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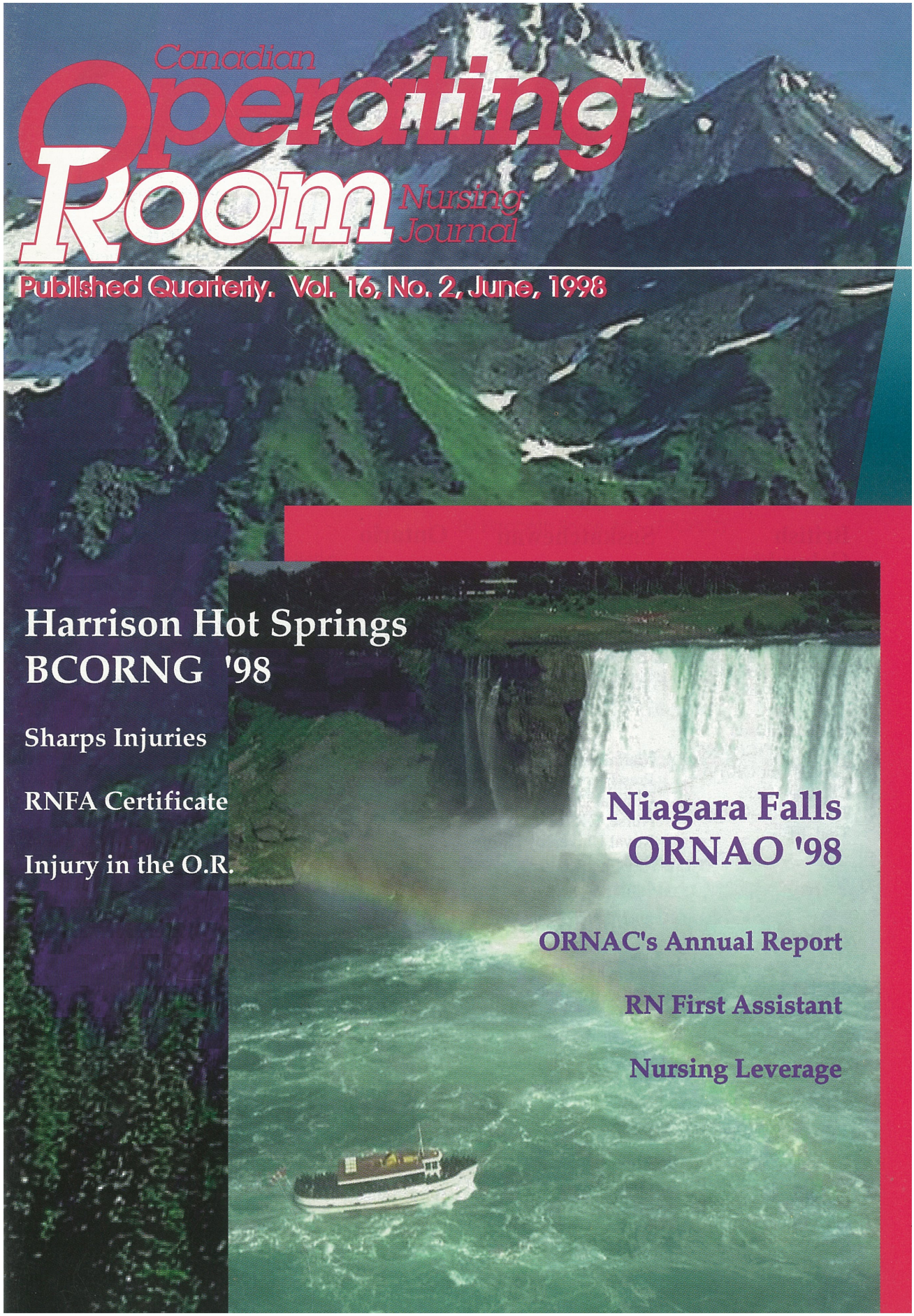

Harrison Hot Springs
BCORNG '98

Sharps Injuries

RNFA Certificate

Injury in the O.R.

Niagara Falls
ORNAO '98

ORNAC's Annual Report

RN First Assistant

Nursing Leverage

Canadian Operating Room Nurses Association of Canada

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Editorial Contents

ORNAC's Annual Report

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

As President of the Operating Room Nurses Association of Canada (ORNAC), I report to the Canadian Nurses' Association in Ottawa on our association's aims and objectives, and our activities and accomplishments over the past year.

The following are the highlights of the report presented in May, 1998 covering the period May, 1997 to June, 1998. Firstly I provided an historical perspective of ORNAC, outlined its objectives as reflected by the mission, values, and vision of the association.

General Structure

ORNAC is a voluntary organization whose Executive and Board of Directors consist of Perioperative Registered Nurses from every province in Canada, representing approximately 3,000 members. The ORNAC Executive consists of a President, President-Elect, Past President, Secretary and Treasurer. Their term of office is two years, and they are elected by the members of the Board. Those members running for ORNAC executive office must meet specific eligibility criteria. The ORNAC Board of Directors consists of two representatives from the executives of provincial O.R. Nurses Associations at the level of President, President-elect, or Past President. Their Board term of office is four years. Standing Committees chaired by Board members are: Awards, Bylaws, Finance, National Conference, Nominations, Research, and Standards/Education. Special Committees are: Editorial Advisory, French Translation, and Public awareness. There are two ad hoc committees: Advanced Practice and National Membership. The Past President is a member of the International Planning Committee (IPC) for World O.R. Conferences, and there is an official historian and photographer.

Membership

Membership in ORNAC consists of ten provincial associations representing perioperative registered nurses. Active members are currently engaged in perioperative nursing. Associate members can be comprised of registered nurses with previous perioperative nursing experience, or those interested in perioperative nursing. Membership remains relatively consistent.

Present Special Projects and Activities

The fourth edition of ORNAC's **Recommended Standards for Perioperative Nursing Practice, 1998 Edition** was published for distribution in January, 1998. The standards are available for purchase from the ORNAC Inventory Officer, advertised in the Canadian Operating Room Nursing Journal, provincial O.R. Association newsletters, and the ORNAC Web site.

Perioperative Certification - the fourth exam was written in April by 302 candidates. Currently there are 1,672 Certified Perioperative nurses.

The **ORNAC Web site**, a great source of pride, has been on the net since February of this year. Much

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.

credit must go to the Chair of the Public Awareness Committee, Marg Farley from Saskatchewan, and her predecessor, Faye Meuser from B.C. for their tremendous contributions to establishing this site. It is constantly evolving and being revised as we continue to add new information and establish new links.

A **pamphlet**, developed by the Public Awareness Committee and called "Perioperative Registered Nurses - How They Care for You" was presented to the Board in May in it's third draft form. Following final feedback from Board members, it is hoped it will be approved at the Fall Board meeting for printing. ORNAC wants to make the distribution of these pamphlets to the public a major campaign in every province.

The **RN First Assistant role** is in various stages of development in every province. Some programs have been set up in individual specialties in healthcare facilities, some are being developed in colleges, and others are going through the investigative/approval processes within the provinces.

ORNAC is represented on **CSA Technical Committees**, on a steering committee to develop an International Federation of Perioperative Nurses, and on an ad hoc task force to establish stronger links between CNA and the Associate groups.

Events of the Past Year

Three executive meetings were held September 2, 1997, February 20 - 22, 1998, and May 1, 1998. **Two Board meetings** were held September 3-4, 1997, and May 2-3, 1998.

A **Strategic Plan** was developed at the February Executive meeting and presented to the Board in May. Revisions will be made, and this plan will be used as an annual reference to determine our accomplishments, areas needing improvement, and as a review of goals and objectives.

A **Telemedicine schedule** was compiled and is maintained by ORNAC providing topics, speakers and moderators.

The **Johnson & Johnson - Drake Thompson Writing Award**, in the amount of $3000, was shared this year by two perioperative nurses who submitted articles to the Canadian Operating Room Nursing Journal. These awards were presented by J & J representatives to Grace Groetzsch at the Ontario provincial O.R. Nurses Conference in Niagara Falls on May 13, and to Se uk Walling in Halifax on May 13, at an education day for perioperative nurses.

The **10th World Conference for Perioperative Nurses was held in Toronto, September 5-7, 1997.** Many ORNAC Board and Executive members attended and contributed by moderating and monitoring sessions. Canadian perioperative nurses gave the keynote and closing addresses, and many Canadian speakers were on the agenda.

Issues of Concern continue to be:

- The casual employment of perioperative RNs,
- The current shortage of experienced perioperative RNs,
- The replacement of RNs by other health care workers, both licensed and unlicensed,
- The fragmentation of the roles of perioperative RNs into tasks with little concern for quality patient care,
- Recruitment of RNs into our specialty, and
- The continued cost-cutting measures by downsizing and closures.

1998 STANDARDS NOTE

A typographical error on page 167, the position should read as follows:

Lateral Rt. - patient lying on the right side
Lateral Lt. - patient lying on the left side

The Standards Committee wishes to apologize for any inconvenience this may have caused.

Sharps Injuries & Preventive Measures

By Dr. Elizabeth Bryce, MD, (FRCPSC)

The epidemiology of sharps injuries in the operating room and possible preventive measures will be discussed in this presentation.

Why do Infection Control Practitioners focus on blood-borne disease in the Operating Room ?

• Because the OR is often ranked as number one or two in reporting of sharps injuries to the Employee Health Unit, and this is likely underreported.

• Cutaneous Exposure is of particular concern in the OR because of the high rate of exposure to body fluids and the significant number of personnel with associated dermatitis due to frequent handwashing.

• Prevention of blood-borne disease in the OR should therefore incorporate:

i) a recognition of the importance of cutaneous exposure without sharps injury and

ii) a review of methods, techniques and behaviour to minimize risk.

I would like to first present some background on common blood-borne pathogens before we discuss specific intraoperative risks and preventive measures.

Hepatitis B

The risk of acquisition of Hepatitis B with an exposure varies depending on the viral load and the presence of HbeAg. It is estimated that 4,000 to 5,000 deaths per year related to Hepatitis B occur in the United States. This should provide impetus to those who are not already immune (or a known carrier) to be vaccinated. The majority of those immunized demonstrate protective antibody titres and initial nonresponders may receive additional vaccinations in an attempt to achieve a response. If exposed, nonresponders and those whose immune status is unknown should receive two doses of immune globulin one month apart. An exposed health care worker whose serology is negative should, of course, be vaccinated as well.

Hepatitis B

- Risk of acquisition 5 - 43% per exposure.
- 6 - 10% become carriers
- Response to vaccine 90 -95%
- Vaccine provides immunity for approximately ten years.

Most employee health units will check your antibody titres at the time of exposure if you have not been checked within the last 24 months. It should also be noted that a recent article suggests that the efficacy of immune globulin may decline by day three of exposure.[1]

Hepatitis C

Hepatitis C antibody testing has only been widely available since 1991 and the prevalence in Canada is estimated anywhere from 90,000 to 300,000 cases.[2] British Columbia had 5,000 new cases in 1996 but this may have been a reporting phenomenon as the screening program had recently been implemented. The majority of cases in Canada were from injection drug users and accounted for at least half of newly documented infections.[2]

Author

Dr. Elizabeth Ann Bryce, MD, (FRCPC) Internal Medicine, Fellowship Infectious Diseases, is a Clinical Assistant Professor, University of British Columbia and Medical Microbiologist and Infection Control Officer, Vancouver Hospital Health Sciences Centre.

This presentation was made to the 16th BCORNG Conference in Harrison Hot Spring, BC, April, 1998.

Hepatitis C

- Previously part of non-A, non-B hepatitis
- 45% transfusion acquired, 50% injection drug users
- Risk of acquisition by sharps injury: 3 - 10%
- 5 - 25% symptomatic
- 60 - 70% develop chronic disease and 20-25% progress to cirrhosis
- No prophylactic therapy
- Exposure and seroconversion do not confer life-long immunity

Transmission of HCV after an exposure is estimated to be 3 -10% if the injected blood is anti-HCV positive. The majority of Hepatitis C patients are asymptomatic when first infected, however, over half progress to chronic disease. Between 75 to 90% of acute cases continue to carry the virus indefinitely and a health HCV carrier state has been proposed. Fifty percent of patients will present with chronic fatigue within 10 years and in about 20 to 25% of cases, liver cirrhosis will develop.[3] Currently end-stage liver disease due to HCV is the major underlying reason for liver transplantation in Canada.[4] Overall mortality is unknown as long-term data is not yet available.

At present there is no prophylactic therapy and no support for the use of immune globulin which some have theorized may prevent the development of protective antibodies. Exposure does not confer life-long immunity and one can be reinfected with a different genomic sub-type.

Human Immunodeficiency Virus (HIV)

As much has been written and presented on HIV and the risks of exposure, only a few points will be highlighted. Acquisition may be somewhat dependent on viral titre, however, this may be difficult to correlate with symptoms.[1] In a study of 148 exposures with asymptomatic HIV positive patients, none acquired infection compared to 4/889 exposures in those with AIDS which resulted in transmission of the virus.[5] The results, while not statistically significant, were provocative. The risk of acquisition is approximately one in 300 in the case of an injury involving a known HIV positive source.

HIV

- Risk of acquisition may be dependent on viral load and independent of symptoms?
- Risk of acquisition from sharps injury is approximately 0.4%
- Postexposure prophylaxis should involve at least two antiretroviral agents
- In 50 - 60% of cases, seroconversion is marked by a febrile illness

To give some perspective as to the prevalence of HIV in this province, approximately two million needles were dispensed and there were 6,000 registered addicts in British Columbia in 1996.[6] Currently the British Columbia Centres of Excellence recommends Zidovudine 200mg TID combined with Lamivudine 150mg BID for prophylaxis.[7]

Institutions in the province have been supplied with five-day starter kits and the Centre is an excellent reference source.

Risks Specific to Operating Rooms

There have been a few studies examining the risk specific to operative procedures. Gerberding performed an observational study of 1,367 consecutive surgical procedures at San Francisco General Hospital (SFGH) and examined 960 pairs of gloves.[8] She documented 117 exposures in 84 procedures, 22 of which were parenteral and 95 cutaneous. None involved the actual injection of blood and all but one laceration was deemed superficial. Almost 50% of the gloves worn for greater than three hours were perforated. No differences between specialties over time was noted but the highest rates of exposures were seen in trauma, plastics, obstetrics/gynaecology and orthopedics (No cardiac or transplant surgery is done at her institution.) The factors predictive of exposure were blood loss greater than 300 ml, a procedures greater than three hours and selected surgeries. Knowledge or perception of the blood-borne disease status of the patient did not result in a lower exposure rate.[8] A theoretical risk to surgical personnel of acquiring HIV was calculated to be 0.125 infections per year or one infection every eight years, based partly on the prevalence of HIV in their patient population. The authors believed this calculation to be relatively low because of the high compliance with double gloving in the OR, the extensive use of the no touch technique, the high infection control awareness and less frequent surgery for trauma, transplant and cardiac cases. Supporting their advocacy of double gloving was an estimation that there was a two to five times reduction in the risk of perforation of the inner glove.

Other studies have confirmed at least the same level of glove perforation rates and generally noted higher rates of exposures to blood-borne diseases.[9,10] Other authors have stressed the role of non-intact skin

in exposures. Quebbenan emphasized that one must also consider the "strike zone" (i.e. where body fluid exposures were greatest) in applying protective barriers.[9] This varied depending on the type of surgery, for example, orthopedic cases had a much higher risk of exposure to the upper arms and lower legs. The results of nine hospitals in the EpiNet surveillance group were compiled from 1992 to 1992 for a total of 660 suture and scalpel injuries. Twenty five percent of injuries occurred while passing instruments and this increase to 35% when scalpels were involved. Many of the injuries were self-inflicted, however, 44% were related to the actions of others.

Folin and Nordstroom examined accidental blood contact during orthopedic surgical procedures and noted that in 622 instances, 82 people had 88 contacts with blood (11% of all observed procedures). Of these, 79% were contamination of skin while 13% were sharps injuries, usually involving the surgeon.[10]

At Vancouver General Hospital, we were interested in how many OR staff knew the information previously outlined and how many practiced preventive measures. In 1996, we conducted an anonymous survey and were gratified to receive a response rate of 62% of nursing staff, 50% of anesthetists and 52% of surgeons. Credit goes to the OR managers and medical director for encouraging participation in the survey and we were pleased with the frankness and honesty of the replies. The majority of nurses had spent at least two years in the OR and had an average of 18 years in health care. Less than 50% felt they had received sufficient information on body substance precautions (BSP) and blood-borne diseases, although the majority felt they understood the principles of BSP.

Questions on glove use and on what to do in the event of a sharps injury were correctly responded to 66% and 80% of the time respectively. (This is important when one considers that one fifth of the staff did not know what to do if they had an exposure.) Over half the staff was aware that passing of sharps using the no touch technique decreased the risk of a sharps injury, however, only 38% always practiced the technique. Fifty six percent understood that double gloving decreased the risk of cutaneous exposure to blood but less than one third of that number regularly double gloved. Other questions on the prevention of risk had variable responses.

Preventive Measures

I am a strong proponent of double gloving although I realize that some procedures carry relatively little risk of exposure (e.g. laser eye surgery). However, I believe it is a good idea to develop the habit of double gloving. A small glove over a larger glove seems to give better dexterity and most surgeons state that they had minimal to no loss of dexterity when double gloving in this manner.

Other protective attire needs to be mentioned. For example, there are reusable gortex or microfibre gowns. There is a wide variety of protective eyewear from glasses with side shields to face shields, some of which have detachable masks. Footwear is often not considered but some procedures have significant blood pooling. In addition, there is also the risk of dropping a sharp instrument and injuring oneself. I believe that covered footwear should be strongly endorsed in the OR. Exhaust suits have been advocated by some, however, they are expensive, uncomfortable and are usually used only when one perceives a risk to exist. This, of course, belies the tenets of BSP which advocate treating all patients as potentially having a blood-borne disease. In addition, the risk of aerosols, causing a blood-borne disease is likely minimal. I feel their place is largely in the high risk autopsy, such as tuberculosis cases, where the risk of acquiring an airborne disease is significant, or perhaps in OR suites where airflow is suboptimal and ultra clean surgery is desirable.

Operative techniques can be used to minimize risk. These include the use of blunt needles for fascia; cutting off the needle at the end of a suture line before tying; the use of blunt retractors; and the use of staples wherever possible. These seem inherently obvious but are not consistently practiced. Scalpel removal devices are on the market as well as specialized basins and equipment for sorting and cleaning instruments post-operatively.

The final preventive measure I wish to discuss is the use of the "no touch technique" or hands-free technique where a neutral zone is designated and sharp instruments are placed. Instruments are not passed hand to hand and verbal notification of a sharp being placed in the zone is given. Accessory items such as magnetic drapes and basins have been developed but the neutral zone can be as simple as a kidney basin or an area in the operative field. No observational studies existed until recently when Stringer followed 3,765 of 5,388 eligible surgeries. The hands-free technique was used 72% of the time, 50% some of the time and never in 8% of cases. The overall glove tear rate was 4%. Calculation of the risk of contamination showed a significantly decreased rate of cutaneous exposure and glove tear by 59% in surgeries with greater than 100ml of blood loss. No significant statistical association was seen with surgeries having less than 100 ml of blood loss (Stringer, B. personal communication, PhD Thesis)

Conclusion

I would encourage all personnel to report exposures in a timely fashion, to be vocal in being as assessed as soon as possible for HIV prophylaxis , and to know one's institutional policy on time-off to report an exposure and sick-time if required because of side-effects of prophylaxis. Information on reporting and treatment of exposures should be readily available and hopefully part of an orientation or in-service package. Education needs to be continuous as new products and techniques enter the workplace and new information comes to light.

I would like to conclude this presentation by acknowledging my Infection Control colleague, Ms. S. Scharf, for her active role in researching the literature and participating in the OR survey.

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Needlestick Injury:
My Personal Story

By Marjorie G. Kallstrom, R.N., (CPN)C

During the summer of 1996, while "scrubbed" on a vaginal hysterectomy, I received an accidental needlestick injury from a contaminated, blood covered suture needle. At the time of the occurrence the patient/client was bleeding profusely. I immediately informed the surgeon, surgical assistant and circulating nurse of my injury, exclaiming "I've been stabbed!". It took approximately five seconds for the ramifications of the injury to register in all of us. While removing my outside gloves I asked my circulating nurse to get the bleach bottle and the two of us began our immediate first aid. We ran the bleach over the area and I proceeded to manually express blood from the puncture site with my left thumb. During this time I maintained my sterile field; the surgeon kept suturing and the bleeding was controlled. I regowned, gloved and finished the case. The case ended approximately 15 minutes after my puncture.

Prior to doing the surgery, I had introduced myself to our patient/client. A pleasant, young female with many tattoos. The surgeon had given me a brief history prior to the case which included information pertaining to her use of I.V. drugs and a positive Hepatitis C test. There was no H.I.V. information on the chart.

The next few hours after my exposure were similar to a roller coaster ride. I was drawing from my waning grey cell supply to remember the "Needlestick Injury Policy and Procedure". From the O.R. suite, I headed to our first aid station in emergency. While there, I remembered there were "some drugs" I should start taking within a short time period. I shared this information with the E.R. nurse who promptly looked for a "Needlestick/Sharps Injury Package", and the two of us went through the material. Enclosed in the kit was an envelope with this label:

Accidental Exposure Kit

- One vial Zidovudine 50 x 100mg Cap
- One vial Zalcitabine 15 x 0.750 mg Tab
- One information handout
- Do not remove contents - give to patient intact.

St. Paul's Hospital, Vancouver, BC

The information was three pages, approximately 3,000 words and included 11 subtitles.

1. **Confidentiality.**
2. **Risk of H.I.V. Infection After Exposure.**
3. **Reasons for taking Antiretroviral Therapy**
4. **What is Zidovudine?**
5. **What is Zalcitabine?**
6. **Evidence that ZDV Can Prevent H.I.V. Transmission.**
7. **Possible Side Effects and Contraindications of Antiretrovirals.**
8. **Instructions For Taking ZDV and ddc.**
9. **How Long Before An Exposed Person Can Be Reasonably Sure That They Have Not Been Infected.**
10. **Precautions To Avoid Transmissions to Others.**
11. **Other Reminders.**

Author

Marjorie G. Kallstrom, RN, CPN(C), is a staff Nursing in the OR at Cowichan District Hospital, Duncan B.C. She has 25 years of Critical Care nursing experience in Emergency, Recovery Room and the Operating Room.

I skimmed through the first six subtitles until I found Number Seven, Possible Side Effects and Contraindications of Antiretrovirals. The subjective toxicity, such as fatigue, nausea and headache were a non-item. As I am a wife, mother and perioperative nurse I had experienced all, often! My concerns were with the objective toxicity. The drugs were contraindicated in persons with liver or kidney insufficiency, or anemia. However, I had none of these contraindications.

Using the "Definition of H.I.V. Exposure" sheet included in the package, I determined I was a "Probably parenteral exposure to H.I.V. and Hepatitis." I immediately took the medications - forty minutes had lapsed since exposure. The drugs would have to be taken eight times daily for one month as prescribed. The first aid nurse and I filled out lab requisitions including baseline H.I.V. and Hepatitis B and C. Prior to going to the lab I phoned the O.R. Suite and asked the Charge Nurse to request the surgeons get permission from the patient for H.I.V. testing. It was at this time I was beginning to really recognize the danger this "needlestick incident" represented for myself, my family, friends and co-workers. There is no cure for Hepatitis C and H.I.V. exposure was a possibility. These thoughts were screaming through my head as I went to the lab and had blood drawn. From there I headed back to the O.R. where the surgeon involved was waiting for me. He reassured me that he had talked to our patient in recovery and she had consented to H.I.V. testing, which was being done at that moment. While talking to the surgeon, a friend and co-worker for many years, I realized how much his part in the incident had affected him.

Waiting for the H.I.V. results from the patient would take five to ten days. Counseling from our personnel health care department began immediately. The information available to me was both current and informative. The risks involved for my family were explained to me and I was given copies of all the information pertaining to H.I.V. and the different types of Hepatitis for them to read. Never before had I appreciated the risks involved, and steps necessary, following a contaminated needlestick injury. Now I was faced with telling my husband and children what their part would be in protecting themselves from me.

Within a few hours of taking the antiretroviral medication I had developed a headache, severe nausea and light-headedness.

"Are you going to die Mom? " ...

"How long before you'll know if you'll be alright? "

...

"Can we kiss you?"

That evening, in hushed silence, my husband and two youngest children listened to my story. The questions began to flow from my 17 year-old son and 19 year-old daughter. They were blunt and to the point - Are you going to die, Mom? - How long before you'll know if you'll be alright? - Can we kiss you? and for levity's sake, - What colour condoms would you like us to buy for you? My husband and I were looking forward to a long planned "25th Wedding Anniversary" holiday in a few days. Our older kids eventually heard the "news" from their younger siblings and over the next few days and weeks, kept in touch and wanted to be informed of good/bad news.

The first week of medications, contained in the kit, made me extremely ill. I felt very similar to my memory of first trimester twin pregnancy, the difference was, there was no relief from the nausea. It was with me twenty-four hours a day for the first week. Through consultation with my family doctor and the B.C. Centre for Excellence in H.I.V./A.I.D.S., the medications were changed to help reduce the side effects. The prescriptions were sent from St. Paul's Hospital to my family practitioner's office where I picked them up.

During that first week, information from the surgical patient and her family physician indicated her lifestyle had been "clean" for over a year. Although I

never had contact with the patient again, she made it very clear that she was willing to undergo any tests that would help to alleviate my concerns. I was very fortunate and grateful for her cooperation.

Through the next few weeks, I continued to take the medications. Keeping busy, in and outside the workplace, helped me cope with the side effects of the medication. During this period I lost ten pounds, which was the only bonus, and became acutely aware of problems involved taking H.I.V. medication. My Hepatitis B titre was low so I received a booster. For the next year I was routinely tested for Hepatitis and H.I.V.

If you are in a position to consent to take antiretroviral medication, be sure it's "informed consent." Perhaps in recognizing the implications of needlestick injury we can make ourselves and our coworkers practice safer use and disposal of sharps.

My injury happened two years ago and some of the medication and dosages have changed. Also, screening for H.I.V. is much quicker today. For health care workers in smaller units, you may have to call in another staff member to replace you while you seek medical attention and advice. Be prepared, be aware, and use safe practice.■

Conclusion

I want to emphasize how important it is that everyone involved in health care make themselves aware of the individual facilities' policy regarding needlestick injury. If injured, bleed wound freely, cleanse with soap and water and disinfect with alcohol or other disinfectant. Know where the closest supply of medications for exposure is kept. Be certain your first aid personnel know the medication should be taken within one hour of injury if possible. Also, a review of your injury, its implications and severity should be reassessed by yourself and health care department after beginning your medication. Your family physician can use the H.I.V./A.I.D.S. hotline numbers for more information.

Know the precautions to avoid transmission:

- Abstain from sexual intercourse or use latex condoms with non-petroleum lubricant.
- Do not become pregnant, do not breast feed.
- Do not share toothbrushes, razors, etc.
- Do not donate blood, plasma, organs, tissue or sperm.

These are some of the precautions.

There is only one place for a needle/sharp after its use and that is in an appropriate disposable container.

This includes using containers on our sterile fields. No one should put themselves or anyone working in their facility at risk by using folded towels, medicine cups, or kidney basins inappropriately for used sharps. Our advantage in the O.R. is that we are aware who our sharps have been used on. C.S.D. and Housekeeping staff do not have this advantage.

Attention all Perioperative Nurses

The Isabelle Adams Excellence in Perioperative Nursing Award

To be Awarded at the 1999 ORNAC National Conference in Halifax, Nova Scotia

Do you know of an outstanding ORNAC member, who through her dedication and commitment has made a difference in the field of perioperative nursing and deserves to be recognized for her contribution ?

The Isabelle Adams Excellence in Perioperative Nursing Award was established for this purpose on the initiative of the Operating Room Nurses of Québec in 1987. The first award was presented in Vancouver in 1988 and is presented on the year of the National Conference.

Nomination papers can be obtained through your Provincial President or by contacting:

Nora Slater
Chair, Awards Committee
11 Jason Avenue
North Tetagouche, NB E2A 4Y8

Reflections of a Canadian RNFA

Past, Present and Future

By Grace Groetzsch RN, BScN, MEd, CPNC), RNFA

At present I am one of three formally trained Registered Nurse First Assistants (RNFA) in Canada and the only one employed in that capacity. To become an RNFA one must be a registered nurse with a minimum of two years experience in perioperative nursing, and must have obtained perioperative certification (CNOR, CPN(C)), Advanced Cardiac Life Support (ACLS) and/or Basic Cardiac Life Support (BCLS) certification, letters of recommendation and liability insurance. I am currently insured through an American carrier affiliated with AORN. At present, a degree is not necessary but after 1999 in the United States a degree will be required to write the perioperative certification examination(CNOR) and hence to become an RNFA.

In 1980 the American College of Surgeons stated that an RN, with additional training was acceptable as an assistant should a surgeon, resident or fellow not be available. By 1983 RNFAs were able to assist in 17 states. As of 1996, RNFAs are recognized and practicing in all 50 states.

Jane Rothrock, an internationally recognized expert and advocate of RN First Assisting started the first RNFA program in the United States in 1985 at Delaware County Community College in Media, Pennsylvania. There are currently 19 programs affiliated with colleges and universities in the United States graduating RNFAs. I was fortunate to attend Jane's course. At present there are no RNFA programs in English speaking Canada. There is one program in Quebec and a curriculum is being developed at the British Columbia Institute of Technology (BCIT).

Most RNFA programs are structured on Jane Rothrock's model and follow AORN Recommended Education Standards for RN First Assistant Programs. Pre-course material is done by correspondence followed by six days of didactic classroom instruction with RNFA and surgeon faculty members. A supervised clinical internship encompasses one academic semester and a minimum of 120 clinical hours. My pre-course study and didactic instruction was completed between January and May, 1997. To align with the academic calender I began my internship in September. In order to develop my newly learned skills I participated in a pre-internship from June to August, 1997.

Pre-internship

Surgical and hospital, as well as nursing support are important to introduce the RNFA role. Encouraged by my OR manager, I volunteered my services three days a week as a RNFA pre-intern at my place of employment, the Orthopaedic and Arthritic Hospital, Toronto. Two days a week I continued to work as a paid perioperative staff nurse. I was reluctant to pre-intern at my own hospital for a variety of reasons. Physicians assisted routinely and I did not want to get in the way and what would happen if I failed?

Author

Grace Groetzsch RN, BScN, MEd, CPN(C), RNFA, is a full time RNFA employed by the cardiac surgeons at Sunnybrook Health Science Centre, Toronto. She is also a staff nurse in the operating room at the Orthopaedic & Arthritic Hospital, Toronto.

This is an abridged version of her presentations in April 1998 to the BCORNG Conference, Harrison Hot Springs, BC, and the ORNAO Conference, Niagara Falls, Ontario.

The RNFA is a Nursing Role

I was often asked "Are you a nurse today?" The question meant was I scrubbing/ circulating or assisting? My response was always "I'm a nurse everyday". I feel strongly that the RNFA is a nursing role and that nursing brings a unique perspective to first assisting pre-, intra- and post-operatively.

I spent much of my pre-internship on an emotional roller coaster. Some days were wonderful. Other days I felt stupid and inept. I was considered a good scrub and circulating nurse and still I had much to learn. Anticipation of the surgeon's needs and the operative sequence were still important. Now the ability to discern tissue planes was an additional requirement. I had to think and see like a surgeon. This was anatomy from a new dimension. My nursing textbooks lacked sufficient detail and medical textbooks and journals became my reading of choice. What I thought I knew, I did not know in sufficient detail.

"As the supply of Canadian physicians decreases, there will be ample opportunity for non-physicians to assist at surgery".

I spent most of my time assisting an orthopaedic surgeon, Dr. Jeffrey Gollish. I became his 'shadow'. In addition to the intra-operative assisting we did pre- and post-operative patient rounds and clinics together. I developed a true appreciation of the entire perioperative experience and how I, as a RNFA could facilitate the process. Here was a perspective outside my usual sphere and experience.

Manual dexterity was a major focus in learning knot tying and suturing. There are many ways to develop these skills all requiring guidance, practice, patience and time. The full-time physician assistants taught me a tremendous amount. It is better to be slow and precise, than to be quick and careless. Speed follows precision.

Diplomacy

Diplomatic skills are integral to the role of an RNFA. Just as you observe nursing and medical colleagues in a new light, they will also regard you differently. You need to know when to speak up and when to keep quiet; to understand what is helpful and appropriate, and what is not. You need to be articulate, intelligent and maintain a professional image.

In retrospect, I am glad that I began my RNFA career at the Orthopaedic & Arthritic Hospital with people who knew me and my abilities. As an RNFA novice, I lacked experience and professional confidence. I was often teased that the wound would close by granulation tissue by the time I had it sutured. Without the patience, support and encouragement of my colleagues I am not sure I would have succeeded in this new role.

Internship

My internship was completed at Sunnybrook Health Science Centre, Toronto. I did not know the hospital and it did not know me. The word "temporary" featured largely on my new name tag. I worked there four days a week without pay and continued one day a week as a staff nurse at the Orthopaedic & Arthritic Hospital. I interned primarily in cardiac surgery where Dr. Bernard Goldman was my mentor. I worked, however, with all the cardiac surgeons.

I spent an hour a day with the nurse practitioner and clinical fellows on the cardiac floor. I gained an understanding of the pre- and post-operative care of cardiac patients. I spoke with patients about their perioperative experience. I pulled my stethoscope out of mothballs, and listened to patient's hearts, lungs and abdomens. I reviewed cardiac rhythms. I removed pacemaker wires and chest tubes. I observed the daily progression to recovery and the impact of complications. In the operating room numerous individuals, each with his own technique, taught me to harvest the saphenous vein. In time I developed my own method and with practice gained sufficient speed to independently harvest the vein.

Unsure of where my RNFA future lay, I spent time in general surgery. The experience was very different. There was a medical student, clinical clerk, PGYI (intern), junior resident, senior resident, and in some cases a clinical fellow. Now there was also an RNFA intern. To be accepted as a potential assistant meant doing what was appropriate and sometimes that meant letting someone else assist. In spite of that, Dr. Sheriff Hanna, my mentor in general surgery, ensured that I had ample opportunity.

I had seven clinical objectives to achieve during my internship. My performance was formally evaluated bi-weekly and at the end of the internship. I worked and studied long hours, and learned a tremendous amount. On weekends, and pending sufficient energy after hours during the week, I completed the program's thirteen written internship assignments. Establishing priorities was quite a balancing act.

Courage

The acronym **COURAGE** (Carlton Cards), helps to express some of my feelings about my RNFA experience.

C *stands for confronting the dragons.* There are lots of dragons in nursing, and perioperative nurses are renowned as such. Traditionally nurses are not good at supporting nurses perceived as different. Rather than pushing you up, there's usually someone trying to pull you down. If the RNFA role is to succeed we cannot fight amongst ourselves. We need to stand united.

O *is overcoming the obstacles.* The emotions you experience along the learning curve are difficult to endure at times. For me they were the biggest obstacle of all. I've never felt so stupid in my life. I went from being a well paid independent consultant to an unpaid novice who could not accurately discern tissue planes. It was my friends and colleagues who made it tolerable to carry on.

U *is understanding the risks.* Anyone considering a career as an RNFA must understand and consider the risks involved. I gave up full-time employment to take a course that is not recognized in Canada, to work in a province where the role is considered officially outside my scope of practice, where there is no method to remunerate the position within current funding mechanisms, and hoped that I would get a job. When you set off on this journey, there may not be a prize at the end. I was lucky. The other two RNFAs in the country have not been so fortunate.

R *is really living.* I failed miserably at that. I worked long hours, saw little of my family and friends and became very tired. Thanks to some great friends and frequent flyer points, I celebrated my graduation with a ski and sun holiday.

A *is always believing.* With the exception of a few emotional lapses brought on by overwork, I always believed in myself, my ability to complete the program and find a job. My hard work paid off.

G *is going the distance.* It means working long hours. It means you do not get coffee and some days, lunch. It means you do not get to go home at the end of an eight hour shift, you go home when the work is complete.

E *is expecting the best.* Not of others, but of yourself. You need excellent clinical skills, and the ability to anticipate and react to the unexpected situations. The RNFA must be adaptable.

Financial Costs

In the end I had a certificate that said I was an RNFA and six university credits. The cost was approximately $5,000 Canadian plus lost earnings from June to December, 1997.

Financial Aspects

Tuition	$1428 US
Textbooks	$251 US
Airfare	$364 Cdn
Hotel	$636 US
Car Rental	$233 US
AORN Membership	$ 60 US
Liability Insurance	$158 US
ACLS	$195 Cdn
ACLS Pre-course	$ 35 Cdn
CPN(C)	$348 Cdn
Physical	$ 75 Cdn
Courier	$150 Cdn
Photocopy	$100 Cdn
Time/Lost Wages	$??????

Currently, I am not a hospital employee. I am employed directly by the cardiac surgeons at Sunnybrook Health Science Centre, whom I bill through my consulting business. I am paid a fixed salary irrespective of my hours. Many of my nursing colleagues have difficulty comprehending that I work for less than a staff nurse's wages. I believe it is better to be employed and demonstrating one's worth and abilities, than to be unemployed holding out for more. I have a job that I love, feel passionate about, and know is going to get better.

A Day in the Life of an RNFA

My typical day starts at 07:00 hours and finishes between 17:00 and 19:00 hours. I continue to spend time on the cardiac floor visiting patients post operatively and doing post operative wound surveillance. Two mornings a week I attend cardiac rounds. In the operating room I check the chart and X-rays for relevant information. If time permits, I assist the circulating nurse prepare the room and open supplies. At a minimum I try to ensure that the scrub nurse has gloves and enough gowns. I catheterize, position, prep and drape the patients. I harvest the saphenous vein and then assist at the chest. Depending on the type of surgery and the availability of assistants, I either first or second assist at the chest. As first assistant I help with cannulation, grafting of the conduits, decannulation and chest closure. As second assistant I keep the operative field blood free, retract and assist with chest closure.

Sixty-five percent of blood borne exposure incidents occur to the surgeon and first assistant,(Bryce, 1998). The risk of being stabbed as an RNFA is significantly higher than the risk to the scrub or circulating nurse. You learn to take precautions but you can never completely protect yourself. This is not a hazard-free position.

After closure, I apply dressings, remove drapes, help move the patient onto the bed and then assist with transfer of the patient to ICU. I spend time after transfer helping the ICU nurses get the patient settled and augmenting the report from anaesthesia.

The Future

I am often challenged to articulate where I see myself fitting in. Do I see myself in the department of surgery or in the department of nursing? I describe myself as a bridge between the two. I believe strongly that the RNFA is a nursing role and the nursing aspect brings a unique perspective throughout the patient's perioperative experience.

As the supply of Canadian physicians decreases, there will be ample opportunity for non-physicians to assist at surgery. Perioperative nurses must position themselves to fulfill that role. RNFAs understand aseptic technique, the operative sequence and the workings of the perioperative environment. With additional education, the perioperative nurse becomes the ideal first assistant. There is a growing need and many ways to solve the problem. One Ontario hospital has already hired someone outside the healthcare professions to act in this capacity. I see a challenge to ensure that surgeons and hospitals choose RNFAs as the alternative of choice when physician assistants are not available.

RN First Assisting is a demanding, yet rewarding and exciting career path. If you are able, willing and interested give RN First Assisting serious consideration.

References

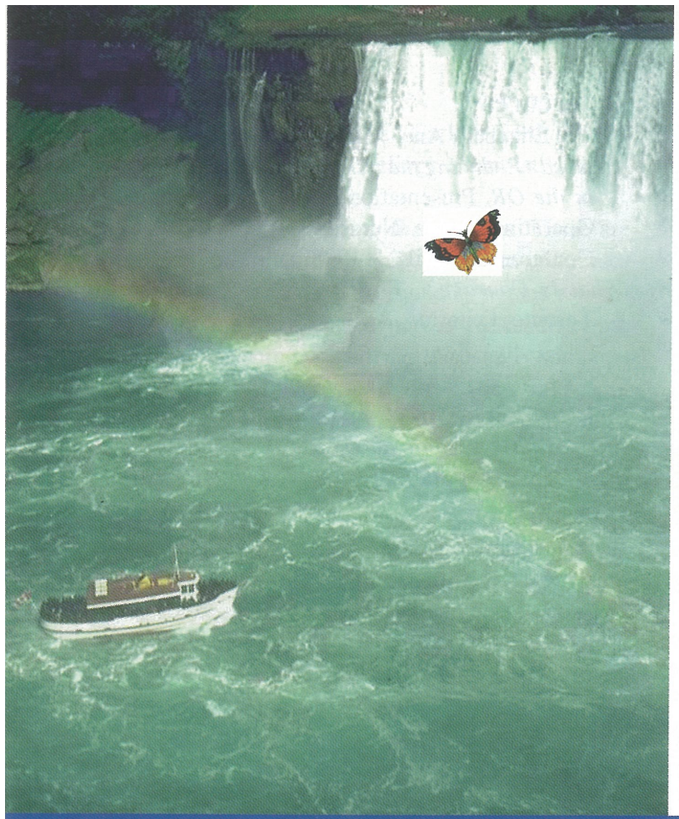
Bryce, Elizabeth Ann, MD. *You Too Can Be Punctured - Reducing the risk of Blood Borne Diseases in the OR.* Presentation to the British Columbia Operating Room Nurses Group 16th Biennial Conference, April 24, 1998.

What is Courage? Positively!™ Carlton Cards, Toronto, Ontario.

Grace Groetzsch is starting a database of individuals across Canada participating, formally and informally, in the role of the RNFA or surgical assistant.

Please contact her at :

(416)781-0929,
fax (416) 781-0645,
or email, groetzsc@idirect.com.



ORNAO '98
Image & Influence
Niagara Falls, Ontario

The 5th Operating Room Nurses Association of Ontario Conference held April, 1998, was excellent in educational program content, in social events and especially in locale - spectacular Niagara Falls, Ont., where the blossoms were bursting and the new Butterfly Museum just opened. *(Anne Thorne, a retired St. Catharines' OR nurse painted beautiful butterflies on the Hostess shirts to celebrate the Museum's opening.)*

Sharon Ball completed her term as president of ORNAO and Conference Chair. She is succeeded by **Rosemarie Atwill** of Ottawa. Sharon thanked her colleagues for their hard work over the past two years, thanked the exhibitors for their support, and in keeping with the *Image and Influence* theme challenged delegates to a higher level of professionalism and political activism. "One in 64 voters in Ontario is a nurse", she said. "We should be able to mobilize a strong and consistent voice in our hospitals and with the government. Yet, we seem to be drowned by more organized groups, often smaller groups. Our image must be perceived as an educated, knowledgeable, interested health care professional. We must have an opinion and it must be voiced in the OR, in the hospital, in the boardroom, at district health councils and in editorials".

Sharon encourgaed OR nurses to develop skills in influencing those who make decisions and recommended they get more active in their professional associations, and more supportive of their nursing colleagues. ♦

Δ At the 60's theme party Ottawa & area OR nurses (L-R) Maureen Egan, Ann Rodney, Cindy McLennan and Grame Narni of Carson Group.
Photo right – Hippies give the peace sign (L-R) Mark Horvath of Auto Suture, two of the best dressed, Sharon Corbie and Sharon Gabriel. Good food, great music, great fun as always. ♦

In the **Focus Session** OR nurses were encourgaed to become proactive in promoting their views on healthcare to their MPs and to the public. In a survey of delegates it was discovered **RN's were used exclusively in 12 hospitals in Ontario**. See Dr. J. Shamian's article "Skill Mix and Clinical Outcomes" page 36.

Grace Groetzsch described the Role of the RNFA to both the Ontario and BC OR conferences. Her presentation is on page 15.

When asked why nurses should pursue degrees when good jobs were not available, Grace replied: "Do it for yourself!...Nursingis cyclical...Advanced education makes one more marketable".

'98 Conference Planning Committee - **Back Row (L-R)** ORNAO President-Rosemarie Atwill, Wanda Collins, Mindy Shinoff, Susan Barrett, Sharon Gabriel, Judi Tyndall, and Helen Friend. **Front Row (L-R)** Audrey Macdonald, Linda Wilson, Alaine Young, Sharon Ball - (Chairperson & Past-President), Kathy Radcliffe &Cathy Isman.

Image & Influence

Linda Wilson set the theme for delegates by asking: "One hundred years from now, what will be said about us? What **Image** will we have portrayed and, indeed, what **Influence** will we have had? "

She referred to the vast changes in our lives and quoted from the poems *"My Heart Soars"* by Chief Dan George of the Co-Salish tribe, born nearly 100 years ago in North Vancouver.

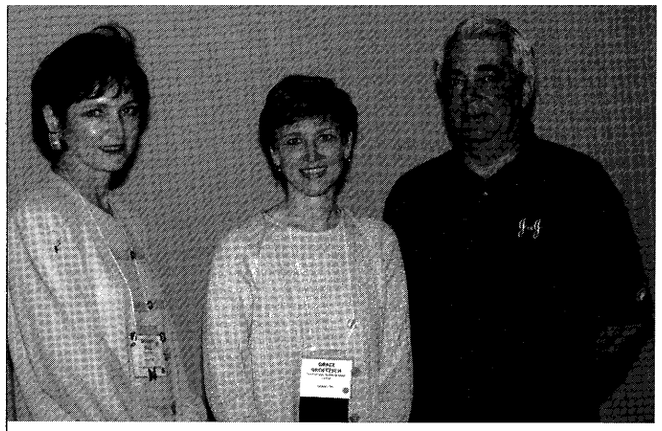
> "Oh, Great Spirit ! Give me back the courage of the olden Chiefs. Let me wrestle with my surroundings. Let me once again live in harmony with my environment.
>
> Let me humbly accept this new culture and through it rise up and go on. Like the thunderbird of old, I shall rise again out of the sea; I shall grab the instruments of the white man's success - his education, his skills. With these new tools I shall build my race into the proudest segment of your society. I shall see out young braves and our chiefs sitting in the houses of law and government, ruling and being ruled by the knowledge and freedoms of our great land". ♦

Delegates from Ottawa and areas hospitals were well represented in Niagara Falls.

Ann Marie Guilmette, PhD, in her keynote presentation recommended humor for good health and good working relations. "Humor unifies groups. When people laugh together, barriers are broken down.

Humor makes authority palatable. Often we are confronted with situations when egos get in the way of communiction. A touch of humor may break down such status barriers."

"Humor may reduce stress, anxiety and burnout", said Dr. Guuilmette, ..."but, time must pass after a stressful event before we are able to look back on it and smile". ♦



ORNAO Past President Sharon Ball, (left) and Deryk Taylor, Executive Director, (Marketing) J&J, present Grace Groetzsch (centre) the 1997 ORNAC/J&J Writing Award.

ORNAC/J&J Writing Awards

Se uk Walling receives the ORNAC/J&J Writing Award from Ian Lawson of Johnson & Johnson Medical Products.

The ORNAC/Johnson & Johnson Medical Products Drake-Thompson Writing Award of $3000 was shared this year by two outstanding authors publishing in the *Canadian Operating Room Nursing Journal.*

Grace Groetzsch, RN, BScN, MEd, RNFA, Sunnybrook Health Centre,Toronto, received the award for "RN First Assisting - 1997 Canadian Update", December 1997, Vol. 15, No. 2.

Se uk Walling, BA, RN, DPHN, Queen Elizabeth II Health Science Centre, Halifax, Nova Scotia, received the award for "Prevention of Neoplastic Seeding During Surgery: An Investigation into OR Protocols and Practice in Canada", June 1997, Vol. 15, No 4. Presentations were made at Provincial OR Conferences in Niagara Falls and Halifax.

Medical Bursary Winners

Medical Bursary Winners incliude:
Heather E. Mingo, Staff Nurse, Toronto Hospital, $3,000.
Antoinette Labricciosa, Mount Sinai Hospital, Toronto, $1500.
Deborah Garnier, Staff Nurse, Neurosurgery OR,Queen Elizabeth Health Science Centre, Halifax, $500. Congratulations to all winners.

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

Cresting The Wave

ORNAC's 16th National Conference will offer concurrent sessions in Clinical issues, Forensics, Computers, and Environment. Social events will have a maritime flavour. Plan your '99 summer vacation to include the National in Halifax.

17th Provincial Conference

Stepping Out of the 90's

Operating Room Nurses of Alberta Association

October 21 - 24, 1998

Capri Centre, Red Deer, Alberta

Educational Sessions: Motivational speaker **Terry Evanshen** will open the conference. Lawyer Noella Inions, RN, will address Legal Issues.Other topics - Do Not Resuscitate, Personal Directives, Leading An Empowered Organization, Antibiotic Resistance, Smoke Evacuation, and Alternative Health Issues. A Panel Discussion will address Professional Standards, RN Status in the OR, Certification and RNFA/Surgical Assistance.
Educational Exhibits: New Trends and New Products
Social Events: Wine & Cheese Reception, Fashion Show & Reception, Exhibitors Night - "Blast From The Past" - Dress-up or Dress-down in a costume from the Past.
Contact Conference Chairman: **Dorothy Cocks,** @ Fax: (403) 343-3812 or Phone (403) 343-3081

Expanding the Perioperative Role with RNFA Certification

By Marnie Simon, RN, MN, MEd

In 1989 the Operating Room Nurses Association of Canada, (ORNAC) began to explore an expanded role for perioperative nurses in the areas of perioperative nurse-anesthesia (PNA) and perioperative nurse-surgery (PNS). Three years later, ORNAC conducted an initial national survey of the current practice of perioperative nurses, and at the same time asked whether they were interested in an expanded role. To verify the data recorded, we conducted another small survey at the national conference in 1993. Both surveys supported the analysis that nurses wished for an expanded role.

Between 1994 and 1996, the advanced practice committee from ORNAC worked on developing core curricula for the advanced practice roles. A blueprint for the RNFA curriculum was developed and was sent to a variety of educational institutions and stakeholders in the industry. We needed to interest an institution able to develop the RNFA program. In British Columbia, BCORNG approached the British Columbia Institute of Technology, (BCIT) and as a consequence jointly formed a task group to coordinate the RNFA project. The task group had three mandates, first to ensure that there was a need for this role provincially and across Canada. Second to lobby in every area for support and advice on introducing this role. Third, to initiate the development of an educational program.

In order to launch the RNFA program, in mid-1997 a proposal was written and a $35,000 grant was received from BCIT, matched by $15,000 from BCORNG to develope this educational program. A project team was formed, headed by the author. A curriculum team was established, members included Grace Groetzsch, Marguerite Wahl, Amy Doi and Marnie Simon. An Advisory Committee was formed with representatives from the field of Perioperative Nursing, hospital administration, medicine, RNFA, and nursing education. BCIT provided experts to consult in all phases of the project and will continue this consultation as the program develops.

The RNFA program we are developing will be a BCIT certificate and will earn credits towards a Bachelor of Technology in Specialty Nursing in the perioperative component. It will have diverse educational approaches and be based on the U.S. RNFA model. This will ensure we meet the U.S. criteria for RNFA certification as our neighbors to the south will be a potential market.

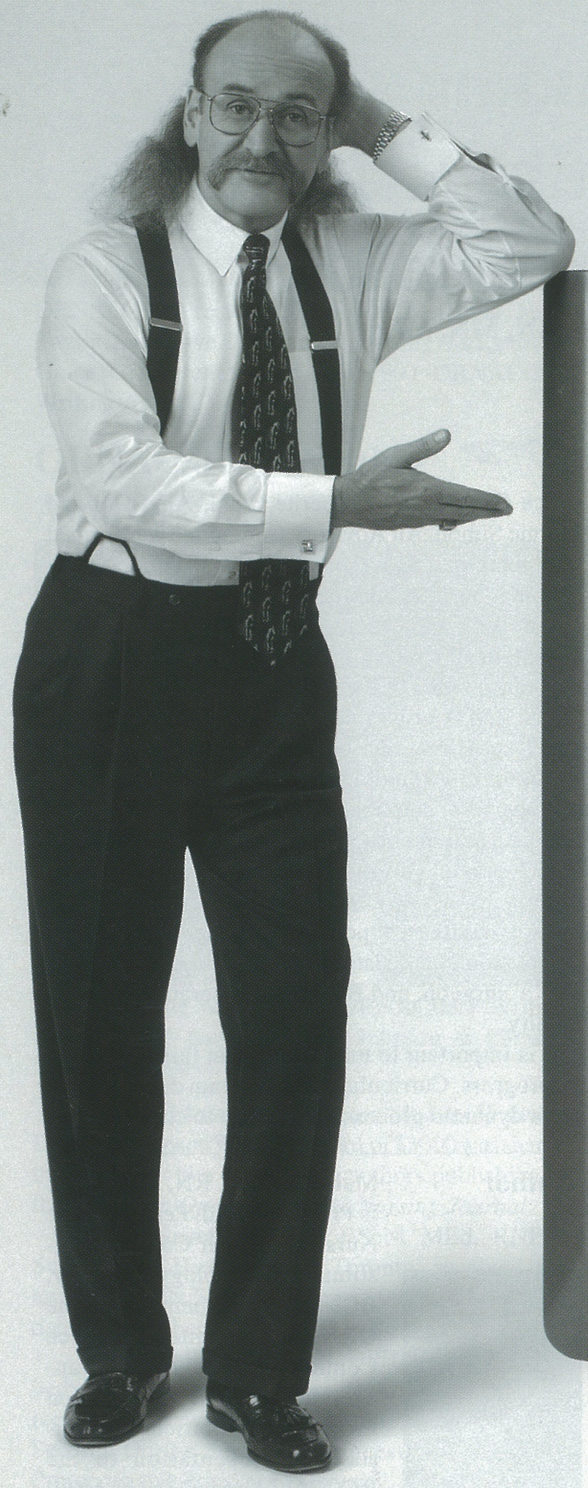
The faculty consists of a RNFA mentor/instructor, a surgeon, and BCIT's Perioperative Nursing faculty.

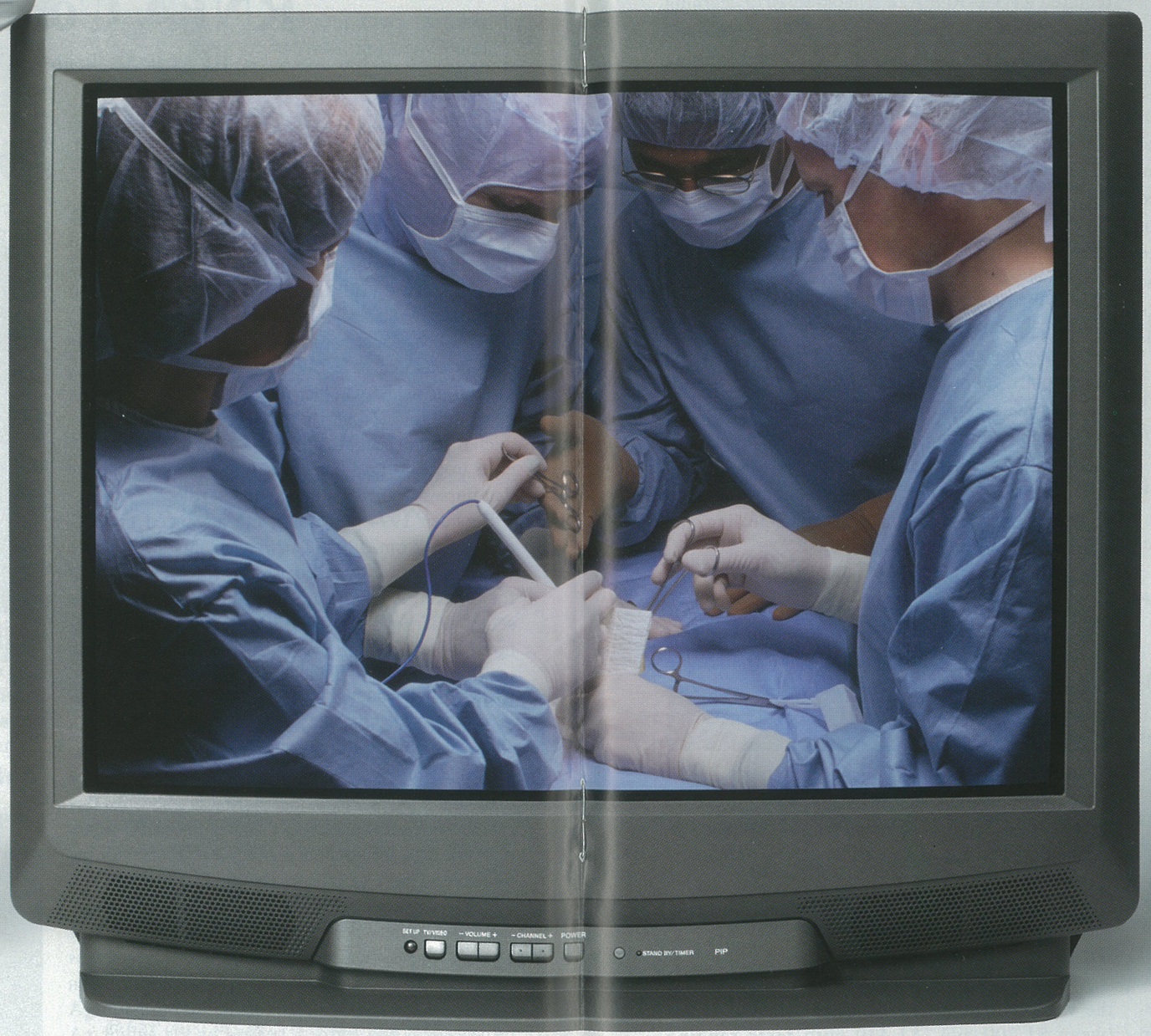
It is important to understand that this is a work-in-progress. Curriculum and program development are a dynamic process and subject to changes.

Author

Marnie Simon, RN, MN, MEd, is Program Head, Perioperative Nursing, British Columbia Institute of Technology, Burnaby, BC. She is a member of the ORNAC Expanded Practice Committee and Project Manager for the RNFA Education Program. This article was initially a presentation to the BCORNG Conference in April, 1998, at Harrison Hot Springs.

The Maxxim Extra–Results





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Program Outline

Theory Review: 12 to 18 weeks of directed, independent part-time study of RNFA theory.
Face to Face: 5 to 6 days of full time labs, instruction and interaction with faculty at the BCIT campus.
Internship: 200 hours of supervised clinical practice in the RNFA role.

Theory Review

This directed, independent study of RNFA theory is designed to assist the participant to gain the theoretical knowledge that will be expanded upon and applied in the other two components of the program. Course content and directions for study are provided in written modules that are supported by telephone or on-line tutoring. Computer assisted communication techniques are a feature of the program and the participant is supported to study at his or her own pace through flexible learning options. Learning goals include but are not limited to:

(i) Establishing one's own level of perioperative nursing knowledge of topic areas.
(ii) Reviewing areas of knowledge where a deficit is identified.
(iii) Expanding perioperative knowledge to a level appropriate for RNFA practice.
(iv) Exploring knowledge which is unique to RNFA practice.
(v) Identifying the difference between peri - opertive nursing knowledge and the knowledge required for RNFA practice.
(vi) Preparing questions or identifying topic areas that require clarification and discussion in the face to face component.

Face to Face

During this six to seven day, full time component of the program, participants will interact with faculty to explore the scope and practice of the RN first assistant and discuss some of the issues related to the role. Through "hands on" participation during labs, participants will have the opportunity to develop specific RNFA skills such as suturing and knot tying. Understanding of the RNFA's role in assessment, wound management, tissue handling/retraction and post-operative follow-up will be gained through participating in innovative learning activities. An interactive team approach will be used by faculty (RNFA & surgeon) to present a broad range of surgical procedures, review the related anatomy and physiology, pathophysiology, pharmacology, and describe the responsibilities and surgical techniques required of the RNFA. Preparation of a learning contract for the internship will be developed collaboratively with faculty and skills and learning will be evaluated. Successful participants will be qualified to progress to the clinical internship.

Clinical Internship

Participants will have the opportunity to develop beginning-level clinical competency during this supervised practical experience.

Activities to support learning and the development of clinical competency include:

- Providing supervised surgical assistance during diverse surgical procedures.
- Maintaining a log of clinical experiences.
- Completing and documenting comprehensive preoperative assessments.
- Assessing and documenting patient outcomes related to pain, management, wound healing and surgical complications.
- Participating in patient/family teaching and discharge planning.
- Using systematic inquiry and accessing different sources of knowledge to investigate factors affecting patient outcomes.
- Identifying, anticipating and selecting appropriate RNFA activities to respond to surgical hazards/ emergencies.
- Communicating and collaborating in order to develop professional partnerships and promote understanding and acceptance of the RNFA role.

Implementation of Program

A pilot group of five or more is planned for the winter of 1999. Tuition is estimated at between $1,200 and $1,440 with texts ranging between $200 - $300.

Financial assistance will be available through the education funds of ORNAC and the provincial perioperative groups.

Admission Criteria

The admission criteria is:

- **Currently licensed RN,**
- **2-5 years recent perioperative experience,**
- **Certification - CPN(C), and**
- **BCLS required, but ACLS preferred**

Articulation with BCIT's Specialty Nursing Degree

The curriculum philosophy for the RNFA program is congruent with that of BCIT's Bachelor of Technology in Specialty Nursing.

There will be six RNFA credits transferable to the Specialty Nursing Degree, for those who wish to follow that route. The RNFA program will be Coordinated by BCIT's perioperative nursing faculty, and will be a BCIT credential.

Figure 1

RNFA Certification

RN
↓
CPN(C)
↓
2 - 5 years Perioperative Nursing Experience
↓
RNFA Certificate

6 RNFA Transfer Credits

Bachelor of Technology in Specialty Nursing

48 credits core and Specialty Nursing courses
12 credits Liberal Education
↑
2 years relevant experience
↑
RN Diploma Program

Educational Partners' Responsibilities

As we develop and implement the program the educational partners will work towards establishing the role and promoting the RNFA program nationwide.

BCIT responsibilities include:
- Complete curriculum development,
- Pilot the Program,
- Market the program, and
- Coordinate ongoing program delivery/maintenance.

ORNAC/BCORNG responsibilities involve:
- Lobbying both government and industry,
- Supporting perioperative nurses to gain RNFA education and jobs,
- Promoting the RNFA role to the membership,
- Work to establish the RNFA Role, and
- Establish Canadian RNFA standards, credentials and criteria.

Conclusion

Opportunities and challenges face perioperative nurses in this time of rapid change in healthcare. The RNFA role is an opportunity for perioperative nurses to expand their practice in the next millennium. ■

Call for Proposals and Posters
for
World Conference of Surgical Patient Care
July 25 - 30, 1999 Helsinki, Finland

Canada has traditionally been well represented at the World Conference by excellent perioperative Nurse presenters. We invite you to participate at the World Conference in 1999.

Proposal submissions are to be mailed or faxed by **July 10, 1998 to: Vija Hay**, Past President ORNAC, 4421 Rainforest Drive, Gloucester, ON K1V 1L5 Fax: (613) 822-0003.

Poster Presentations are to be submitted by **October 1, 1998 to Sue Hardin**, World Conference Program Coordinator, AORN, 2170 South Parker Road, Suite 300, Denver, CO 80231-5711 USA Fax: (303) 338-4841 and (303) 755-5494, email: shardin@aorn.org
Information, submission ciriteria, and forms may be obtained from ORNAC website **www.ornac.ca** or
Vija Hay @ Fax: (613) 822-0003.

BCORNG 16th Biennial Conference

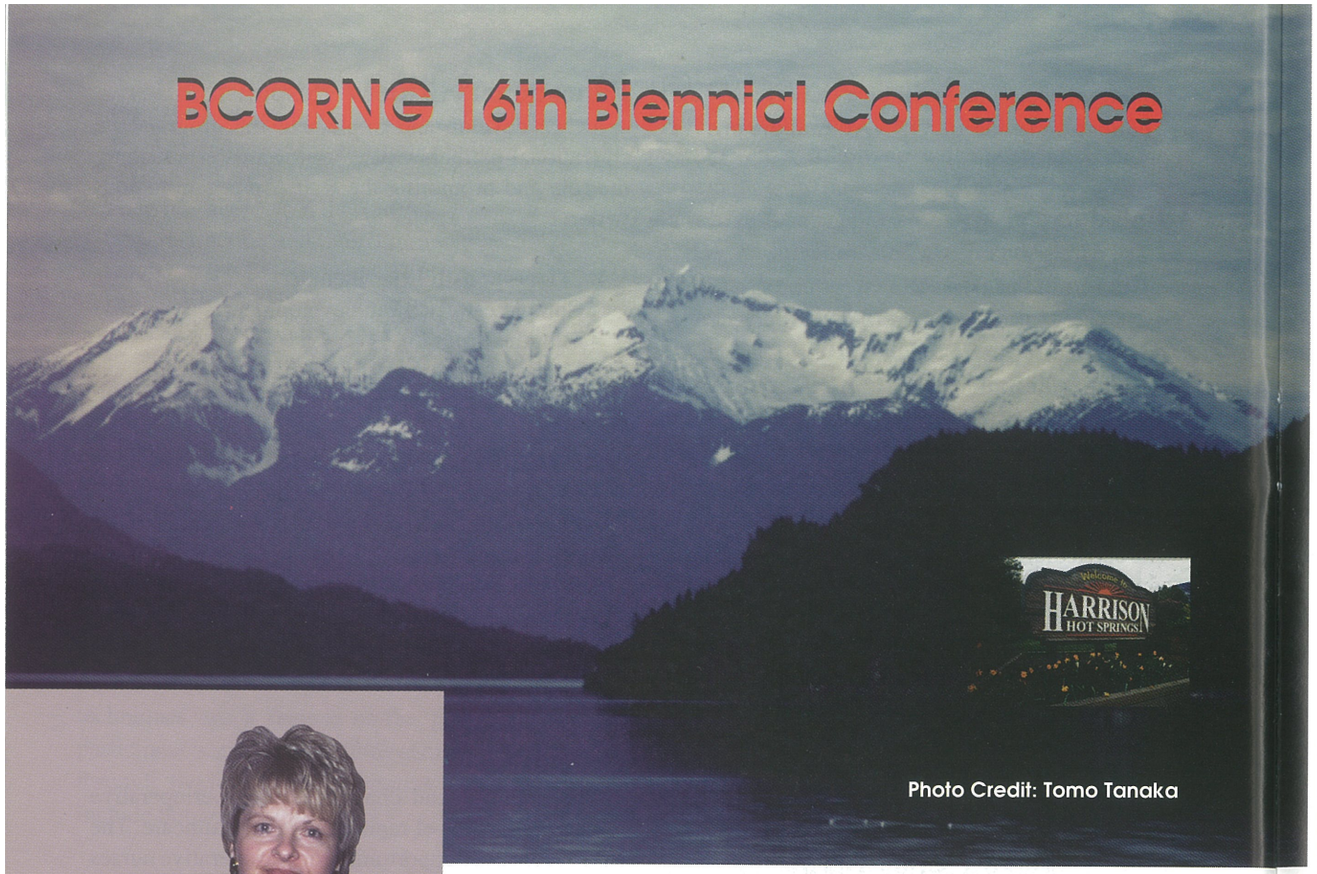

Photo Credit: Tomo Tanaka

Cory Both, Conference Chairperson, was presented flowers of congratulations from her committee members in recognition of the superb educational and social content of the 16th conference. The beautiful BC spa offered a perfect mountain setting for the three-day conference. Developing "**Attitude**" was a repeating theme. "Soar with the Eagles and you get attitude with your attitude", said motivational opening speaker **Peter Legge.** Over 350 OR nurses heard **about blood borne diseases and needlestick injuries. Marnie Simon** and **Grace Groetzsch** described the planned RNFA certification program in BC, and of the role of the RNFA. **Dr. Katharyn May** wanted nurses to get attitude. "Find the wild ones among you ... and point them at something ... to move nursing forward." Five major speakers from the conference are published in this issue. Social events included a fabulous dinner and dance, cocktail parties and a Casino Night.

Shirley Hemerling, RN, of Kelowna, BC was honored with the BCORNG ***Award of Excellence*** for her many years of service to both the national and provincial OR nursing groups. She was BC's rep to the 1st ORNAC Board in 1983 and served as President of BCORNG.

Shirley's focus today is international with her work for the foreign missions.

BCORNG 16th Biennial Conference Planning Committee Members: Standing (L-R): Susan Beye, Lyn Watson, Diane Beadle, Donna Good, Pattie Beradine, Candace Franke, Maggie Giesbrecht, Linda Goranko, Cory Both, Elaine Berze, and Lynda Johnson. **Seated** (L-R): Sue O'Rourke, Sarah Singh, Bev Chobotar, Bonnie McLeod, and Pam Gonzalez. *Missing:* Nadine Mahony

Δ Keynote speaker Peter Legge, ("Soar with the Eagles") autographs his books for delegates.

∇ BCORNG President **Sandra Grimwood** (centre) with Peter LaFontaine of Valleylab Canada and Susan Wynne, BCORNG Treasurer. Rob Richardson, Trail, BC, is President-Elect. Christine Hunter, Prince George is Secretary.

Putting Nursing Forward

Strategies for the Next Millennium

By Dr. Katharyn A. May, DNSc, RN, FAAN

Canadian Nursing faces an extraordinary set of challenges and opportunities in the next decade. I will talk about what some of the opportunities are, but mostly I will speak of the challenges. I will attempt to convince you that if Canadian Nursing can do a few very simple and very important things, that Canadian nursing may very well be poised to make the next great leap forward in demonstrating nursing's capacity to contribute to the health of all. And I also want to stir you up a little bit and scare you a little, because I will argue if Canadian nursing doesn't rise to these opportunities that you will lose ground like you've never lost ground before. This courage is not an optional feature of a nurse anymore and I hope that I'll be able to convince you of some personal strategies that you can make use of in your professional career that will carry you forward.

What I mean by putting nursing forward is essentially the following:

- Putting the message out about nursing's contribution to the greater good consistently and in very public ways.
- Rallying support for that message.
- Being creative about the practice of nursing and having the courage to innovate.
- Putting the news out about innovations.
- Being accountable for the outcomes of those innovations.

Putting nursing forward is not self-serving. It is not about self-aggrandissement or pumping up the image of nursing for collective advantage. Rather, it is putting nursing's message out to make certain nursing will continue to be able to make contributions. Nurses expect that they're going to get what they deserve. Nurses are never going to get what they deserve, nurses will get what they negotiate in the sense that the people who control resources must understand the importance of nursing's contribution. You should be negotiating with a big stick!

My entry into this interesting country was kind of a shock. I had done a lot of graduate work in anthropology, so I understood a lot about different cultures, and getting into different cultures and I had done an awful lot of reading about Canadian life and culture, so I was prepared to enter a deceptive kind of place, deceptive in that it looked similar to the U.S. - we speak the same language, but under the surface the differences are huge and legendary.

One of the first things I realized on moving to Canada was that I wasn't going to exactly fit in quietly. There is an attitude, I hope it's dying, that Canadian women are supposed to be cool and refined. Understated is a compliment in Canada. I grew up in a world where loud, expressive, and in-your-face, is more or less expected and of course we all know that's what Americans are like. Well, I'm an extreme type of American, so I faced a considerable challenge. But I began to recognize the places where I thought this Canadian "niceness", politeness almost unto death, this unwillingness to put oneself forward, was hamstringing nursing. Everyplace I looked I saw the potential not quite realized.

Author

Dr. Katharyn A. May is Professor and Director of the School of Nursing, University of British Columbia, Vancouver, BC. This is an abridged version of her keynote address to the 16th BCORNG Conference, April, 1998, Harrison Hot Springs, B.C.

Canadian system - best on the planet

The Canadian Healthcare system is the best system on the planet. If you harbour latent sensitivities around the possible good of privatization, come talk to me and I'll take you on a bus tour of the chaos down south. There is nothing to be gained by privitization for the vast majority of Canadians. My nursing colleagues are no longer making decisions consistently for the betterment of the American people. They find themselves trying to make decisions for the good of people in a system where the only person who counts is the one who pays the bills. Anybody want to venture a guess as to who owns the American healthcare system now? The insurance industry. The doctors thought they owned it about five years ago. They didn't then, but now they've figured it out.

Insurance companies are firmly in control of what gets decided about patient well being, and the health of Americans is what insurance companies decide is in their stockholder's best interest. Now the major networks are bailing out of their commitment to the poor who were previously covered by the healthcare system called Medicare/Medicaid. They realize they can't make a profit on those folks, and nurses in the United States told them that five years ago. The ANA's proposal for healthcare reform would have protected those patients in a fully federally supported, capitated system which would have allowed the private sector to take the profits where they could from people who don't need much healthcare. The nurses were not listened to in the United States, despite a valiant effort to get their message across.

Once again, the poor, the disenfranchised, the women and children of the United States, in the next 18 - 24 months are going to have inadequate access to healthcare, and we're going to start seeing preventable deaths as we saw them prior to 1992. So if you have any doubts about this system being the best on the planet, don't hesitate to give me a call and I'll give you American Healthcare 101, short course.

So, I want to make two major points:

1. Canadian nursing is privileged to sit right smack in the middle of the best healthcare system on the planet.

2. Canadian nurses work in a healthcare system which is almost perfectly designed to allow nursing to shine.

Most nurses don't understand the advantages they have, so I'm offering an American's perspective of the things you've got going for you that you really haven't put to use yet.

Why do I say Canadian nursing is poised for greatness and sits in the perfect position to make use of this very high functioning healthcare system? First, this is a humane system based on principles of moral position. I refer to the Canada Health Act. The five principles of the Canada Health Act square absolutely with nursing's view of what should happen. Absolutely, it's like hand and glove. It's as if nurses wrote the Canada Health Act. Did nurses write the Health Act? Probably, but you did it behind the scenes, quietly. And you didn't get credit for it, did you?

So the moral position of the Canada Health Act and the profound commitments of Canadians to those principles are absolutely square with nursing's moral stand.

Nursing Has Points of Leverage Everywhere

Second, nurses are everywhere in Canada. I had the opportunity to talk to a group of nurses who were employed by Medical Services Branch but are now employed by First Nation's Bands all over B.C. They work in the smallest places. Canadian Nurses are everywhere like little points of leverage in each community.

Third, Canadian nurses have a general sense of the direction things should go. You have a shared vision of what the end goal is because of the comprehensiveness of the under pinnings, the Canada Health Act. That's a huge advantage because south of the border, nurses do not, generally speaking, have a shared vision for the future because they're in a system awash with chaos. Some are convinced capitated systems work, and some are now convinced that they don't work, and a fully-funded federal insurance system is necessary. And there are other nurses who are convinced that the profit motive is the thing that will drive the improvement of health care. Amongst those three positions there is no common ground. There is no common ground between a nurse who thinks profit will drive an appropriate health care system and the nurse who believes that capitated systems funded by the users will work, and the nurse who believes that the federal government has a responsibility to its citizens to support federal insurance. There's no common ground, there no single point of contact between those views.

Despite this, nursing in the United States has promoted their public image better than Canadian nurses - guaranteed. American nurses have publi-

cists. They appear from the outside to be a pretty coherent group. But, from the inside they are fighting out some pretty nasty wars. Not wars about turf, but wars about what is possible.

Canadian nursing is exactly the opposite. There is more commonality of vision in Canadian nurses than I've ever seen in any other professional groups, but no public image, and no clear unified voice.

Now I'm going to say some things that are going to irritate you. When I came to B.C., I was appalled that the professional association was working so far behind the scenes as to be invisible. I couldn't find it. I could find association people, but I could not find the association's public stance. But I sure could find the Union. Their public stance was visible from the first day.

My fantasy would be to take some union stewards and some association activists, get them talking issues, then lock them in a room and then walk away. After the fighting and the screaming finished, they would come out with one strong plan. You know they would! They'd get over each other eventually. They would discover they agreed on what was good for the people of Canada and the people of BC, and they would come out with a strong voice. They'd come out with the capacity to sing from the same page.

Nurses can disagree in private. But in public they should have one strong voice. If that happened nursing would be unstoppable for the following reasons:

(a) Canadians like what nurses have to say. Opinion polls clearly show nurses rank right up there in the public trust.

(b) Nurses speak about a health care system which is one Canadians want.

(c) Everybody knows a nurse and most of the time it is someone they love and respect and trust. If nurses used that political clout to advantage to the common good, to the advantage of the people they serve, they would be unstoppable.

This is not true across Canada. I've talked to folks in other provinces and there are local conditions which hobble the strength of nursing.

Now I know Ontario thinks they've got everything bigger and better, and how Ontario goes, so goes Canada. Unfortunately, I don't think so.

The next great innovation in Canadian Nursing will not happen in Ontario. Too many competing vested interests. Too close to the seat of power.

Quebec, I'm afraid, is seriously derailing nursing with recent government decisions around nursing education. Hopefully our sisters and brothers in Quebec will turn it around.

The Maritimes, well maybe. There are some wild people in nursing in the Maritimes. But they're too small to make a difference. Not a critical mass here.

The Prairies? I don't know. Ralph Klein has turned himself around a bit, but my colleagues in Alberta are still not entirely sure that the system isn't badly damaged. The confidence of the people in Alberta has absolutely been eroded. Albertans don't trust the system anymore. They saw it go bad, go wrong. So that leaves us in B.C.

Affinity for the brakes

Canadian Nurses have an affinity for the brakes. They have to look everything over and over, from every angle. Is there a possibility that we can be making a mistake? Has anyone else done it? What will the physicians thinks? What will the administrators think? What will my mother think?

In the United States - the affinity is for the accelerator. The default position is "floor it". The default position in Canada is "brakes on!", with your foot dragging. Now I don't begin to understand where that comes from, it might have to do with the cold climate. I don't know what this passion is for the brakes. It serves you well sometimes, because you don't do stupid stuff a lot, but you don't do stuff a lot. The passion for the brakes is absolutely getting in the way of forward progress.

Despite this tendency, I am still convinced that Canadian nursing, perhaps British Columbia nursing, has the potential to make the next great innovation in nursing. Probably the most important reason, if you'll use it, is this weird thing that Canadians have about their healthcare system. And it's weird because your system is not that old. This is a relatively new innovation in Canadian culture, and you took it into your genetic material directly didn't you? When you ask people to talk about what is Canadian, by and large they say, their healthcare system. Or hockey. One or the other. That's cool, but it's weird.

Nursing and healthcare are not central to a perspective on life in the United States. In the U.S. nursing in many people's lives is irrelevant. It's big down there, it's bad down there, we've got 300 MRI machines on every city corner, but healthcare is not central in the minds of people. I'm not certain that healthcare is central to the minds of very many people on the planet. And you are sitting here amongst people who believe that the health of all is a goal worth paying high taxes for, putting up with some compromises for that's powerful stuff.

I wish somehow you could see it from my eyes, and understand what drives my passion for Canadian nursing. Because if you don't take advantage of these opportunities, it will be tragic. The failed potential of Canadian nursing would be a tragedy.

Nurses With Attitude Needed

You need to get over this Canadian niceness. What it is you're afraid of ? I understand that not everyone is comfortable in the limelight, but there have to be more nurses with an attitude. I've noticed that unions selectively pick their spokespersons with attitude and provided coaching. That's all it is, learned behaviour. I fear that Canadian nursing has structured itself so those with the passion for a bit of a fight become convinced the only place where they can express themselves is in collective bargaining for the good of all nurses. But this is not the only place to show your passion for nursing! How do we change this?

First, I think you need to find the wild ones among you. There are some. There are some wild ones among who have the voice and somehow along the way learned how to use it, the ones who can look a threat right in the eye, be shaking in their shoes and not show it on the outside. Those are leadership qualities, they should be nutured. You don't have to have the brains to formulate the plan, there are plenty of brains to do that. So if you find a wild one among you, who cleans up nice, who doesn't swear in public, who can get agitated about something and show some of that passion, line them up and point them at something. Get them fired on an issue, an issue on which you feel quite strongly and point them at a problem. This doesn't have to be dramatic but it works!

I witnessed an example almost a year ago where I was attending a nursing practice council and I heard a report from O.R. nurses at St. Paul's Hospital, Vancouver, who had done a research utilization project looking at whether it made any sense to wear masks if you weren't leaning over the patient. I was shocked - of course, masks are necessary! We always did it this way. How could this be? Well guess what - these nurses got organized and lost their fear of research and decided to investigate masks. They looked at the literature and discovered clear evidence that it is not necessary for some people in the operating theatre to mask. Clear evidence if you stop wearing unnecessary masks it will save a ton of money, clear evidence if nursing made this change then nursing would get the credit. They found some wild ones among them. Got them riled-up and pointed them at a problem. *They put nursing forward.* Not by making the changes behind the scenes quietly and hoping someone noticed. They put it right there, right in front of the physicians and administrators who say, "how much money do we save?" That's how it's done. That's putting nursing forward. So get rid of your shyness. Find wild people, rile them up, give them information, point them at some issue you care about.

Second, it is really important that we constantly encourage those organizations which representing nursing and those volunteers within your specialty groups who work so hard on your behalf to improve the standards of practice. When I don't like something that a professional association has done, I pick up the phone and I call a Director. Cheeky? You bet. Necessary, oh yes. Absolutely necessary. I pick up the phone and call. They know I'm listening, they know I'm paying attention. If everyone of you agreed to do that after the meetings, would we see a change in how nursing organizations function? Oh trust me, we would. You may not like what your organization does, then you call the executives and say I don't like that and this is the reason why. You don't give them emotions, you give them some evidence. You show them that you've thought this through. If nurses did that, if one in ten nurses did that, we would acquire a voice like no other, but we don't do it. Why not? Whenever there is an issues on which you have some passion, call someone and tell them you didn't like the decision they made or you liked the decision they made, but make sure they know you are paying attention.

Quebec - A Recent Example

The Minister of Education in Quebec early in 1998 decided the baccalaureate programs would be for preparing managers and teachers, and entry into nursing practice in Quebec would be at the diploma level which would be delivered through the college system. A politician made that decision for nursing, and so far it's sticking. However, there was a letter writing campaign from nurses all over Canada and that Minister is now buried in paper. Unfortunately all they have managed to achieve is to delay implementation of his policy for three years. The Policy is not gone.

When that happened in Quebec I said to my colleagues in B.C. "This could very well happen here." We don't have a unified position. We all have various positions on whether the baccalaureate is the entry level into practice. What offends me is this: who gave the government the right to make such a decision? Will they pull that with law, engineering or with medicine? No. But they feel then can do it with nursing because we don't call them on it. Because we are too nice.

Putting Nursing forward requires a little attitude, a little courage, and a lot of support. It's a little scary to be out there but putting nursing forward is necessary now. If we do not, the opportunity, the window will close. This unfreezing in the health care system is not going to last for very long. It's a mess now but it will refreeze. Trust me, systems always do, and if we don't move now while things are still unfrozen, then the new structure will set down and I'm not sure where nursing will be in the new structure. I am not confident it will be as we wish it.

Lessons from Star Trek: Next Generation

I enjoy the science fiction for lots of reasons but perhaps most importantly it enables me to "get out of the box". If you can imagine a being who lives in seven dimensions, as opposed to three, even for a second, you've got the mental wheels pretty well greased. I especially enjoy fiction about space travel because it helps me get clear about the matters of real importance. The vacuum of space gets you real focused. This is a quote from *Leadership Lessons from Star Trek: Next Generation.*

> "In deep space (or in the Canadian Health Care System) conditions rarely favor even the most experienced officers and crew. Therefore, mission success depends on those willing to work through obstacles with tenacity and persistent effort. One's incentive is a direct expression of ones ambition. There are times when one is granted considerable freedom to act. Such freedom does not permit inaction when action is required. ... We must allow each other to disagree on how to achieve the goals of the mission, and then we must support each other and meet the common threat with a common voice."

Perhaps Jean Luc Picard was thinking about Canadian Nursing when he wrote that.

Quite simply the difference between the insignificant and the exceptional achievement is a matter of the enthusiasm and the determination with which one carries out one's duties.

Progress is often due to those who acted when action was required, and those who acted when others saw no reason to act. If Canadian nurses can find a voice and use it as a tool to the common good, then the full potential of nursing can be realized.

Conclusion

If Canadian Nursing does not choose to act, does not show the Canadian public how nursing benefits them, and can continue to contribute to the health of all Canadians, then the full promise of nursing and the full promise of this wonderful healthcare system will not be realized

I challenge you to seize the day. I challenge you to practice putting nursing forward on a local scale, and on a regional scale.

If nurses choose to act, then the energy and the drive will be unstoppable.

I hope that you will see opportunities to act and take them. I hope you will encourage your colleagues to act, and support those who act with vision and passion on behalf of Canadians by putting nursing forward. ■

Skill Mix and Clinical Outcomes

By Dr. Judith Shamian, RN, PhD

My orientation and education to Operating Room nursing was provided by one of Canada's finest nurse leaders in this field, Ms. Isabelle Adams. In 1980, when I was hired for my first management position at the Jewish General Hospital, Montreal, Ms. Adams was the Nursing Coordinator for the Operating Room (OR). She managed the place with caring and tough hands. She managed the operating room like nothing I've seen since. Consequently, I have had the mentoring experience of watching somebody simultaneously use knowledge, expertise, and the art of management.

I also want to mention and congratulate Dr. Joan Donald, from Mount Sinai Hospital (MSH) in Toronto for completing her Ph.D. Completing a Ph. D. is quite an accomplishment. I believe she is the first Ph.D. prepared nurse with a specialty in operating room nursing in Canada. I am sure there will be many more of you who will be continuing your education and attaining new degrees. In so doing, you will begin to build some of the necessary research and science that needs to be generated in the area of operating room nursing

In my presentation, I will deal with the topic of skill mix, reflecting on research, management, policy and political perspectives. I hope that my comments will be of value to you in lobbying for the right nursing care for all of your patients. Although my interest in skill mix is multi-faceted, it derives primarily from my role as Vice-President Nursing, in an acute care hospital. In this position, it is my responsibility to advise hospital senior administration and the Board of Directors on matters related to patient care. Furthermore, I am accountable to ensure that quality patient care is delivered at all times. I want to assure that you understand that my interest and opinions about nursing skill mix research is grounded in my day to day responsibilities and is not just an academic exercise. My knowledge and expertise in this area has a day to day practical application as I advise the hospital on decisions about management, economics, and care delivery.

The question I ask myself everyday is "what is best for patient care?" How can I ensure that the patients at Mount Sinai Hospital get the best care possible and achieve the best clinical outcomes? Within that context and based on existing evidence, we are able to draw conclusions that formulate our decisions.

Late in 1991, we made a decision at MSH that given the changing health care environment; we needed an all-RN staff. We reached this decision after careful examination of the types of patient populations we were caring for, their acuity and clinical needs, the scope of practice of RNs and RPNs as defined by the regulatory framework, and a review of the research literature.

In the budget year of 92/93 we eliminated all nursing care personnel that were not RNs. This reduction included nursing assistants and OR technicians. I remember the discussions before, during and after the decision. There was opposition to close the OR non-RN positions. Opposition came from within the OR, from both nurses and surgeons, and from sources external to the OR. The reality is that when making a policy decision that is driven by what is best for patient care, there is a moral obligation to see it through to completion. You should not veer from the right decision because of political pressure along the way. To date, six years after implementation, there is an overall recognition that we made the right decision. As we look at how health care in acute care hospitals has unfolded and what kind of care is required by patients, moving to an all RN staff is the right decision. Given the acuity and severity of illness of our patients, we need the knowledge of a registered nurse who can constantly assess, plan, and work with patients and their families. We need to know that we make every effort possible to provide the best care possible. So, my interest in skill mix comes from the perspective of being a nurse executive and a health care executive who is accountable for the care patients receive.

My interest in skill mix also arises from the unfortunate misinterpretation of the value of nursing work by those outside of nursing. One of the most consistent aspects of hospital reform across the country is the dilution of skill mix and the elimination of nursing structures and nurse executives. The national phenomena of introducing unskilled workers to provide direct patient care is going to impact negatively on the quality of patient care. There is an urgent need to have a cadre of well informed individuals that can set the record straight and challenge the faulty assumptions that are driving skill mix decisions.

Finally, I have an international interest in the skill mix issue. Mount Sinai Hospital's Nursing Department is a designated World-Health Organization (WHO) Collaborating Centre. In the context of the Centre, we are involved with many international groups of nurses. In a number of international meetings it was stated that we need studies to prove that "nurses make a difference". The general sentiment was that with such evidence, we could convince policy makers and others of the relevance of professional nursing to health care. Such statements used to infuriate me because there are a significant number of studies that give us the relevant knowledge on the clinical and financial value of nursing.

Following one of these meetings, I decided that the WHO Collaborating Centre at MSH should compile existing evidence in a book to be used by both the public and professionals. In 1996, we published such a book and it summarizes, analyses, and synthesizes the findings of existing research. This document "Nurse Effectiveness: Health and Cost-Effective Nursing Services", provides assistance to those who want to argue the rationale for proper skill mix using relevant evidence. The document has utility in making arguments to politicians, policy makers, nursing and hospital administrators.

What are the skill mix issues in the OR? Your challenge as it relates to skill mix in the OR occurs on at least two levels. The main threat (that I hear you talk about the most) is dilution of skill mix from RNs, to Practical Nurses, and/or to OR technicians, and unskilled workers. This potential shift is a serious issue. I find very few advocates for all RN staff in the OR. In addition, there is a second issue that is quickly emerging. I worry that many of you are so busy advocating for the proper skill mix, that this new issue will catch you by surprise as it quietly emerges in the background. By the time you realize the severity of this threat, it will be an immense and difficult issue to deal with.

What I see is a carving away of your roles horizontally. Look around you and see who is new on the scene, who wasn't there several years ago? Do you have non-surgeons assisting surgeons? Do you have respiratory therapists who are ready and willing to take on any technical role in order to expand their scope of practice? Who else is moving in and creating further fragmentation of patient care? Remember we are committed to holistic care; the more players on the scene, the less holistic the care. Furthermore, the financial envelope is usually sealed, so if new players come on the scene their payment has to come from somewhere else. I would hate to think that you are putting all your energy into fighting for skill mix issues among different nursing groups. Yet while you're focusing on this one area, your role gets diluted sideways. You have to make sure that you keep your eye on the ball in all directions. You might succeed in eliminating the threat of skill mix, but suddenly realize that what you protected was actually a very narrow and unsatisfying dimension, and the whole patient has been fractured - body parts given away to other disciplines. I think you are in a situation where you are being pressured from both sides and it's important to acknowledge and watch for potential changes in both directions. I suggest that you map out the different players in your Operating Rooms and determine how to make sure that your scope of work remains holistic, not fragmented.

Based upon existing research, and on what I have seen so far, the RN is the ideal person to provide the most comprehensive care both in the OR and in acute care settings. So if the basic assumption of holistic,

Author

Judith Shamian, RN, PhD is the Vice-President of Nursing at Mount Sinai Hospital, Toronto, and currently President of the Registered Nurses Association of Ontario.

Dr. Shamian's paper was originally presented to the 15th National Conference of Operating Room Nurses Association of Canada in Ottawa last year.

non-fragmented care is the desired perspective for OR nursing, then make sure that any changes or new initiatives do not interfere with that basic assumption.

There are a number of strategies you have to consider in attempting to be part of the solution rather than a victim of the decisions. Some of these strategies include:

- Be clear on the issues;
- Participate in decision making;
- Build alliances;
- Be knowledgeable about the relevant research;
- Be knowledgeable about the cost issues associated with skill mix.

Participate in Decision-making

All of us across the country are dealing with downsizing, side sizing, restructuring, reorganizations, and any other form of change one can imagine. These changes come with a sense of urgency. This sense of urgency is coupled with a sense of panic, fear, and the need for rapid decision making. These changes in the system often are not thought out systematically. Often these changes are not grounded in reasoning and evidence. Most often, they are grounded in PERCEIVED (often incorrect perception) benefits—that the change is cost effective. Six to twelve months later when institutions realize that their decision was a poor decision that did not work—or metaphorically, the wrong leg was cut off—they quietly try to put things back in place. The reality is, that even when everything is reinstated to the state of pre-decision, the damage caused within the organization is tragic and may be irreversible. Unfortunately nurses are often the victims of these decisions. Change can happen at any part of the organization but its impact will be vibrated to, and felt at the patient care level. Often these poor decisions can be avoided if nurses and nurse executives participate in the decision-making process. It is extremely important to remember and remind executives that nurses support change, but it needs to be the right change implemented in the right way.

Build Alliances and Relationships

The whole notion of alliances and relationships is undervalue. OR nurses often pride themselves about their wonderful relationships with surgeons. If that is the case, what do you do with that wonderful relationship? Why do you not take advantage of that relationship and use it to educate surgeons of the importance of professional nursing both in the OR and at the bedside? If you are able to recruit surgeons support to the notion of professional RNs in the OR, much of your lobbying work is done. Although you often do not sit at the decision-making table, you would be surprised by how influential your surgeon colleagues are in and out of the boardroom.

Building relationships goes beyond the walls of the OR. As you promote your views of how the OR needs to be staffed, you want to make sure that the nurses in your institution will support you. OR nurses often do not have a meaningful relationship with the nurses outside of the OR. If that is the case in your hospital, it is time to change it. To achieve meaningful and lasting change, you need a coalition with your fellow nurses and nurse executives.

Your professional associations and interest groups, should all be engaged to support your efforts. Do remember that support is a two-way street. If you expect to be supported in achieving your agenda, support these organizations in return. Hence the whole notion of alliances, externally and internally, is extremely important.

Know the Relevant Research

Earlier, I indicated that there is nursing literature and research available that demonstrates the clinical benefits of high ratios of RN skill mix. There is research that dates back more than 20 years. It is not that we don't have the information, it has been in existence for the past 20 years. We simply ignore it and do not use it properly for either decision making or communication purposes. In this speech, I will review a few of these studies. For a more elaborate literature review, consult the document I mentioned earlier, "Nurse Effectiveness: Health and Cost-Effective Nursing Services".

In 1993, Prescott published a review paper in Nursing Economics summarizing thirteen research papers which examined the relationship between clinical outcomes and skill mix. These collective papers demonstrated that with a higher ratio of registered nurses, clinical outcomes are consistently better.

Another study conducted by Linda Aiken (1994) from the University of Pennsylvania, has been examining mortality rates as they relate to a number of nursing factors (skill mix being one of them), nursing organizational structures, and the valuing of nursing within an organization. Aiken's findings showed that 39 magnet hospitals (those with specific positive characteristics related to nursing care delivery) when compared to 149 hospitals (exactly the same in all characteristics, except nursing) had 4.6% lower mortality rates. This means that for every 100 deaths in the 149 comparison hospitals, the magnet hospitals had 95.4 deaths. Magnet Hospitals had 4.6% fewer deaths attributed to differences in nursing factors. There are additional quality research papers on this topic.

It is important to remember that the existing research supports the notion that higher RN skill mix leads to better patient outcomes. Bear in mind that Chief Executive Officers (CEOs) and hospital executives make decisions about who will care for our patients and how much care they will get. The key question is "how are you involved with these decisions?" What information and research are you able to offer? As a matter of fact, we all have an ethical obligation to provide information and shape the decisions as much as we are possibly able. Often times, despite all of our efforts, the decision is not consistent with our values and recommendations. These results should not deter you from repeating the process as many times as needed in the future.

What is The Real Cost of Skill Mix?

When institutions make decisions to dilute their skill mix, the cost calculations are often based on a straight conversion of the hourly RN rates with those of either practical nurses, technicians, and/or multi-skill workers. In some provinces, like Ontario, the difference in beginning salaries between these categories of workers are minimal. A beginning RN makes $17-18 per hour while a practical nurse starts at $16-19 per hour. A technician makes around $17 per hour, and multi-skilled workers start at $13-16 per hour. In some provinces, the salary differences are larger. Nevertheless, in either scenario, calculating the cost-benefit of a staff mix has to be grounded in multiple factors, not just rates of pay. The education cost, replacement cost, turn over cost, productivity cost, the cost of losing experienced staff, and the cost of supervising less qualified employees, are but a few of the areas that need to be considered in the cost-benefit analysis.

We need to examine carefully the de-skilling phenomena and the associated costs. Often the savings come from reducing experienced RNs and hiring replacement staff at the first step of the salary grid. How much has the lost experience cost the hospital? How much will it cost to train these new people? I hear stories from colleagues in the U.S. and Canada, that hospitals have to provide education programs in-house and teach and supervise the clinical experience of the new workers. In addition to the training requirements, the turn over of many of the multi-skilled workers is very high necessitating continuous educational sessions. The recruitment, teaching, and payment of salaries for both instructors and new employees, are all costs that need to be factored into the analysis. It has been shown by a number of organizations that targeted savings have not been achieved. This is because they failed to take into account all of the additional costs incurred. In the end, not only do hospitals not saving anything, they also have less qualified staff to do the work and, they have an unhappy work force.

You know from your personal experience, that in order to become proficient in the OR, it is not enough to go through a four to six-week course. It requires years of learning, education and experience. So how much does training and education cost? How much does the supervision of new people cost you?

The concept of productivity is another area that hospitals often do not understand and do not factor into their calculations. A recent Canadian study by Linda O'Brien-Pallas (1994) of the University of Toronto, examined the productivity levels of RNs, practical nurses, and multi-skilled workers in nursing homes. The study findings indicate that the RN is the most productive worker among the three groups, followed by the practical nurse. The least productive worker was the multi-skilled worker. This finding implies that you get the least work per hour from the multi-skilled worker, and you get the most work from the RN. These findings are probably related to the fact that the RN is the most diversified worker among the three. The RN can do all of the functions that the other two categories can do, and will do so with a holistic, patient-family centered approach. The practical nurse can do fewer activities than the RN. The multi-skilled worker can do the least. I believe that all three groups of employees (RNs, practical nurses, and multi-skilled workers) are willing to work. I am not taking issue with the sincerity and hard work of any health care worker. But you can only do what you are educated and allowed to do. But if there isn't any work that you are capable of doing and permitted to do, then you are non-productive. And I, as an executive, pay you for being non-productive. And then I pay overtime to the registered nurse because she needs to do the work that the others cannot do. So, when you start to stretch the skill mix at the unit level, you realize that this "wonderful" cost-saving decision that was made—to hire less qualified workers with an hourly rate that is $1 to $10 cheaper - becomes a non-cost effective exercise.

Quality effectiveness also needs to be factored into cost effectiveness. Studies demonstrate that there are

lower levels of adverse affects like pneumonia, decubitus ulcers and other complications, when there are higher ratios of RNs. Fewer complications result in a lower cost per case. Length of stay is another factor that has been shown to be associated with RN ratios. A higher ratio of RNs lead to reduced lengths of stay (American Nurses Association, 1997). Decreasing lengths of stay is highly desired by hospitals and can lead to cost effective management.

Often times the argument you hear from hospital executives is that they had no choice but to reduce the RN complement because the nursing budget is the largest budget in the hospital. The other side of the same coin is that nursing salary budget (excluding non-nursing personnel who are charged to nursing cost centres) is more like 25%-40% of the salary budget, a far cry from what executives argue. Furthermore, in our experience at MSH with all RN staff, every time that our patient care costs are compared to other hospitals with a diluted skill mix, we at MSH have not been the most expensive nursing cost centre. We usually sit at the mid range of costs, or below. More than half of comparison hospitals spend more than we do on nursing services and have a lower professional skill mix. The earlier discussion about the true cost of skill mix could explain these interesting findings. All in all, it is safe to repeat again that an all RN staff is both a cost and clinically effective approach to patient care staffing in acute care settings.

In order to make an all RN model work, nurses need to be willing to be part of the solution of cost cutting. Every hospital in Canada has been facing serious budget cuts that are imposed by external forces. Hospitals do not have the privilege of refusing to reduce their budget. We also are not interested in moving into a private health care system where we can charge patients to make up for lost income. The reality of hospitals, boards and executives is that government budget cuts have to be absorbed and reductions in expenses have to take place. Many hospitals turn to the skill mix solution as a cost reduction method. It is clear that, such an approach is not preferred by RNs because it compromises the quality of care. What are some alternative solutions that you can put forward as potential solutions to reduce expenses?

It is essential to understand that any significant budget cut in a hospital will be associated with layoffs. Maintaining an all RN formula does not guarantee that no RNs will be laid off. At MSH, we had to reduce some services to meet our budget targets, and in doing so, closed a number of nursing positions which resulted in the layoff of RNs. Remember that this is about doing the right thing and maintaining quality and cost effective care with the most qualified nursing staff. This is not about how can I protect every nursing position (although it would be wonderful if we could do it).

Here are some of the solutions that I hear of from my colleagues that have been implemented at MSH, and which have helped to trim budgets, while maintaining the professional nursing complement.

Center diagnostic and therapeutic aspects of patient care in the hands of the nurse caring for the patient: including IV therapy, blood taking, ECG, respiratory therapy and other activities.

Care delivery: Institute Primary Nursing, this will eliminate the need for additional nursing coordination of care. The Primary Nurse and associates will do all the care coordination.

Unit Management: With all RN staff, the staff should be expected to have the professional knowledge and skills so that they will require less supervision and guidance. This will allow for a reduction of the overall nursing management complement.

Nursing Support Staff: In an all-professional staff environment, there is a reduced need for professional staff of clinical instructors and others. These roles can be taken on as needed by staff.

Equipment and supply: Active involvement in determining what supplies are needed and determining whether certain items can be replaced by less expensive products.

Non-nursing tasks: Reduce non-nursing tasks from nurses work (e.g., transcribing orders, running specimens to labs, passing food trays, stocking carts).

Patient Management: Many in-patient days can be saved by having a pre-admission unit, day surgery program, clinical utilization program, home care program and other initiatives.

OR: In the OR, the way surgical minutes are being managed is an important area to examine. How many minutes a day are being wasted because of delays of surgeons, anaesthesiology, room cleaning, patients delays etc. All these delays are costly since staff is being paid to stand idle (non-productive). If those unused minutes were shaved off, the OR could be run with a lower budget.

Staffing: staffing is a sensitive and difficult area. It is essential to strike the balance between having the needed staff and having excess staff. Different methods of on call, sharing staff among like units and other strategies need to be explored in order to achieve maximum use of available resources.

These are some of the areas in nursing units that need to be examined and considered as possibilities for cost reduction.

Conclusion

Although the changes in health care are enormous, I believe there are also enormous opportunities, and the only time that you make serious gains is when there is enormous chaos. Being able to stay focused and take advantage of opportunities will be critical. When there is a lot of money and everyone can do anything they want, our tendency is to make everybody happy. So you want five more respiratory therapists, here are five more. You want 10 more of this; here are 10 more. Money is used to solve problems. There are opportunities today - take advantage of them. There is a Jewish saying: "Time doesn't go by, me go by time." So when you look at what you're doing and where you're going, it is you walking through time and shaping that time. It is not time that passes by you. I am confident that all of you will put this information to good use.

The notion of anyone feeling like an insignificant player in a large organization is not acceptable to me. Each of us has an enormous ability to make a difference. By generating good ideas, each of us is a pearl, and together we create a wonderful necklace. ■

Acknowledgement

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Newsbriefs

Evidence-based information for use by Nurses in Practice

The Canadian Nurses Association (CNA), Health Canada, the Canadian Association of University Schools of Nursing, McMaster University, and the Canadian Association for Nursing Research have established a partnership to develop a model for the dissemination of evidence-based information. This model will assist nurses involved in practice, administration and research, and policy makers to access research evidence for practice and policy decisions.

The initial phase of this project is currently underway and includes the development of the dissemination model, a database of sources of evidence and a literature review on factors affecting dissemination and utilization.

Two consultations will be held with nurses and other stakeholders to validate the model. The first, a paper review of the literature and the model, was held in February 1998. The second consultation will bring together potential users of the model and other key stakeholders who may have an interest in refining and elaborating aspects of the model. This second consultation will be held in March 1998.

If you have any comments or questions about this project, contact Brenda Shestowsky by email bshestow@cna-nurses.ca through the Canadian Nurses Association.

Nancy Malloy Memorial Fund

The Canadian Nurses Association (CNA) is raising funds with the Canadian Red Cross Society and PATH Canada to build a national monument in Ottawa for the many Canadians who have lost their lives while helping others in our international aid programs. Canada lost a find nurse, CNA member and Red Cross nurse, Nancy Malloy dedicated her life to giving humanitarian aid to people in world trouble spots. She lost her life while nursing in Chechnya in late 1996. For your information or contributions, write :

Nancy Malloy Memorial Fund
Canadian Nurses Association
50 Driveway
Ottawa, ON K2P 1E2
1-800-361-8404

WWW for OR nurses

ORNAC ONLINE http://www.ornac.ca
The Operating Room Nurses Association of Canada (ORNAC) has a brand new web site which provides varied information on perioperative nursing in Canada. We are fortunate to have members of ORNAC 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 journal, reference library, current events affecting nurses in the USA.

AORN Clinical Online Consultative Service http://www.aorn.org/CLINICAL/ONLINE
This online service is available to all members of AORN. You can submit questions regarding AORN standards, and suggested practises. The consultants online are good about sending back information to you, and within days.

PERIOP is an electronic forum for perioperative nurses, and those interested in Perioperative nursing. You receive information through email messages. Currently there are over 500 subscribers, representing 12 countries, and 4 continents. It processes 30+ messages each day on a variety of topics. This forum allows nurses in rural and isolated areas to network with their peers and get opinions and answers to their questions. It introduces North American nurses to healthcare culture in other parts of the world and lets nurses from that world listen in on our concerns. Once you join this **free service**, you can submit questions to the group. For example: you want to know how other hospitals deal with minimal access surgery. What do they count? What if they convert to laparotomy? So you send off the email to the centre. Your message is sent to all the subscribers on the list. In turn, the responses to your questions are sent to your email address.

To subscribe: send a message to listproc@u.washington.edu
Leave the subject line empty.
In the body of the message, type only: subscribe periop Firstname Lastname

Of course, substitute your name in the above expression. Turn off any automatic signature that attaches to your message, as this will confuse the computer. You will receive a confirmation message. Just reply automatically and send back the message. This confirms your subscriptions. Within 24 hours you receive a welcome message indicating a successful subscription. Save this message for future reference, as it will give information such as temporarily stopping the service (when you are on holidays). From then on, the messages will come everyday. This list is maintained by the List Processor at the University of Washington.

Conference Calendar

October 1 - 3, 1998
MAPAN/MORNA 4th Joint Provincial Conference at the Westin Hotel Winnipeg, Manitoba. "Perioperative Nursing: Exploring the Future" Keynote speaker: Dr. Susan S. Fairchild on developing the skills necessary to carry perioperative nurses into the 21st century. Program offers continuing education certificates for registered attendees. Contact June Hill (204) 235-3276 or email: jhill@mail.sbgh.mb.ca for further information.

October 16 - 18, 1998
Saskatchewan Operating Room Nurses' group presents: *"Relax, Revitalize, Reconnect Personally & Professionally"* at the Temple Gardens Mineral Spa in Moose Jaw, Sask. Book your Spa treatments early because of limited space 1-800-718-7727. Further information: Sheila Kock, Conference Chair (306) 586-2730 or Gail Kell, Registration, (306) 693-3310.

October 17 - 18, 1998
14th ORNAHD Conference at Beacon Motel, Joran Ontario. *Theme - Mind, Body, and Soul.* Further Information: Bonnie Brown, 24 Kinsington Street, Guelph, ON N1H 3P4.

October 21 - 24, 1998
Operating Room Nurses of Alberta Association - 17th Provincial Conference - Red Deer, Alberta. *Theme - "Stepping Out of the '90s"*

November 3 - 6, 1998
27e Conférence provinciale - 27th Provincial Conference from CIISOQ/CORNQ
"New century ... New Challenges" at Queen Elizabeth Hotel in Montreal, Quebec. Further information Louise B. Vadeboncoeur, 791 de Boulogne, Repentigny QC, J6A 7T7.

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.

July 25-30, 1999
World OR Conference. Helsinki, Finland.

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

Telemedicine Canada
Operating Room Series
Fall 1998 Wednesdays @ 13:00 - 13:45 EST

September 23, 1998
"Pediatric Laparascopic Surgery. Starting a Program & educating Staff". Presented by Marla Ewen & Marion Morrissey, Saskatoon Health District, Saskatchewan.

October 14, 1998
"A Practical Approach to OR Count Policy". Presented by Muriel Shewchuk, Calgary Regional Health Authority, Alberta.

November 4, 1998
"Creutzfeld - Jakobt Disease: Implications for the O.R." Presented by Skyla Lundgren & Marcy McKay of the Victoria General Hospital, Victoria, BC.

November 25, 1998
"The Circulating Role - Who is the most appropriate Care Provider: An Ontario Perspective". Presented by Judi Tyndall & Aline Young, Hamilton Health Sciences Corporation, ON

December 10, 1998
"Hazards of Electrosurgery" Presented by Peter Lafontaine of Valleylab Canada.

February 10, 1999
"Legal Issues Related to Computerization in the O.R." Presented by Anne Grant & Judity Clarkson, Principles, Mediated Solutions, Inc.

Published report says even *correctly* administered drugs are causing thousands of deaths

A disturbing and controversial new study by researchers at the University of Toronto is suggesting that *correctly* administered drugs have killed an average of 106,000 people every year in the U.S., and about 10,000 in Canada.

The study, reported in the April 14 issue of the *Journal of the American Medical Association,* says that approximately 2.2 million Americans annually suffer a drug reaction severe enough to require hospitaliza tion, a prolonged hospital stay, cause a permanent disability, and even cause death.

Dr.Bruce Pomeranz, a professor of physiology, and the principal investigator, said that figures extrapolated from the US would estimate that about 10,000 Canadians die annually from severe drug reactions.

The author of the report, student Jason Lazarou, along with Pomeranz, examined 39 studies conducted in U.S. hospitals since 1966. The deaths, says Pomeranz, "are not because of malpractice or negligence, but are a side-effect of properly prescribed and erly administered medications." About4 of the reactions were allergic responses.

The key to combatting the problem is public awareness, says Pomeranz. He suggests drug recipients ask more questions of their doctors, especially about possible reactions so they'll know what to look for.

Prescribing cascade

A researcher at the Baycrest Centre for Geriatric Care in Toronto, Dr. Paula Rochon, explained that patients are often hit by a "prescribing cascade." This occurs when an adverse drug reaction is mistaken for a new illness and the person is prescribed even more drugs. "It happens a lot, and it can go on for a long time," said Rochon.

Most detractors of the study agreed that, even if the true incidence of ADRs is considerably lower, it is still higher than generally accepted.

Power of suggestion

Why is it that some doctors who prescribe drugs deliberately fail to warn patients of potential side-effects? One reason is put forward is that these doctors believe in "the power of suggestion," that by telling the patient of the possible side-effects, they will abetting the increased incidence of these very side-effects.

(From a study reported in the Archives of Internal Medicine, December, 1994.)

New antimicrobial paint kills pathogens on contact

Health care facilities worried about the spread of pathogens on walls, heating ducts and flooring may find the solution in a new kind of paint.

A recently developed paint containing an antimicrobial additive destroys all microbes that come into contact with it. The chemical additive, provisionally named BNA for "biological neutralizing agent," kills bacteria, fungi, mildew, and several kinds of viruses. It is said to be lethal to staphylococci, salmonella, E. coli, tuberculosis, hepatitis, and cholera. Says inventor Brian Mallow (Southwest Research Institute, San Antonio, Texas), " we haven't found anything it doesn't work with."

The key ingredient of the biocidal paint is calcium hydroxide. This compound, says a research spokesperson, kills micro-organisms in seconds by destroying their enzymes.

Earlier attempts to use calcium hydroxide (slaked lime), were unsuccessful because it is quickly deactivated by carbon dioxide in the air.

After testing hundreds of molecular structures (polymers) capable of forming a protective shell for the calcium hydroxide, the researchers discovered that a binding compound from a formerly developed product was ideal for the job. The binder makes the new biocide suitable for both oil-based and water-based paints.

Harmless to humans

The microbe-targeting ingredient re-mains active for at least four years and is harmless to humans, Mallow says.

The U.S. Food and Drug Administration has approved it for use in food and pharmaceutical environments.

The price of the BNA-laced paint, now undergoing tests by major paint companies, will be competitive, making it attractive for application in hospitals and nursing homes.

(Source, Equinox, February/March, 1998)

World's oldest dies in Ontario at age 117

When Jeanne Calment of France died last year at the age of 122, she was the world's oldest living person at the time. With her death, the mantle passed to Marie-Louise Meilleur, born 117 years ago in Kamouraska, Quebec.

Marie-Louise died this past April at the Nipissing Manor Nursing Home in Corbeil, a small community outside North Bay, Ontario.

Kicked the habit

When told she was the oldest person in Canada, she replied in jest, "poor Canada." Marie-Louise, like Jeanne Calment, smoked, but both wisely kicked the habit before they reached their 115th birthdays.

Other coincidences between the two include: both were Francophones, both entered a nursing home after age 100, both had a sharp sense of humour, and both died in their sleep of natural causes.

When Marie-Louise entered the nursing home at the age of 107, she was able to walk in with only the aid of a cane. Jeanne Calment also only used a cane because of her failing eyesight.

"Hard work"

Asked to explain the secret of her longevity, Marie-Louise replied, "hard work." Asked the same question, Jeanne Calment said, "never get bored with life."

Statistics and probability indicate that the next oldest person will be another women. There are a number of contenders around the world, but the documentation required does not meet the standards required by *The Guinness Book of World Records.*

So, anyone with aspirations for the record should make sure their documentation is in order.

Wake-up & smell the roses!

Of all the senses, smell is the least understood - and studied. A healthy sense of smell can detect over 10,000 different odours, and much of one's sense of taste depends on the sense of smell. Thus, anything that lessens olfactory sensitivity will decrease food flavours. Here are some interesting points:

- Women have a keener sense of smell than men.
- Hunger heightens sense of smell.

Hyposmia and anosmia

- 50% over age 65 and 75% over age 80 have *hyposmia*, a reduction in the ability to smell. There is also a decline in the ability to detect odours and identify them.
- Total lack of smell is called *anosmia;* those who complain about odd or imaginary smells, *phantosmia.*
- Reasons for the decline in ability to smell as we age include: neurological changes, chronic disorders, AD, Parkinson's, hypothyroidism, medications, smoking and drinking.
- Just as we have a dominant hand, we have a dominant nostril. If you're left handed, your left nostril will be more sensitive because of greater nerve sensitivity on that side.
- Cultural (and genetic) variations determine odour preferences.
- Constant or repeated exposure to an odour will result in the decline in the ability to perceive that odour.

Aromatherapy

- For those scoffing at the tenets of aromatherapy, this should wake them up to smell the roses: memories triggered by an odour tend to be more emotionally intense and evocative than those linked to any other sensory cues. Also, 85% of people have a childhood memory associated with an odour.

(From University of California *Wellness Letter,* Vol. 14, No. 7, April, 1998)

Banff booked for 2001

Gloria Nemecek as chairperson for the 17th National ORNAC Conference met for the first time with her committee in Edmonton, June, 1998, to plan for the conference. She says its very exciting to be planning for April 20 - 27, 2001. It is both weird and wondeful just writing the date 2001.

In the meantime set your sails for Halifax, June 1999 for the 16th National ORNAC Conference.

How to Submit Your Article to the OR Journal

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

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

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

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

Authors may submit **computer diskettes** in Word, Word Perfect or Text file (.txt).

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

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

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

Benjamin,G. (1987).Opportunities for nurse entrepreneurs. *Nursing Outlook* 35(4),182-184.

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Authors will receive a letter from the publisher announcing receipt of the article. Later a letter of acceptance and possibly some revisions may be suggested by the editorial review board.

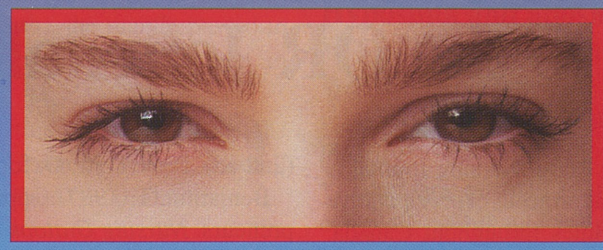
Manuscripts submitted to the Journal **should not** be submitted to another publication or newsletter while under review or awaiting publication.

Award for Authors valued at $3000

In 1983 with the launching of the "Canadian Operating Room Nursing Journal", Johnson & Johnson Medical Products committed an annual $3,000 award to be presented to the author of the best article of the year published in Journal.

The award recognizes Canadian nurses who contribute to the advancement of perioperative nursing knowledge and education of their colleagues through the medium of the Journal.

The Editorial Awards Committee was established in 1983. The first award was presented at the National Conference in Jasper in 1984, and is presented annually at the National ORNAC Conference or at a Provincial Meeting. The recipient receives a plaque as well as the cash award which is administered by ORNAC. This year's Awards Committee Chairperson is Nora Slater of Bathurst, New Brunswick.



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