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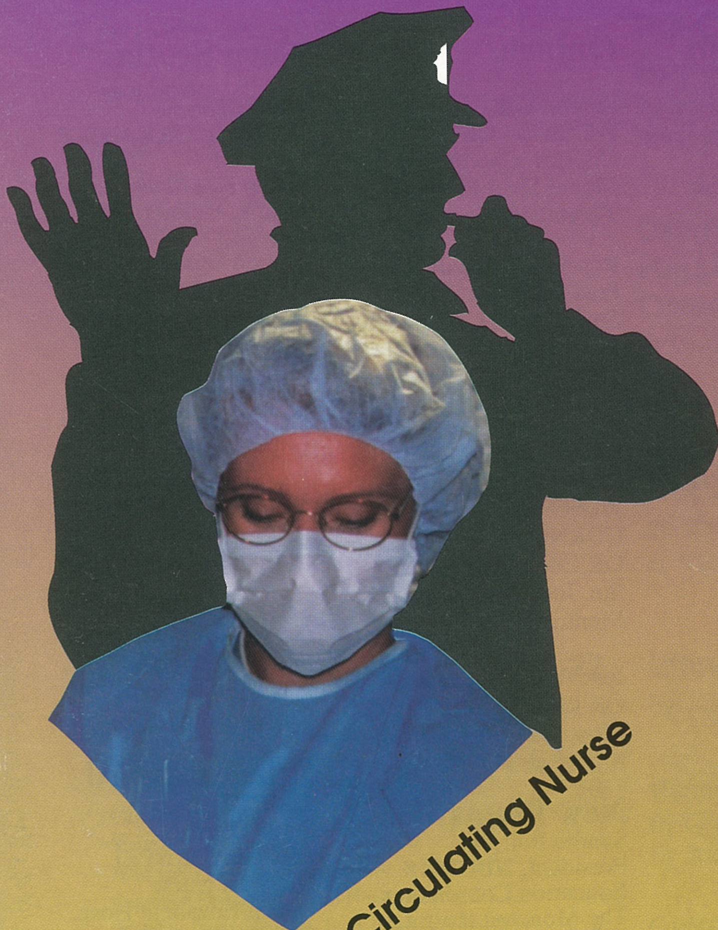

The Circulating Role: Who is the Most Appropriate Care Giver ?

Preparing for the Future - World OR Conference paper By Dr. Joan Donald

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Lifting the Fog in Endoscopic Surgery

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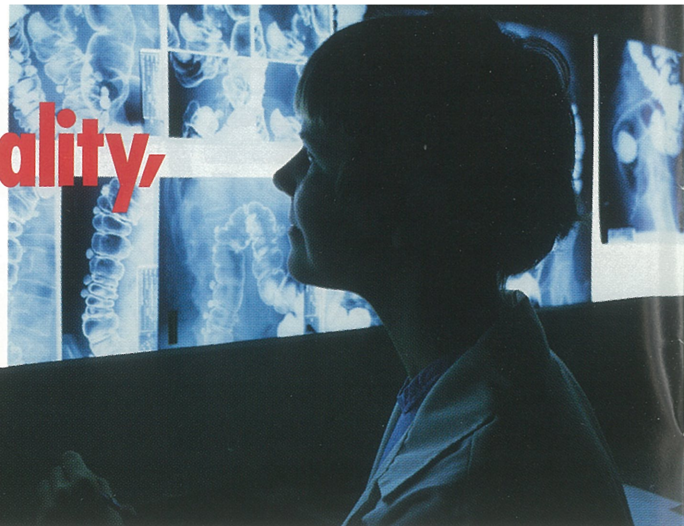

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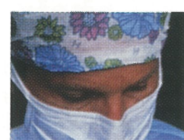

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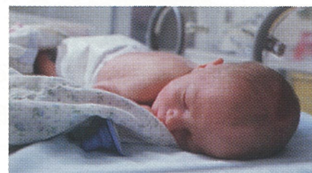

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Security ... and Hope

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

Of all the key issues identified by Perioperative Registered Nurses at the 15th National ORNAC Conference Forum, the third issue, Job Security, gave me the greatest struggle.

The question kept recurring, "Does job security exist anywhere in Canada in this economic climate?" I am sure each one of you personally knows someone who has been the victim of downsizing and fiscal restraint, whether they worked in the health care field, or any field for that matter. But, of course, the nursing profession is our area of concern, and it has taken a beating over the past few years.

Ten years ago, job security for nurses simply meant that you were a full-time employee in a health care facility with benefits, paid vacation, and a fairly decent salary. Nurses who have been employed that long have some sense of security as long as their age/length of employment ratio isn't close to the magic sum of 80 (years of employment plus age), when they may be "encouraged" to take an early retirement package, or unless they were among the last of the full-time nurses hired, therefore the first to be cut within the downsizing scheme. So you may be able to breathe a little easier if you are somewhere in the middle of that range.

There is a glimmer of hope, however. On November 6th, 1997, I represented ORNAC at the National Nursing Forum in Ottawa. The participants came from a comprehensive cross section of nursing organizations, e.g., CNA provincial/territorial associations, associate and affiliate members, regulatory bodies, nursing unions, student nurses and government nurses.

The purpose of the Forum was to provide an opportunity for nursing leaders representing all registered Nurses in Canada to examine the impact of health care changes on the public and on nursing. Specific objectives were to identify and discuss key issues, to develop national strategies and action plans, and to provide a stimulating networking opportunity. The agenda was based on discussions by the Forum Planning Committee, input from the CNA Board of Directors, and the results of a synthesis of questionnaires sent to Forum participants in advance.

It was incredible to see representatives from so many nursing organizations, each with their own perspectives and mandates, come to agreement on key issues and develop national strategies to address them.

The seven national strategies which were developed are:

1. Reaffirmation of our publicly funded health care system and funding for all services, including nursing services, across a broad continuum of health care.
2. Support for families and informal care givers including access to community-based services and home care.
3. Health care reforms based on principles of primary health care, not fiscal restraint.
4. Restructuring and health care delivery decisions based on sound evidence.

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.

5. Establishment and maintenance of high standards of care across the country.
6. Human resource planning to ensure the right number and type of qualified professionals to meet the needs of our increasing aging population.
7. Strong leadership by governments and health care providers, and public involvement in decision-making.

CNA had taken the initiative by sending a letter on behalf of the nursing organization who participated in the Forum, (representing 264,000 RNs across Canada), to federal and provincial Ministers of Health. The results of our discussions were shared in this letter, along with an invitation to governments to work with us on the strategies for action. A news release containing this information was issued as well.

The results of a report commissioned by CNA, were provided to the Forum participants by Dr. Mary Ellen Jeans, Executive Director, revealing that there will be a severe shortage of RNs in Canada in the next fifteen years if corrective steps are not taken now. CNA President, Rachel Bard, met with Federal Health Minister, Allan Rock early in November to share the results of this important study and to suggest a course of action.

Each strategy is being assigned to a working group to determine its implementation.

Our nursing leaders are working hard to secure a solid future for RNs and quality health care for Canadians. Although job security may be on shaky ground today, surely, true health care reform based on the real issues will help to alleviate that uncertainty. You can contribute by keeping abreast of current issues and activities as they occur, and by assisting in keeping the public informed. The report on the Forum, a copy of the letter to the Ministers, and the news release will be sent to the ORNAC Board members prior to the spring Board meeting. You can obtain this information from the provincial presidents, or from CNA. A second forum will take place at the CNA Biennium in June. As new information becomes available, it will be passed on to ORNAC Board members.

Dr. Judith Ritchie, who gave the key address at the beginning of the Forum said "Through this National Nursing Forum we can develop concrete outcomes for future collaboration. We need to ensure that the conclusions and resulting actions from this Forum are both needs-based and evidence-based and that we take the next steps hand in hand with consumers."

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The Circulating Role:

Who is the most Appropriate Care Provider?

By Bauce, Braid, Goold, Hopwood-Jones, Moroz, Radcilffe, Ross, Tyndall & Young

Introduction and Historical Background

The Hamilton area hospitals, like all hospitals in Ontario, were faced with downsizing, mergers, redesign and restructuring. Realizing that realignment of the health care system would lead to movement of Registered Nurses (RN) and Registered Practical Nurses (RPN) between the hospital, a meeting of the managers and educators of the Operating Room sites was held. The goal of the meeting was to review the need for standardization within the roles of the RN and RPN. It became evident at this meeting that the RPN scope of practice varied with regard to the circulating role.

The Process

The journey that led up to the Nursing Position Statement on the Appropriate Care Provider in the Operating Room was a long and arduous one. It took over a year for the task to be completed. With the passing of the Regulated Health Professions Act (RHPA) in 1993 and the ongoing health care restructuring, it became evident to the Operating Room administration in the city of Hamilton that there needed to be some dialogue with the College of Nurses of Ontario (CNO). With this in mind they met with Lynne Purvis, the representative of the CNO in November 1996 to discuss the issues.

From that meeting it was decided that Operating Room nursing staff should be given the opportunity to participate in a discussion with the College of Nurses. Operating Room nurses from the surrounding area were invited to attend. In January 1997, Susan Jenkinson, Nursing Practice Coordinator with CNO, presented information on the RHPA and scope of practice of RN's and RPN's.

To clarify outstanding issues from the January meeting, the OR managers and educators met to plan a Perioperative Nursing Roles workshop. Each hospital was asked to select one RN and one RPN to represent their peers. In March of 1997, the workshop was held with the 20 hospital representatives facilitated by Susan Jenkinson. The aim of the workshop was to clarify the RN/RPN scope of practice as it relates to the care of the perioperative patient. Using the CNO's Decision Guide Determining the Appropriate Category of Care Provider, the participants worked through various simple and complex case scenarios to determine the roles within the Operating Room. It was identified that the RN role was consistent across the sites but there were inconsistencies within the RPN role.

Abstract

This article describes the long and arduous journey to the development of the Nursing Position Statement - Appropriate Care Provider for the Operating Room in Hamilton and Burlington, Ontario. From the first meeting to the final presentation of the Position Statement to management, it took over a year of intense review. The entire process was done in consultation with the College of Nurses of Ontario, Operating Room Management, educators and staff nurses.

Authors

Cathy Bauce, RN,BA,MEd, Marjorie Braid, RPN, Judy Goold, RN, Laurel Hopwood-Jones, RN, BScN, Mary Moroz, RPN, Kathy Radcliffe, RN, CPN(C), Joanne Ross, RPN, Judi Tyndall, RN, CPN(C), Alaine Young, RN, BA, CPN(C), were members of the tri-hospital committee shown on page 9.

At the May 1997 meeting each respective hospital presented their ten most commonly performed surgical procedures and provided their role description for the RPN. At this meeting the decision was made to invite Susan Jenkinson back for further clarification of issues before a position statement was drafted.

Susan met with the group in June 1997 to clarify issues and concerns that had been raised. At the end of the meeting it was recognized that all surgical procedures in the Operating Room had some aspects of unpredictability. Since it was not possible to have an RN readily available at all times in case of emergencies; the RN would be the primary circulator for all surgical procedures. This decision was disturbing to some of the RPN's who had previously functioned in the circulator role and who wished to maintain and expand their skills.

A small working group of RN's, RPN's, managers and educators was established to develop the position statement. Drafts were sent out to all hospital representatives to critique over the next few months. In December 1997, the final draft was completed and accepted by the members of the committee.

Summary

The process involved in developing this position statement was a long one: at the same time, an excellent learning experience for all involved. It gave the participants an opportunity to work in a group and on a large committee as well as the chance to meet with representatives from other hospitals. Nurses were able to discuss the way their operating rooms were staffed and express any concerns about this issue.

The group consisted of twenty members - fifteen RN's and five RPN's. Given the higher ratio of RN's, it is not surprising that some of the RPN's felt a little overwhelmed and were reluctant to express their views in the meetings. This became apparent when the RPN's expressed their concerns in writing to ensure that they were heard. They were very disturbed about the decision of who would be the first circulator. This letter served as a basis for further discussion and clarification as to why the decision was made that the RN would be the first circulator in all cases. The RPN's understand and support this decision, though with some reluctance.

The Nursing Position Statement - Appropriate Care Provider for the Operating Room for Hamilton and Burlington (**Appendix I**) was presented to the senior administration of the hospitals for their support to ensure excellence in perioperative nursing care is continued. This position statement is scheduled for review annually.

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1. A Decision Guide "Determining the Appropriate Category of Care Provider": College of Nurses of Ontario, Toronto.
2. Operating Room Nurses Association of Canada - Position Statement - Staffing the Operating Room.

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Operating Room Nurses Association of Canada: *Position Statement "Staffing the Operating Room"*, (1995).

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Appendix I

Nursing Position Statement

Appropriate Care Provider

For the Operating Room for Hamilton & Burlington, Ontario

The Position Statement has been developed in accordance with the Decision Guide published by the College of Nurses of Ontario "Determining the Appropriate Category of Care Provider". "The College of Nurses (CNO) developed this decision guide in recognition of the challenge to efficiently and effectively ensure safe and effective nursing care in the current health care environment." (1).

The Operating Room Nurses Association of Canada (ORNAC) published the following Position Statement for Staffing the Operating Room:

"For the patient undergoing surgical intervention, one of the most critical periods of care occurs in the Operating Room. Every patient has a right to a high level of nursing care, and each facility has the responsibility to ensure that the Operating Room is staffed appropriately in order to:
1. Meet individual patient's needs;
2. Maintain acceptable levels of safety for both patients and staff;
3. Function within legal limitations as set forth in Provincial licensure standards." (2)

For the above reasons and with the intent of providing optimum perioperative care to the surgical patient, the Operating Room staff of the hospitals in Hamilton and Burlington, Ontario, have adopted the following position:
1. The management of the Operating Room Suites must be coordinated under the leadership of an experienced Operating Room Registered Nurse;
2. The care of the surgical patient in the Operating Room must be coordinated by a certified** and/or experienced* Registered Nurse, who as circulator, is physically present in each Operating Room at all times, and is immediately available to respond to emergencies;
3. When a Registered Practical Nurse with Operating Room nursing certification** and/or experience* is part of the surgical team, the Registered Practical Nurse will function in either the scrub nurse role or the second circulator nurse role with the circulating Registered Nurse;
4. Complex patient care requirements in the unpredictable Operating Room environment require the knowledge, skills, and judgment of a nurse to perform the scrub role;
5. Each surgical procedure must be staffed by a minimum of two nurses at all times, one of whom may be a Registered Practical Nurse. Additional staffing may be required to provide patient care for induction, changeover and relief;
6. Depending on the acuity level of the patient and/or the complexity of the procedure, it will be necessary for additional Registered Nurses to be present in the Operating Room to provide care.

Note:

* Nurse with recent relevant experience who has participated in a formal operating room program provided by a recognized employer

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Learning Together: Preparing for the Future

Address to the World Operating Room Conference - X

By Dr. Joan Donald, RN

Looking down the road to the future of Perioperative Nursing, I find it hard to even expect what the year 2017 will look like. I can only be guided by the great advances in the past 20 years. The world of surgery and perioperative nursing has already been transformed into something quite different from what it was 20 years ago. At the rapid pace that we are heading into the next millennium, we can only expect that things will change even faster. So how do we prepare for that? What do we need in order to be ready for the next 20 years?

I will share some of the things that I believe in and that I have learned in the past few years. Some of these lessons I have learned from colleagues from around the world. I am grateful for the opportunities that I have had for learning, and for this opportunity to share my thoughts and ideas with you. I returned to school three years ago to pursue doctoral studies which had been a lifelong dream of mine. My husband was retired by this time and kindly consented to join me in my pursuit of knowledge. I come from a small community on the east coast of Canada - small by Toronto standards, so the big city seemed quite overwhelming at first. I learned a great deal at the university, but some of the greatest lessons were learned from life itself and nursing colleagues. Some of the things I learned were:

- You are never too old to learn. Two people can live in a one bedroom apartment and still be speaking to each other at the end of the week.
- You meet wonderful people who become good friends, even in the big city.
- You must ruin your eyes with too much reading because I now have to wear glasses.
- Becoming a student again is rejuvenating - there were times when I'd get on an elevator, look around the crowd and think - they're younger than my children - and I'm "one of the crowd"

One of my greatest joys was receiving my student card. This made it official - I really was one of them. I would get a great chuckle when my husband would walk up to a box office to buy tickets for the theater and ask for one student and one senior. I would tease him about taking a student out on dates ... until one day we were travelling by train to a conference in Montreal. The conductor asked for our tickets - one a student, the other a senior. He looked at the tickets, looked at my husband, then at me, then back at the tickets and again at the both of us and asked "Which one is the student?"

Learning Together

As with any true student, in preparing for this talk, I began with defining the key words of the theme for this conference. **Celebrate** - To observe with ceremonies of respect, rejoicing, or festivity. **Global** - World-wide or comprehensive. **Partnership** - One who is associated with another in a shared activity. There have been many examples of shared activity and comprehensive rejoicing this week. But how do we sustain this enthusiasm and take control of our future? To start with, I believe there are fundamental skills that we will all require in order to meet the challenges of the next 20 years. I will identify four major skills. You may have your own list which is right for you, your country, and the times in which you live. Pursue your own goals, but do consider these. I call them the four "C's".

#1 - Computer Skills

Has any other medium of communication opened up our horizons and enlarged our boundaries as dramatically as computers? I think not. It is not unusual today to be sending a message to a colleague in any one of the five continents. What a wonderful opportunity to network and share global information! Just as a matter of survival, can we bank or shop today without the benefit of computers? Hospitals record of all activities - patient care, finances, quality improvement - everything is done on computer. As Tim Porter-O'Grady said recently at AORN, "Not only have computers changed what we do, they have also changed who we are". Think about it - each one of us who has been forced into computer literacy is now different because of it. We think differently, we access information sources differently, and we accept change differently. As the saying goes "Change is mandatory, Growth is optional". Change will continue to bombard us throughout the next millennium. In order to grasp it and grow with it, you will need computer skills. This brings me to the second item on the list for, along with computer skills we will need communication skills.

#2 - Communication Skills

In the future, communication skills will entail more than speaking and actively listening to each other. These are important aspects of communication but we need to do more. We need to be able to think on our feet and then we need to be able to present our ideas so that others understand and appreciate them. We need to be able to communicate to other disciplines and to the world that patient outcomes are different because we are there. If you ask yourself "How did I make a difference for that patient?" - can you answer that question? And can you answer it in a way that others know how you made a difference? Not an easy challenge but one that we must all accept and pursue with dedication and enthusiasm.

I am reminded of an example from our hospital that speaks to making a difference in patient outcomes. I noticed an elderly woman who was coming to have her eye surgery and who was walking to the OR with one of my perioperative nurses. They were arm in arm and chatting happily down the corridor as the nurse was preparing her for the surgical experience. I was struck by what a beautiful picture of caring this moment of friendly communication was and I later told the nurse. She looked rather surprised when I mentioned it, but smiled and I know she realized that she made a difference in that patient's life. We do it automatically. Communication is so important in our world. That is why we provide translation of documents and presentations. But we don't all have to speak the same language, in fact, we may not have to speak at all in order to be understood. Actions of caring speak much louder than any spoken word. I learned this once again during the past year.

One of my units provides two beds for outpatients to come in and receive blood transfusions. This is an outpatient surgical unit so it is staffed by operating room nurses. One of the patients who comes to us regularly for a transfusion is a frail Chinese lady who doesn't speak English. She is usually accompanied by a family member who provides translation services. One day she arrived, the transfusion was started, and for a period of time the family member had to leave. During that time it became evident that this lady was slipping down further and further in the bed. She became anxious and worried which concerned the family members of the other patient in the room. They called for the nurse who came and assessed the situation. The nurse knew she could not talk with this patient. As she gently lifted her up and secured her once again in the proper position, she leaned over and kissed her on the forehead. The grateful Chinese lady immediately relaxed and smiled. They communicated - far better than words ever will.

Caring is communication. As Tim Porter-O'Grady says, "Change is the music of the universe, we provide the lyrics". As change surrounds us, we need to provide lyrics that communicate caring and expertise in perioperative nursing. And we must be able to communicate the value of our role in patient care to others!

#3 - Cooperation

The third "C" stands for Cooperation - being a Cooperative Team Player. One of the greatest skills you can bring to perioperative nursing is the ability to get along with people. People of all races, religions,

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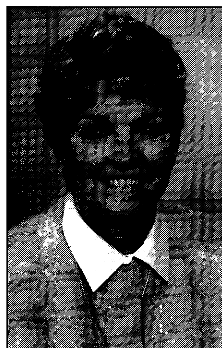

Joan Donald, is the Associate Director, Perioperative Services, Mount Sinai Hospital, Toronto. She is a past president of the Operating RoomNurses Association of Canada and recipient of the Isabelle Adams Award for Perioperative Excellence. This is an abridged version of her address to the World Conference of Operating Room Nurses in Toronto, September, 1997.

colors, and ideologies. Teams are made up of individuals - you and I. We each bring to the team our own unique skills, talents, and points of view. The International Planning Committee is a model of global teamwork with representation from various countries who come together to plan conferences such as this. Each members' contribution is unique and valued. As increased emphasis is placed on the importance of multidisciplinary teams in health care, we need to learn to work with others. To share our ideas while being open to the concerns and views of others. On the global scene, we must continue to respect others who may be different from ourselves. We must invite people from around the globe to join in and make them feel welcomed. Canada recently sent a delegation to South East Asia in an effort to promote Canada as a trading partner. The delegation was known as "Team Canada". It struck me that we could take an example from this and develop something I might label "Team World" - this would be representative of our world of perioperative nursing. Wouldn't it be wonderful if we could get a team together that would be representative of many countries whose mandate would be to dialogue on global issues. To actually make decisions and recommendations with a truly global perspective. This could be done by computer and various tasks groups could be brought together in global problem-solving. A true example of partnering for all the world to see!

4 - A Commitment to Life-Long Learning

There is likely nothing more important for preparing for the future than a commitment to lifelong learning. How else will you learn about the new technologies, computers, different ways to communicate, how to be a team player, and the million other things you need to know unless you are committed to learning? The trick is to keep on learning despite the constant change around us. Fullan and other scholars say that learning is linked to our own quality of life. If we have not learned to control our own lives, no amount of learning will make things better for others. We must achieve balance and harmony internally before we can learn and make a difference in others. Learning begins with self and you must take the initiative. Attending educational conferences such as this World Conference is one avenue. Hearing what our colleagues are facing and concerned about helps to put things in perspective. Paying attention to the signposts along the road to the future and to what is happening all around us - these are the keys to being prepared. Being prepared will help us ride the roller coaster of change - change in our jobs, not only in technology but our changing roles and responsibilities. The fact that some nurses are losing their jobs confirms the importance of continual learning which becomes our safety net. When one door closes another opens and what you have learned will help turn disappointments into opportunities. Personal change is the most powerful route to system change. Organizations learn through individuals who learn. Without personal growth, organizations stagnate and die. Organizations and nations don't change - individuals do. The world is constantly changing and we had better pay attention. We learn from each other. It's all about connecting - connecting to people as people - Princess Diana and Mother Theresa taught us that well. Look at the people around you - those around you at work, your family, your professional relationships, and your social relationships outside of work. Learning prepares us for all aspects of our life. Make your connections work for you. They will help you achieve balance in work and play. Learning makes each and every one of us who we are. Again, I agree with Tim Porter-O'Grady who says that we should be known for who we are, not for what we do. I am increasingly convinced that you are employed for who you are, not for what you do. Any number of other people could do some of the things that you do - maybe not as well, mind you, but the fact remains that it is you in that position, not someone else. The knowledge that you have makes you stand out - you are special because of who you are and everything that you have learned throughout your lifetime contributes to who you are. Never stop learning.

Learning Together!

We have looked at the four "C's" or talents that I think you might need in preparation for the next 20 years - computer skills, communication skills, cooperation, and a commitment to life-long learning. Now we will look at the keys that will help us unlock the door to the future. How will we use these talents and skills to benefit our global partners and the patients in our care? As we think about the future, we have to consider the here and now and what we have that can help us in preparing for the future.

Preparing for the future

In his book entitled "Shared Values for a Troubled World" Kidder talks about worldshrink, technobulge, and consensus building. Worldshrink simply means that our world has become "smaller" - the ease of long

distance travel, computers and global communication means that every nation now has access to experts and information that is literally at our fingertips or an airplane trip away. Technobulge is a result of a shrinking world for as the world shrinks, technology expands. Technology related to genetic engineering or weather control is so awesome that it is both impressive and at the same time worrisome. Genetic engineering presents us with ethical dilemmas that are likely to become increasingly complex.

Consensus Building relates to the need for global problem solving. Can we hope to save our planet if we can't agree on how to save our rain forests? In this world that is shrinking, where technology is bulging, and at a time that consensus building is required - can we bring people from around the world into a true global partnership for problem solving? I believe it comes down to values. We need to identify our shared values. The question is "Is there a set of values that wise, ethical people around the world might agree on?" - A Global Code of Ethics? Just this week it was announced that a global code of ethics for business has been established. Is there a common core of values in our world of perioperative nursing? If you were asked to help create a global code of ethics for perioperative nursing, what would you put in it? If a committee that represented perioperative nurses from around the world were struck - or, as was discussed at the World International Forum on Wednesday, an International Federation - and their mandate was to develop a global code of ethics, what moral values would you bring to the table from your own culture and background?

Following interviews of people from around the world, Kidder identified eight moral values that should shape our future. They are:

- Love
- Truthfulness
- Fairness
- Freedom
- Unity
- Tolerance
- Responsibility
- Respect for Life

These eight moral values were identified and published in 1994 - what portion of them has been achieved? Do we see a world that reflects love, truthfulness, fairness, and freedom? Is there global unity, tolerance, responsibility, and respect for life? What role has each one of us played in helping to promote a set of values that will dissolve borders, transcend races, and be sensitive to cultural traditions? This is no easy task to be sure. However, if you believe, as I do, that values are the moral glue that binds us together as a profession, then I also believe that we have both the ethics and the will to establish a Global Code of Ethics for Perioperative Nursing.

How do we go about this? Where do we start? As with other things, we start with self. What values do you live by? Each and every one of us is a teacher of moral values. We do this whether we know it or not; whether we want to or not; whether we admit it or not - we do it by the examples we set, the choices we make, and the lives we live. What you think, what you say, what you do - all reflect what you value. We are setting the example for our children, for the people around us, and for the young OR nurses of the future. Each one of you is teaching the next generation of perioperative nurses and preparing them for what lies ahead. This is called leadership - and you didn't even apply for the position.

Just as we must accept responsibility for nurturing our children, we also must accept responsibility for nurturing our periop nurses of the future. Look at that young novice who is trying so hard beside you, and ask yourself, "What can I do to make her or his future better?" "How can I help that nurse become keener, more dedicated to perioperative nursing, and more self-assured?" What can I do to help?

A few weeks ago our teen choir at church sang a song which said that "If we can learn to give, we can live as one". As I reflected on these words in the days thereafter, I questioned whether or not these kids were on to something. Had they learned the answer to the age-old question of how to stop wars, how people can get along, how to end famine, and how to truly love our neighbor? The more I thought about it, the more convinced I was that, yes, they were on to something - something of value to the world. How often are wars fought because of an inability to give on an issue? How often are people starving because of an inability to give? And on and on questions continued in my head. Then I thought of our world of perioperative nursing. Can we as perioperative nurses around this globe live as one? I asked myself, "What do I have to give that might help?" What do we have to give to each other? And as the days and nights thereafter passed, the thoughts came flooding in - so many things that it was hard to narrow the list down. My list goes like this **1 - I can give of my prosperity.** Many areas of the world have so much and others have so little. To feed a hungry child for a week in one country can mean as little as a few extra cups of coffee for people in other lands. To help with relief work in

war torn areas of the world, areas devastated by natural disasters such as floods and earthquakes, may not be possible personally, but we can give in other ways of a personal nature such as donations of clothing, finances, and emotional support. We are all members of this global community and we must help each other.

The global community of OR nurses

One of my early memories of World OR Conferences that touched my heart took place at the closing ceremonies. A nurse from an area that was ravaged by war came to the microphone. As was the custom at the time, she had no gift to present - instead she wanted to give thanks for the gift that she had received. This one week away from the broken bodies, the crying children, and the desperate parents was a gift that she would cherish for the rest of her life. She had been inspired by fellow OR nurses from around the world. She was going back with a renewed passion and devotion to her role as a perioperative nurse, mending broken bodies and praying for peace. Our heartfelt support went out to her as we renewed our pledge to remember our colleagues less fortunate than we around the world . Yes, we can give prosperity.

2 - I can give my Knowledge and Expertise. You have taken the time to invest in yourselves and I know you will continue to do so throughout your lifetime as you commit yourselves to life-long learning. Now it is up to you to share this knowledge and expertise with partners around the globe. Today is just a beginning, not an ending. Although our conference ends today, you will just be beginning to share what you know and the skills that you have acquired. Each thing that you can share or give to others will make their lives easier. You are familiar with the saying that "we don't need to reinvent the wheel". I like to say that "if we know how the wheel works, show others how to roll it". We have a responsibility to share our knowledge and skills. Remember my definitions, partnering is shared activity. We can give knowledge and expertise.

3 - I can give Caring. Perioperative nurses, in my opinion, possess a very special kind of caring. We are tough when we need to be, but we are also unique and superb at caring and giving. I am reminded of my staff educator who spent many hours outside of her regular working hours with a family whose only child had advanced cancer. She met the family as they brought their daughter to the OR for an amputation. They were distraught and anxious and my nurse educator went to them following the surgery and provided information and support for as many days as they needed it. That is giving. I see nurses who give of their off time to work on staffing schedules or to improve the layout of supplies and equipment in the OR. Nurses may not think of these day-to-day things as giving or caring, but they are. Perhaps an even more dramatic example lies in this next story. It involved the nursing manager of the OR of a pediatric hospital in a large Canadian city. One day a youngster came to the OR for heart surgery. The child was terribly upset, crying, and turning bluer by the minute. The OR manager picked the terrified child up and cuddled her in her arms. The youngster settled down and clung to the nurse. There was a delay in starting the surgery so the nursing manager went back to her office where the child fell quietly to sleep on her lap. An hour passed while the nurse managed to do a few things as the child slept peacefully in her arms. When it was time to begin the operation, she carried the sleeping child to the OR where she continued to sleep into a peaceful induction and anaesthesia. The tragedy is that the child did not survive the operation. However, the glory of this story is that this little child spent the last hour of its life in the loving arms of an OR nurse. A nurse like you - she is one of you and she sits in this audience today. This is Caring - this is perioperative nursing - this is our gift to the world. Mother Theresa and Princess Diana would both be proud. We can give caring.

4 - I can give Hope. In a hurting world, the one thing that we can all give is hope - hope for an end to famine, to poverty, to ignorance, and to war. The dictionary says that hope is "a wish or desire accompanied by expectations of its fulfillment". Can we fail to hope without trying to make it happen? I think not. Each and every one of us has a responsibility to see that our wish or desire is accompanied by the expectation to make it happen. If we can learn to give, we can live as one. Celebrating global partnerships as we move toward the next 20 years challenges us all to learn, to share, and to hope. As we join hands around the globe, we all hope for a better future - or as Jeany Botsford, President of AORN says, a preferred future - one that we design for ourselves, not one that we inherit by default. We can do that! We can live our vision of perioperative nursing; we can teach our young nurses what that vision is, we can join hands around the world and develop a Global Code of Ethics for Perioperative Nursing. We can design our preferred future.

As I look out over the sea of faces here in this audience, I see representatives from different backgrounds, different countries, and different cultures. But I believe you all share one thing in common - a commitment to life long learning - otherwise you would not be here. You came here to learn about emerging disease threats, new technologies, ethical concerns, and on the list goes. Increasingly you will learn how computers can assist you in your work and how they will allow you to communicate with colleagues around the globe. You will communicate with confidence and clarity and you will tell the world how we make a difference in the lives of our patients and that the outcome is better because we are there.

Faith in The Future

I have talked about the four "C's. I want to add another "C", C for Courage. So many of you have demonstrated courage that has been above and beyond the call of duty. You have had the courage to submit papers, to display posters, to go to a microphone and speak, and to initiate conversations with people from other countries who may not speak your language. You have had the courage to articulate your views, to present in a language other than your mother tongue, and to share your experiences even though it meant reliving the pain and the sadness. For some, the very act of flying to another country is an example of enormous courage. This week you have given your gifts of courage to others.

With today's economic conditions, many hospitals no longer provide funding for staff members to attend conferences such as this. Many of you are here on your own initiative. Some have taken vacation and some have had to pay their own way. I think the message is very clear You are willing to give!

You are willing to give in order to learn together and to prepare for the future. You are willing to give that we may live as one. As you leave here today and return to your homes, your families, and your work place - take time to reflect on the week and on the future. The many nurses at this conference are testament to our faith in the future. But even more important, they are the pathway to the future. Think of the courage displayed this week by your colleagues from around the globe and take time to say "Thank you". Remember the gifts that you have been given that you now must share with others. Give of your prosperity, Give of your knowledge and expertise, Give of your caring, and Give hope - hope for a preferred future - one that you can help shape because you have been here. One that you can help shape by preparing the perioperative nurses of the future, One that you will shape because you care and because you are the world of perioperative nursing. Last week as we listened to Elton John sing "Candle in the Wind" at the funeral of Princess Diana, we heard the stirring words:

> *"Your candle's burned out long before your legend every will".*

Now as the lights go out on this the tenth World Conference of Operating Room Nurses, the legacy will live on in each and every one of you. I thank you for caring, and I thank you most of all for being the future world of perioperative nursing. Yes, YOU ARE THE FUTURE !! YOU ARE THE WORLD!! May you be richly blessed in all that you do.

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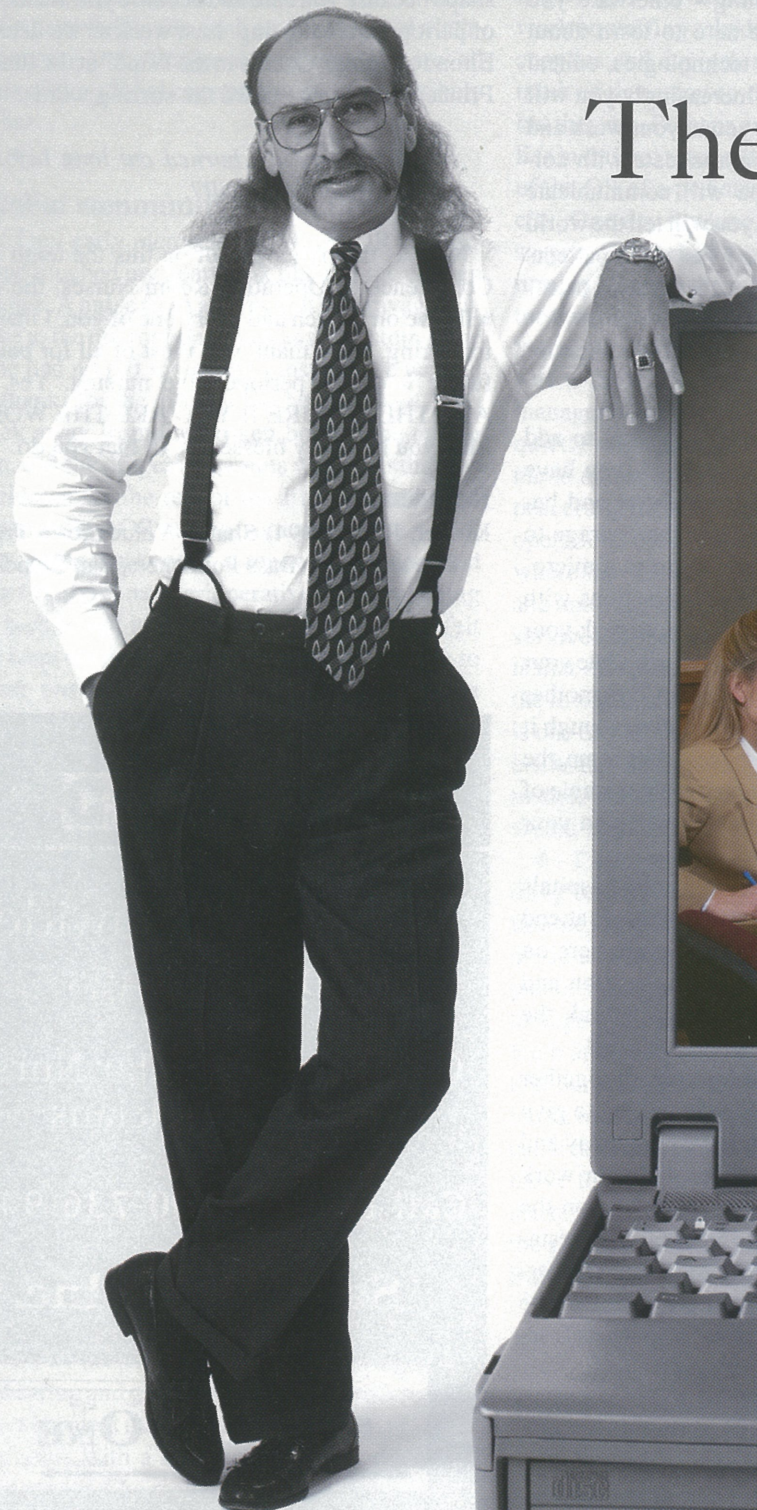

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Here Today - Gone Tomorrow:

Coping with Organizations of the Future

By Vija Hay, RN, CPN(C)

By now the terms downsizing, rightsizing, re-structuring, re-engineering, streamlining are well worn and overly familiar to us in the corporate as well as the health care world. The process has affected everybody in one way or another directly or indirectly.

Much has been written and said already, much more can and will be said as time goes by and we study the effects. This article will address the realities of restructuring: the issues and effects on the health care worker, dealing with transition in layoffs, staying energized in the new organization, and being positioned for the future.

Realities of Restructuring

Downsizing equates to reduction of the work force, in other words "dehiring", cut in payroll through a layoff process, early retirement, and termination. In most situations, however, the workload has not been downsized, in fact it has increased - the work has not gone away.

The corporate world now reports from studies that many, if not most, downsizings fail. Experts are quoted as saying layoffs do not save money in the longrun but increase overtime, lower morale, and force companies to hire again. Early retirements have left the organization bereft of memory. I call it brain drain and loss of continuity and mentorship. The aftermath of restructuring has left casualties, the walking wounded - not just the victims, but also the survivors. To sum it up, according to Lloyd Cooper (who is in charge of career management at Watson Wyall Worldwide) "lean and mean has not worked", we should rather "move to lean and keen".

In the health care sector there is no choice but to restructure. The success or failure then is dependent on good planning and strategy. In hospitals the restructuring, the overall reduction in the workforce, the "bumping" process, the staffing ratio adjustments of professional employees, the introduction of generic workers, and the contracting out of services, has been a particularly traumatic experience to hospital personnel, and has impacted on patient care. Our belief has been that we are in the business of health promotion, healing, and caring, and providing expert nursing care to our patients. When these elements are not evident in the process of restructuring, the best practice principle may be sacrificed for the survival of the hospital.

Similarly to the corporate studies, some health care organizations are discovering that de-skilling of nursing is not working. The result is longer patient stay, more complications and errors, and even deaths, ultimately no cost savings.

Downsizing

In Downsizing we see four segments of personnel:

1. Laid off staff - usually union
2. The early retirement staff - union and non union - voluntary - involuntary
3. Terminated staff - usually management
4. Survivors - all levels, including top management - the "displaced" through the "bumping process"

Who is the victim and who is the survivor in this process? Being both a survivor and a victim I have personal experience with the consequences. Victims and survivors both share the same feelings: a combination of anger, anxiety and frustration, guilt and depression. New research shows damage to peoples' health, even if the jobs are only threatened. Allergy symptoms, high blood pressure, heart disease, mental illness are on the rise.

Peter Drucker's comments on the aftermath of restructuring are: "the cynicism out there is frightening. Middle managers have become insecure. They feel unbelievably hurt. They feel like slaves on an auction block". There is an impact on human costs, downsizing begets downsizing, there is a state of continual downsizing and jobs are continuously at risk. We are losing good performers.

According to *Sports Illustrated* eight out of ten Americans will be fired at least once. Apparently 1/3 of Canadians polled say they are in fear for their jobs. My title "Here Today, Gone Tomorrow" is apropos: you can be instantly transformed from an over employed worker to an unemployed worker. This fear of being downsized is driving people to work harder and put in longer hours. In a New York poll, 82% of people said they would work longer hours if it would save their jobs. The prolonged overwork may lead to absenteeism, burnout, poor productivity, substance abuse etc. It can also turn you into a workaholic.

We have all worked within the old paradigm and beliefs that we could remain employed with and organization until voluntary departure or retirement. One thought that being loyal to the organization, honest, meeting performance standards, having skills and expertise, made you an asset to the organization. You felt part of the family and would be taken care of. But suddenly you are a target, you are a cost, a dollar sign to be reduced, eliminated. On the other hand, the organization believed that loyalty required the individual's total commitment.

All our management models and motivational theories were rooted in the old reality. We really had a codependent relationship - both the employee and the organization.

In the new paradigm there is no long term security and change is inevitable. The relationship of the employee to organization, the obligation of employer have changed. The paradigm has shifted from long term employee to short term employee, from career to job. In organizations that had the old paradigm and had captured the family concept and employee spirit, the survivors have particularly strong feelings after layoffs of anger, fear, anxiety and distrust. Workers have gone through emotional turmoil: first feeling relief of not being laid off, then a combination of guilt and despair.

There is a sense of loss to any change. People need to be given a chance to mourn feelings of loss. They can only handle so much change at one time or they may become immobilized and lose effectiveness. Most of us have lived in a whirlwind of change and most of us continue to do so.

Dealing With Transition

It is a responsibility of both management and employees (coworkers) to take care of those who have left and those who remain. We should recognize the change model of: endings, transitions and new beginnings. Losing a job, losing friends and coworkers is like a death in the family, or a divorce, and it affects not only your income, but your own sense of worth. The process of grieving is very similar and has to take place before moving on to begin the healing process. The literature shows that survivor feelings are long term. Dealing with these feelings promptly is a priority. To revitalize the organization as a whole, the layoff survivors must be dealt with or layoff survivor sickness is inevitable and serious.

David Noer in his book recommends four levels of intervention to deal with layoff survivor sickness, and says that creating organizational systems to prevent recurrence of this sickness is the most fundamental priority of organizational leaders. **Level 1** Process interventions: deal with the way layoff process takes place from the survivor's perspective - doing it right. **Level 2** Grieving Interventions: facilitate emotional release. **Level 3** Empowerment Interventions: breaking organizational codependency (employees recapture their sense of control and self esteem). **Level 4** Symptoms Intervention: accommodating the new employment contract.

Reading and hearing layoff survivor stories, it is clear there has been dissatisfaction with planning, administration and communication of layoffs. They express anger ova layoff process; found lack of strategic direction; lack of confidence in upper management; lack of communication.

Level 1 - Process Interventions

The layoff process is predominant in survivor stories as well as in my own experience, and is the basis in Noer's intervention model. In the layoff process you could say there is the good, the bad, and the ugly. There is a great deal of thought put in the process of severance pay, benefits, outplacement services, the physical exit of the victim, and meeting the requirements of service union contracts. But not much thought is given to the impact on those who stay. They should be grateful they have a job, so to speak. Much thought is given to the implementation, and little to survivors.

Author

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It has been documented that survivor involvement in decision making process, the level of attachment to victims, and their perception of fairness and equity of layoffs are important process factors. The process research highlights survivors' needs for fairness, equity, participation, caretaking and prior notification. The longer the advance notification the better. There is more control, ability to plan for future and face and manage anxieties. That is particularly true for the victims.

Survivor stories relate great concern for layoff/fired victims - how they were treated. Being fully employed one minute and dismissed the next: given the pink slip/ called into the office and then escorted out - the employee simply vanishes, and comes back as a stranger in the night to collect items from the office. This is demoralizing and humiliating for the employee. The survivors are concerned for the feelings and dignity of the victims and what it says about the organization's values.

Communication is part of "doing it right". There is a great thirst and need for communication throughout the downsizing process. People want to be treated like adults. They want honesty and have little tolerance for fuzzy answers. Lack of information generates lack of confidence in upper management and limited credibility in what they say. When people are in a state of fear and anxiety they search for clearer understanding of the organization's plan and direction. To quote Noer "it is impossible to overcommunicate during layoffs". Unfortunately through lack of strategic direction, the focus of direction can change day by day. It is difficult to inform everyone in a timely manner. However, free-flowing direct, open communication - "straight talk" is essential, even if it is repetitious. The messengers, top executives, should be accessible throughout the process.

Level 2 Intervention - Grieving

Before we can go on and the healing begins we must release our feelings. Group work is the most effective and efficient method of bringing survivors emotions to the surface. Short term fixes do not work. Many survivors repress their feelings, their anger turns inward. There is a sense of unfairness, stress and fatigue. People are afraid to speak up, there is a feeling of distrust and betrayal. Facilitating the release of feelings and the grieving is a key management role. The Kubler-Ross stages of grieving can be applied here. The five stages are: denial, anger, bargaining, depression, and acceptance, (which is not equated with happiness).

Reactions of layoff victim and layoff survivor in the five stages:

Layoff Victim	Layoff Survivor
Denial	
"It can't happen to me"	"That's how business operates"
Anger	
"It's not fair. I resent those who stayed"	"I feel guilty and angry. I'm a victim too"
Bargaining	
"I'm better than some who are staying" "Get better terms"	"How can I negotiate my safety. Look at options other than laying off colleagues"
Depression	
"I'm not worth keeping"	"It'll happen to me sooner or later"
Acceptance	
"I'm out of the system"	"I'm not the same - I've been violated"

Level 3 Intervention - Empowerment

Empowerment of staff breaks codependency, and gives the solution to preventing survivor sickness. It is a transition from the old paradigm to the new. From the way we used to do business to the new reality. The transition is a challenge to both the employees and leaders of the organization to function in this complex and uncertain future. The leaders who make a difference are those who facilitate transition. Employees need to take personal responsibility for self esteem and **good work ethic.** Not to rely on the organization to provide for their needs, not to please the boss, but to detach themselves, shed the control/codependency model. Organizations also need to shed control. We need to respond to transition and become learners with a capacity for change and subsequent comfort with that change. Staff need to be involved in the downsizing process, and be realistic about the consequences.

Level 4 Intervention -The New Organization

It is time to emerge from the old confusing environment and emerge in the new paradigm. In the new organization we will have a flexible work force and self directed teams. Managers will have a helping, facilitating and coaching role. Obviously it is easier said than done. However, a conscious effort has to be made to embrace the change to the new paradigm, otherwise we will never evolve from the survivor syndrome. You need to find a way to let go.

How to make a successful transition

Employee: Be a learner and learn skills and behaviour relevant to the new reality. David Noer in his book says that the people who will make the difference will be the learners. They are challenged, stretched and optimistic. I can't emphasize enough the importance of education and learning. Read, take additional courses, specialty courses, university courses. Become certified in your speciality. Stay current in your field. Be aware of the trends affecting your work. This will make you a flexible employee and will add to your personal growth. It will not guarantee your permanency nor displacement during the layoff process.

Unfortunately service unions do not consider education, experience, and expertise in general as priority factors. Their determination to maintain seniority as the basic principle is fair to senior employees and a simplistic method, however, it eliminates and devalues individual skills and abilities that are the criteria in your area of work.

During transition work hard to help find positive outcomes and understand the challenges, then move forward. Ensure your work experience is up to date. Maintain a list of educational attendance. Prepare a resume and keep it current. Have self esteem. Don't invest emotionally in your work. Find humour to reduce tension and anxiety. Break codependency with employer. Stay for the work and the customer. Define yourself by your work, not where you do your work.

Increase your role as patient advocate to ensure quality of care, and that appropriate staffing levels and ratios are realistically maintained according to patient acuity levels. Know your supporting data and standards of practice to validate best practice issues. Invest in your health. Suggested health tips from Dr. Shah, Professor of Preventive Medicine University of Toronto: **Openness:** be open with family - less conflict. **Lifestyle habits:** no increase of smoking or drinking. **Keep fit**: natural endorphins are released during physical activity. **Be spiritual**: increased sense of well being. Support each other during the layoffs and transition. Don't shun the victims, help them by open communication and recognition of their past work. Think of yourself as a temporary employee. Define your job skills, abilities and options. If you lost your job today, what would you do? List your options, so when the time comes you will be prepared. You may be surprised at how entrepreneuring you may be.

The Victim: the employees who have been or will be "dehired" should examine the release agreement and options available thoroughly, and take adequate time to do it. At a time when you are in shock, it is difficult to focus on the documents and the options even with the help of consulting assistance and lawyers. Look to see if your separation allowance and benefits are just or should be negotiated. Seek guidance and/or legal assistance in event of unjust dehiring.

Take advantage of employee assistance programs and professional assistance in career transition consulting services. Prepare a resume if you have not already done so. Actively pursue a job search.

The Organization: Finally, what can organizations do to assist the employee to deal with the multitude of transitions and the effects of layoffs. Place more attention on cutting unnecessary work than on eliminating unnecessary jobs. Involve and recognize staff input in best practice issues. Explore flexible arrangements.

Have a good layoff process. Involve people in issues that impact them. Communicate, communicate, communicate. Tell the truth, but don't be cruel. Lead from the heart and follow with the head. Have free flowing communication, honesty and authenticity. While saving the organization, recognize and devote adequate time to deal with survivors. Facilitate the change in the new organization. **Treat people with respect and dignity.** Give recognition and acknowledgment, and celebrate their past contribution. Establish a new orientation - a shared process. Provide a clear plan, a clear strategy under strong leadership.

Conclusion

Change is not predictable, comfortable or very safe. Organizations of the future will be characterized by unending transition. Organizations will never regain the enthusiastic commitment of once loyal employees.

Employees have to break away from codependency with the organization, and think in terms of being a short term employee. The survivors have a choice of succumbing to the survivor syndrome or moving into the future of the new organization. The victims have to come to terms with the loss, and pursue new job opportunities. Organizations have to facilitate the grieving process for the past, and facilitate the move into the future. To quote Noer: "the only thing that will separate the winners from losers will be the quality of the human resources".

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Lifting the Fog in Endoscopic Surgery

By Jan Legeros, RN & Collette De Schutter, CRCST

In 1994, St. Boniface General Hospital (SBGH) Operating Room, a 14 theatre tertiary care facility, began preparing for the 1996 phase out of the use of Chlorofluorocarbons or CFCs, as mandated by the Vienna Convention.1 One of the measures taken in preparation, was to review purchases for new equipment and where ever possible, choose equipment that could withstand steam as opposed to using Ethylene Oxide sterilization. The article that follows describes a problem encountered in addressing the phase out of CFCs, the subsequent reduction in the use of low temperature sterilization modalities and the move towards greater utilization of steam sterilization.

The ban of CFCs drastically changed the way processing of sterile supplies and equipment is performed in Hospitals. Operating Rooms and Central Processing departments had typically utilized two main methods of sterilization:

1.) Steam Sterilization
2.) Ethylene Oxide Sterilization (which utilizes a mixture of 12% Ethylene Oxide and 88% Freon).[2]

Ethylene Oxide sterilization is a low temperature sterilization process. Items with rubber or plastic components, glued parts and fragile items such as telescopes historically could not withstand the high temperatures required for steam sterilization.

The required temperature for Ethylene Oxide sterilization is between 37 and 55 degrees Celsius. Steam sterilization temperatures range from 121 to 135 degrees Celsius.

In response to the Vienna Convention mandate, alternative methods of low temperature sterilization were designed over time, which did not use CFCs.

Abstract

This article describes a problem encountered in addressing the phase out of CFCs, the subsequent reduction in the use of the low temperature sterlization modailities and the move towards greater utilization of steam sterilization.

The ban of CFCs drastically changed the way reprocessing of sterile supplies and equipment is performed in Hospitals. In 1994 at St. Boniface General Hospital Operating Room in Winnipeg, Manitoba, preparations began to meet the challenge. One of the measures taken was to review purchases for new equipment and where ever possible, choose equipment that could be sterilized using steam as opposed to using Ethylene Oxide sterlization. Medical device companies responded to the CFC ban by modifying the manufacture of delicate equipment to withstand the high temperatures used in steam sterilization. Equipment such as rigid telescopes could be steam sterilized for the first time.

[1] In 1985 the Vienna Convention for the Protection of the Ozone Layer established an international framework that controls the production and consumption of Ozone Depleting Substances such as Chloroflurocarbons or CFCs and Hydrochloroflurocarbons or HCFCs. In 1992 the Vienna Convention set a target date of January 1, 1996 to phase out the use of CFCs.

[2] Freon is an Ozone Depleting Substance; specifically a Chloroflurocarbon (CFC).

Authors

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However, the new sterilizers had a significantly smaller capacity due to restrictions in the safety and efficacy of the chemicals employed. The smaller capacity units could not meet all of the processing demands for large operating rooms. Clearly it was necessary to decrease the demand for low temperature sterilization. Companies began to offer equipment designed to withstand steam sterilization to meet this need. Rigid telescopes, which were in high demand for use in Endoscopic surgery were one of the first redesigned to withstand steam sterilization.

St. Boniface began using the new steam sterilizable telescopes in 1994. Coincidentally, problems with visual acuity during Endoscopy procedures began to occur. This caused serious delays intraoperatively. The surgical images were continually "foggy".

Initially, numerous possible causes for the foggy image were cited. The first step was to identify everything that could affect the surgical image. During Endoscopic surgery, several interconnected pieces of equipment provide the visual effect. Starting from the sterile field and working to the outer unsterile area, these are: trocar, telescope, light source cable, light source, camera head, camera cable, camera control module, monitor, VCR, and printer. Other variables that could affect the surgical image include all procedures and processes involved in reprocessing, such as chemicals employed in the processing of linen wrappers, sterilization agents, sterilization methodologies, and steam production.

Documenting Results

The investigation began by methodically evaluating the equipment one item at a time, assessing and documenting the results. In addition to the new telescopes, SBGH had purchased a new camera system for Endoscopy. We were initially elated when we found and corrected one problem with the camera head but the "foggy" images persisted.

Next we looked at reprocessing procedures. The processing staff diligently cleaned and visually inspected the telescopes prior to sterilization but the intraoperative complaints of foggy images continued. We decided to try using the higher magnification and stronger light of the camera system to inspect the telescopes prior to sterilization to ensure that they were clean. As soon as we hooked up the camera, we could visualize a translucent film that appeared etched into the lens of the telescope. The impact of the film on visual acuity was immediately apparent. The image was "foggy".

In consultation with the manufacturer of the telescopes, we instituted a new cleaning procedure postoperatively. This consisted of soaking the scopes immediately after use beginning in the theatre, using an enzyme cleaner. The enzyme cleaner is designed to dissolve the tenacious protein deposits found predominantly in Orthopedic surgery. However, this protocol did not consistently alleviate the problem.

The last area to be tested was the steam sterilization process. In an effort to insure the integrity of the test, we sent all of the telescopes to the manufacturer to have the lenses professionally cleaned and polished. Upon return, we tested the visual acuity of the scopes utilizing the camera system. Visual acuity was perfect. The lenses were clean and free of film. We prepared the scopes for surgery in the usual manner by subjecting them to the steam sterilization cycle. We examined the scopes again, upon completion of the cycle. A film was apparent on all of the telescope lenses. We concluded that the problem somehow involved the steam sterilization process. We requested assistance from departments outside the Operating Room and formed a committee of multidisciplinary professionals within our facility consisting of Laundry Services, Infection Control, Chemistry and Physical Plant.

With assistance from our committee members, we explored and tested procedures and chemicals employed in reprocessing of linen used to wrap the telescopes for sterilization. We used glass plates to mimic the lenses of the telescopes. The results showed that the film was apparent on the glass plates when sterilized with and without linen wrappers.

Cleaning Agents and Protocols Tested

We reviewed cleaning agents and the cleaning protocol used for the interior of the sterilizers. We examined the drains in all of the steam sterilizers to rule out the possibility of abnormal bacteria counts. Unfortunately these efforts did not provide any clues.

In Winnipeg, the water is derived from Shoal Lake. In the summer "Algae Blooms" occur. At the time of the "bloom" the numbers of impurities in the water are at their highest. SBGH Physical Plant advised us that filtering takes place as the water enters the hospital. As well, chemicals called conditioning agents, are added to the pipes that transport water and ultimately the steam to the sterilizers during the Algae Bloom peak as a precaution. Because these chemicals were added at the same time as the purchase of the new telescopes, we investigated the possible impact of the chemicals in steam processing. First, we removed all of the conditioning agents from the

system and processed new glass plates in the steam sterilizer. A film was present on all of the plates. We added the conditioning agents back one at a time. After each conditioner was added, we sterilized new glass plates. No appreciable difference was observed with or without the conditioning agents.

The steam process and ultimately the quality of the water used to produce the steam remained the primary suspect. Somehow a clean telescope went into the sterilizer and a "foggy" telescope resulted. In consultation with the company who manufactured the telescopes used at SBGH, we obtained a list of other hospitals who had also purchased steam sterilizable telescopes. We conducted a survey to determine if they had experienced this problem and if so, how was it resolved. At each hospital we contacted three departments: OR, Central Processing and Physical Plant. We found that the majority of hospital ORs were using ETO to sterilize even though the telescopes could be steam sterilized. (Using ETO was thought to prolong the life of the telescopes due to the exposure to lower temperatures.) One hospital, Rockyview General, Calgary, was using steam sterilization for their telescopes and had not experienced problems with visual acuity. They were intrigued by our dilemma and expressed an interest in the outcome. We agreed to keep them informed.

Our committee suggested that an analysis of the film might bring us a step closer to resolution. New glass plates were steam sterilized to obtain and transport the sample of the film. We sent the plates to an outside agency for analysis. The analysis revealed Calcium and Magnesium deposits greater than .1 micron on the glass plates. The filters in the water lines at SBGH were not designed to filter out impurities so minute.

Testing the Water Supply

Focus on the water as the source of the problem continued. To prove our theory that impurities in the water supply were causing the film, we needed to run a test using a steam sterilization process that incorporated a pure water source. The SBGH committee discussed the use of distilled water to produce steam. Because of the mineral depletion required to distill water, the water becomes very aggressive in nature. It essentially tries to recover the lost minerals. It will attack anything it comes in contact with in an effort to regain these lost minerals. Therefore, in order to use distilled water for steam production, all of the materials such as the pipes and pipe fittings, used in transport of the water must be stainless steel. Because of this, using distilled water was a cost prohibitive option for us even on an experimental basis

A Winnipeg Dentist, Dr. J. Bassey was intrigued by our investigation and offered his assistance. In his office, distilled water is used to generate the steam in portable stainless steel sterilizers. This method of sterilization met our criteria for testing. After sterilization using distilled water, the glass plates were completely clear and free of any film or deposits. On the basis of this test the committee concluded that when using purified or distilled water to generate steam in the steam sterilization process, the glass plates are free of deposits.

We called Rockyview to share the information gathered to date and to ask if they had ever experienced problems with their water supply. They had not. However, as part of the installation of the sterilizers, at Rockyview, filters were connected to the steam lines. The filters are located immediately adjacent to each sterilizer. Further research into the function of these filters revealed that they were capable of filtering out particles .1 micron or greater.

Significance of the Filters

We had found the cause of the "foggy" telescopes. Our committee had established that the deposits were Calcium and Magnesium greater than .1 micron. Now we knew that these deposits came from the water supply. The significance of the filters used at Rockyview became apparent. Working with our committee, we researched and found filtration systems that would prevent these minerals from entering the sterilizer and contacting the telescopes during steam penetration. SBGH installed a filtration system capable of filtering out solids of .1 micron or greater on each sterilizer. With careful, regular maintenance of the filters, the Calcium and Magnesium deposits on the telescope lenses were eradicated.

The fog lifted!

Acknowledgments

The authors gratefully acknowledge the assistance of the following: N. Ingram, OR, Rockyview General Hospital, Calgary. Dr. J. Bassey, Winnipeg. SBGH staff includes: D. Brandenburg Chief Engineer, Physical Plant; K. Ferreira, CSR; G. Keena, Supervisor Buildings & Equipment, Physical Plant; C. Lapointe, Engineer, Physical Plant; N. MacFarlane, Infection Control; Dr. R. Meatherall, Associate Clinical Chemistry; S. Ritz, Central Processing; and G. Plamondon, Manager, Laundry. D.McPherson&R. Patrick, Service Reps,Getinge Castle Canada Inc. B. Scales, Health Devices Inspector, Health Protection Branch, Health Canada

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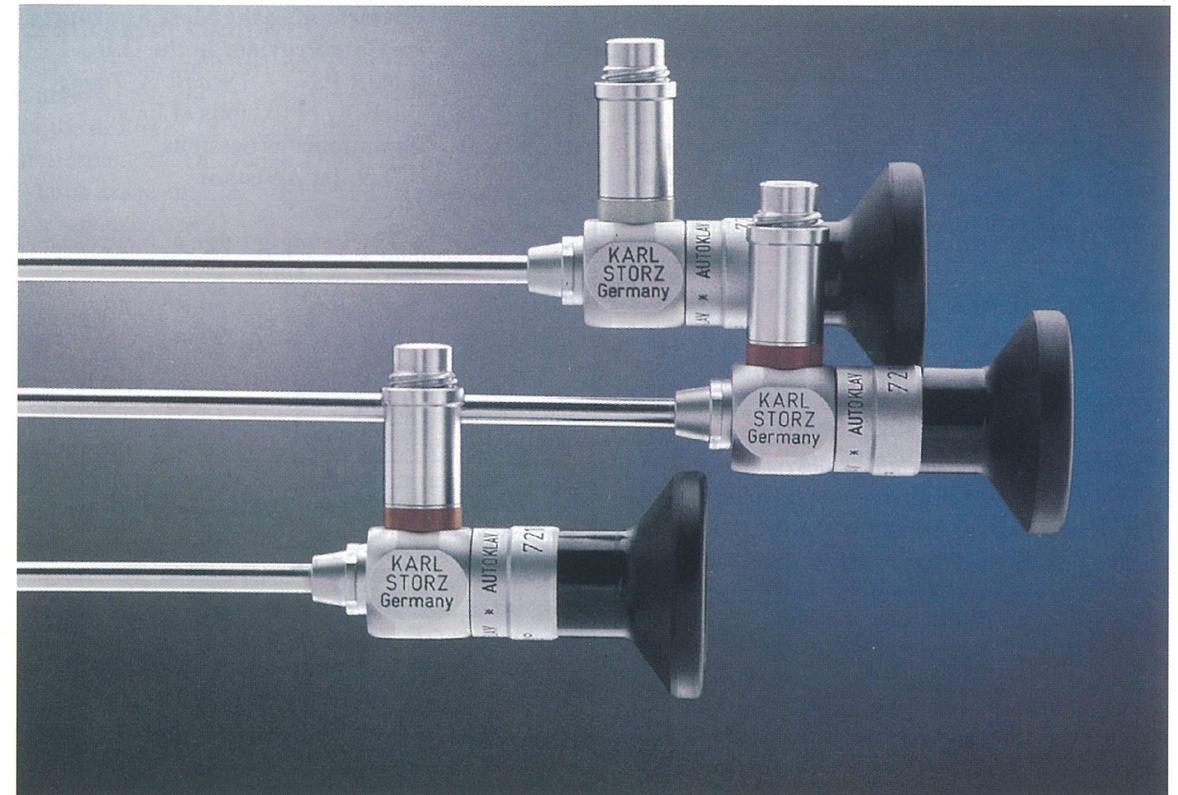

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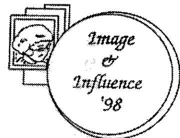

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0815-0915 Opening Ceremonies
0930-1000 Keynote Address
- Humour & Health
Dr. A. M. Guilmette
1000-1030 Health Break
1030-1130 ORNAO Information Session
1130-1500 Opening/Viewing of Exhibits
Lunch
1515-1630 **Simultaneous Sessions**
- Shared Governance in the O.R. Setting *H. Hutton, N. Rahim*
- Laparascopic Swenson Pull-Through *Dr. M. Walton*
- The History of Nursing
Dr. J. Desmond
1630-1730 Focus Group
1900-2030 JJMP Night

Tuesday, April 21, 1998

0715-0815 Registration
0830-0945 **Simultaneous Sessions**
- Meeting the Profession's Educational Needs in the Millennium. Are We There Yet?
A. Labriciossa
- Minimally Invasive Direct Coronary Bypass: Clinical Impact
S. A. Harvey, R. Blohon, Dr. I. Gill
0945-1015 Health Break
1015-1130 **Simultaneous Sessions**
- Perioperative Professional Nursing Practice and Lifelong Learning. Are You a Victim or a Navigator of your Personal Learning? *S. Bell, L. Morson*
- Determining the Most Appropriate Care Provider in the O.R. - R.N./R.P.N. *J. Tyndall, A. Young*
1130-1500 Viewing of Exhibits / Lunch
1515-1630 **Simultaneous Sessions**
- R.N. 1st Assistant
G. Groetzsch
- The Leading Edge of Neurosurgery *Dr. Mintz*
1830-1930 Exhibitors' Cocktail Reception
1930-0100 Murder Mystery Dinner / 60s Theme Dance
(Flower child/Hippie/Go-Go attire encouraged)

Wednesday, April 22, 1998

0715-0815 Registration
0830-0945 **Simultaneous Sessions**
- Image Consulting
E. Zabitsky
- Recognition and Treatment of Lesions *Dr. M.L. Baxter*
- Why Net? An introduction to the Internet *C. Kelly*
1015-1130 **Simultaneous Sessions**
- Perioperative Nursing: A Caring Practice *A. Haggan*
- A Missed Nursing Opportunity: Intraoperative Progress Reports to Families of Surgical Patients
S. Bell, R. Poopolo
- Third World Nursing: It's Challenge and It's Rewards
B. Boles-Davis
1130-1400 Viewing of Exhibits / Lunch
1400-1600 *Closing Speaker - TBA*
1600-1630 Closing Ceremonies

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Newsbriefs

2 Year Inquest into 12 Winnipeg OR deaths near completion

A surgeon's inexperience and a Hospital's Cardiac Surgery Program have been under scrutiny because of the deaths of 12 infants related to cardiac surgery performed by Dr. Jonah Odim, according to the March issue of *Elm Street* and a recent issue of *Canadian Nurse.*

The Children's Hospital in Winnipeg has previously shutdown their Cardiac Surgery ward in 1981 and the hospital administration, under restructuring at the time, did not want to face closures again. Several trained professionals, from OR and ICU nurses to six anaesthesiologists, knew of the high mortality rates of Dr. Odim's patients and yet surgery was continued. Odim's surgeries were considered "excessively long" and his mortality rate was over 50 per cent on infants under the age of one. At Toronto's Hospital for Sick Children the rate for same surgery is 11 per cent.

Two Toronto doctors from The Hospital for Sick Children were asked to observe Dr. Odim and the Winnipeg Cardiac Surgery Unit. They found the program "unacceptable" and some serious questions have been raised as to the necessity of the program, the 12 deaths and the actions of hospital and medical officials.

Odim, would not resign his position as cardiac surgeon and since May 1996 works as a Clinical Instructor at UCLA. He returned to Canada for five weeks of testimony.

Provincial judge Murray Sinclair is expected to release his report in June, 1998, a full 25 months later and civil suits are expected to follow.

Good nursing care proven scientifically to makes a difference

Ellen Hodnett, the former deliver-room nurse, who is now a professor in the Faculty of Nursing, University of Toronto, has shown that one-to-one nursing care for women in labour reduces the need for medical interventions. Patients are less likely to have a caesarian section, use medication for pain relief, need an episiotomy or have a forceps delivery, and they are more likely to feel happy with the birth experience.

Hodnett, who is director of the Perinatal Nursing Research Unit at Mount Sinai Hospital, holds the Heather M. Reisman Chair in Perinatal Nursing Research that was established jointly by the university and hospital in 1996. It is the first nursing research chair in Canada.

A couple of years ago, the Society of Obstetricians and Gynaecologists of Canada issued a set of guidelines based on Hodnett's research. Hospitals say they cannot afford to follow them. But, counters Hodnett, "They cannot afford not to. The guidelines are cost effective, and if hospital would adopt flexible staffing patterns, they would see how it works."

Much of her research questions the ways in which women are supported through labour. Her PhD students, meanwhile, are studying practices that are used in labour but have no scientific basis. For example, should women be permitted to eat and replenish the calories lost through energy expended in labour or continue to be deprived of food and fluids? Should they be encouraged to have baths to enhance labour and increase comfort rather than being confined to bed or walking?

Paid health services reduced

Toronto - the province announced a cutback in services it will pay for under the Ontario Health Insurance Plan. Coverage will cease April 1 for 22 medical or cosmetic procedures, including wart removal, male mastectomies of non-diseased breasts and surgical cutting of a nose nerve to prevent stuffiness. Also, the province will only pay for routine eye examinations every second year for people aged 20 to 64. The revisions will result in savings of about $50-million to the health system, the ministry said. - CP (Canadian Press)

Child has flesh-eating disease

Victoria - A five-year old kindergarten student had his leg amputated below the knee because of necrotizing fasciitis after a bout of chicken pox. Provincial health authorities said yesterday it is rare for the flesh-eating disease to attack a child. The child is a student at Elsie Miles Primary School in the Cowichan Valley, B.C., a rural district north of Victoria. The school has remained open. Health authorities said most other children at the school were at very low risk.

Conference Calendar

April 20 - 22, 1998
Operating Room Nurses Association of Ontario - 5th Provincial Conference, Sheraton Fallsview, Niagara Falls, ON.
"Images & Influence '98" - Increase your confidence and credibility. Prepare for the 21st Century. Contact Publicity Chairperson: Audrey Macdonald (905) 878-2383 Ext. 2310. Exhibitor Chairperson : Alaine Young (905) 521 - 2100. Ext. 3030.

April 23 - 25, 1998
16th Biennial Conference - B.C. Operating Room Nurses Group. Harrison Hot Springs, Harrison, B.C.
Theme: "Towards 2000"

October 1 - 3, 1998
MAPAN/MORNA 4th Joint Provincial Conference at the Westin Hotel Winnipag, 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 22 - 24, 1998
Operating Room Nurses of Alberta Association - 18th Provincial Conference - Red Deer, Alberta. Theme - "Stepping Out of the '90s"

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.

Telemedicine

April 1, 1998
"Navigating Professional Learning: A Benefit to Hospital and Nurse" presented by Susan Bell, Nurse Eductor Perioperative Care, The Hospital for Sick Children, Toronto, President, Operating Room Nurses of Greater Toronto and Loretta Morson, Manager, OR/Recovery, Humber River Regional Hospital, Finch Centre Site, Downsview. Member, Operating Room Nurses of Greater Toronto. Code: 04003

April 22, 1998
"Giving Intraoperative Progress Reports to Families" presented by Julie Cordasco, Nurse, OR, The Hospital for Sick Children, Toronto and Rose Puopolo, Resource Person, Plastic Surgery, The Hospital for Sick Children, Toronto. Code: 04093

May 13, 1998
"Transient Osteoporosis During Pregnancy: The Perioperative Nurse's Role" presented by Antoinette Labriccioso, Nurse, OR, Mount Sinai Hospital, Toronto. Code: 05051

June 3, 1998
"Necrotizing Fasciitis" presented by Amoy lowe, Nurse, Mount Sinai Hospital, Toronto. Code: 06015

June 24, 1998
"Shared Governance in an Operating Room Setting" by Helena Hutton, Manager, Child Health Services, OR, The Hospital for Sick Children, Toronto and Nurallah Rahim, Resource Nurse, OR, The Hospital for Sick Children, Toronto. Code: 06105

What's In A Name ?

A Canadian RNFA's Perspective

By Grace A. Groetzsch, BScN, MEd, CPN(C), RNFA

The word assistant is felt to have negative connotations, hence the term Perioperative Nurse - Surgery (PNS). The following outlines one Canadian RN First Assistant's view of this controversy.

Registered Nurse First **Assistant**,
Surgical **Assistant,**
First **Assist** for Surgery,
RN Surgical **Assistant,**
Nurse First **Assistant** ,
Perioperative Nurse - Surgery.

Currently most Canadian hospitals and other organizations that formally recognize perioperative nurses assisting at surgery utilize a title that encompasses the word assistant - RN First Assistant (Sunnybrook Health Science Center, Toronto); Surgical Assistant (The Toronto Hospital Corporation, Toronto, and The Queen Elizabeth II Hospital, Halifax); RN Surgical Assistant (University of Alberta, Edmonton) Surgical Nurse Assistant (Heart Institute of Montreal); and Nurse First Assistant (L' Ordre des infirmières du Québec).

The Operating Room Nurses Association(ORNAC) has coined the term Perioperative Nurse - Surgery (PNS). It identifies the role known in the United States of America and the literature as Registered Nurse First Assistant (RNFA). PNS was conceived specifically to avoid the use of the word 'assistant'. Why? The term was believed to have negative connotations. Recently a perioperative friend challenged me to defend the use of assistant in my title.

The *American Oxford Dictionary* (1980) offers the following definition:

As•sis• tant (a-sis-tant) *n.* a person who assists, a helper. assistant *adj.* assisting, helping a senior, and ranking next below that person, as in *the assistant manager.*[1]

The New Roget's Thesaurus (1961) provides the following synonyms for the word assistant - helper, apprentice (work), subordinate; auxiliary, help, aide.[2]

All these words hold elements of truth; I am a person who assists; I do help - the patient, the nurses, the surgeons, and the anaesthetists. I am subordinate in the sense that I work under the authority of the attending surgeon. I am subordinate, not inferior.

By virtue of my RNFA education I have the knowledge, skill and judgement to collaborate with the surgeon intraoperatively and to assist with patient care pre- and post-operatively. I do not have ultimate responsibility but I am responsible and accountable for the care that I provide. The objective of the multidisciplinary team, of which I am a member, is to assist the patient achieve an optimal outcome.

Is it wrong to be called an assistant? Does it not merely describe what is inherent to the role - assisting? How many non perioperative nurses know what "perioperative" means two decades after it was brought into our terminology? I believe this is just another game of semantics.

How much of my concern stems from the fact that the word 'assistant' is in my title? Does being called an assistant make others think less of me and my ability? No. I have watched and felt how people react to me and my new role. Their response is based on my ability and performance, not on the name that appears on my certificate. Does it negate my contribution to

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Grace A. Groetzsch works full-time as a Registered Nurse First Assistant with the Cardiac Surgeons at Sunnybrook Health Science Centre, Toronto. She is also a staff nurse in the operating room of the Orthopaedic and Arthritic Hospital, Toronto.

Acceptance of RNFA by surgeons and staff overwhelming

By Susan Carver RNFA (Intern) and Karen Allen, RNFA (Intern)

We were very interested in the ORNAC President's Message, (page 5, Dec. 1997) regarding the RNFA/ PNS programs emerging in Canada. The Brantford General Hospital in Brantford, Ontario is supporting two RN's taking Dr. Jane Rothrock's RNFA course from Delaware County in Pennsylvania. We are a teaching hospital, in an underserviced area for family physicians, where we have 10,000 residents without a doctor. The perioperative nurse who is trained to assist at surgery can be beneficial to the community. We are overwhelmed by the acceptance of this program from our management, and surgeons, especially our mentors Dr. R. Kessaram and Dr. G. D. Maddison. Throughout the hospital, staff have willingly shared their knowledge and time to teach and help us in gathering information needed for the course. Positive comments from the patients we have been involved with, have made the long hours of study and internship fly by. Our fellow perioperative nurses, who are sharing this experience with us, have given us the confidence to complete this advanced perioperative nursing role.

Eventually, the value of the RNFA/PNS role will be acknowledged in Ontario, because the need is definitely obvious. As mentioned in President Donna Farid's message last issue, the role is not for all perioperative nurses. However, for those who choose to follow this path it can be very rewarding.

The value of this position can only be shown by preparing perioperative nurses for this advanced role. In turn, acknowledgment of this position will follow due to positive outcome created.

Authors

Susan Carver, RNFA (Intern), and Karen Allen, RNFA (Intern), Operating Room, Brantford General Hospital, Brantford, Ontario.

Grace Groetzsch (Continued from page 29)

positive patient outcomes? Does it make me less of a team member? More to the point would utilizing the title PNS improve their understanding of my functions or gain their respect? In my experience it would make no difference.

Dan Kaplan, the President of Hertz Equipment Rental Corporation stated, "I know who I was, who I am, and where I want to be." I know who I am, what I do, and the contributions I make to patient care. Clearly the hospitals utilizing perioperative nurses in this new role have chosen not to use the term PNS. Wouldn't the energy involved in getting recognition for this new title be better spent getting the role accepted and reimbursed? Lets leave semantics to the semanticists and focus on expanding the scope of perioperative nursing.

References

1. Ehrlich, Eugene et. al. (1980). *Oxford American Dictionary.* New York: Oxford University Press, p. 36.
2. Lewis, Norman, ed. (1961). The New Roget's Thesaurus In Dictionary Form. USA:

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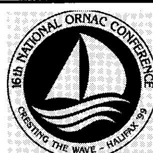

The conference will provide many learning and networking opportunities for staff nurses, educators, managers, and researchers. Key areas of focus are:

1. Clinical Issues in Perioperative Nursing Practice, Issues affecting practice, New Procedures.
2. Management Issues in Perioperative Nursing Practice Case cart, Computerization, Reengineering, etc.
3. Self-Development, Stress Management, Continuing Education, etc.
4. Research related to Perioperative Nursing Practice.

Abstract submission may be for oral or poster presentation. Maximum of 150 words on single-spaced page, typed with minimum of 12 characters per inch. Abstract heading should include title, the author's name, institution name, city and province and indicate your specific area of focus.

Send three copies of the abstract by **Oct. 1, 1998** to:
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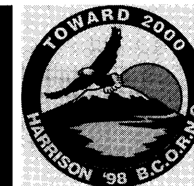

Thursday, April 23

Opening Ceremony
Keynote Speaker - **Peter Legge**
"Soar with the Eagles"
Ribbon Cutting Ceremony - Exhibits

Concurrent Sessions:
"Parental Involvement with Pediatric Anaesthesia Induction"
Dr. Norman Wickett
"Tourniquet Safety & Guidelines for Use"
Dr. James McEwen

Concurrent Sessions:
"Organ Transplantation - The Gift of Life" - **Loretta Romanko, RN**
"Men's Health" - **Dr. John Warner**

1800 - 1900 *Cocktails, Dinner & Dancing*

Friday, April 24

BCORNG Breakfast & Business Meeting
Plenary Session:
"Putting Nursing Forward - Strategies for the Next Millenium"
Dr. Katharyn May

Concurrent Sessions:
"DNA hits the rubber - hits the Road"
Dr. Patrick MacLeod
"Medical Care in Vietnam - How We Can Help"
Dr. Hugh Parsons
"Sharing The Wealth"
Janet Dysart, RN, CPN(C)

Concurrent Sessions:
"You Too Can Be Punctured - Reducing the risk of Blood Borne Diseases in the OR"
Dr. Elizabeth Ann Bryce
"Operation Rainbow" - **Dr. Kimit Rai,** Mary McLaren, RN, Betty Naidu, RN

Concurrent Sessions:
"Humour in the Workplace"
Linda Gomez, RN, MSN
"Financial and Fiscal Fitness"
David Chalmers BA, CHFC, RFP
2000 - 0100 *Casino Night*

Saturday, April 25

Concurrent Sessions:
"Managing Midlife Mysteries - Perimenopause & Beyond, Part 1" - Dr. Jerilynn Prior
"Registered Nurse First Assistant (RNFA)"
Grace Groetzsch RN BScN MEd CPN(C)
Marnie Simon RN BGS MEd MN

Concurrent Sessions:
"Managing Midlife Mysteries - Perimenopause & Beyond, Part 1" - Dr. Jerilynn Prior
"New Legislation and New Cases"
Penny Washington LLB

Closing Ceremonies
Charmaine Crooks, Olympic Silver Medalist
"one of the fastest woman runners in the world"

Registration Information

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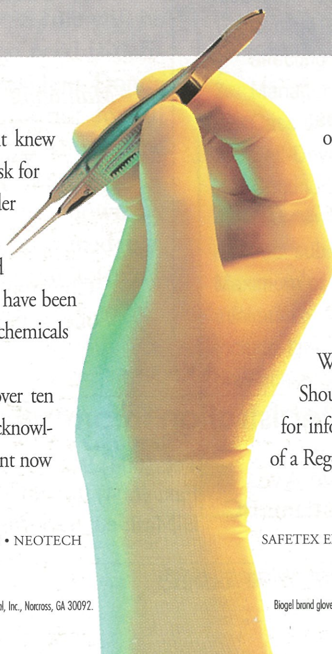

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