care begins to take shape. Information exchange among the nurse, parent and child is critical to ensure all needs are met. After all, the parents are entrusting the care of their child to a perfect stranger. By allowing a parent to accompany their child to the OR, the fears of both the parent and child could be reduced.

A parent provides love, support, and helps soothe and calm their child's fears. No other person or nurse can substitute. The induction of anesthesia in pediatric patients can be one of the most stressful parts of the surgical experience. An induction that does not go smoothly may result in terrifying memories, (LaRosa-Nash et al 1995). If a parent participates during the induction, the role they assume provides strength and reassurance to their child. At the same time, it allows the parent an opportunity to have an active role in their child's care, thereby decreasing their anxiety.

Research in nursing never stops. Hospitals could survey the community they service to determine if parental presence during induction was a need that was not being met. Developing a questionnaire specific for pediatric patients and their families, listening to parent advisory groups and polling their own operating room staff, would be the first step in implementing a PPI program. However, some staff members may feel uncomfortable offering this service, as change is difficult and they may feel they are being observed too closely and their delivery of service critiqued. These issues will need to be addressed in order for the program to move forward.

When this process is completed and the research determines the need exists, how does a PPI program take shape and who implements it? The nurse manager of the OR would form a committee interested in putting a plan together. This committee would decide on everything, from tools necessary to implement an educational program to the number of people it will take to keep the program going. All costs would have to be considered including the cost of extra staff, to the cost of providing appropriate OR attire for parents to wear. A budget would then have to be submitted to Administration for approval. With funding in place and the educational component complete, approval for such a program must go through the Departments of Surgery and Anesthesia. Staff must be given an opportunity for input and an orientation session must be scheduled. Everyone must clearly understand the importance and the value of a PPI program.

See *"Michael's Surgical Experience"* my personal saga of such a program in the next two pages.

"All he wanted was his mommy. I gave him a big hug and assured him that I was not going anywhere."

Michael's Surgical Experience

One day in March I was enjoying my usual day spending time with my three children. David was almost four, Michael had turned two and Janice was just six months old. Michael was just starting to toilet train but still wore a diaper. During one of these diaper changes I was shocked to see that his scrotum had increased to three times its normal size.

Immediately I called our family doctor and he saw us that day. When we arrived I explained what I had observed and that I was worried it might be something serious. We unpinned the diaper for a look, and his scrotum was back to a normal size. Had I imagined it?

The doctor reassured me that from my description Michael had a hydrocele on the left side and I had several choices: leave it alone; do something about it now; or, wait until he was a little older, as it really posed no threat. None of these choices really appealed. I just wanted the problem to go away.

Following a discussion of the choices with my husband, we both agreed that now was the best time to take care of it.

I wanted to comfort and support him after his surgery

One of the first things I did was call our local hospital. We were living in Sarnia at that time. I wanted to find out what sort of programs they had in place to care for my child. I wanted to stay with Michael over night, post-operatively to comfort and support him after surgery, and I was shocked to discover the hospital did not allow parents to help care for their own child. They made me feel like I was asking for the world. Clearly this was not the place for my son to have surgery, but what was my alternative?

Fortunately, we have a good family friend, a doctor, whom we called for advice. He lives in Hamilton, Ontario, and we lived a two-hour drive away. He sensed I was worried and suggested that the surgery could be done in Hamilton. I asked him to please recommend a doctor to whom he would send his own child. He did, and the consultation appointment was made for two months later.

We were sent to a pediatric urologist who had a calm, easy-going manner and I immediately felt comfortable with him. The diagnosis indeed was correct and if we chose to proceed the surgery would be booked for August. The idea of travelling to Hamilton for a simple surgery seemed ridiculous, but what helped make our decision was the fact that the Health Sciences Centre encouraged parents to care for their child during the surgical experience. By chance I learned that they even allowed parents into the operating room. I was intrigued and thought once I arrived for my son's surgery I could find out a little more about this program.

In those days patients were admitted the night before. On August 12 we arrived at the paediatric surgical floor. A nurse took us to a semi-private room which we could call home for a time. The room was like many hospital rooms, and next to Michael's bed was a cot waiting for me. It was all very stressful and overwhelming but we knew this needed to be done. We had a few hours to relax and unwind before the final pre-op assessment. The staff was extremely helpful and friendly which confirmed that we had made the right decision.

During dinner, both the surgeon and anesthetist arrived to check on Michael and answer any questions I might have. At this point, I mentioned that I had heard parents were allowed into the OR and if this was true could I please go with Michael? Since they were not aware that I was interested in accompanying Michael into the OR, they were not prepared

to support my request, and I was devastated. This was the main reason I had chosen to come to Hamilton and McMaster Health Sciences Centre. I then informed them that I was a perioperative nurse and assured them that I was very familiar with an operating room and knew what to expect. Michael's chart was then flagged indicating that a parent would accompany him. Michael settled down for a quiet night without a care in the world. I had a restless night's sleep.

Michael's surgery was scheduled for 11:00 am. Unfortunately, the OR was running two hours late. My two-year old was starting to get cranky and complained of hunger and I was becoming more anxious. Finally they called for us and Michael was getting his long ride. When we arrived in the OR, the circulating nurse greeted us. She introduced herself and the volunteer that would take care of me. I explained to Michael that I had to get dressed in special clothes to go with him and that I would be right back. When this was done, we were ready.

A Mickey Mouse screen hid the set-up

As we rolled down to the room Michael was starting to become frightened. He did not know where he was going but I reassured him that I was going with. When we arrived in the room the only things really noticeable were the bed, the anesthetic machine and a huge Mickey Mouse screen. Behind the screen, the scrub and one of the circulating nurses were setting up and doing the count. I was very impressed that they were so thoughtful and felt it was a clever way to disguise the purpose of the room. The other circulating nurse was helping me with Michael and introducing me to the anesthetist and the resident, whom I had met the day before. Michael was very co-operative and allowed me to help the nurse place his monitors. All was ready and they then asked me if I was. With the feeling of fight or flight, I helped Michael place the mask over his face and the anesthetist spoke in a very soothing manner. He started to tell Michael a fairy tale. I almost lost my composure. Michael was at the point of fighting the mask and the anesthetist. He clearly did not like this environment and was starting to scream. I reassured him that everything was fine and that I would see him soon. With some help from the nurse, I had to gently restrain him while the anesthetist kept telling his story. Finally, he was asleep. Tears were rolling down my cheeks and I was grateful that I was wearing a mask.

Tears are a release for me when facing an overwhelming situation and this definitely met the criteria. I thanked the anesthetist and told him how much I appreciated his technique. I also thanked the rest of the OR crew and was then escorted by the volunteer. She helped me calm myself and pointed out the PACU entrance, then took me back to the change-room. I had two hours to wait before I could see Michael again.

Michael was screaming !

Two hours could not go by quickly enough. Finally, I was being called into the PACU. Michael was screaming! The nurse quickly introduced herself, assured me all went well and told me she had just given Michael something for pain. All he wanted was his mommy. I gave him a big hug and assured him that I was not going anywhere. The nurse said that I could pick him up and snuggle with him in a big cozy rocking chair placed by his crib. He was immediately quiet, calm and asleep within minutes. It was a wonderful feeling knowing we had overcome the biggest hurdle. Post-op management was on my mind but I decided I would worry about that later. It was quiet in PACU because it was late in the day and the other patients had been sent back to their floors. I settled in for the next hour or more and had a pleasant conversation with the nurse about nursing, what else?

We were back in our room in no time it seemed. Michael had been checked a few times to see if all was well and it was. We put on his own pajamas and spent some quiet time. The doctor came and spoke to me, assuring me that all went well and asked if I had any questions. My only comment was that he seemed to be pain free and that surprised me. He explained that he had given Michael a block before leaving the OR, which had a prolonged effect. I then thanked him and mentioned that our whole experience had been a very positive one. I also stated that allowing parents into the OR, as well as participating in their care was a tremendous privilege. As the evening progressed, Michael still showed no signs of discomfort. I was amazed! It was as though nothing had happened. We settled down to a good night's rest looking forward to going home the next day.

Morning came quickly. A final check was done and Michael and I were free to go. We said our goodbyes and off we went to Sarnia. I could not get on the road fast enough. It had been a stressful three days and I just wanted to get Michael back home and see the rest of my family.

When we arrived, my husband was surprised that Michael was running around as usual and asked me if I was sure he had surgery? "Yes" I said, "I was there."

Parental Presence During Induction

(continued from page 2)

From the moment a child steps through hospital doors, many disciplines are involved with their care. Therefore, an on-going program must be designed to include and explain the roles of all personnel that will be involved. The goal is to educate and prepare the pediatric patient and the family, ensuring their surgical experience will be a positive one.

A hospital tour would create a valuable tool in educating patients and parents. It would also provide an opportunity for staff to assess the best way to help parents and children assume their upcoming roles in the OR. Developing teaching methods such as a videotape, photographs, pamphlets, coloring books etc., will all contribute to educating both the child and parents. A hands-on approach is also encouraged. This provides an opportunity to see and feel what an intravenous needle looks and feels like, what an anesthetic mask looks and feels like, what they will wear and what mommy or daddy will wear. If a child is given the information he or she needs, they feel as though they have some control.

Most parents are eager to participate

Once the surgical date is confirmed the parent and child need to complete their preoperative assessment. A physical examination must be conducted, consent obtained and tests done. Usually this is completed by the child's family physician. A visit to the preoperative assessment clinic is scheduled for a few days prior to surgery. The chart is assembled and checked to ensure all necessary information is included. A team of specialists, determined by the program that is established could be available to speak to the parent and child. This team of individuals may include a perioperative nurse, a pediatric nurse, a child life worker and finally the anesthetist. He/she takes the opportunity at this time to meet the child and parent to explain what type of anesthesia will be provided and answer any questions the child or parent may have. It should emphasized that the parent can touch and talk quietly to their child during induction, which helps to provide encouragement and support, (Zelikovsky, 1996). Questions parents need to have answered are: what to expect as a child progresses through anesthesia, a brief description of the OR equipment, monitors and personnel in the room, and what happens if an emergency situation occurs? (Halverson Carpenter, 1998).

Most parents are eager to participate in their child's surgery. Some however choose not to, as they find it too stressful and perhaps feel their child may not benefit from their presence. At this point, the child and parent will be assessed by the perioperative nurse, as to their suitability as candidates for participation in the PPI program. Not all children or parents for that matter are good candidates for PPI. Children who are overly frightened or anxious, may have difficulty cooperating, even if parents are present. In addition, a child with a tenuous airway or past anaesthetic problem may most likely need pre-operative medication. If this is necessary, an explanation would be given and the appropriate medication administered in the presence of the parent. The parent should appear to cope with their role. If a parent is angry, hostile, or emotionally overwhelmed, they will have difficulty providing support for their child. Some parents may not wish to participate in the induction for reasons such as queasiness, fear of the unknown or feelings of stress. Whatever the decision, the nurse must support the parents' choice, (LaRosa-Nash, Murphy, 1996).

If a child refuses to cooperate, a back-up plan can be used

When the parent and child arrive in the operating room, the personnel present should be introduced and a brief description of the equipment serves as an orientation to the environment. The child is asked to lie down on the bed and given a nice warm blanket. As monitors are positioned, their function should be explained. If the child refuses to cooperate with the placement of the monitors, the anesthetist may delay this step until the patient is asleep. Mask induction is usually the anesthetist's first choice. However, if the child refuses to cooperate, a back-up plan of giving an intramuscular injection, which provides total sedation within two minutes, will be used. The time of initial administration of anesthetic agents to the loss of consciousness is considered the first stage of anesthesia and usually takes less than ten minutes As the child loses consciousness he or she experiences complete amnesia, analgesia, and sedation(LaRosa Nash, Murphy, 1997). The parent may notice changes in the appearance of the child's eyes and involuntary movements of extremities. The perioperative nurse must provide reassurance that this is normal and it may even be necessary to gently restrain their child to prevent injury. At this point, the risks of clinically significant reflex activity such as vomiting, arrythmias, and laryngospasm increase (LaRosa Nash,

Murphy, 1997). A pediatric airway differs from the adult airway because of its size and positioning, causing it to obstruct more easily. If these problems should occur, it would be considered an emergency situation and therefore, the parent would be escorted out of the OR back to the waiting area by a designated person, for example, an OR volunteer. The perioperative nurse must stress that these emergency situations can occur, but will be brought under control immediately.

Numerous hospitals have implemented a PPI program

Numerous hospitals throughout the United States and a few in Canada have implemented a PPI program and have recognized parents as active participants in the care of their child. Researchers have documented that parental presence facilitates smoother anesthesia induction and decreases the use of pre-medication. Questionnaires developed by various hospitals discovered that parents expressed great satisfaction at being present with their children during anesthesia induction and in the PACU. Having clear explanations given to them and their children, experiencing the care and concern of staff members and having interactions with the anesthesia care provider were all reported as positive experiences.

Nursing staff members and physicians also completed evaluations stating that the presence of parents posed no danger and helped with the children during anesthesia induction, (Blesch, Fisher, 1996).

The greatest moment of anxiety for the parent and child is when the child is taken away from the parent, in the OR corridor, (Halverson Carpenter, 1998). Because of pressure from parent groups and special committees, parents have been granted their basic right to provide their children with physical and emotional support, (Zelikovski, 1996). Parental support during a child's hospital stay seems quite natural today. Therefore, perioperative nursing practice must move with the times and face the challenge a PPI program implementation would present. Children rely on their parents for support and guidance. It has been demonstrated that a PPI program eliminates the need for pre-operative medication thereby, shortening the recovery period. The program eliminates separation anxiety, since the parent remains with the child. For the child PPI promotes cooperation, a quiet calm manner and control of their surgical experience. The advantages of PPI are a significant reduction of stress and anxiety and an increase in self confidence. Studies indicate that parents are willing to help their child and cooperate with staff given the appropriate education and tools.

Do parents play a significant role in the operating room? Yes, I was there! ■

References

Blesch, P., Fisher, M. L. (1996) The Impact of Parental Presence on Parental Anxiety and Satisfaction. *AORN Journal,* Vol. 36, No.4, pp. 61-768

Erikson, E. H. (1950) Childhood and Society. *Psychology Today, An Introduction* (3rd.ed.) New York: Random House, Inc. pp. 418-419

Halverson Carpenter, K. (1998) Developing a pediatric patient/parent hospital preparation program. *AORN Journal,* Vol. 67, No.5, pp. 1042-1046

Howe, J. (1975) Principles and Theories of Child Development. *Comprehensive Pediatric Nursing,* New York: McGraw-Hill, Inc. pp. 69-85

LaRosa-Nash, P. A., Murphy, J. M., Wade, L. A. Clasby, L. L. (1995) Implementing a Parent-Present Induction Program. *AORN Journal, Vol.* 61, No.3, pp. 526-531

LaRosa-Nash P. A., Murphy, J. M., (1996) A Clinical Case Study: Parent-Present Induction of Anesthesia in Children. *Pediatric Nursing,* Vol. 22, No.2, pp. 109-111

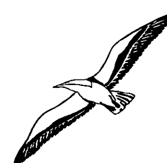
LaRosa-Nash P.A., Murphy, J. M., (1997) An Approach To Pediatric Perioperative Care - Parent-Present Induction. *Nursing Clinics of North America,* Vol. 32, No. 1, pp. 183-199

McGraw, T. (1994) Preparing children for the operating room: psychological issues. *(Canadian Journal Anaesthesia,* 41:11, pp. 1094-1103

Noble, R. R., Jenks Micheli, A., Hensley, M. A., McKay, N. (1997) Perioperative Consideration For The Pediatric Patient - A Developmental Approach. *Nursing (Clinic) of North America,* Vol. 32, No. 1.

Vessey, J. A., Bogetz, M. S., Caserza, C. L., Liu, K. R., Cassidy, M. D. (1994) Parental upset associated with participation in induction of anaesthesia in children. *Canadian Journal of Anaesthesia,* 41:4, pp. 276-280

Zelikovsky, N. (1996) Parental Participation During Induction Stage of Children's Anesthetic Procedures in Israel. *Seminars in Perioperative Nursing,* Vol. 5, No.4, pp. 213-217



Operating Room Nurses Association of Canada

16th National Conference

World Trade & Convention Centre
Halifax, NS
June 14 - 18, 1999

Delegate Registration Planning Committee: ☐ Hostess: ☐ ORNAC Board: ☐ ORNAC Executive: ☐

First Name: ____ Last Name: ____
Address: ____ City: ____ Province: ____
Postal Code: ____ Telephone No. ( ) ____ Fax ( ) ____
Hospital Name: ____
Hospital Address: ____ City: ____ Province: ____
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Professional Information: ☐ ORNAC Member ☐ RN ☐ ORT ☐ Other
(Please check one and include a photocopy of Provincial RN registration & Provincial Operating Room Association membership)

Conference Events (Please check off each event you will be participating in:)

Day Sessions		☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri
Evening Activities	☐ Sun Welcome reception	☐ Mon Maxxim Night	☐ Tues Ceilidh Night	☐ Wed Fashion Show	☐ Thurs Pub Crawl	
Guest Tickets (limited number)			☐ Tues Ceilidh Night	☐ Wed Fashion Show	☐ Thurs Pub Crawl	

Ceilidh Night menu is **lobster!** Please check the box if you require an alternative main course. ☐

Registration Fees:

	ORNAC member	Non Member	Guest Tickets
5 Day conference, Ceilidh Night & Fashion Show	395	500	n/a
Welcome Reception, June 13, 1999	n/c	n/c	n/a
Maxxim Night, June 14, 1999	n/c	n/c	n/a
One Day Session Rate	85	100	n/a
Ceilidh Night (included in 5 day rate) June 15, 1999	75	75	75
Fashion Show, June 16, 1999	20	20	20
Pub Crawl, June 17, 1999	20	20	20

Total Fee Submitted: $____ Payment method: ☐ Cheque ☐ American Express ☐ Visa
(A $3.00 fee to offset credit card processing charges will be levied)

Card No. ____ Expiry Date ____ Cardholder Signature ____

Make Cheque payable to **16th National ORNAC Conference** and send
c/o **Alberte LeBlanc, CMP, Compart Event Management Limited** - 5511 Stairs Place, Halifax, NS B3K 2C7
Tel: (902) 454-4714 Toll Free: 1-877-313-0333 Fax: (902) 454-4930 Email: compart@ns.sympatico.ca

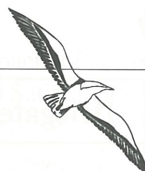
Payment Must Accompany Registration

Refund Policy - After May 21, 1999 an administrative charge of $25.00 will be withheld in the event of a cancellation.
Confirmation of registration will not be issued, receipts will be issued in delegate packages.

(Cut or Copy this **Registration Form** and mail soon !

Cresting the Wave

16th National
O.R.N.A.C. Conference
World Trade & Convention Centre
June 14 - 18, 1999
Halifax, Nova Scotia



Conference Objective

The conference will provide an opportunity for perioperative nurses to celebrate our collective endeavors, to recognize the challenges that lie ahead and to chart our future.

Exhibitors: The support of our Exhibitors is valued and appreciated. For more information, please contact: Shelley Zareski, PO Box 36045 Halifax, NS B3J 3S9 Tel: (902) 428-8304 Fax: (902) 420-6477

Topics include but are not limited to the following:

- Sailing Into the Millennium:
  - New Waters - New Realities
- The Cost-Effectiveness of the RN
- Ethical Issues in Perioperative Nursing
- Multiple Resistant Organisms - Are Universal Precautions Enough
- Anesthesia Care of the Trauma Patient
- Woman to Woman
- Informatics in the OR
- Tearing Down the Walls Between the OR and SPD

Special Features

Sunday Historical Walking Tour - Downtown Halifax.
Welcome reception/cocktail party
John Alphonse Quartet

Monday Maxxim Night !!

Tuesday "Maritime Ceildhi" Lobster Dinner

Wednesday "Nurses Night Out"
Buddy Wasis Name & the Other Fellers - Spring Garden Merchant's Fasion show.

Thursday Free afternoon & evening

May we suggest: Shopping, tours, Peggy's Cove, Boat Cruise, Pub Tour. (Additional cost for some tours.)

***Friday afternoon and Saturday June 18 & 19, '99**
Learning and Networking Opportunity for OR Leaders sponsored by ORNAC Past Presidents. Contact:
Pat Pocock @ (519) 646-6100 (Ph) Fax (519) 646-6006

Speakers

Senator Lucie Pepin - our keynote speaker, a nurse and political activist involved in women's and children's health care issues.

Dr. Nuala Kenny - a pediatrician and nationally recognized Bioethics Specialist.

Dr. Roberta Bondar - our closing speaker, an astronaut, neurologist and researcher. She will discuss goal setting and environmental issues.

Dr. Tim Porter-O'Grady - a nurse and international health care consultant will discuss leadership issues and constructing a vision for the futue.

Dr. Judith Briles - a nationally recognized management consultant, specializing in women's workplace issues.

Other confirmed speakers include

Dr. Judith Shamian, VP of Nursing and **Dr. Joan Donald**, Associate Director of Perioperative Services, Mount Sinai Hospital, Toronto. **Lorna Murphy** - Clinical Services Specialist, Steris Corporation. **Sharon Ball** & **Karen Meadwell**, Nurse Educators. **Margaret Fullerton** - Nurse Consultant, Allegiance. **Dr. John Butt** - Forensic Pathologist and **Dr. Michael Murphy** - Emergency Room Physician

Registration Information

See **Registration Form** opposite page

Information also available www.ornac.ca

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See us June 14-16, 1999 at
National O.R.N.A.C. Conference, booths 213 & 215

Hotel Information - 16th National ORNAC Conference

Guest rooms have been blocked at the four hotels which are linked to the World Trade and Convention Centre by pedway, underground walkway or both. The Sheraton Halifax Hotel will be the Host Hotel, and though it is the furthest from the World Trade Centre (see map), it is a distance of only three blocks. The Sheraton will also be where the majority of social functions will take place.

All guest room rates are subject to HST (Harmonized Sales Tax of 15%)

When booking rooms, please mention that you will be attending the ORNAC Conference so that you will receive the conference rate.

The deadline date for booking guest rooms at all of the hotels is May 5, 1999. Any bookings after that date will be subject to the current room rates.

Sheraton Halifax Hotel
1919 Upper Water Street
Halifax, NS B3J 3J5
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(902) 422-5805 Fax
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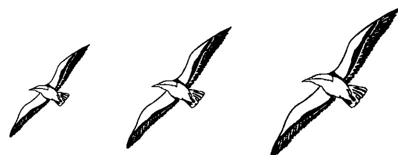

Hotel Halifax
C.P. Hotel
1990 Barrington St.
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(902) 425-6214 Fax
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1-800-565-1263
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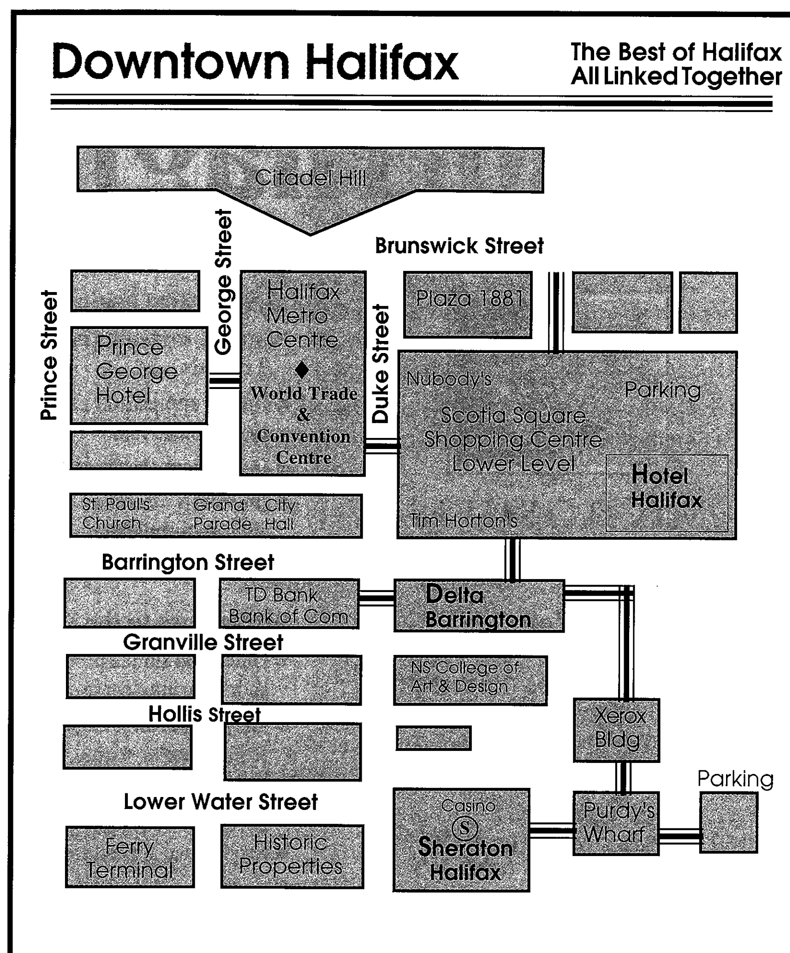
$145 Jr Suite, Single
Double incl. Continental breakfast



Conference Calendar

June 14 - 18, 1999
16th National ORNAC Conference-Halifax '99 Sheraton Hotel & World Trade and Convention Centre, Halifax, Nova Scotia. Chairperson Donna Farid, President of the ORNAC. Sharon Green, Program Chair. Program & Registration Form **page 15**

July 25-30, 1999
World OR Conference. Helsinki, Finland. for more information see **page 31.**

April 20-27, 2001
17th ORNAC Conference - Banff, Alberta. Conference Chairperson- Gloria Nemecek.

WWW for OR nurses

ORNAC Online http://www.ornac.ca
The Operating Room Nurses Association of Canada (ORNAC) has a web site which provides varied information on perioperative nursing in Canada. Members of ORNAC are working continuously on this website to improve it. Through this site you can access several other nursing sites and keep up to date on what is happening in Canada.

AORN ONLINE http://www.aorn.com
This website provides access to the American OR journal, reference library, and current events affecting nurses in the USA.

Overheard in the OR ...

"I try to take one day at a time, but sometimes several days attack me at once."
Anonymous

$7.9 million funding for 26 breast cancer projects

The Canadian Breast Cancer Research Initiative (CBCRI) announcement of $7.9 million funding for 26 breast cancer projects across the country is applauded by the Canadian Cancer Society (CCS) and its research partner the National Cancer Institute of Canada (NCIC). These two organizations are founding and funding members of the CBCRI.

"The CSS and NCIC led the drive to form a partnershp with the federal government to create the CBCRI because we knew we could do more to beat this disease by working collectively,: says Maaike Asselbergs, Exectuvie Director, CCS. "Breast Cancer takes a high toll on Canadian women. In 1998, approximately 19,000 women were diagnosed with the disease and more than 5,000 died from it. Research will help fund more much-needed answers about this disease.

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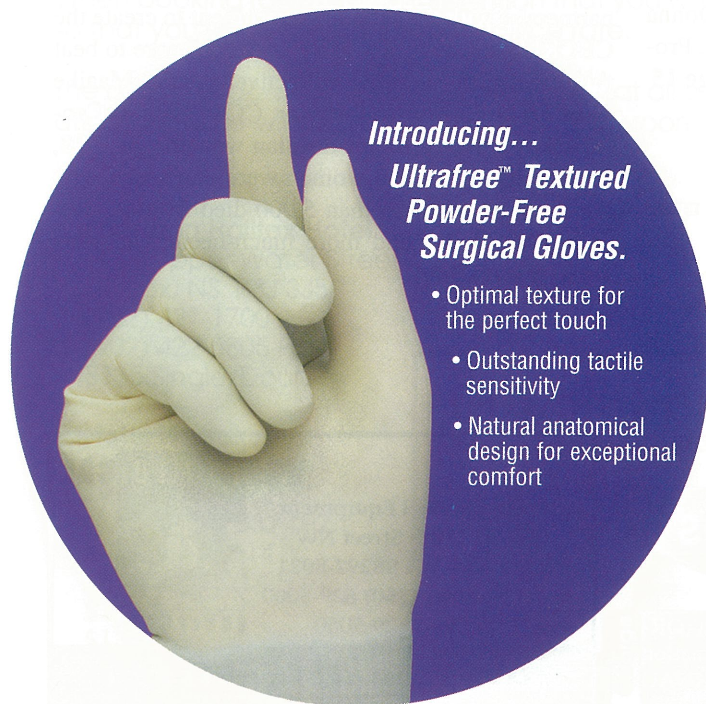

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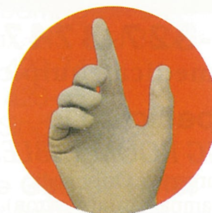
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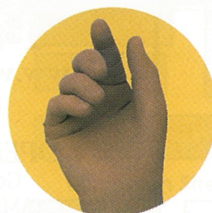
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Intraoperative Progress Reports to Families of Surgical Clients: A Missed Opportunity

By Rose Puopolo, RN, BA, CPN(C), and Julie Cordasco, RN, CPN(C)

Leske (1992) reported that family members feel left out during the intraoperative period. Nurses observe clients, as well as families, exhibiting feelings of fear, tension, irritability, anger, powerlessness, and a sense of timelessness. Ironically, during this time perioperative nurses may have little meaningful contact with the family members as they endlessly wait. Perioperative nurses can effect positive outcomes for the family (and for the health care professional) in a family-centred care environment by providing psychological support in the development of caring, respectful and trusting relationships, and by decreasing physical stress and anxiety through intraoperative communication with the family.

Abstract

The wait while a family member or loved one is undergoing surgery is stressful and anxiety-producing. Perioperative nursing contact during this period can result in positive outcomes of decreased anxiety, increased receptivity to post-operative information, and increased awareness of the professional practice. Perioperative nurses have the skills and the opportunity to provide progress reports to the client's family, at least once during surgery. Characteristics important to this role include motivation and commitment to be informative; caring; sensitivity and perceptivity; sense of humour; and education. Possible barriers to intraoperative communications include various lacks - of time; attention (related to monitoring requirements in the operating room); support from management, peers, and doctors; and therapeutic communication skills to alleviate anxiety. Progress reports to the family can decrease their physical stress and add to their satisfaction with the hospital.

Why

O'Connell (1989) stated two reasons why intraoperative communications by perioperative nurses should be encouraged: hospitalization and surgery are stressful events for the family; and serious illness can precipitate a crisis in the family system. She also found that the parents of children in surgery verbalized the most anxiety. The family systems perspective regards the individual in the context of his or her relationships and environments, and not in isolation (Becvar & Becvar, 1982). Family system theorists have also noted that family members become extremely sensitized to one another's behaviours and that the family system influences the course of chronic illness or conditions (Frederickson, 1989). Thus, the perioperative nurse should examine the family in the context of how coping with the surgery affects each member.

One such effect is a response to stress: the family becomes increasingly anxious. An emotional reaction that occurs in response to stressful situations, anxiety is subjectively characterized as tension, apprehension and nervousness (Donnell, 1989). In addition, anxiety results in increased activity in the autonomic nervous system. The intense feelings of fear

Authors

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Julie Cordasco, RN, CPN(C), is a Staff Nurse, likewise in POCU at The Hospital for Sick Children. This article is adapted from their presentation at the April, 1998 Operating Room Nurses Association of Ontario Conference, Niagara Falls, ON. Correspondence can be directed to: PH: (416)813-6358. Fax: (416)813-6636. E-mail rosepuopolo@mailhub.sickkids.on.ca

and flight associated with panic behaviour lead to even higher levels of anxiety, which can be seen physiologically as rapid pulse, usually associated with palpitation, rapid respiration, diaphoresis, dry mouth, dilated pupils and clammy skin (O'Connell, 1989; Atkinson & Kohn, 1986). For many years, in perioperative nursing the concern with stress has been exclusively that in clients: how to identify it, and strategies to alleviate it. Providing information to all family members should be an important goal in all models of nursing, including perioperative nursing.

Involving families in client care by sharing information with them has been found to increase client cooperation and promote client adjustment to illness (Leske 1996). Daley (1984) and Kathol (1984) both found information to be one of the principal needs expressed by families coping with illness, and that it helped alleviate anxiety and stress. She has also noted that after intraoperative communications, families reported that they felt reassured, an increased sense of control, and increased appreciation of the caring they received (Leske 1992).

To reduce a family's anxiety, the perioperative nurse can give information to family members during surgery and prepare them for more positive interactions with the client - for example, a child - during the recovery period. The child is empowered by this assistance and will, in turn, be able to direct more energy toward healing and recovery (O'Connell, 1989). Thus, the nurse is contributing to the family's well-being by being there for their child, which is important because currently, clients are being discharged "sicker and sooner". Reducing anxiety will enable family members to understand instructions and positively affect patient outcomes (Leske, 1992).

Another reason why intraoperative communications should be encouraged among perioperative nursing is that (as the philosophy of nursing at The Hospital for Sick Children states) it is the child's right to expect family-centred care. This reason has two aspects. First, only the family knows the child best and can deliver holistic care; whereas, the nurse must first build a trusting relationship with the child and family.

Second, because of the recent economic restraints, hospitals depend on parents to effectively care for their children. By keeping families well informed through intraoperative communications, nurses are cementing this pivotal, trusting relationship between the family and the health care institution. In the consumer-oriented climate of current health care, perioperative nursing intervention may make a difference in the family's satisfaction with the health care institution.

The third reason why intraoperative communications should be encouraged among perioperative nursing is because of our core values. The Hospital for Sick Children Nursing Mission Statement defines them as caring, collaboration, respect, lifelong learning and advocacy.

Caring involves an interpersonal process in which one values the child's and family's comprehensive needs and diverse perspectives about the perioperative experience by providing a support mechanism for families under stress. Collaboration brings perioperative nurses to new frontiers as they involve families more frequently in caring for their children during the perioperative experience. Perioperative nursing can demonstrate mutual respect with children and their families through effective therapeutic communication during the intraoperative experience. Life-long learning is the foundation for professional and personal growth; it is essential to the improvement of nursing care. Implementing intraoperative communications as a research-based nursing practice contributes to this core value. Advocacy for the perioperative nurse includes the ability to influence health care policy, practice and outcomes by working in partnership with clients' families, other health care professionals, and the health institution in implementing intraoperative communications with families of surgical clients.

By embracing the core values of caring, collaboration respect, life-long learning and advocacy, perioperative nurses highlight their knowledge, skill and judgment in promoting holistic health care for the surgical client and their family. The final reason why intraoperative communications should be encouraged in perioperative nursing is the potential benefits of the personal experience to nurses. McNamara's (1995) study cited self-satisfaction, a sense of collegiality, a sense of developing as a whole person, having their personal philosophy reinforced, making the day enjoyable and fun, and validation of career choice as significant reasons why perioperative nurses embraced intraoperative communications.

Who

When a client is undergoing a surgical procedure, family and friends spend hours wondering, worrying, and imagining the worst. Few hospitals can afford to have surgical nurse liaisons or coordinators take vital information from the operating room to the waiting family; however, it is within the professional role of the perioperative nurse to embrace the challenges of intraoperative communications.

Perioperative nurses have extensive, specialized technological knowledge of the anatomy and physiology of surgical intervention, which enables them to interpret complex medical terminology into layman's terms. They also have the theory-based critical judgment and intellectual skills to apply a humanistic approach to their responsibilities as client advocates, to offer families health promotion through emotional support in a constantly changing environment.

How

Leske (1992) found intraoperative communications to be an independent perioperative nursing intervention beneficial in reducing anxiety in family members during the perioperative experience. The study demonstrated that family members who received in-person intraoperative communication were significantly less anxious than those receiving no intervention or attention.

If a perioperative nurse cannot leave the operating room for an intraoperative visit to the families, then a telephone call is the next-best alternative. Leske's (1996) later study of the effectiveness of providing information to clients' family members through telephone calls versus in-person visits suggested that family members who receive telephone calls report less anxiety than those who do not receive this nursing intervention.

When

Much evidence supports the premise that contact with the family during a surgery reduces their anxiety; therefore, a brief, simple, and limited nursing intervention of intraoperative communications should be done for every client's family. During long major surgical interventions (longer than 2 hours) or difficult cases, family members should receive intraoperative communications more frequently. With periodic nursing reports from surgery, bad news at the conclusion of the surgery does not arrive completely unexpected. Craig and associates (1986) found that families who have had to prepare themselves for an untoward change of a loved one's condition are better able to hear and understand the surgeon's explanation of the surgery afterwards, and therefore are less stressed.

What

Information-giving consists of a number of interactions between the perioperative nurse and family (O'Connell, 1989). The first takes place when the family and child arrive in the operating room (OR) waiting area. Here, it is extremely important that a trusting relationship commences between the family, child, and perioperative nurse.

Alert the parents that you will visit intraoperatively in the surgical waiting room and the approximate time. When visiting the family, project a positive body language; for example, smile to communicate that something has not gone wrong with surgery. Here is a possible outline of an intraoperative communication:

> *Hi, I was just relieved by another nurse and I thought I would come to let you know that Danielle is fine and surgery is underway. Danielle accepted the mask very well. She was very cooperative while we put on the monitors. She asked very appropriate questions while we were preparing her for the "special sleep", such as when she would see you. I reassured her, as you did, that you will see her in the "wake-up room". I told her she will feel tired and still sleepy after the operation, but that you would be there. She really likes her Elmo doll and fell asleep holding it the whole time. I'll put Elmo on her bed for her to have once she is awake. Overall, I feel it was a positive experience for her. Do you have any questions that I might be able to answer at this time? ....It was nice to have met you.*

Additional information communicated to family members in the surgical waiting area can include the anticipated length of surgery; the approximate time before the child will be transferred from the OR to the post-anaesthesia care unit (PACU); the arrangements that have been made by the surgeon to contact the parents/family; the hospital vicinity, such as where to get a cup of coffee; and the perioperative nurse's plan to update the family on the child's status (O'Connell, 1989).

Characteristics Needed

Perceived nursing behaviour makes a lasting impression, which clients tend to associate with their perioperative experience. The perioperative nurse can reveal self-confidence (or lack of it), regard (or apathy), expertise and authority (or ineptitude). Furthermore, perioperative nursing characteristics must

express motivation and commitment, caring, sensitivity and perception, sense of humour and education, to inspire confidence, trust and honesty in clients and their families.

As a helping profession, nursing's ideal characteristics include motivation and commitment to be informative and sincere in responding to clients having surgical interventions and their families. Perioperative nurses should share intraoperative information for the mutual benefit of clients and their families, since shared information and forewarning can avert problems. By dealing with client's families honestly and factually, control and trust are enhanced by knowledge about their loved one.

The roots of the concept of caring can be traced to nursing's beginnings, and today remain the essence and focus of nursing practice (Killen, 1996). Although caring is the single most important characteristic that nurses are known for, caring can also be painful because it leaves one vulnerable. To insulate themselves against anxiety, suffering or even death, perioperative nurses sometimes lose their ability to intraoperatively interact with clients' families. The perioperative nurse's analysis of her own feelings ensures a more genuine response to the anxious family in the form of understanding, reassurance and support, as communicated by the caring (Watson, 1994).

Another characteristic of perioperative nursing is that they are sensitive and perceptive. Perceptive nurses exhibit a genuine interest and kindness in holistically caring for the surgical client and in looking after them and letting them know that they mean something to them. Perioperative nurses need to extend their sensitivity to anxious families by incorporating intraoperative communications into their everyday role.

Another characteristic of the perioperative nurse is the need for humor. A study done in Toronto (McNamara, 1995) found that perioperative nurses listed having a sense of humor as an important component of illustrating their caring to surgical clients and families.

Education, too, is important for perioperative nurses because a person with quality education approaches challenges creatively and with confidence that solutions to the barriers of intraoperative communications can be found.

Barriers to Communications

In two separate studies, McNamara (1995) and Frederickson (1989) illustrated the concept of caring as being central to perioperative nursing and described how caring has come to be regarded as a science and a philosophy. However, as nursing moves to establish caring as a central activity as well as an attitude of effective and skilled perioperative practice, it is faced with many barriers to implementation of new interventions. This can also be true with intraoperative communications between nursing and families. While some barriers perioperative nurses face today are extrinsic, dominated by the current crisis in health care, other barriers are intrinsic, entrenched in its patriarchal roots.

Extrinsic barriers to intraoperative communications: With the economic restraint predominant in health care today, nursing has been asked to accomplish more, with diminished resources. One extrinsic barrier defined by a study from Johnson and Frank (1995) states that nursing failed to communicate intraoperatively with families because of perceived lack of time, their priority being patient care. Yet the study supported their hypothesis that even a telephone intervention lasting less than 5 minutes (and more often less than a minute) could be as much as 80% effective in reducing the anxiety of family members.

A second extrinsic barrier impeding intraoperative communications between nurses and families is having functional working equipment in the operating room. McNamara's (1995) study discovered that during surgery, nurses were occupied with highly technical machines and participating in technical procedures that required constant assessment and evaluation of their effects on patients. Likewise, Killen (1996) states, "Technology often forces us to focus on the disease rather than on the person with the disease." Therefore, as personnel decreases because of streamlining by institutions, perioperative nurses can become so involved with the technology that the client and family's identities may be overlooked.

The final extrinsic barrier is having management support. Leske (1992) found that current patient-centred intraoperative practices were woven into traditional hospital policies that neither questioned the purpose of isolating family members nor documented any need for it through research. McNamara (1995) also found that one of the barriers to intraoperative communications was lack of support from colleagues and management.

Intrinsic barriers to intraoperative communications: In McNamara's (1995) study, the caring practices of perioperative nursing illustrated that an intrinsic barrier to new interventions included criticism by peers. Having no support from colleagues meant that it was harder for perioperative nurses to assume new responsibilities. In a study by Johnson and Frank (1995), nurses did not see the intervention of communicating with families as part of their role but rather that of someone with greater interpersonal communication skills, such as a clinical nurse specialist.

Another intrinsic barrier to intraoperative communications between nurses and families is physician-nurse conflict. Craig and associates (1986) stated that nurses' desire to communicate with families of surgical cardiac patients intraoperatively met initial reluctance. Doctors were concerned that what nurses said could possibly have consequences later. But after early positive feedback about the communication between nurses and the families, other disciplines besides cardiac surgery asked to be included in the program.

Yet another intrinsic barrier among perioperative nurses is a lack of therapeutic communication skills to help alleviate anxiety. The perioperative nurse has a very limited preoperative period in which to establish a trusting relationship with the client and family. Sometimes, because of the nature or urgency of the surgery, time to establish a caring relationship through communications is restricted. However, Burchiel (1995) challenges perioperative nurses to advertise, articulate and demonstrate their caring actions (intraoperative communications) to the outside world (families of surgical clients) in a way that illustrates the distinct component of nursing work.

Conclusions

The technological advances in the operating room today require us to embrace a new foundation that includes humanistic and holistic approaches to perioperative nursing care. Perioperative nursing should include evidenced-based findings, to validate their practice in these modern times. This may require changing nurses' traditional attitudes about the isolation of family members of surgical clients to include psychological support through the development of caring, respectful, trusting relationships, and by decreasing physical stress and anxiety through communication with the family. In the current consumer-oriented climate of the health care system, doing something distinct may make a difference in market share due to positive outcomes for the family as well as the health care professional in a family-centred care environment. As an independent nursing intervention, progress reports may add to the satisfaction of family-centred care.

Acknowledgment

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References

Atkinson, L.J., & Kohn M.L. (1986). *Berry and Kohn's Introduction to Operating Room Technique.* U.S., McGraw-Hill Book Company, 3-36.

Becvar, R.J., & Becvar, D.S. (1982). Definitions of systems concepts. In *Systems Theory and Family Therapy: A Primer.* New York, University Press of America, 9-26.

Burchiel, R.N. (1995). Does perioperative nursing include caring? *AORN Journal*, 62, 257-259.

Craig, R., Cioni, D., & Morrison, C. (1986). The forgotten: Families of your surgical patients. *Journal of Post Anesthesia Nursing*, 1(3),170-174.

Daley, L. (1984). The perceived immediate needs of families with relatives in the intensive care setting. *Heart & Lung*, 13, 231-237.

Donnell, S.G. (1989). Coping during the wait: Surgical Nurse Liaison Program aids families. *AORN Journal,* 50(5),1088-1092.

Frederickson, K. (1989). Anxiety transmission in the patient with myocardial infarction. *Heart & Lung*, 18(6), 617-621.

Johnson, M.J., & Frank, D.I. (1995). Effectiveness of a telephone intervention in reducing anxiety of families of patients in an intensive care unit. *Applied Nursing; Research*, 8(1), 42-43.

Kathol, D.K. (1984). Anxiety in surgical patients' families. *AORN Journal*, 40(1),131137.

Killen, A.R. (1996). Caring and competence: Perioperative nurses tell their stories. *Seminars in Perioperative Nursing*, 5(2), 72-76.

Leske, J.S. (1992). Effects of intraoperative progress reports on anxiety of elective surgical patients' family members. *Clinical Nursing Research*, 1(3), 266-277.

Leske, J.S. (1996). Intraoperative progress reports decrease family members' anxiety. *AORN Journal*, 64(3), 424-436.

McNamara, 5. (1995). Perioperative nurses' perceptions of caring practices, *AORN Journal*, 61(2), 377-388.

O'Connell, M. (1989). Anxiety reduction in family members of patients in surgery and post-anesthesia care: A pilot study. *Journal of Post Anesthesia Nursing*, 4(1), 7-16.

Watson, D.S.(1994).Opinion:Technology in the perioperative environment. *AORN Jnl.*, 59(1), 271.

The Operating Room Nurses Association of Canada

Announces

The ORNAC

Research Grant

Value: $5,000

WHY: To promote research activities and integrate research findings into Perioperative Nursing Practice with the objective of improving or validating perioperative patient care.

WHAT: An annual grant of up to $5,000 sponsored by ORNAC.

WHO: Available to researchers who meet the criteria as outlined in the ORNAC Research Grant Guidelines for Applicants.

WHEN: Apply by **May 7th**, 1999. The first ORNAC Research Grant will be awarded at the 16th National ORNAC Conference, June 14 - 18, 1999 in Halifax.

HOW: Guidelines for Applicants and Application Forms are available through members of the ORNAC Research Committee, members of the ORNAC Board, or through the ORNAC Website:

http://www@ORNAC.ca

Contact:
Marla Ewen, RN, BSN, CPN(C)
ORNAC Research Committee
206 Guelph Cr.,
Saskatoon, SK S7H 4S3

ORNAC/Johnson & Johnson Medical Products

Bursary for OR Nurses

This bursary was established to financially assist ORNAC members in furthering their education in areas that will enhance perioperative nursing practice. The ORNAC Awards Committee, comprised of members from across the country, choose successful applicants in accordance with established selection criteria.

Eligibility Requirements

The applicant must be a registered nurse who is licensed with the Provincial Professional Association. The applicant must also be an active member of the Provincial Operating Room Nursing Association two consecutive years prior to submitting the application. The individual must be employed, with a primary focus on perioperative nursing, according to the official ORNAC definition.

Funding is available for post basic operating room nursing programs approved by ORNAC, Baccalaureate nursing programs and Masters and Ph.D. nursing programs related to health care and considered an enhancement to existing perioperative employment.

Application Requirements

The personal profile / resume must be typed and supporting data enclosed with the completed application form. The application will not be considered if this criteria is not met. This data includes letters of reference as indicated on the application form, photo copies of nursing license, membership in a provincial OR association, perioperative nursing certification (if applicable) and proof of acceptance in an education program.

The complete, typed application form and supporting documentation must be submitted to the Chair of the ORNAC Awards Committee before is **March 15th each year.** This information can be found in every issue of the *Canadian Operating Room Nursing Journal*. Late submissions will not be considered.

This bursary is jointly funded by Johnson & Johnson Medical Products and ORNAC and is administered by the ORNAC Awards Committee. The applications are judged by the committee based on established criteria. If there are no suitable applicants, the award will not be presented and funds will be carried over to the next year. Bursary funds are designated specifically for tuition and books. Final approval for disbursement of funds rests with the Awards Committee and the ORNAC Board of Directors. At the end of the term, proof of successful completion of the course must be forwarded to the Chair of the Awards Committee in order to close out the file.

ORNAC recognizes that the education of perioperative nurses plays a pivotal role in providing a strong and successful national organization. The ORNAC Executive and Board of Directors appreciates the financial support provided by Johnson & Johnson Medical Products.

By Shelly Zareski
Chairperson
ORNAC Awards Commmittee

International Federation of Perioperative Nurses

IFPN - A new organization for perioperative nurses: New partnerships for ORNAC

By Vija Hay, RN, (CPN(C)

ORNAC has been participating in the development and formation, and is a member of the International Federation of Perioperative Nurses (IFPN).

The IFPN is a federation of national perioperative nurses associations which are affiliated to the official nursing organization of the member country and which are in compliance with its constitution and have been formally admitted into membership.

Mission Statement

The International Federation of Perioperative Nurses will work towards improving patient care by promoting, preserving and advancing the role of perioperative nurses in member organizations. It will be actively engaged in providing educational opportunities and support to perioperative nurses in all nations. It will encourage, support and assist humanitarian perioperative nursing projects. The organization will seek to become collaborative partners with recognized international nursing and health organizations in order to achieve its mission.

Purpose

The purpose of IFPN is to represent and be the voice of perioperative nurses worldwide, and to promote quality perioperative patient care internationally.

Objectives

1. To represent perioperative nurses and perioperative nursing internationally.
2. To promote perioperative nursing codes, standards and improve the quality of nursing care.
3. To follow a policy of non-discrimination in all IFPN matters.
4. To receive and manage funds and trusts which contribute to advancement of nursing and of the IFPN.
5. To promote and participate in perioperative nursing research.
6. To maintain a networking system for key and emerging issues in perioperative nursing.
7. To promote perioperative nursing at every opportunity by liaising with relevant national and international organizations, e.g. World Health Organization, International Council of Nurses.
8. To act as a liaison group between national perioperative nurses associations requesting humanitarian or educational / other aid and the member association(s) that can provide the assistance.

Background Information

For many years now, ORNAC has been and continues to be a member of the International Planning Committee (IPC) for World Conference of Operating Room Nurses (WCORN), since renamed the World Conference of Surgical Patient Care. Currently there are 11 active IPC members, 6 corresponding members, and 3 other contacts for information, spanning the globe. ORNAC's designated representative to IPC has been the Past President. The responsibilities of the IPC were detailed in the December, 1998 edition of the *Canadian Operating Room Nursing Journal*, but can be summarized to consist of planning the educational component for WORNC and providing speakers and moderators.

The need for a "world council", a truly international collaboration, has long been expressed by IPC members. It has become increasingly evident that perioperative nursing issues and other related topics which affect all international organizations should be addressed and discussed. The format of the World Conference is limiting, and does not provide the opportunity for that type of interaction or focus.

Informal discussions to expand the role of the IPC, were initiated during the AORN Congress in Dallas, Texas in 1996 at an IPC Ad hoc meeting with then AORN President Linda Groah. The role of the IPC and the forrnation of an international global federation was discussed in more detail at the next IPC meeting in April, 1997, in Anaheim, California. The Working Group (representing Australia, Canada, New Zealand, UK, USA) was asked to do the gound work in developing a new organization. Work has been ongoing by this committee through electronic communication and meetings.

Process

A discussion document "Proposal to Form an International Perioperative Nursing Organization" was drafted and distributed to IPC members by the IPC Working Group. Members of IPC (national associations) were requested to consider the proposal and respond to a questionnaire as to their support and interest to join. The response to the questionaire was favorable.

The proposal for the formation of an international federation of perioperative nurses was presented to the delegates at the International Forum during the World Conference in Toronto, Ontario in September, 1997. At the Toronto IPC debriefing meeting, the Working Group was endorsed to continue the project to form an international federation and was renamed as the **Steering Committee.** The members of the committee were: Carolyn Webster (ACORN), Sue Vincent (NATN), Marion Jones (PNANZ), Vija Hay (ORNAC), Jeannie Botsford (AORN). The National Association of Theatre Nurses (NATN), UK was nominated as the administrative headquarters.

The first formal meeting of the Steering Committee was held in Orlando, Florida, March, 1998, following the IPC meeting during the AORN Congress with Judith Oulton, Executive Director of the International Council of Nurses (ICN) in attendance. Judith Oulton was instrumental in providing a global perspective, and helpful in our discussions as we deliberated the development of a constitution. At this meeting the name of the organization was agreed to be International Federation of Perioperative Nurses. Proposed terms of reference for the Committee were to include the development of the constitution, preparation of application forms, circulation of information to potential members, correspondence/communication, developing the process for nominations and elections.

The second meeting of the Steering Committee took place in October, 1998 in Harrogate, UK immediately following the NATN Annual Congress. At this meeting the first draft of the constitution was reviewed in depth. The constitution is based on the International Council of Nurses Constitution. The IFPN logo was selected. During the NATN Congress, the Steering Committee met with Judith Oulton, and spent time to promote the IFPN to international delegates and exhibitors.

Progress to Date

The second draft of the Constitution has been developed. This draft document and IPC member comments will be reviewed at the March, 1999 Steering Committee meeting in San Francisco, California. The final draft will be circulated and formally adopted at the Steering Committee meeting in Helsinki, at the World Conference for Surgical Patient Care in July, 1999.

Promotion information for potential members has been redrafted, a **Business Plan** has been drafted, and will be finalized at the next meeting.

Funding will be required from many sources to ensure that as many national perioperative nurses organizations as possible join, and sustain the operation of the Federation. These requirements have been addressed . Membership fees to cover administrative costs are currently received from each association represented on the Steering Committee. Support will be solicited from sponsors. A conference is projected for the future.

Election of Executive Officers and Transition Process have been developed. Nomination forms have been drafted. Elections for the executive will be held in Helsinki Finland in July, 1999. The management of the transition period is being finalized.

Application of Affiliation **with ICN** has been submitted.

An Abstract Proposal to Present at ICN Congress in June, 1999, in London, UK has been submitted.

Launch of IFPN at the World Conference of Surgical Patient Care, Helsinki, Finland, July, 1999.

Author

Vija Hay, IFPN Steering Committee Member, is the Past President of the Canadian Operating Room Nurses Association of Canada.

Members of the IFPN Steering Committee: Front row: (L toR) Carolyn Webster, (Coordinator) Australia. Sue Vincent, United Kingdom, (Secretary-Treasurer). Standing: (L to R) **Vija Hay,** Canada; **Marion Jones,** New Zealand; and **Ellen Murphy**, U.S.A.

Members of the Steering Committee:

- Carolyn Webster, Australian Confederation of Operating Room Nurses Ltd. (Coordinator & Chairman of the Steering Committee).
- Sue Vincent, National Association Theatre Nurses, UK. (Secretary/Treasurer for the Steering Committee).
- Vija Hay, Operating Room Nurses Association of Canada.
- Marion Jones, Perioperative Nurses Association of New Zealand.
- Ellen Murphy, Association of Operating Room Nurses, Inc. USA.

Conclusion

We have come a long way since IPC members first voiced the need for an expanded role of the IPC. A new organization with global links and impact for perioperative nurses and nursing care is a reality. It is exciting to see the progress that has been made since the first informal discussions in 1996. It is rewarding to see partnerships at work, the true dedication, professionalism and consensus within the committee that spans the globe. It is evident that national organizations recognize the need to unite internationally in common issues that affect and impact perioperative practice. The opportunity for learning and sharing is tremendeous. The liaison with ICN is an important link.

ORNAC has supported the formation of the Federation, has paid the membership fee, and can be considered as one of the founding members by participation on the Working Group/Steering Committee. Just as nursing roles are changing and diversifying, so ORNAC must grow, diversify and respond to global issues.

It is essential to recognize future directions and trends, and the value added partnerships. Becoming a partner in the international organization is recognition and affirmation of ORNAC as a progressive association. ■

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World Conference

on Surgical Patient Care

July 25 - 30, 1999

Helsinki, Finland

Registration Fees (in US dollars)

Postmarked on or before June 11,1999:

Category	Weekly	International Fellowship Night
Participant	$325	$40
Guest	$170	included

Postmarked **after** June 11th, 1999:

Category	Weekly	International Fellowship Night
Participant	$350	$75
Guest	$195	included

International Fellowship Night is NOT included in the participant registration fee.

For registration information/forms please contact:
AORN, Inc. Customer Service / World Conference Registration,
2170 S Parker Rd, Suite 300,
Denver, CO 80231-5711, USA

Canadian Participants

International Fellowship Night will be held Monday (July 26, 1999) at the Helsinki Fair Centre from 2000 to 2400. Please come prepared to wear "Canadian dress", which will be a red hat and red and white combination of attire of your choice. The hat will be available at the ORNAC National Conference in Halifax in June. Those not attending, may order from me. Cost $15.00, plus shipping charges if mailed. Anyone wishing to purchase a red vest, please order from me before May 28, 1999. Cost of vest will be approximately $16.00 to $20. Style is similar to a warm-up jacket with V neck, no sleeves, two pockets. Sizes available: Medium and Large.

At the International Night, it is customary to exchange small mementos. Logo pins of your association and provincial government, and Canadian souvenirs are popular. Arrive before 2000 hours so we can take a group picture.

Hope to see you in Helsinki !

Vija Hay, IPC Member, Past President ORNAC

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Tea - world's most popular drink has exceptional anti-oxidant properties

Tea is the most popular drink in the world, and whether imbibers are aware, it is proving to be an excellent antioxidant. Tea leaves are rich in natural compounds that have similar properties to those in fruits and vegetables.

Fresh-brewed black and green teas are now thought to play a role in reducing the risk of certain cancers, heart disease and strokes.

Researchers at Tufts University in Boston compared the antioxidant capacity of tea to 22 other known anti-oxidant rich vegetables such as kale, spinach, garlic, broccoli, brussels, corn, sweet potatoes, onions and carrots. Green and black teas were found to have much higher antioxidant activity than all the vegetables studied. Tea has also been found to contain flavonoids, which are non-nutritive compounds with antioxidant properties.

Research conducted over 25 years ago strongly suggested even then that the lower rates of cardiovascular disease among the Chinese, compared to North Americans, may be due to tea drinking. Since then, the role of tea's antioxidant activity in improving cardiovascular health has been linked to this.

A study several years ago at Johns Hopkins University in Baltimore involving over 35,000 middle-aged and elderly women showed that regular tea consumption may protect against cancers of the digestive and urinary tracts.

Retards tumour growth

And in a study to determine the extent to which tea may retard the development of lung tumours, researcher Fung-Lung Chung of the American Health Foundation in Valhalla, New York, found that drinking either black or green tea retards the development of these tumours in rats and mice.

Another study, conducted on humans by J.E. Klaunig of the Indiana University of Medicine, found that black and green tea reduced the level of oxidative stress, particularly in smokers. Oxidative stress is cell damage associated with environmental factors such as chemicals, heavy metals and UV rays.

A related study, reported at the Second International Scientific Symposium on Tea and Human Health held in Washington in 1998, showed for the first time that tea plays a major role in preventing the formation of cancer in humans.

In this study, Dr. Junshi Chen of the Chinese Academy of Preventive Medicine in Beijing studied 59 patients diagnosed with pre-cancerous oral lesions (white, bumpy areas on cheeks or gums). Chen had these patients rinse their mouths with the components found in black and green tea, or he topically rubbed a mixture of glycerine and tea on the lesions. It was found that either treatment inhibited the growth of pre-cancerous cells. In some patients, the lesions just disappeared, while in others, there was a marked regression.

Terminally ill overwhelmed by living wills

Experts have long grappled with the issues of the best treatment for the dying. Now, Canadian scientists and ethicists have taken the innovative step of examining how terminal patients themselves answer the question. The results of their examination were published in The Journal of the American Medical Association (Jan. 13, 1999).

The uniqueness of the study is that the perspective comes from the dying patient, says Dr. Peter Singer of the University of Toronto's Joint Centre for Bioethics. He discovered that dying patients have five main objectives:

1. Avoiding a lingering death (the primary concern among terminally ill).
2. Receiving adequate pain control.
3. Easing stress of loved ones as they deal with death and make the necessary treatment decisions.
4. Strengthening relationships with family and friends.
5. Achieving a sense of control over end-of-life-care.

The study said that too much emphasis is placed on drafting living wills in which precise treatments are spelled out.

"That's not really what terminal patients want. They just want a sense that their voice is really important. Managing the smallest detail can overwhelm dying patients and their families," Dr. Singer explained.

Researchers based their findings on face-to-face interviews with 126 terminally ill patients.

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ORNAC Elections - June, 1999

Nominations for Office

The Nominating Committee presents a list of candidates for ORNAC Executive positions of President Elect, Secretary and Treasurer. The officers will be elected by ballot at the Annual ORNAC Board of Directors Meeting to be held in Halifax, Nova Scotia, June, 1999. The current President Elect, Marlene Hill, will automatically become the President at the closing ceremonies of the '99 National Conference. The newly elected officers will be introduced at that time. The election results will be published in the *Canadian Operating Room Nursing Journal.*

Profiles of the candidates have been assembled by the Chair of the Nominating Committee, Vija Hay, and presented in abbreviated form as follows:

Mary Knight

Nominated for President-Elect

Manager, Perioperative Care, Grace General Hospital, Winnipeg, Manitoba. Effective April 13, 1999: Director of Patient Services, Surgery Program, Health Sciences Centre, Winnipeg.

Professional Activities

ORNAA - Operating Room Nurses Association of Alberta, North Central District (Edmonton), 1992-1995, served as Treasurer.
MORNA - Manitoba Operating Room Nurses Association, President-Elect 1996-1998.
President, 1998-2000.
ORNAC Board member 1996 - present.
Coordinator,Telemedicine Canada, OR Series (through to the summer of 1998).
Member Research Committee, Chair Research Committee, Ad-hoc Membership Committee to form a national data base.

Objectives for ORNAC

- To build upon ORNAC's tradition of promoting excellence.
- To address the projected nursing shortage by developing strategies to attract qualified Registered Nurses to a career in Operating Room Nursing.
- To promote evidence-based practice in perioperative nursing.

Election Statement

Perioperative nurses have an integral role in ensuring successful outcomes from surgical interventions. Our roles vary depending upon need, and range from patient advocate, to clinical experts and caregivers, to critical thinkers, and finally to technological experts. ORNAC activities and leaders promote activities and opportunities which strengthen our professional roles, develop our potential in such areas as advanced practice roles, and communicate to others the knowledge and expertise required by perioperative nurses to provide care to patients undergoing surgical interventions.

Gloria Nemecek

Nominated for President-Elect, Secretary

Clinical Coordinator, Surgical Suite, Lethbridge Regional Hospital, Lethbridge, Alberta

Professional Activities

SORNA (district) active member since 1982. Served as Treasurer, District Representative, President-Elect, President, Past President and Chairperson for the 1994 Provincial Conference.
ORNAA, Operating Room Nurses Association of Alberta, served as Sectretary, President-Elect, President and currently as Past President, Chair of the 2000 ORNAA Provincial Conference.

In 1991 Gloria was the recipient of the ORNAA Writing Award.
ORNAC Board member 1900-1998. Served on Nominating Committee, Finance Committee, National Conference Committee, and continues to be ORNAC Inventory Officer, responsible for distributing ORNAC Standards. Chair of the 2001 ORNAC National Conference. Certified in Perioperative Nursing-CPN(C).

Objectives for ORNAC

- Promote the role of the Perioperative Registered Nurse.
- Support and promote the expanded roles for the Registered Nurse.
- Continue to support and promote ORNAC.

Shelly Zareski

Nominated for Treasurer

Health Services Manager, Childrens Perioperative Care, IWK Grace Health Centre, Halifax, Nova Scotia.

Professional Activities

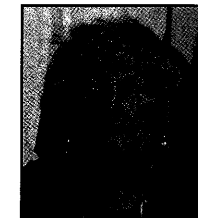
ORNANS, Operating Room Nurses Association of Nova Scotia - Served as Treasurer and President.
ORNAC Board - Member 1992-1997. Currently serving in first term as Treasurer 1997-1999. Chair of Awards Committee. Chair of Finance Committe. Member of Bylaws Committee. Member of the 1999 National Conference Planning Committee. Recipient of the Excellence in Nursing Practice Award (Atlantic Region). Member of Perioperative Examination Committee - CNA. Perioperative Nursing Certification CPN(C).

Objectives for ORNAC

- Maintain and broaden the visibility of ORNAC.
- Endeavour to connect the Operating Room Nurse to the Association.
- Work to increase membership

Margaret Farley

Nominated for Secretary



CVT Co-Ordinator, Regina Health District, Regina General Hospital Site, Regina, Saskatchewan

Professional Activities

SORNG - Sakatchewan Operating Room Nurses Group founding member. Held the position of President twice: President SORNG 1995-1998, President of South SORNG chapter 1981-1983. Editor of *The Circulator,* SORNG's Newsletter since 1995.
ORNAC Board member - 1995- present. Member of Public Awareness Committee since 1995. Chair Public Awareness Committee since June 1997. Member Ad-hoc Membership Committee to form a national data base. Instrumental in creating and maintaining ORNAC website.

Objectives for ORNAC

- Increase awareness of Perioperative Nursing.
- Encourage return of Operating Room rotation in curriculum.
- Lobby for awareness of our specialty.

Election Statement

The aim of the Public Awareness Committee of ORNAC is to put ORNAC clearly in the global arena of Perioperative Nursing. I feel with all the hard work of this committee we are there. The formation and creation of the ORNAC website is reaping the rewards of such a detailed project. Along with the plans to form an International Federation we are impacting and having a say in the global sphere of perioperative nursing. ■

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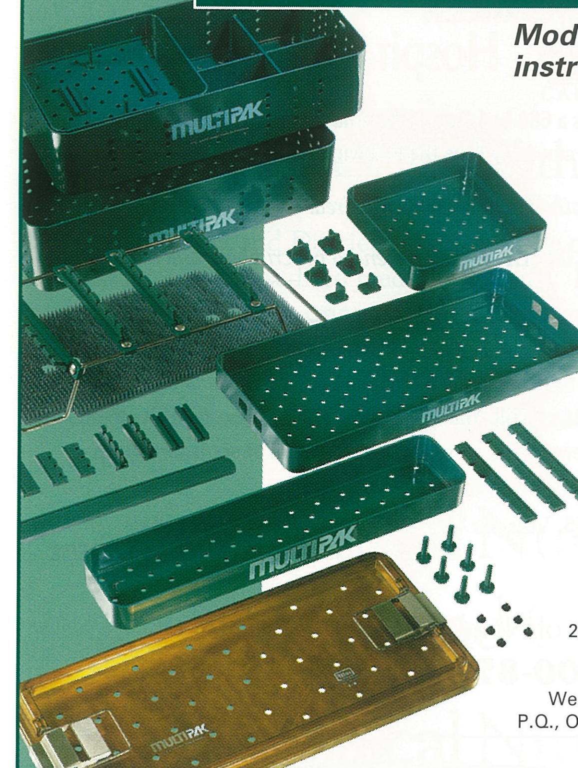

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The Canadian Operating Room Nursing Journal is intended to serve the information needs of perioperative nurses in hospitals and clinics throughout Canada. Readers include staff nurses, head nurses, nursing supervisors, coordinators, clinical instructors, directors of nursing and other perioperative nurses. The journal is peer-reviewed and published quarterly by Health Media Inc. under the aegis of the Operating Room Nurses Association of Canada (ORNAC).

Manuscripts are reviewed by the editorial review board members appointed by ORNAC, and when necessary by outside experts. Submissions are invited **on new surgical techniques**, **descriptions of new technologies** or new programs and educational material. Selection is based chiefly on the following criteria: originality, timeliness and relevance to the needs of the journal's 3,000 OR Nurses.

Preferred length is approximately 10 to 15 typed, double-spaced pages, numbered consecutively throughout (including tables, figures, references, which should be on separate pages). Authors should submit **three copies** (one should be the original or an excellent photocopy) of the manuscript and include:

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2. An autobiographical statement that includes the author's full name, current title and academic qualifications. e.g. Jane M. Smith, RN, MNSc, is head nurse, Thorasic Surgery, General Hospital, Perth, ON.

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All illustrations, graphs, tables, etc. should be clearly labelled and, if necessary, reference should be made as to where they are to be inserted in the text. The author should submit the **original manuscript and two(2) copies** for reviewers. A copy of the edited text will be sent to the author for final approval.

References are arranged in alphabetical order by author surname. References are cited in the text by author-date method of citation, e.g. (Smith, 1987). Follow the APA Manual for style when typing the list of References, e.g.:

Smith, M. & Curtis, J. (1987). Ethics in Nursing (2nd ed). New York: Oxford University Press.

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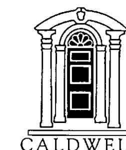

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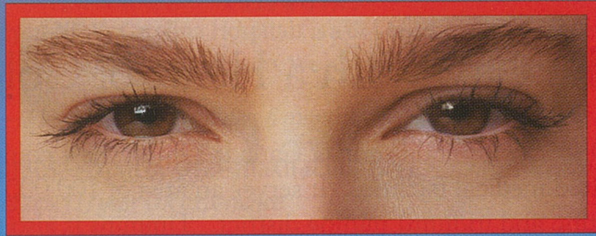

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