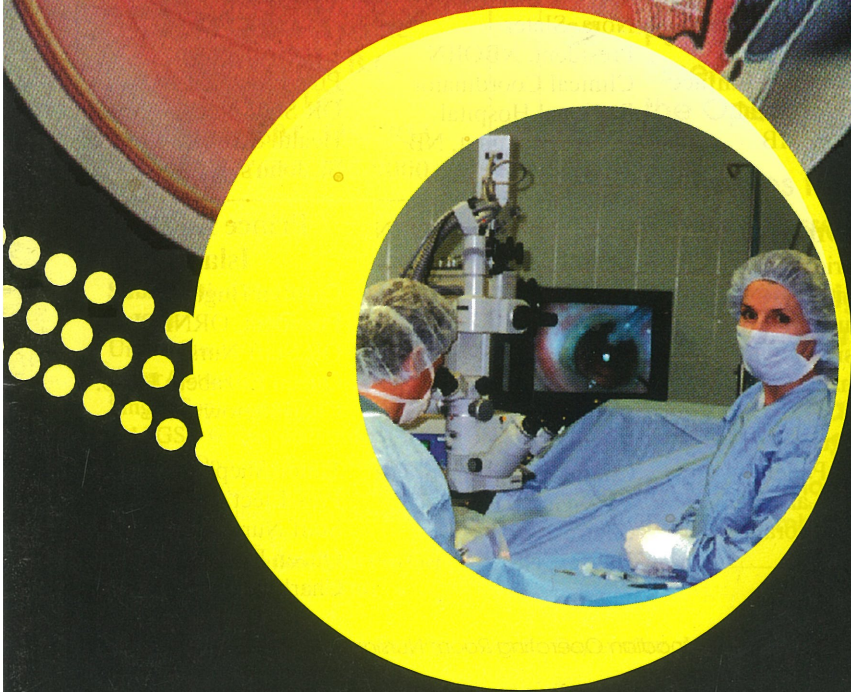
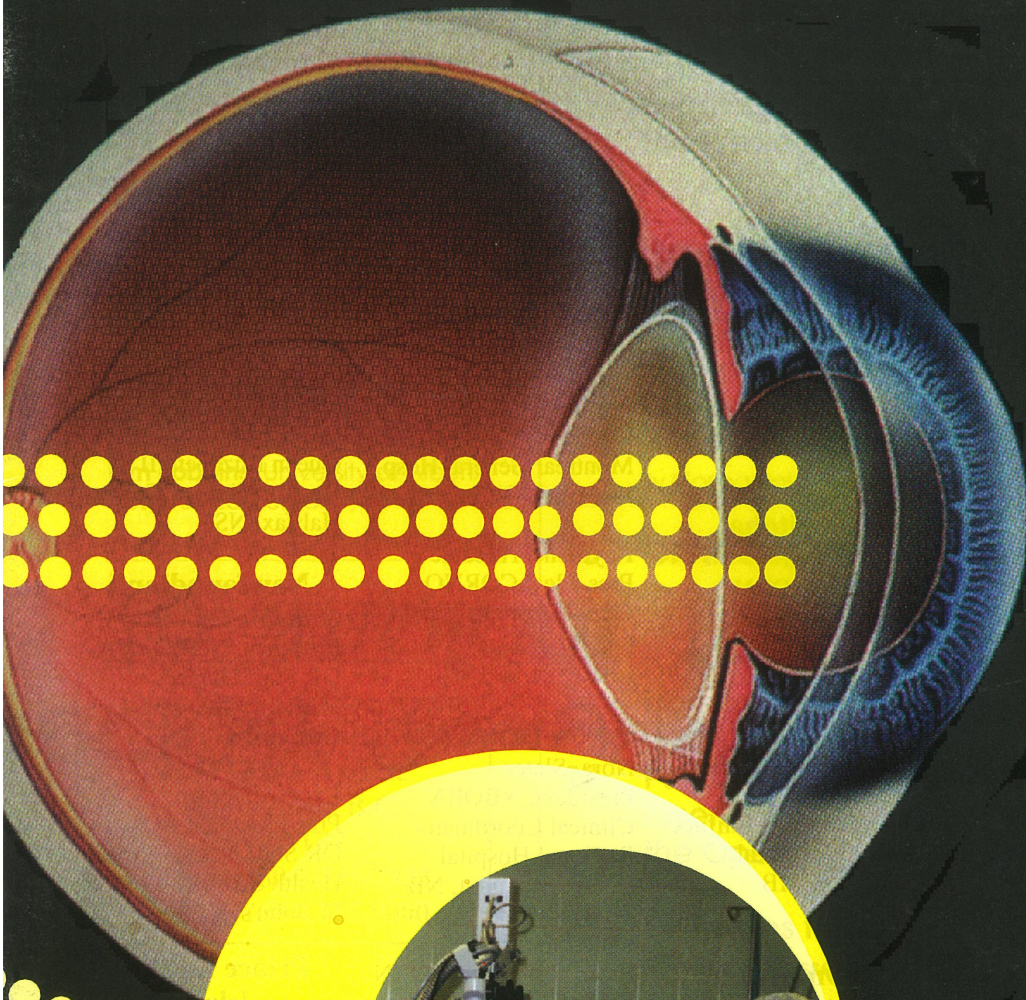


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Published Quarterly. Vol. 16, No. 4, December, 1998



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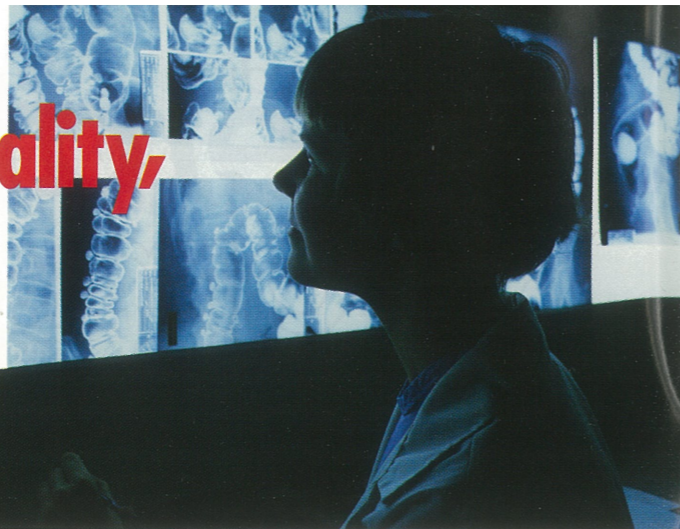
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Cresting the Wave Together

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

We wanted to depict certain things when we chose our 16th National ORNAC Conference motto "Cresting the Wave". First, we wanted to depict the area where the conference was being hosted, and clearly, Nova Scotians have a fundamentally strong affiliation with the sea. Next, we wanted to symbolize a celebration of ORNAC's many accomplishments over the sixteen years of its existence. When one rides the crest of a wave, one has reached a pinnacle. ORNAC deserves recognition for reaching this pinnacle, by representing Perioperative Nursing so well; from the development and revisions of National Standards of Practice, to initiating and facilitating the National Certification process, to developing position statements, offering bursaries and awards to her members, supporting advanced roles, and promoting Perioperative Nursing at every opportunity. Finally, we wanted a symbol to congratulate Canadian perioperative Nurses for their commitment to the highest standards of surgical patient care, despite the enormous obstacles they have faced during massive changes in the Canadian Health Care System.

However, no more can ORNAC rest on her laurels than she can remain on the crest of the wave. As in health care, the sea is ever changing, we must respect and appreciate all it has to offer, while at the same time, be prepared to meet its challenges with confidence and determination. As ORNAC strives to serve her members well into the future, we must chart our course and learn to navigate in new waters.

In this issue of the *Canadian Operating Room Nursing Journal*, you will find preliminary information about the conference program and social events, a registration form, and information about hotel reservations. The program has been finalized since this printing, and there are more excellent speakers and topics on the agenda. Having the good fortune to have attended several Perioperative Nursing Conferences

over the past few years, I judge a conference by the difficulty to choose between the concurrent sessions, wanting to hear them all. I may be showing my prejudice, but this is how I feel about our program. Our plenary sessions are all on current topics with excellent speakers, and we are especially appreciative of the generous sponsorship of speakers and events by many of the surgical supply companies. We value their ongoing support.

A new endeavour to host a Perioperative leaders and managers workshop immediately following the conference is well under way, thanks to the vision and commitment by Pat Pocock, the Past Presidents of ORNAC, and the sponsorship of Johnson & Johnson and 3M.

When I attended some provincial conferences this past year, there was a great deal of interest shown in coming to Halifax. However, I realize that it is very expensive to attend conferences half way across the country, especially in this climate of diminishing education dollars. Our nurses in the Maritimes have been fundraising to provide the opportunity to cover some of their costs with bake sales, goody basket raffles, and so on. Where there's a will, there's a way!

I wish to extend a warm welcome to Perioperative Nurses from across the country to our conference. We are eager to treat you some fine Maritime hospitality, and to show you a very beautiful part of our country. Together, let's ride the crest of the wave into the challenges of the new millennium.



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.

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ORNAC Elections - June 1999

Preparations are under way for elections of ORNAC Executive positions for President Elect, Treasurer, and Secretary. Elections will take place at the June, 1999 Board meeting in Halifax.

At the ORNAC Board of Directors meeting, November 8, 1998 in Montreal, the Board and Executive Eligibility Criteria and Eligibility List were confirmed. Timelines for nomination process are set.

Having served on the Board of Directors, the eligible candidates have gained valuable experience and understanding of the responsibilities in letting their name stand for office. In the March/April 1997 Journal edition I wrote "we have been fortunate that so many operating room nurses have been willing to be actively involved. The success of ORNAC can be attributed to their knowledge, ability and commitment". The Nominating Committee now looks forward to many nurses to continue to take the challenge to serve the Association and lead us into the new century.

Look for the slate of nominees and biographical information in the spring edition of the Canadian Operating Room Nursing Journal.

For information regarding the eligibility criteria, eligibility list, and/or election process contact your Provincial ORNAC Board member or ORNAC Executive (listed on page 2 in the Journal), or myself at: 4421 Rainforest Drive, Gloucester, ON K1V 1L5.

Vija Hay

Past President, ORNAC
Chair, Nominating Committee

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Laparoscopic Swenson Pull-Through Procedure for Hirschsprung's Disease

By Leonore Arany, Kathleen Jennings, Katherine Radcliffe & Joanne Ross

In October of 1995, the Laparoscopic Swenson Pull-through Procedure was introduced in our operating room to surgically treat Hirschsprung's Disease. As with any new procedure a multidisciplinary team approach is needed to prepare the Operating Room, determine the instrumentation and equipment required and to educate the staff about the procedure. This article describes Hirschsprung's Disease, the perioperative nursing care required and operative technique of a Laparoscopic Swenson Pull-through Procedure.

Pathophysiology

Congenital megacolon or Hirschsprung's Disease is caused by an absence of the parasympathetic ganglion cells of the myenteric plexus of the colon. The parasympathetic ganglion cells control the movement of bowel contents by coordinating contraction and relaxation of the bowel wall. The absence of these cells prevents the normal peristaltic movement of fecal matter through the bowel leading to intestinal obstruction or severe constipation. The bowel becomes distended proximal to the affected portion of the bowel. The segment of bowel affected by this disease is variable in length but usually involves the rectum.

Abstract

The introduction of a new procedure into the operating room is always a challenge that requires careful planning and teamwork. This article describes the pathophysiology of Hirschsprung's Disease, the perioperative nursing care required and the operative technique of the Laparoscopic Swenson Pull-Through Procedure.

The incidence of Hirschsprung's Disease is estimated at 1 in 5,000 births. There is some evidence that suggests males more than females are affected by this disease.

Clinical Manifestations and Diagnosis

In neonates the classic symptom is delayed passage of meconium. Meconium is usually passed within the first 24 to 48 hours after birth. Infants can present with the signs and symptoms of a bowel obstruction, i.e. abdominal distention, green vomitus and dehydration. If untreated, perforation of the bowel and septicemia can result. Infants and older children may present with constipation or infrequent stools, abdominal distention, poor appetite and little weight gain. Enterocolitis is a complication of Hirschsprung's Disease and may be the first clinical sign. The patient presents with fever, abdominal distention and diarrhea, which can be explosive, malodorous and bloody.

The most reliable diagnostic test is a rectal biopsy. A full thickness rectal biopsy, punch biopsy, or a suction biopsy technique may be used. A full thick-

Authors

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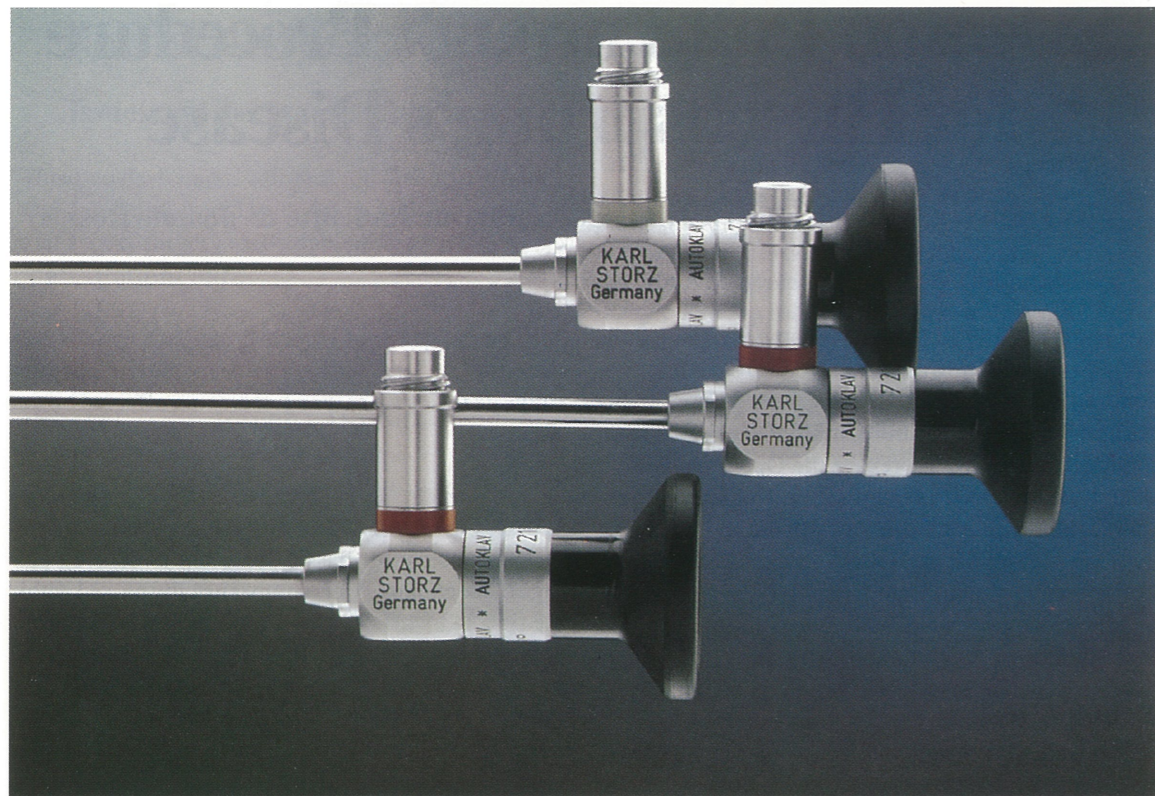
Kathleen Jennings, RN, CPN (C), Pediatric and ENT Resource Nurse, Hamilton Health Sciences Corporation, McMaster Site.

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ness rectal biopsy must be performed under a general anesthetic whereas the later two techniques may be performed on an awake and cooperative patient. A Barium enema is used to identify the transition zone that is apparent in patients with congenital megacolon as well as to assist in ruling out other causes of the bowel obstruction. The transition zone is the cone shaped area seen extending from the proximal dilated colon to the nondilated distal aganglionic colon on the Xray film.

Preparation of the O.R. Room

Three nurses are assigned for this procedure, two of whom must be registered nurses. A scrub nurse is required for the abdominal part of the procedure and a second scrub nurse is required later for the perineal part of the procedure. The second scrub nurse will assist one of the Registered Nurses with the circulating nurse duties until needed. At the McMaster Site of the Hamilton Health Sciences Corporation, an OR room is designated for pediatric surgery. This room is one of the largest rooms in our OR suite and is decorated in soft colors with cartoon and Sesame Street characters on the walls. This assists in creating a soothing and non-threatening environment for our pediatric patients. A large room is required to accommodate the special anesthetic and surgical equipment required for this procedure (Table #1 Pediatric Anesthetic Equipment and Supplies). The room temperature is increased to 24 - 26 degrees Celsius before the patient is brought to the room. It will be lowered after the child has been prepped and draped if his/her temperature is within the acceptable range. All equipment required for the procedure must be placed in the appropriate location and checked to ensure proper functioning prior to the child being brought to the room. (See Diagram #1) The head and foot sections of the OR table are lowered to provide access for the anesthetist and surgical team. A warming device is placed on the OR table and will continually provide warm air flow as well as providing padding to the vulnerable areas of the body. The child is laid directly on top of the air-flow warming blanket. The warming machine is placed on the base of the OR table.

The video and camera system is positioned on the left side of the OR room close to the wall initially. It will be moved within a few feet of the OR table after the patient has been positioned. The suction apparatus and electrocautery machine are positioned at the top right corner of the OR table close to the anesthetic machine and automatic blood pressure machine. The

foot pedal of the electrocautery is placed by the surgeon's right foot once the patient has been prepped and draped. The sterile instrument table is set up at the

Table #1 Standard Pediatric Anesthetic Supplies and Equipment

- 2 Pediatric laryngoscope handles
- 2 ea 0, #1, #2, #3 MAC laryngoscope blades
- 2 Pediatric Mouth Suctions
- 2 ea 0, #1 Miller laryngoscope blades
- 2 Pediatric Intubating Stylets
- 2 Pediatric Magill forceps
- 2 ea #5 & #8 Suction Catheters
- 3 ea 000, 00, 0, 7, 8 Oral Airways
- Uncuffed Endotracheal Tubes, 2.5mm up to 6.5 mm
- Anesthetic Masks, 2 ea sizes 0, 1, 2, 3
- Angiocaths, Sizes #20, 22, 24, 26
- Assorted L.L. Syringes
1cc, 3cc, 5cc, 10cc, 20cc
- Pediatric Anesthetic Bellows
- Pediatric size Breathing Circuit
- 1 litre rebreathing bags
- Small Eye Pads
- 2" Kling and IV armboards
- Pediatric Filters
- Pediatric Stethoscope
- Feeding Tubes #5 & #8 (2 ea.)

end of the room where there is space to prevent accidental contamination during positioning etc. This table is for the abdominal laparoscopic portion of the procedure. A second table for the second or perineal stage of the procedure is set up to the right of the OR table. (Table #2 Instruments and Sterile Supplies). All positioning devices are gathered, prepared and placed within easy reach. (Table #3 Positioning Devices). The scrub and circulating nurses complete a separate count of sponges, instruments, needles and designated miscellaneous items contained on each table. The scrub nurse checks all instruments to ensure that they are in proper working order, especially the insulated laparoscopic forceps. This is important, as a break in the insulation may cause an electrical burn.

Preoperative Phase

During the time between diagnosis and the surgery date, the parents are taught to keep the child's bowel decompressed with warm saline rectal irrigations. On the day prior to surgery, Pedialyte is given ad lib and mechanical preparation of the bowel is accomplished with magnesium citrate (4-5 ml/kg/dose) three times daily.

The patient is brought to the patient receiving area usually accompanied by their parents. An intrave-

nous solution of 0.9% Normal Saline or D5W/0.45% Saline is started on the inpatient unit prior to the patient coming to the OR and Gentamycin 5 mg/kg and Metronidazole 10 mg/kg are given. The Registered Nurse assigned in the OR patient receiving area introduces herself to the patient and parents. An explanation of the sequence of events is given at this time. The chart is reviewed for the usual preoperative requirements (signed consent, history and physical, etc.) As the patient is unable to verbalize answers to questions, the RN asks the parents questions regarding NPO status and known allergies and the surgical procedure to be performed.

The anesthetist assesses the patient and answers any questions the parents may have regarding the anesthetic to be given. The surgeon visits the patient and parents in the receiving area and answers any last minute questions and tells the parents that he will speak with them in the family waiting room after the procedure.

Intraoperative Phase

After receiving a report from the patient receiving nurse and reviewing the patient's chart, the primary circulating nurse introduces herself to the parents and patient. Due to the patient's age (usually less than 12 months), parents are not permitted to remain with the child during induction of the anesthetic.

Once in the OR room the child is placed on the OR table in the supine position and monitoring devices are applied. The ECG pads (pediatric size) are positioned on the chest, the appropriate size of blood pressure cuff is placed on the child's right arm and two pulse oximeter probes are applied, usually one on each thumb. The probe opposite to the arm with the blood pressure cuff is connected to the pulse oximeter monitor. The second probe is applied to facilitate a quick change if the anesthetist is concerned about the patient's oxygen saturation level during the surgical procedure. For the induction phase of the anesthetic, a probe may be applied to the child's foot but must be

removed prior to positioning. The circulating nurse assists the anesthetist with preoxygenation of the patient and endotracheal intubation.

Once the anesthetist has confirmed the position of the endotracheal tube and taped it into position, a second IV line may be established if required. The anesthetist applies eye pads to the patient's eyes to prevent an accidental injury. A #6 urethral catheter is inserted into the bladder. Waterproof tape is used to secure the catheter to the upper thigh to prevent accidental removal of the catheter. Continuous drainage of the bladder is required to provide good visualization of the pelvis and measurement of urine output during the procedure. See Fig 1. ↑



on itself. A foam pad is placed over the child's face for added protection. A padded anesthetic bar is attached and positioned parallel to left the side of the OR table. The patient's buttocks are positioned at the edge of the mattress. An incontinence pad is placed under the patient's buttocks to prevent soiling. Using soft roll and flannel bandages the patient's feet and lower legs are secured to the padded bar. Care is taken not to occlude blood flow or compress any of the nerve supply to the feet or lower legs.

A second anesthetic bar is attached to the OR table and positioned at right angles to the padded anesthetic bar. This provides the anesthetist with access to the IV and monitoring lines and to the patient's face. It also prevents the drapes, cords and tubings from laying on the patient's face and upper body. Padding is placed under each elbow. Once positioning is completed the circulating nurse performs a head to toe check of the patient to ensure that correct body alignment has been maintained and that all bony prominences are padded.

An appropriate size electrocautery pad is applied to the patient, usually to the lower back.

Positioning

The patient is moved down to the bottom end of the OR table and positioned transversely with the patient's right side to the end of the table. Care is taken to ensure that the anesthetic tubings, monitoring and IV lines are free before the patient is moved. The patient's head is placed on a gel filled donut and turned to the left. A check is made by the circulating nurse to ensure that the pinna of the left ear is not folded over

**Table #2
Instruments and Sterile Supplies**

Abdominal Set Up

- major linen pack & laparotomy basin set
- opside strips
- laparotomy sheet
- 3 surgical gowns & appropriate glove sizes
- minor pediatric instrument tray
- fibroptic light cord
- 30 degree 5 mm pediatric laparoscope
- allport 5 mm clip applier
- Step SL 75 5mm Cannula and Dilator with Radially Expandable Sleeve
- Insufflation & Access Needle antifogging solution
- 1cc syringe and 25g needle
- drape for camera head and cable
- suction tubing
- Ratex Sponges 5/package
- 1/2" steri strips and 5-0 Monocryl
- small needle board
- catheter tray and catheter (#6 or #8)
- irrigation tubing
- #15 scalpel blade
- 5 mm Pediatric Laparoscopic Instrument Tray
- 3.5 mm Pediatric Laparoscopic Instrument Tray (for smaller patients)

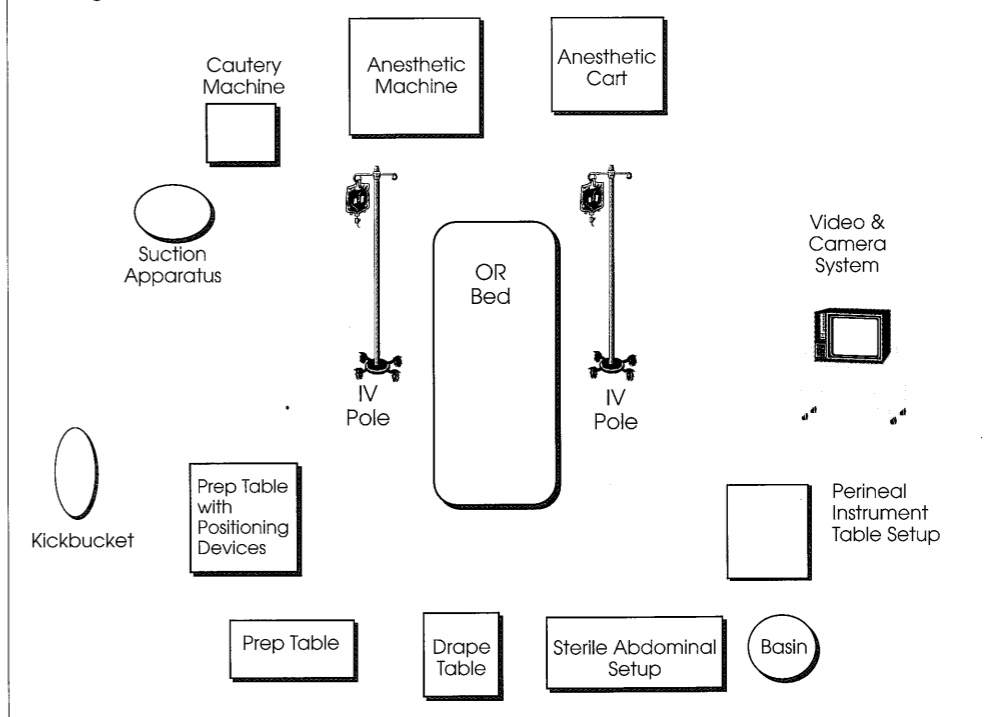
Perineal Set-Up

- minor basin set
- major linen pack
- hand control cautery & needle tip
- guard for cautery tip
- Scabbard
- minor pediatric instrument tray
- 5 babcock forceps
- 5 small towel clips
- langenbach fine retractors
- Hagar dilators
- Sterile lubricant
- 5 curved mosquitos
- Ratex Sponges 5/pkg
- # 15 scalpel blade
- 3-0 or 4-0 Vicryl sutures (uses approximately 12)
- large needle board)

**Table #3
Positioning Devices**

- 2 universal holders
- 2 anesthetic bars (1 padded with eggcrate foam)
- 3" Soft roll or Webril (2-4 rolls)
- 4" flannel bandage (2)
- 6 egg crate foam pads
- roll of lap padding
- micropore tape

Diagram #1 Room Set Up for Laparoscopic Swenson Pull-Through Procedure



Prepping and Draping

The circulating nurse applies the Proiodine prep solution to the patient's abdomen from the nipple line down to and including the perineum. A check is made to ensure that pooling of the solution has not occurred under the patient to prevent a chemical burn.

Once the prep is complete, the surgeon and scrub nurse begin the draping procedure. A draw sheet is placed under the patient's buttocks. Towels are placed on each side of the abdomen and across the chest and secured with towel clips. Towels are wrapped around each leg and the left anesthetic bar and secured with adhesive strips and towel clips. A laparotomy sheet is placed in the usual manner, bringing the lower end to the top of the anesthetic bar. Zimmer clips are applied to fasten the laparotomy sheet to both anesthetic bars.

Operative Technique

The video camera system is moved into position at the side of the OR table. The fiber-optic light cord and CO₂ insufflating tubing are passed off the sterile field to the circulating nurse for connection to the light source and insufflator. The camera system is connected to the telescope and a white balance check is completed to ensure correct color setting. The electrocautery cord and irrigating and suction tubings are passed off to the top of the OR table and connected appropriately by one of the circulating nurses.

A small incision is made in the right upper quadrant of the abdomen. Using a Radially Expandable Sleeve and an Insufflation and Access Needle (InnerDyneInc. Southmedic), the pneumoperitoneum is created by insufflation of CO₂ into the abdomen. The patient pressure setting is set at 12 mmHg initially. The flow rate is set at 1 litre per minute until confirmation of correct placement of the needle is made. The flow rate is then increased to 6 litres per minute. The insufflation needle is removed and a Step SL75 5mm Cannula and Dilator (InnerDyneInc. Southmedic) is inserted into the sleeve. A 30 degree 5 mm laparoscope can now be inserted through the enlarged sleeve. Under direct visualization 5mm trocar and cannula are inserted into left upper and right lateral abdominal incisions. In smaller patients, a 3.5 mm trocar and cannula can be used in the left upper quadrant port site. A suction irrigating apparatus is available for removal of any fluid that may be present in the abdominal cavity.

Using a 5 mm Endoscopic Allport Rotating Multiple Clip Applier (Ethicon) and laparoscopic babcock forcep and scissors, the mesenteric blood vessels are ligated and divided. A laparoscopic hook cautery is

used for the smaller mesenteric and perirectal vessels. Dissection is carried out to the pelvic floor, mobilizing the sigmoid colon and rectum.

The colon is prolapsed out of the anus by inserting a sponge stick and applying downward traction. A second surgeon performs this maneuver. At this time a full thickness biopsy of the bowel is taken. The specimen is sent directly to pathology for examination to determine the presence of ganglion nerve cells. It may be necessary to take more than one biopsy if ganglion cells can not be identified in the first specimen. The circulating nurse indicates the location of the biopsy on the specimen label and pathology requisition as stated by the surgeon. Biopsies are sent in sterile jars without formalin. While waiting for the pathology report the patient pressure for the CO₂ insufflation is lowered to 6mmHg.

Once the pathologist determines that the biopsy shows ganglionic bowel, the bowel is resected at that level. Reanastomosis is made using absorbable 3-0 Vicryl sutures (Ethicon). After the anastomosis is completed, Hagar dilators lubricated with Muko are inserted into the rectum to determine the size of the lumen of the anastomosed bowel.

Using the laparoscope, the abdominal cavity is visualized to determine the presence of tension and the anatomical position of the bowel and for any bleeding. If necessary, the abdominal cavity is irrigated using warmed 0.9% Normal Saline and then suctioned clear. The pneumoperitoneum is evacuated and all cannulas and instruments are removed. The incisions are approximated with 1/2 inch steristrips or 5-0 Monocryl (Ethicon). The tubings, light cord and camera are passed off to the circulating nurse and the final sponge and needle counts are completed for both of the sterile tables. The drapes are removed and the soft roll and flannel are removed from the patient's feet and legs, returning the patient to the supine position as quickly as possible. The child is turned and moved carefully to the head of the OR table to facilitate the safe removal of the endotracheal tube by the anesthetist. All monitoring devices remain on the patient until the anesthetist is ready to move the patient from the OR table. The electrocautery pad is removed and the site is assessed. The scrub nurse cleans the prep solution from the patient's abdomen, legs and perineum. An appropriate size diaper is applied. The circulating nurse remains at the head of the OR table with the anesthetist to assist with extubation and moving the patient to the crib.

The amount of blood loss and irrigation are noted by the circulating nurse and reported to the anesthe-

tist. The circulating nurse completes documentation on the Operative Record.

Postoperative Phase

The anesthetist and surgical residents transport the patient to the Postanesthetic Care Unit (PACU). The anesthetist gives a report to the PACU registered nurse. Once the child is conscious, one of the parents is brought into the PACU to comfort the child until he/she is ready to be transferred to the pediatric ward. Once oral intake is resumed, usually within 1 to 2 days, the intravenous line is discontinued. The patient is discharged from the hospital in three to four days. A follow-up appointment with the surgeon is made for two weeks postoperatively.

Summary

The introduction of a new procedure into the operating room is always a challenge that requires careful planning and teamwork. Since we began performing this procedure, we have revised the care plan and reduced the amount of time required for preparation, patient positioning as well as the surgical time needed. □

Acknowledgment

The authors wish to thank pediatric surgeons, Dr. Peter Fitzgerald and Dr. Mark Walton for their support and encouragement during the writing of this article.

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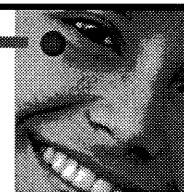
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Located on the scenic North Shore, across the inlet from the city of Vancouver, British Columbia, the North Shore Health Region prides itself on a strong tradition of caring. Our mission is to maintain and enhance the health and well being of everyone on the North Shore, one of BC's most prosperous and diverse communities, providing comprehensive and integrated health care services and programs to approximately 172,000 residents.

Lions Gate Hospital is the sole primary acute care facility of the North Shore Health Region, with 331 acute care beds and treats an average of 24,000 patients a year both on an inpatient and outpatient basis. We offer a wide variety of career opportunities that include a broad range of health care, administrative and support disciplines - all in a friendly and supportive work environment. A shared commitment to exemplary health care guides our staff whether in our primary acute care hospital, our residential care facilities or in our community health services. We are currently looking for a dynamic individual to fill the position of :

Clinical Instructor, Perioperative Regular Full Time

Reporting to the Manager, Perioperative Unit, the Clinical Instructor teaches staff through orientation and staff development programs and is the clinical resource for the Perioperative Unit.

Qualified applicants will possess a BSN, hold valid registration with the Registered Nurses Association of British Columbia, and three years experience in a related role supplemented by courses in perioperative nursing or an equivalent combination of training, education and experience.

Lions Gate Hospital also has Regular Full Time and Casual vacancies for Registered Nurses in the Operating Room.

Please reply in confidence to: **Brenda McDonald, Recruiter and Classification Analyst, North Shore Health Region, Lions Gate Hospital Site, 231 East 15th Street, North Vancouver, B.C., Canada V7L 2L7. Fax: (604)984-5770 Email: bmcdonal@nshr.hnet.bc.ca**

Cresting the Wave

16th National O.R.N.A.C. Conference

World Trade & Convention Centre, **June 14 - 18, 1999**, Halifax, Nova Scotia

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

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 future.

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

ORNAC In A Nutshell

National Board Report

November 1998

The Board and Executive of the Operating Room Nurses Association of Canada (ORNAC) met November 7 - 8, 1998 in Montreal Quebec. There were five Executive and twenty Board members present. Following are highlights of the two day meeting:

1. Issues relating to the International Planning Committee (IPC) and the new International Federation of Perioperative Nurses (IFPN) were discussed at length and the following changes were voted on:

a) The president will take on the role of IPC and IFPN representative instead of the Past President who presently has this role. The transition process may take some time to allow for a smooth passing of information from one to another and familiarization with the role.

b) ORNAC will send three Executive members to the Helsinki Conference in July 1999, orienting the transition person.

c) Executive members will be funded to Provincial Conferences which are attached to ORNAC Board meetings at the request of the planning committee of the host province.

2. ORNAC continues to be represented at the Canadian Council on Hospital Services Accreditation (CCHSA). Information on surveyor credentials and the AIM program (accreditation's plan for the year 2000) is available from V. Hay on request.

3. ORNAC has requested CNA decrease the number of hours required to be eligible to write the Certification exam. A response from the Certification Committee indicates all certification groups will have to be contacted for approval and a survey will have to be conducted. This could take about two years.

4. It has been determined that past presidents will possess (during their lifetime) original J & J paintings presented at each National Conference. Since these are ORNAC property guidelines will be drawn up to allow for paintings to be returned to ORNAC on the demise of the possessor, if ORNAC should need them for a commemorative display, or when a National Headquarters is a reality.

5. A motion at the April 1994 Board meeting recommended ORNAC be an all RN association. A

motion at the recent meeting makes this mandatory by June 1999.

6. Word has been received that the Telemedicine Education program has been cancelled.

7. Nominations for Executive officers will be received by the committee in December. A new Executive will be elected at the June 1999 Board meeting.

8. Research Committee is prepared to receive applications for ORNAC Research Grant funds. It is hoped a recipient can be announced at the National Conference in Halifax.

9. The Standards Committee will review the Criteria for approval of Post Grad OR programs.

10. The Editorial Advisory Committee reports all provinces will be part of the Canadian Operating Room Nurses Journal (CORNJ) subscription program soon. The French Translation Committee continues to hope French articles will be published in the CORNJ.

11. Public Awareness reports the ORNAC Web Site will expand to include provincial information. The committee is putting the final touches on the pamphlet "Perioperative Registered Nurses Care for You".

12. ORNAC is working on a National Membership list. This will include gathering of data on members, a new application form, a numbering system and membership card.

13. The importance of lobbying for OR nurses has been identified. A workshop for Executive and Board members will be conducted and facilitated by Carol Pessault from CNA prior to the Halifax June 1999 Board meeting.

14. The Historian is preparing ORNAC documents for microfilming. Pictures and pamphlets will be stored in archival protective sleeves.

15. Plans for the National Conference in Halifax in 1999 are almost complete. The program and registration form will be on the WEB page in December and in this issue of CORNJ, (See page 16-18).

Adapted from the minutes of Nov. 7 - 8, 1998
C. Balcom, Secretary ORNAC



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: _____
 Postal Code: _____ Telephone No. () _____ Fax () _____

Professional ORNAC Member RN ORT Other
 Information: (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	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	Ceilidh Night menu is lobster! Please check the box if you require an alternative main course. <input type="checkbox"/>
Evening Activities	<input type="checkbox"/> Sun	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	
	Welcome reception	Maxxim Night	Ceilidh Night	Fashion Show	Pub Crawl	
Guest Tickets (limited number)		<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs		
		Ceilidh Night	Fashion Show	Pub Crawl		

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

Early Bird Draw - 4 nights complementary accommodation at the Sheraton
 Participants must be registered both the the conference and in the Sheraton Hotel by March 19, 1999 to qualify.

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 _____

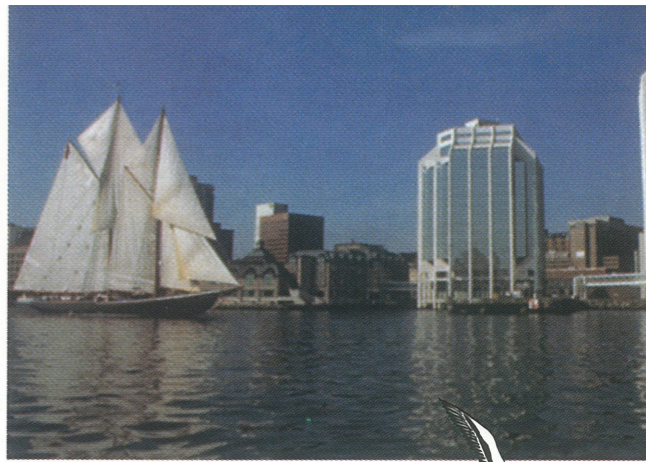
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 Tel: (902) 454-4714 Toll Free: 1-877-313-0333 Fax: (902) 454-4930 Email: compart@ns.sympatico.ca

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

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

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

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

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.

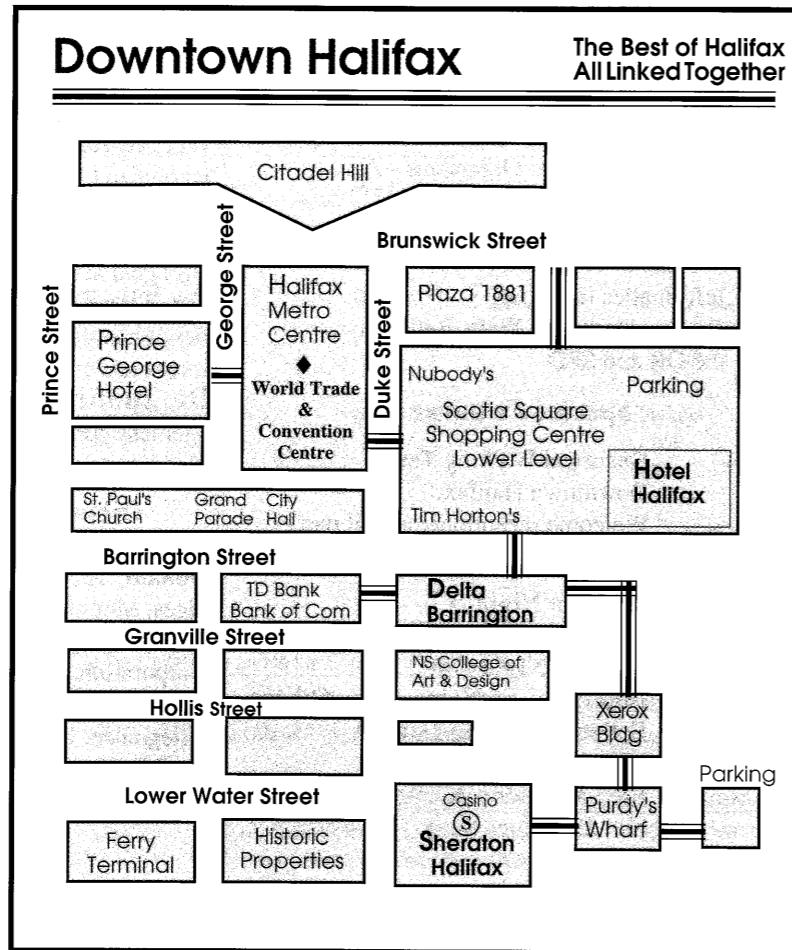
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(902) 429-6048
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Cambridge Suites
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Halifax, NS B3J 3P5
1-800-565-1263
(902) 420-9379
\$145 Jr Suite, Single
Double incl. Continental
breakfast



Alberta OR Nurses mark 20th Anniversary with honors and a Party!

Meeting in Red Deer, Alberta for their 17th Annual conference, the Operating Room Nurses Association of Alberta (ORNAA) marked the occasion of their 20th anniversary with a big party and a special event honoring of their past presidents, (see page 20).

Alberta's '99 Conference in Kananaskis

The 18th ORNAA Conference will be held October 27 - 30, 1999 in Kananaskis, Alberta. Mark your calendar now.

Dorothy Orr honored with Governor General's Award for community service

Dorothy Orr, ORNAA's founding president (1977 - 1979), was honored this past August with the Governor General's Caring Canadian Award - one of only 20 Canadians selected to receive the award in 1998.

Dorothy retired from the Brooks Health Centre, Brooks, Alberta, as the Operating Room Manager in 1993 and continued to work in the hospital and the community as a volunteer. She has worked as a committee member for the fluoridation campaign, hypertension clinics, Red Cross blood donor clinics, and her pet Cardiac Rehab Program.

Dorothy served on the ORNAC Board in her professional nursing years, and as the first ORNAC Historian. Continued good health to a wonderful, high energy lady who chooses to continue using her nursing and administrative skills in her retirement.

Congratulations Dorothy from all your nursing colleagues and friends across Canada.



Cake Cutting

Gloria Nemecek (Past President), Kendall O'Brien, (President) and Kim Robbins (President-Elect).

ORNAA 1998 Planning Committee

(LtoR) Back row: Shane Gormley, Barb Wooff, Carol Rolfe, Melodie Gawryletz, Nadine Englehart, Kim Robbins, & Marilyn Starling. Front row: Rosemary Strand, Dearla Liivam, Dorothy Cocks, (Chairperson), and Marilee Saunders. ▼





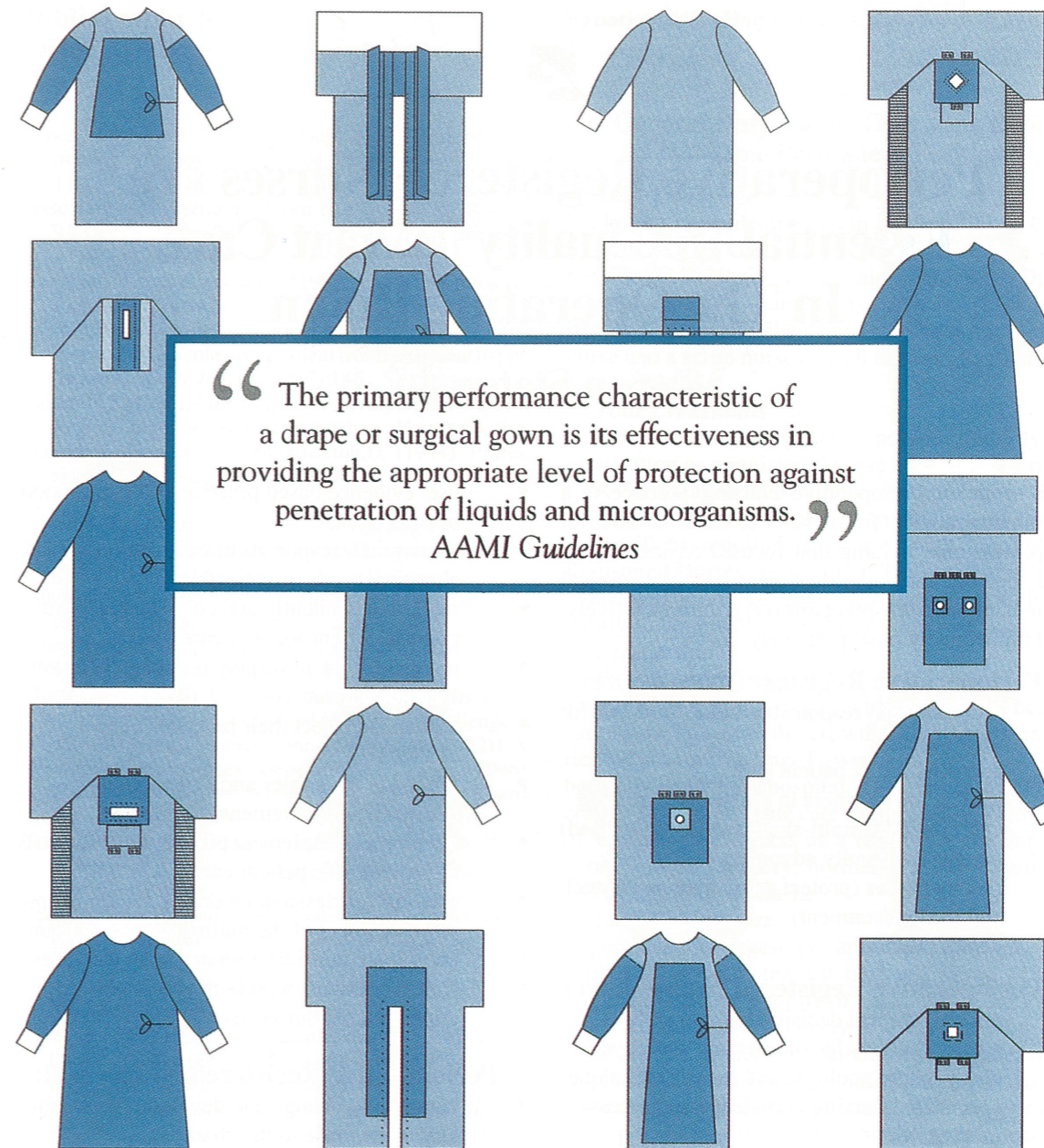
ORNAA Past Presidents Honored

Shown at the 20th Anniversary Celebrations are 8 of the 11 past presidents of the Operating Room Nurses Association of Alberta. The presidents were honored by the delegates and guests of the 17th Annual Conference of ORNAA. In addition to the Birthday Cake and a commemorative plaque each president was presented with a corsage and a 20th anniversary pins. Pins were also distributed to the delegates and guests. Standing (L to R) Marge Ensminger, ('86-88), Dee Robinson, ('94-96), Sharon Balkan, ('90-92), Sara Dougherty, ('79-81), Dorothy Orr, '77 - 79), Gloria Nemecek, ('96-98), Muriel Shewchuk, ('82-84) and Carol Rolfe, ('84-86). (Not shown) Jane McLain ('92-94), Jackie Waisman ('88-90) and Phyllis Culley ('81 - 82).



ORNAA Executive

Back row (LtoR) Rosemary Strand, Red Deer, (District President); Trudie Dangerfield, Lethbridge, (Secretary) and District President; Peggy Ziegler, Edmonton (Education Director); Kris Rollins, (District President) Linda Makar, Darleen Engel, Dearla Luvan.
Seated (LtoR) Kendall O'Brien, President; Gloria Nemecek, Past President; Marilyn Starling (District President) and Kim Robbins, (President-Elect).



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Perioperative Registered Nurses are Essential To Quality Patient Care In The Operating Room

Mission Statement

The scope of Perioperative Nursing practice is a continuum ranging from a basic to an advanced level of professional nursing that focuses on identifying and meeting the individual needs of the surgical patient immediately preoperatively, intraoperatively, and immediately postoperatively.

Perioperative Registered Nurses are:

- professionally responsible and accountable for their practice
- coordinators of patient care
- leaders and teachers in the health care field
- cost effective (multi-skilled and cross-trained)
- patient and family advocates
- risk managers (protect the patient, personnel, and the environment)
- health promoters

Perioperative Registered Nurses have:

- critical, clinical decision making skills
- a broad knowledge of anatomy and physiology, pharmacology, and aseptic technique
- specialized nursing knowledge and assessment skills
- Recommended Standards for Perioperative Nursing Practice
- a functional knowledge of medical legal aspects
- a certification process (examination established by the Canadian Nurses Association)
- a Code of Ethics which guides nursing practice

Perioperative Registered Nurses:

- establish respectful, trusting, therapeutic relationships with patients and their families
- use the nursing process to direct care

- use evidence based practice in the provision of nursing care
- assume new responsibilities in response to the changing needs of patients
- work independently and collaboratively to provide patient focused care
- recognize that all surgery is a major life event for each patient
- define and direct their practice (Scope of Practice)
- articulate their roles and expectations (Competency Statements/Standards)
- develop and implement policies and protocols to provide safe patient care
- establish professional working relationships with members of the multidisciplinary team
- coordinate multidisciplinary team activities
- care for patients with both predictable and unpredictable outcomes

Perioperative Registered Nurses will:

- continue to change and develop professionally in response to the changing needs of patients, the health care system and society

Endorsed by ORNAC to promote Perioperative Registered Nurses.

PROMOTING EXCELLENCE
Date Issued: November, 1998
Operating Room Nurses Association of Canada
ORNAC
Association des Infirmières et Infirmiers
de Salles d'Operation du Canada
AIIISO

Bibliography for ORNAC Mission Statement

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Experience the Magic and the Mystery of the Yukon

White Horse General Hospital operated by Yukon Hospital Corporation

General Duty Nurse, Operating Room 3/4 Time Permanent Position

Your Challenge

Under the general supervision of the Clinical Care Manager of the O.R., the successful candidate will provide professional and technical care in the Operating Room (O.R.), and Post-Anesthetic Care Unit (PACU). The incumbent operates as a circulating nurse and a scrub nurse as well as providing nursing care in PACU.

Your Credentials

Qualifications for this position include eligibility for registration as a registered nurse in Canada, current CPR Certification, and training or experience in O.R. Nursing. Prior to employment, the successful candidate will be required to register with the Yukon Registered Nurses Association. The successful candidate will be a highly motivated individual with the ability to cope with emergency situations, and provide leadership.

Your Expectations

To work with an innovative and enthusiastic health care team. To add to the growth of your work experiences in a rural setting. To work in a newly built 49-bed fully accredited hospital. The Whitehorse General Hospital is an acute care facility serving the City of Whitehorse and acts as a referral centre for the entire Yukon Territory, northern British Columbia and some areas of Alaska.

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Experience the longest day at Dawson City, hike the Chilkoot Pass, raft the Tatshenshini River, photograph the sites and wildlife of Kluane National Park, drive the Dempster Highway to Inuvik crossing the Artic Circle, participate in the annual Rendezvous celebrations, visit Skagway and Haines, Alaska for fresh seafood, ski the endless trails. With an approximate population of 25,000 Whitehorse has schools for all grades including two high schools. Our unique Yukon college provides post-secondary education courses in several different fields ... there is much to see and do in the **YUKON!!**

Annual Salary Range - \$47,888 to \$59,874 prorated for 3/4 time hours to \$35,923 to \$44,905 plus a comprehensive benefit package. Relocation assistance.

Please forward resume quoting reference #ORJ001 by Jan. 20, 1999 to:

Human Resources Department
Whitehorse General Hospital, Whitehorse, YT
Y1A 3H7 Fax: (867) 393-8707
For more information contact:
Penny Rawlings, Clinical Care Manager, O.R.
Phone: (867) 393-8773



Saskatchewan Operating Room Nurses' Group Board of Directors

Standing (LtoR) Ginny Mielke (South Liaison), Leona Zboril (Public Relations), Fran Clark, and Jan Maier (Secretary/Treasurer). Seated (LtoR) Sheila Koch (Coordinator Education), Marg Farley (Past President), Marla Ewen (President), and Willow Underwood (Membership).

Saskatchewan conference an excellent stress reducer

Moose Jaw: Relax, Revitalize and Reconnect was the conference theme of the 1998 Saskatchewan Operating Room Nurses' Group. They Relaxed at Temple Gardens Mineral Spa, (all the masseuses were booked solid for months in advance), at a Jazz Concert, and in the tunnels of Al Capone's underworld. Over an October '98 weekend 78 SORNG members and non-members reconnected with their nursing buddies at a banquet, in the spa, in two full days of educational sessions, at buffet lunches and at coffee. It was so relaxing the group wants to meet at the Spa again in '99, or somewhere similar in creature comforts.

More than strained nerves and tired bodies were revitalized at the spa. Speakers were of major league quality, heavy-duty brain cells stimulating delegates and offering enlightenment and strategies to deal with the stress of constant change in the workplace.

(See Sanda Bassendowski address page 25).

Keynote speaker Dr. Marlene Smadu conducted a revitalizing workshop exploring the issues associated with nurses caring for themselves and their colleagues, their clients and the world. She stressed the importance of self-care and a recommitment to the purpose of nursing. Dr. Smadu is the Saskatchewan Assistant Deputy Minister of Health, and her workshop deserves a full four page article as it was filled with the educator's structured lessons on the purpose of learning and giving and many wonderful anecdotes and words of wisdom. The following two samples best sum up her workshop until the full

Continued page 30



Conference Planning Committee Members (Seated LtoR) Barb Schoenroth and Susan Machmak. Standing (LtoR) Selma Empey and Gayle Kell. Elsa Silverson and Diane Dixon (not shown) were also in on the planning.

"Eighty percent of the technology that we will use in the next 5-10 years has not yet been invented."

Strategies to Deal with Change

Saskatchewan Operating Room Nurses Group

By Sandra Bassendowski, RN, MEd.

My presentation will focus on change and on strategies that can assist us to deal with change. You know all about change and what it is like to experience change day after day and month after month. You have experienced the feelings and emotions related to unending chaos.

I based my presentation on a model related to stories. The model assumes that individuals take meanings from stories and there are different kinds of stories that filter our ways of knowing. The importance of storytelling is recognized throughout the world as one the most significant ways to preserve the history and culture of various groups.¹

The therapeutic benefits of story telling were recorded in the nursing literature more than 60 years ago. It can be used to teach values, strengthen community and family bonds, educate, and share practical information necessary for daily living.

When significant change occurs in a society or group, there is a "new" story to tell, one in which there are different values and people behave somewhat differently than they did in the old story. In many instances, we create this new story by experimenting, reflecting, and responding to the very real changes happening in the world in which we live. Looking through the frame of the story model, we can begin to understand our perspectives by examining our present personal, cultural, and global stories. We also see the importance of our past in relation to the future.

Experiencing Change

Most of us are addicted to feeling competent. We are uncomfortable when we feel incompetent. We like the feeling of knowing.² We are living in times when the assumptions that we live by are being challenged in every area, including government, economy, health care, education, and social issues. It is little wonder that we find ourselves embroiled in controversy and transformation. If you can become comfortable with the uncomfortable feelings you experience when learning new skills, and if you can

become accustomed to the discomfort that change brings, then you will be able to engage your broad range of talents. Our future will increasingly depend upon our ability to learn and change.³ Yet what we fear most is the sense of discomfort we feel when learning and changing. At times, we lack the confidence that we will ever learn the new skill. Or we are impatient with ourselves when we cannot get the skill or theory the first time. Other times, we are too embarrassed to ask for help and we try to figure it out ourselves and after several false starts, we give up in frustration. If this is a recurrent pattern, we may eventually doubt our abilities. Becoming comfortable with being uncomfortable is the root of the new security. It is not so much that we're afraid of change or so in love with the old ways, but it's that place in between that we all fear. It's like being in between trapeze bars. It's Linus when his blanket is in the dryer! There's nothing to hold onto!⁴

In these rapidly changing times, people are uneasy, uncertain about what will happen in their lives and their jobs. There is no such thing as a secure job anymore- **only secure people**. In this world of change, here are three main sources of security today (1) our ability to learn throughout our lives, (2) our ability to

Author

Sandra Bassendowski, RN, MEd., is President of the Saskatchewan Registered Nurses' Association. This is an abridged version of her presentation at the Saskatchewan Operating Room Nurses Group Annual Meeting, Moose Jaw, Sask., October 18, 1998.



be flexible, and (3) our ability to cope with uncertainty.

We can't change the world if we can't change ourselves. If we can't change ourselves, we will not be able to bring about change on a grander scale. Change for the individual comes about by involving the head, the hand, and the heart. Clearly, people know that they have to change (head), but many fear change (heart), and this fear can be so strong that it paralyzes them (hand).⁵ Our personal attitudes and behaviours flow out of our belief systems.

Therefore, it is critical to begin the change process with a serious examination of our openness, our proactiveness, and our commitment to improving our profession. Openness to change is easily detected through an honest assessment of our language: do you hear yourself saying "I choose," "I prefer," "I will," as opposed to "I can't," "I won't," or "if only."

To change our way of thinking, we must be able to see new patterns and new connections. The word that has been overused in the 1990s is *paradigm shift*. We must be willing to see things in a new light. If we want to transform or reshape our organizations, reinvent government, or create a new society, we must change ourselves first by questioning our own belief systems and our own paradigms.⁶

The changes we are undergoing today promise to be significant; nursing will never be the same. Looking through the frame of the Story Model, we can begin to understand our perspectives by examining our present personal, cultural, and global stories. We must also look at the past, present, and future. We cannot and should not ignore our past. We need to examine our accomplishments and our struggles in order to establish our benchmarks for the future.

From a Canadian cultural perspective, health care reform, nursing shortage, and new curricula and programs color our stories. The change in emphasis from a system of predominately illness care to one that of population health, health promotion and illness prevention is a reality in 1998. The media portrays the health system as remaining in crisis, and now a new crisis looms with casualization of the workforce, aging of registered nurses, and the need for dedicated recruitment of students.

From a global perspective, no country seems satisfied with their health care system as it is. Systems are too expensive, highly bureaucratic, and most do not focus on health but illness. Countries are all looking for increasing effectiveness in promoting population health. The information highway, trade agreements, global economies, and expanding travel has brought us together as humans. We live in a world of chaos that is interconnected and interdependent.⁷

How did we come to our situation in nursing? A look at the old story provides some clues. At the turn

of the century, people were cared for in their homes with strong local community support. About 80% of nurses worked in the community as private duty nurses. They had responsibility and a strong sense of autonomy. Following the Second World War, many, many hospitals were built and nurses chose to move in great numbers into the institutions for the guarantee of steady work. They held steady jobs but the price was damaging! Some of the old story values for nursing include hierarchies and lack of power, undervalued role of women, physician dominance, institutional rules and regulations, centralized government structures, low autonomy, and high conformity.⁸

Today we are the largest group of health care providers in Canada. Would you say that our image, power, status reflects this position?

For the "new" story, we need to consider our world from a different perspective. We need to re-examine public issues such as chronic diseases, violence, abuse, occupational injuries, antibiotic resistant diseases, addictions, stress, poverty, illiteracy, and increase our accountability to people affected by these issues. We must examine professional issues such self-regulation and value the responsibility that has been provided to us to govern ourselves. We must deal with issues related to competencies, education, practice environments, and scope of practice. We must not only consider these issues from our local perspective but from one of global dimensions.

Global Quiz

If we could shrink the earth's population to a village of precisely 100 people, with all existing human ratios remaining the same, there would be:

- ◆ 57 Asians, 21 Europeans, 14 North & South American, and 8 Africans
- ◆ 51 females and 49 males
- ◆ 70 nonwhite and 30 white
- ◆ 70 nonChristian and 30 Christian
- ◆ 6 individuals who have 50% of the entire world's wealth and all of these individuals would be from the U.S.
- ◆ 70 who cannot read
- ◆ 50 suffering from malnutrition
- ◆ 1 with a college degree
- ◆ 0 with a computer (From: TR-Dev listserv)

When one considers our world from such an incredibly compressed perspective, the need for both tolerance and understanding becomes glaringly apparent. As registered nurses, many of you care for individuals who come from other cultures or work in other countries. We cannot afford to be ethnocentric in our beliefs.

Fear of the Future

Canadians fear the future for several reasons, but research indicates that the predominant source of worry is job security. The reality is that society and the economy are changing at a speed that we have never experienced before. The old ways of doing things, the reliable patterns by which we once governed our lives, no longer work. The constant barrage of change gives rise to widespread anxiety. The profound changes that we are experiencing today would normally take 2-3 generations to be assimilated. We are trying to make the stretch in a decade—the *nanosecond decade*.

Technology and Economic Change

The technology shift is now familiar to us - from instant bank machines, to work settings, to home computers. Computer technology has drastically changed our work habits.

The economic changes around us are important to understand because they will dictate the skills that will be in demand in the next century. Never before have we had an economic shift of this depth and magnitude. There is a nostalgia to return to what has been lost coupled with the urge to resist the new.

Think in the Future Tense

As a society, we need to plan successfully for the future by using what we know today and having the necessary flexibility to adapt as we go along. We cannot go backward, we cannot stand still. The key is the ability to think in the future tense.⁹ We will need skills such as perspective, flexibility, vision, energy, and global values.

Nurses have the qualifications to reflect, dialogue, take risks, and to celebrate the changes in nursing. You can create the future and not be victimized by future events. You can perceive the complexities of a situation, analyze these complexities, and develop possibilities, and reshape the usual. You can stimulate others to embrace change rather than fear it or struggle against it.

Keep an unwavering vision and commitment to your purpose and the profession. Knowing yourself and what you stand for are admirable traits.

We know that the nursing environment is difficult. We need to change our history regarding the perceived or real lack of power as a profession and as women. We need to think beyond today, and into the new world of health care, and transform our nursing profession to meet the needs of the people of the world.¹⁰ Collectively, we must strengthen our professional attributes of caring, responsibility, authority, autonomy, commitment, and collaboration. We must continue to build upon our expertise, continually improving our knowledge, skill, and judgment.

Margaret Wheatley in her book, *Leadership in the New Sciences*, states "The change is like a ripple; it doesn't matter where you make the change, it doesn't matter how large the ripple, it doesn't matter how isolated you may feel, if you make the change it creates a ripple that ultimately changes everything."

The key to your profession in the new millennium, is to continue to develop yourself. You will have a satisfying career if you can respond flexibly to chaos and rapid change, and present yourself as a positive role model. Innovation is in! Being innovative means being able to look objectively at current systems and processes and determine how they can be done more efficiently and effectively. You will have to make changes and choices as you go along.¹¹

Now is the time for each of us to reflect on what we truly believe is worthwhile and how best to be a registered nurse. •

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*Overheard in the OR ...
I don't have an attitude problem.
You have a perception problem!*

World Conference of Surgical Patient Care

(formerly known as the World Conference of Operating Room Nurses)

Helsinki, Finland, July 25 - 30, 1999

Plan to attend this event, and join the Canadian contingent at the International Fellowship Night.

The theme for the Conference is "The Essence of Perioperative Care" with the following topics:

- Global Economics of Health Care
- Care of the Health Care Professional
- Care of the Aging Patient
- Ethics
- Resource Management
- Infection Control
- Recruitment & Retention Strategies
- Specialty Education
- The "Before & Afters" of Surgery
- Workplace Issues
- Research Poster Display

Background Information

It has been the role of the ORNAC Past President to represent ORNAC on the International Planning Committee (IPC) for the World Conference. The IPC Committee consists of active and corresponding members. The active participants at the planning meetings are AORN, Australia, Canada, Finland, Japan, New Zealand and the UK.

The IPC's Scope of Responsibility is to:

- Select conference theme.
- Identify education topics.
- Select opening and closing speakers (host country)
- Propose speakers
- Review and recommend proposals
- Serve as liaison for their country's speakers and attendees
- Assist in promoting the conference
- Assist with on-site participants
- Evaluate the conference
- Moderate session(s) on volunteer basis
- Bear their country's flag at Opening Session

AORN selects the site and organizes all other aspects of the conference. Originally the IPC meetings were held on site in the host country. Since 1996 these meetings are held in conjunction with the AORN Congress for cost containment and convenience reasons.

As you note, the focus of the conference has now been changed from that of the operating room nurse to surgical patient care, which encompasses other care providers. This was an AORN decision.

Canadian Delegate Information

It has become a tradition for the Canadian delegates to wear the same attire at the International Fellowship Night - a combination of red and white providing an impressive, colourful sight. Conference delegates look forward to the Canadian entrance. In Helsinki we plan to do the same. The attire will consist of a red cap and a combination of a white or red top and skirt or pant. The caps will be available for purchase at the ORNAC National Conference in Halifax, or from myself. Anyone wishing to spend a little extra can also purchase a red vest. Details regarding cost will be published in the next Journal.

For the purpose of planning the International Night, it is important to know how many Canadian delegates will be attending the conference. If you plan to be at the World Conference, please contact me at: 4421 Rainforest Drive, Gloucester, ON K1V 1L5
Fax: (613) 822-0003

Vija Hay
Past President, ORNAC
IPC Member

Seeing the Light in Day Surgery

By Amoy Lowe, RN, CPN(C)

I would like to share my experience and professional views of how the mature perioperative nurse need not be afraid of microintraocular and extraocular surgery.

As we age, many of our faculties diminish. We may even infantilize ourselves if we allow the inevitability of aging to preoccupy our very existence. Two years ago I decided that I would experiment on myself. When asked to work in the hospital's eye room, it was with apprehension and a lack of spirit that I said yes. After a few days I realized that my entire physical being and mature attitudes had to take on new form. How was I going to keep up with the pace, the silence and the body language which is needed to show patience and kindness to our aging surgical patients.

The first thing I had to do was acknowledge that I was aging, but it was not necessary for my mind and body to succumb. I started exercising, eating properly and most of all my inner thoughts of negativism had to change.

As the months progressed in my new Day Surgery position I discovered how wonderful it is to have real contact with our patients. I allowed myself to listen to their concerns, touching, smiling and offering words of encouragement.

Mount Sinai Hospital's Day Surgery has been a wonderful experience for me. I am able to meet one or more family members of the patients and get a sense of many things. Is this patient coming from a caring environment or has the family accompaniment been done out of duty?

Our pre-operative assessment of patients has to be performed in a calm, efficient and caring manner in view of an aging population whose hearing and eyesight may be impaired and mobility may be diminished. The majority of these patients look forward to their preoperative time because we may be the only social contact he or she has had in weeks.

I found that I had to spend a longer time studying the anatomy of the eye. Special skill had to be acquired in order to handle the delicate instrumentation of eye surgery; and most of all, my entire personality,

in terms of being silent. It was a great discipline for my character.

The skills that I had acquired as a general duty O.R. nurse came into good standing in identifying very ill patients and in the ability to assist with anaesthesia as required.

At this point in my career I must give credit to the younger O.R. nurse with whom I worked and who showed me so much respect and caring. The Ophthalmology surgeons encouraged me in my new practice and the auxiliary O.R. staff shared with me many wonderful conversations while cleaning the room.

Overall, I became a much better integrated Operating Room nurse and could now find the time to appreciate many funny situations.

As a mature and experienced perioperative nurse I was able to make many suggestions to the surgeons in view of monetary restraints and improved organization. I helped implement changes in draping, in the standardization of instruments and contributed to the reorganization of the Ophthalmology room so that the flow of work reflected more effective and efficient patient care.

These thoughts are shared with all my perioperative colleagues - do not allow aging to become a deterrent in your winding-down years. Be strong, be proud and always remember... "we are the brick layers and the sunshine of the Operating Room". We belong to that batch of fine wine which is best tasting and the most marketable because it has aged well.

My grateful thanks to Dr. J. Hurwitz, Chief of Ophthalmology, Mount Sinai Hospital, Toronto; Dr. Feldman and Dr. Mandelcorn, and all the others who were patient and instrumental in my introduction and education in the Ophthalmology Day Surgery.

Most of all thanks to my nursing colleagues, especially Mindy Shinoff, RN, (CPN(C)), for showing me that there is renewed sight and life after 50.

Author

Amoy Lowe, RN, CPN(C), is a Staff Nurse, Ophthalmology Service, Operating Room, Mount Sinai Hos-

- If your life works, you influence your family.
- If your family works, your family influences the community.
- If your community works, your community influences the nation.
- If your nation works, your nation influences the world.

Remember that your influence begins with you and ripples outward. So be sure your influence is both potent and wholesome.

In the workshop section on caring for colleagues, Dr. Smadu recommended (i. Networking, (ii. Mentoring, (iii. Sharing Vision and Values, and (iv. Using humor. "Generosity is the Key", she said. "If you share your best nursing practice, you get it back throughout the unit. Like the candle, you don't lose the light when you give it away, and you don't lose your power when you share it. You empower others."

Margaret Fullerton, a nurse consultant with Allegiance, presented at both the SORNG meeting and the Alberta OR Conference the next week. Her "Managing Your Manager" presentation offered scenarios of tricky situations involving verbal abuse issues, noise levels, dealing with rumors and professional practice issues. Her suggestions for challenging management and living to tell the tale were valid, highly original and applicable in most workplaces. Watch for these techniques in a future issue.

"Turning Off the Nightmare - Surgery for Parkinson's Disease and Fine Tremors" was jointly presented by Lori Stricker and Laureen Kreiger. This presentation was seen on Telemedicine Canada before it ceased to exist in February, 1998. Lori is currently writing-up this 12 hour surgical case for an early 1999 issue of this Journal.

NBC's *60 minutes* introduced this tremor halting surgery this past September with great fanfare, however, a Regina General surgeon has been refining the procedure for several years. Watch for the article in March '99, it's a remarkable story. ■

Overheard in the OR ...

There are very few personal problems that cannot be solved through a suitable application of high explosives.

Hey is your postal code correct? Hey did you get married again? Hey do you get all your mail? Hey have you moved?

The Canadian Operating Room Nursing Journal is mailed quarterly to 3,000 Operating Room Nurses across Canada, a few to the U.S. and some to foreign soil. If your Journal is not arriving, or if you change your name, address or postal code (particularly your **postal code**....please please send us your changes via FAX or mail only. *Please no phone calls!*

In the months of October and November there were 30 postal code corrections, two marriage name changes, and two address changes. Please check your mailing label, ensure your postal code is correct. If not Fax or mail your old and new address and code to us at (604) 535-9000. See our full address on page 3.

Bursary for OR Nurses

The ORNAC/Johnson & Johnson Medical Products 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.

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.

The personal profile/resume must be typed and supporting data enclosed with the completed application form. 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 **March 15th yearly**.

Applications are judged by the ORNAC 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. The bursary funds are designated specifically for tuition and books. The final approval for disbursement of funds rests with the Awards Committee and the Board. Contact your provincial representative for more information and assistance in applying.

Planned Change in the Evolution of Cataract Surgery

By Teresa Taylor, BScN, CPN(C) & Theresa Tremblay, BScN CPN(C)

Perioperative nurses are challenged, in these times, to keep ahead of new techniques and newly designed intraocular lens implants for cataract surgery. Cataract removal through small incisions and foldable lens implantation have become increasingly popular.

Our goal, as perioperative ophthalmic nurses in a community hospital, is to continue to provide the patient-centered care for patients with cataracts but still maintain efficiency. We found that a change in the overall process in our hospital was required to meet the challenge of the new faster surgical technique. There were several problems that created stress and disruption in the previous system.

No matter how well things are functioning in an organization, such as a hospital, it is unlikely that a system will reach a stable equilibrium (Bernhard & Walsh, 1981). Our surgical environment needed to change in response to the demands of safety and

performance with the new surgical techniques and new technologies.

In Kurt Lewin's theory, the development of a need for change is the "unfreezing" mode, i.e. disturbing the equilibrium, (Lippitt, Watson and Westley, 1958). Awareness and a desire for change is the first step. Once the equilibrium is upset then change can occur, (Bernard and Walsh 1981). Lippitt et al(1958), have expanded on Lewin's theory to include five phases of the change process:

- the development of a need for change, (*unfreezing*);
- establishment of a change relationship working towards change, (*moving*);
- generalization and stabilization of change, (*freezing*); and
- achieving a terminal relationship.

Unfreezing

In our operating room (OR), surgical delay problems became a major impetus for change. We identified problems that caused delays in areas of patient preparation, administrative requirements, patient transport, theater preparation, turnover times, instrument processing and standardization and documentation. Failure of a nursing care delivery system to meet the needs of its practitioners, patients or employers ensures change or death of the system, (Douglas and Bevis, 1981).

Authors

Teresa Taylor, RN, BScN, CPN(C) is Team Leader, Ophthalmic Surgery, and Theresa Tremblay, RN, BScN, CPN(C) is Clinical Educator, Hotel Dieu Grace Hospital, Windsor, Ontario.

Abstract

The subject of this paper is a description of how perioperative nurses and other health care professionals worked together to meet the demands of change.

New technologies and new techniques in cataract surgery with lens replacement has decreased dramatically the amount of operating room (OR) time required. With the reduction in OR time, the process of moving cataract patients through the perioperative experience became chaotic. Change was necessary. Planned change and teamwork made the change process less chaotic and more rewarding.

Our patients with cataracts are generally elderly, have limited mobility compounded with the vision deficits, hearing deficits and therefore sometimes comprehension problems. For example, they have difficulty preparing for surgery such as changing personal clothing to hospital attire and climbing onto a stretchers. They require assistance time and patience to get ready. Attempting to increase the pace was frustrating for everyone.

The start time of personnel in the admitting department and ambulatory care department did not allow enough time for patient preparation for an early morning start. As the surgery time decreased and the caseload increased, patient delays increased dramatically.

The administration requirements, history and physicals, electrocardiograms, and blood work were sometimes a last minute scramble, when the patient did not make a preadmission visit. The preadmission visit was sometimes difficult for elderly patient. It was time consuming and physically and emotionally demanding to make two visits to the hospital.

The transporting of patients to the operating room for cataract surgery was included in the mainstream with other surgeries. Other patient surgery often took priority over the cataract surgery. When the surgery time for cataracts decreased dramatically, there was such a demand for stretchers that the porters had to go on a search to find a stretcher for the next patient. At this time, patients remained on these stretchers for post operative recovery, first going to the post anaesthesia care unit (PACU) then to the ambulatory care department, making stretchers less available.

The shortened procedure caused pressure for shorter turnover time, affecting the scrub and circulating roles, housekeeping and the processing aides. There was a limited supply of instrument sets and these delicate and microscopic instruments were difficult to clean and required extra care and handling. At this time the scrub nurse was responsible to clean them properly. The processing aids were then pressured into flashing them quickly for the following cases. There was also a delay in waiting for housekeeping to clean the room, change linen and garbage bags, then mop the floor before nurses could open the several sterile packages required for each procedure.

The circulating nurse was also under pressure to hurry the preoperative assessment and bring the patient to the OR suite. This caused anxiety, and anxiety and rushing have the potential to cause mistakes. With the shortened procedure time, it was also difficult for the circulator to complete the documentation

before the surgery was ended.

To reduce the frustrations, a diverse group of team members collaborated as change agents. Establishment of a change relationship and working towards change to solve problems is the "moving" phase of Lewins' model (Lippitt et al, 1958). At different times in the unfreezing phase and moving phase different team members acted as change agents.

Moving

Firstly, physicians worked on administrative process changes. The surgeons and anesthesiologists identified policy changes such as the removal of the requirements for history and physical, electrocardiogram and blood work. Rationale for this removal was that the surgeon was now using topical anesthetics instead of blocks with limited IV sedation given by an anesthesiologist. The anesthesia department devised an anaesthesia questionnaire with the information they required. This would be given to the patient in the surgeons' office and reviewed with the nurse in the ambulatory care unit on admission, thus omitting the need for a preadmission clinic visit. This benefited the elderly patient who would no longer be required to make two trips to the hospital.

Secondly, the Ophthalmic team researched and trialed eye stretchers in order to reduce extra moves for the patient and to examine ways to keep the flow of patients more continuous. We wanted a head and neck stretcher that simulated the hydraulic capabilities of an OR patient table and were patient, physician and nurse friendly. One person was able to operate this new eye stretcher easily. On cataract procedure days, we evaluated the benefit of having a designated porter to bring the patients to and from the OR. We then purchased six stretchers to make the system work smoothly, and the overall result was increased patient comfort and reduced waiting time.

Standardized Packs and Procedures

We trialed custom packs that were designed for cataract surgery in order to avoid opening several packages. This accomplished two things; the three surgeons had to standardize their instruments and supplies, and the time to open cases was reduced significantly.

Next, the surgeons learned to perform the same technique for the small incision cataract removal with foldable intraocular lens implantation. Then, they collaborated with the nurses on standardization of

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instrument sets. This facilitated the education of the nurses orientating to the room and the processing aides.

In order to deal with the demand caused by the shorter time frame and the increase in the booked procedures, the admitting and ambulatory care department assigned an earlier shift. The shift relieved the backlog of patients waiting to be admitted. The ambulatory care department worked out a rotation system so that patients were assessed as they came in, placed on a stretcher, given eye drops, vitals taken then placed in order of admission so that no one would be taken out of turn. They also developed an eye drop kit that followed the standard orders of the doctors. The pharmacy also cooperated with drugs required in the OR and ambulatory care department by starting earlier and providing the service needed.

A Patient Friendly Process

The process for cataract surgery became more and more patient friendly as changes were made. The patients no longer had to undress completely, only their tops. They now keep their dentures and hearing aids throughout the surgical experience. Once on the stretcher, they remain there till after surgery and their family remains with them up to the time they enter into the OR. The outcome was a decrease in the amount of moves and less stress on the elderly patients. At times, family members came into the OR to interpret for the patient. This gave them a greater sense of control and less anxiety. Ongoing communication between the OR and ambulatory care prevented problems caused by untoward changes. Ambulatory care nurses worked on a systematic approach to move patients in and out of the hospital with the help of their families in approximately a two hour total time span.

The porter now brings our patients directly outside the ophthalmic suite where a registered nurse is assigned to do the preoperative assessment. This includes interviewing, explaining the steps of the procedure, discussing patient participation, positioning patients comfortably for surgery, preparing for, or establishing an IV line, attaching monitor leads and blood pressure cuff and generally beginning discharge planning. The nurse documents on the chart form and communicates any concerns to the other team members. This preparation reduces the overwhelming pressure on the inside circulator and increases the quality time between the patient and the perioperative nurse.

The processing aides were instructed on the proper cleaning and processing of the delicate eye instruments for *just in time use*, which reduced the pressure on the nurses. We also increased the number of instrument sets to prevent waiting time on sterilized instruments. Specialized cleaning equipment was invented to make the job easier. As the aides learned and developed their own routine, the tasks became less stressful.

We made a decision to reduce housekeeping but still follow the Operating Room Nurses of Canada (ORNAC) standard of spot cleaning between procedures. The patient stretcher became the OR patient table, as well as transport stretcher, so that OR table cleaning was eliminated. Nurses and housekeepers worked out a system of double sets of garbage and linen containers so that when one was filled it was pushed outside the room and replaced with a clean container.

Changes allowed the anesthetist to take a few minutes, prior to surgery, to start the IV and talk with the patient about the neuroleptic sedation. They also decided to bypass PACU because of the decrease in neuroleptic drugs required, but the option for PACU was still available, if required.

Further change included designing a specific record for cataract eye surgery. We trialed the record and received feedback from staff, then made changes for easier documentation, for example, tick off boxes.

“Freezing”(Generalization and Stabilization of Change)

One of the important questions about any process of change is whether or not the change, which has been accomplished, will remain a stable and permanent characteristic of the system, (Lippitt et al, 1958). Our change process was deemed successful because it actually affected the efficiency and productivity of the staff. Once the nurses firmly believed in the process that was developed, more procedures were accomplished in less time. A retrospective evaluation identified that our caseload had increased 60%, from 12 cases to 20 in a four hour period. Turnover time was decreased from twenty minutes to less than five. Changes have resulted in a system that allows the hospital to book cataract surgery with implants every fifteen minutes.

One strategy for increasing the caseload without compromising quality care, was to simplify the nursing roles. Utilization of three registered nurses, one for preoperative assessment, one for the circulating

role and one for the scrub role brought about a synchronized focused approach that used nurses efficiently and resulted in increased teamwork and less turnover time. These roles are interchangeable since all nurses were oriented to each role.

Other working staff, such as porters and processing aides became dedicated team members. This staff felt a responsibility to their roles because they had input to the changes that were made.

Economical advantages of change were also realized by the hospital. Cost reduction came about in the following areas:

- no preadmission clinic visit
- no lab., EKG, history and physical
- no sutures
- no recovery room visit
- no hospital stay
- less equipment, i.e. blades
- less eye medication, i.e. miochol
- less anaesthesia meds. and equipment, and
- less exposure to nosocomial infection.

The high volume caseload lowered cost in all areas and volume buying and standardization of lenses and equipment reduced cost. Reusable equipment also made an impact.

Our goal of quality patient care was measured by patient satisfaction surveys. Survey results showed that the operating room process, procedure, nursing care and efficiency were excellent 90% of the time and satisfactory 10% of the time. One patient wrote that the operation was so uneventful that she never recalled being in the operating room. Research has shown that outpatient cataract surgery is as safe but more cost effective than inpatient cataract surgery.

We noted several benefits to our patients that included but are not limited to following areas:

- increased comfort by avoiding the debilitating effects of movements,
- limited sedation eliminating unsettling after affects,
- minimal separation of family and support networks,
- family involvement when required, i.e. interpreter,
- minimal interruption from their regular routine including diet and medication,
- reduced anxiety from explanation of the process,
- participation in the procedure and post-op discharge instructions given by the nurse, and
- reduced pain by elimination of injections and the use of topical anaesthesia.

There is a reduction in the chance of endophthalmitis related to the small incision with a cartridge delivery system of a foldable IOL, which eliminates the contact between the eye and the IOL, (Kellan, 1996). Eliminating injections leads to an easier and safer procedure, (Fine, 1996). Patients experience less trauma in the eye because instruments are not physically introduced into the orbit, (Rowen, 1996).

Success is measured by the way planned change is transformed into actual achievements. One critical factor in the stabilization of change, is its affect on other systems where there is a strong likelihood the innovation will be esteemed and retained, (Lippitt et al, 1958). Our change in the process has made our cataract surgery program successful as other ophthalmic teams have adopted our system. Ophthalmic surgeons and operating room nurses from across Canada and the U.S.A. attended workshops to view the procedure and the process, in place at our hospital. All who attended were extremely impressed by the efficiency, skill and care provided by the team. They expressed a keen interest in adopting all or part of the program at their hospital or clinic. We continue to have visitors from all parts of the country to view the process.

Conclusion

Cataracts are a significant cause of visual disability for the elderly patient. This patient population values their independence and the demand for good quality vision is increasing. The idea that they can walk in, have a two-hour stay, participate in the process, walk out with immediate vision and without a patch gives them satisfaction and increases the demand for this procedure. It's nice to have them sit up after surgery and be surprised that they are able to see and that the procedure is over. □

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We would also like to thank the anesthesia department, RNs, and all OR staff at Hotel Dieu Grace Hospital. As team players, they made change possible. ■



Theresa Tremblay



Teresa Taylor

◀ Carmen Murdock, RN, (left), Dr. Brijesh Arya (right) in the Eye Surgery Assessment Area outside the OR. Also shown are the special *Eye Stretchers*.

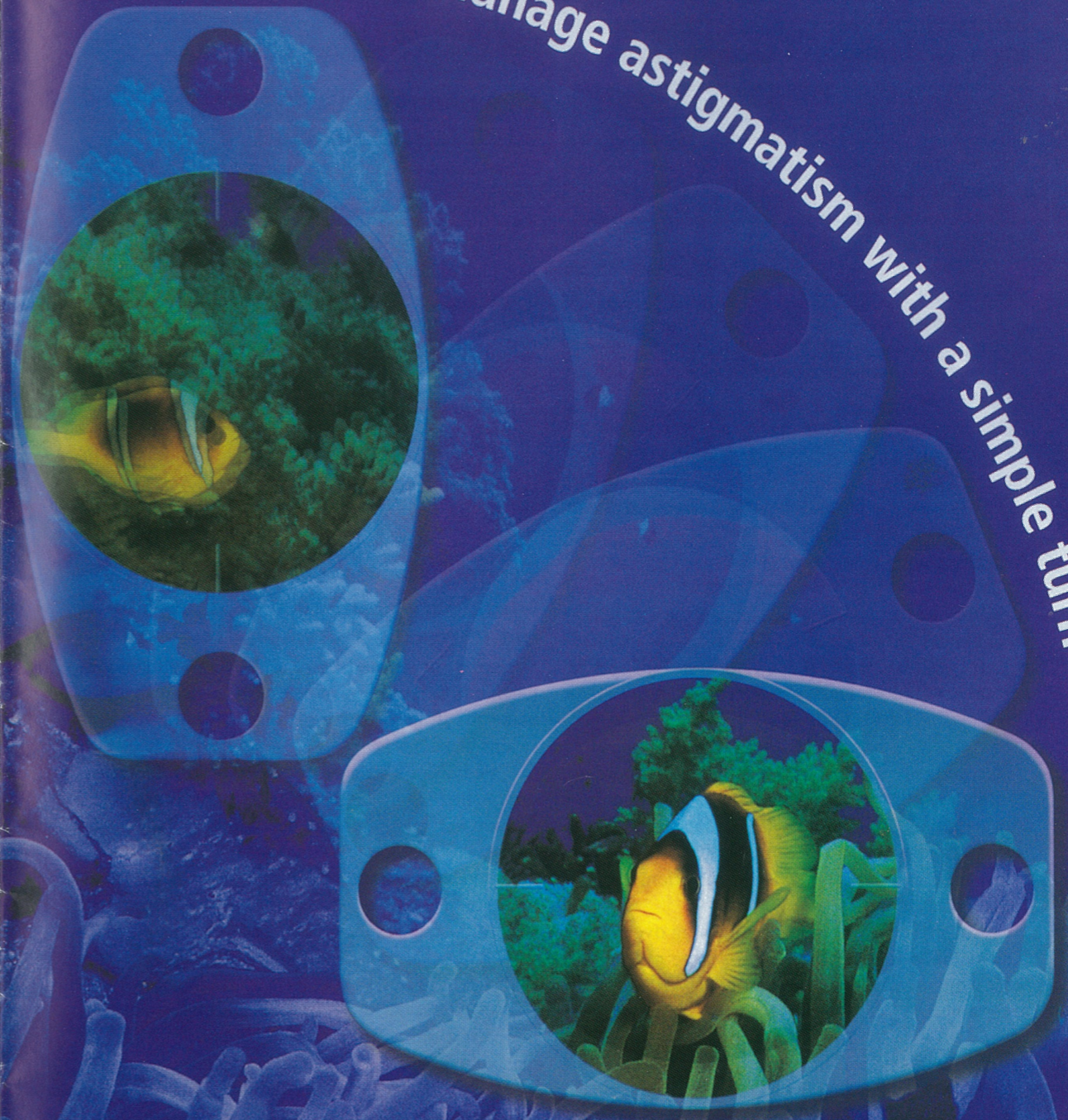
▼ Cataract Surgery in progress. Victoria Lypps, RN, scrubs for Dr. Fouad Tayfour.



▲ Insertion of the new foldable I.O.L.



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Study implicates antidepressants in increased falls and hip fractures

Psychotropic drugs, including tricyclic antidepressants (TCAs), have been shown to increase the risk of falls and hip fractures in the elderly. Although the reason for this has not been elucidated, analysts think it may be related to side effects such as from sedation, orthostatic (or postural) hypotension, arrhythmias and confusion.

Although selective serotonin re-uptake inhibitors (SSRIs) are reported to have fewer anticholinergic and cardiovascular side effects than TCAs, it was not known prior to this study whether SSRIs are associated with a lower risk of hip fractures and falls than TCAs.

Determining risk factor

A study was recently undertaken to determine the risk factor associated with antidepressant (SSRI and TCA) use in the elderly. The study consisted of a group of eligible elderly aged 66 and over who had been discharged from hospital with a hip fracture. Antidepressant use was determined by information obtained through coverage provided by a common drug plan in the province of Ontario. This included SSRIs (fluoxetine, fluvoxamine, paroxetine, sertraline), and secondary and tertiary amine TCAs (protriptyline, nortriptyline, desiprine, amitriptyline, clomipramine, doxepin, imipramine, etc.).

Medical conditions such as osteoporosis, Parkinson's disease, cerebral disease, etc), and drug use (sedatives, anticonvulsants, cardiac medications) which could increase the risk of falls and hip fractures, were also determined for each patient selected for the study.

An analysis was performed using over 8,200 patients in which antidepressants were used. 78% were women, with 40% age 85 or older. Ratios were ascertained by comparing those using antidepressants with those with no exposure to antidepressants, and then adjusted for other drugs.

The (adjusted) odds ratio for hip fracture was 2.4 for exposure to SSRIs, 2.2 for exposure to secondary amine TCAs, and 1.5 for exposure to tertiary amine TCAs. The study also found that recent antidepressant users (prescriptions filled within 30 days of the hip fracture) were at greater risk than continuous users.

"Antidepressant use, especially secondary amine TCAs and SSRIs, increase the risk of hip fractures and falls in the elderly," the study claims. SSRIs, they say, offer no advantage over TCAs in terms of risk of hip fracture.

(Additional details from: Liu, B., Anderson, G., Mittmann, N., et al, Lancet, 351: 1303-1307; 1998).

Canadians refuse to take advantage of flu shots

Canadians don't really understand the benefits of flu vaccinations according to a survey done by vaccine maker, Pasteur Merieux Connaught Canada.

The study of 1000 Canadians found that only one in five got a flu shot, with over 50% of them believing they were not at risk of getting influenza.

Even among those over age 65 and those with serious health problems, two of the groups for whom the vaccine would provide the most protection, almost half thought they didn't need the vaccine. Among the elderly, only about 30% usually get an annual flu shot, while among the chronically ill, about half get the vaccine.

Technique discovered that alters penicillin making it effective against antibiotic-resistant strains of bacteria

Scientists in Ireland have discovered a technique that alters the structure of penicillin in a way that may make the drug effective against antibiotic-resistant strains of bacteria.

Penicillin's effectiveness as an antibiotic has diminished significantly since its widespread introduction in the late 1940s, due to the ability of many bacteria to develop resistance to it.

The technique, developed by a team of researchers at the University of Limerick, alters the structure of the penicillin by incorporating a unique fragment in the penicillin molecule that is fatal only to resistant bacteria.

Some bacteria are able to nullify penicillin's infection-fighting properties by producing enzymes that split or cleave a critical part of the penicillin molecule, thereby making ineffective the penicillin. To counteract the action of this enzyme, drug manufacturers have introduced a chemical substance to the penicillin that inhibits the action of these enzymes. However, bacteria have developed additional resistance to this chemical substance and have made the antibiotic ineffective.

The Irish discovery, however, involves "booby-trapping" the antibiotic. The unique fragment introduced into the penicillin molecule becomes activated only when the penicillin comes in contact with the resistant bacterial strains.

Conference Calendar

March 26 & 27, 1999

Windsor & District Operating Room Nurses Association Conference, Cleary International Centre and Hilton Hotel, Windsor. For Information Contact Theresa Tremblay @ (519) 973-4421 Hotel Dieu Grace Hospital. Watch for your Registration Flyer in the mail. **Education Session:** "Multiple Trauma". **Entertainment:** Cabaret Night and major Casino within walking distance.

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 16.

July 25-30, 1999

World OR Conference, Helsinki, Finland. For more information see page 28.

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.

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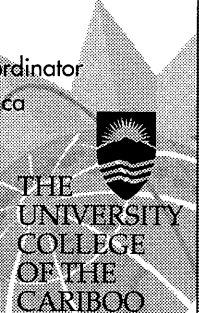
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