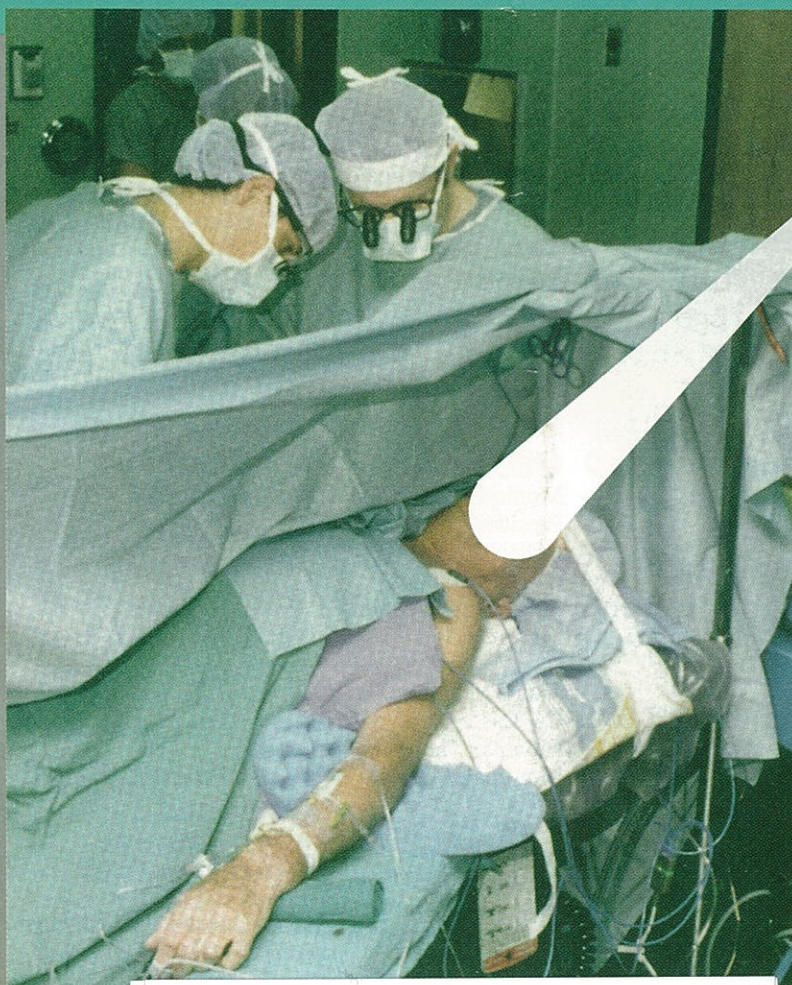


Canadian
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Journal

Published Quarterly. Vol. 15, No. 3, October, 1997



**Cervical Plexus
Block for Carotid
Endarterectomy**

**Evidence-Based
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**Orderlies & Aides
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ORNAC in a Nutshell

#1 Concern of OR Nurses - the increasing replacement of RNs in the OR

The Board and Executive of the Operating Room Nurses Association of Canada (ORNAC) met September 5 & 6, 1997 in Toronto. There were five Executive and twenty Board members present. Following are the highlights of the two day meeting.

1. A forum at the National Conference in April, 1997 identified key areas of concern for OR nurses across the country. The number one concern is the increasing presence of other health care workers in the OR and their replacement of RN's. This and other major issues will be addressed in the President's Message.

A document was sent by the Saskatchewan ORT group to the Regina Health Board proposing an increase in ORT staffing and their replacement of perioperative RN's. Donna Farid has sent a letter to the C.E.O. of the Health Board outlining ORNAC's position with regard to this proposal, for the record.

2. ORNAC has requested that CNA review the number of employment hours required by OR nurses to write the Perioperative Certification Exam. It is hoped lowering the hours will allow casual nurses to qualify to write the exam.

3. The Standards Committee is in the final stages of preparing the 1998 Standards. They will be ready for sale in January, 1998.

Telemedicine Canada sessions for Operating Room Nurses continue to be prepared on topics of interest. The committee is attempting to prepare a study guide to assist those writing the Certification exam.

4. The Editorial Advisory Committee is hopeful the Nutshell and President's Address will be translated into French for the Journal and will participate in seeking funding. Hopefully in the future a French article will be included in each issue as well.

5. The Translation committee reports the standards are being translated into French. They will be available through the Quebec Board Member Monique Perazzelli.

6. The Public Awareness Committee presented a Business Plan to develop an ORNAC Web Page. Approval was given for this with a target date of Dec. 31, 1997. Draft three of the pamphlet "Why an RN is needed in the OR" is being reviewed.

7. A National Membership Card and numbering system is being investigated as a means of tracing membership statistics.

8. The Advanced Nursing Practice Committee is hoping for closure on the NAFTA, Nurse Anesthetist project. ORNAC has remained an observer on these meetings to be certain the message is sent that this position is not in place in Canada.

9. ORNAC continues to lobby the government (HRDC) to co-fund the development of competencies for the anesthetic assistant role. This is a joint project of ORNAC, the Canadian Anesthetic Society and the Canadian Society of Respiratory Therapists.

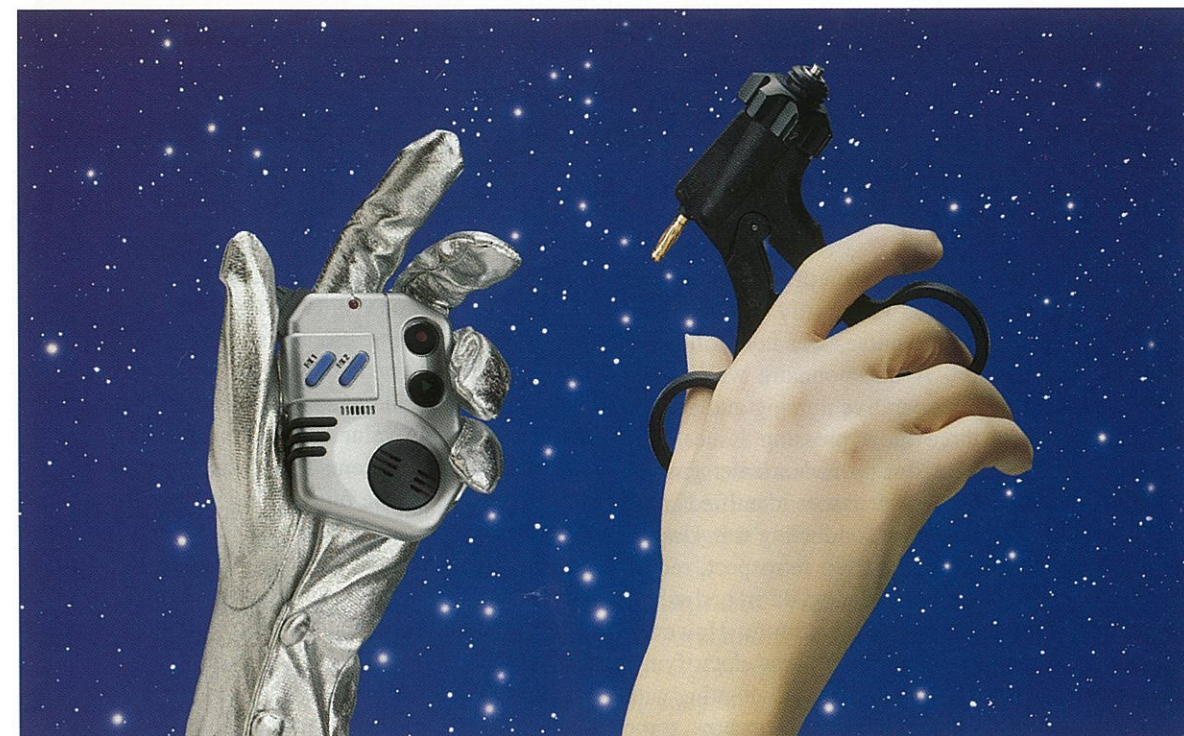
10. The Research Committee is developing a structure in order to support nurses conducting Perioperative nursing research projects. The committee will be investigating potential topics, developing an application form, asking for a research grant and exploring methods of advertising, both in English and French.

11. Plans are progressing for the National Conference 1999 in Halifax, and in 2001 in Banff. The Board accepted a Business Plan for the 2003 Conference to be held in Manitoba.

12. Twelve nurses from the Yukon have expressed an interest in joining ORNAC. They have been advised to do so through the BC group.

13. The next ORNAC Board meeting will be in May, 1998 in Toronto.

Adapted from the Minutes of September 5 & 6, 1997. Corina Balcom, Secretary of ORNAC



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Delivering the Right Message to the Right People

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

During the 15th National Conference in Ottawa last April, a forum conducted to identify key issues of concern for perioperative nurses was held following the Opening Session. A questionnaire was passed around asking the perioperative nursing audience to write down their three most pressing issues. The audience was then broken up into smaller groups, each with a facilitator, so the issues identified could be discussed. ORNAC was conducting this kind of process for the first time, and, in retrospect, recognized some glitches that needed to be ironed out to facilitate a smoother process in the future. However, there was a buzz in the room that was electrifying. Nurses from across the country were dialoguing with each other - expressing their common concerns, some venting their frustrations, some sharing their ideas and resolutions. They were connecting!

The top three issues identified were:

- Replacement of Perioperative Registered Nurses with other health care workers (both licensed and unlicensed).
- The Expanding Role of the Registered Nurse (Advanced Practice).
- Job Security.

I will attempt to address the first issue.

Recently I have noticed that we are getting better at articulating our roles, mostly to each other. Articles promoting perioperative nursing roles and RN roles are more predominant in our specialty journals, such as our CORN journal, in the CNA journal, newsletters, research papers, jurisdictional publications, and so on. However, we are preaching to the converted. Perioperative nurses who take the time to read the CORN journal and other publications related to their profession are already convinced that their practice is of great value. The message needs to be sent further afield - to our client base - the public. What better way to promote our role than to have a surgical patient ask to be care for by a Perioperative Registered Nurse because they are familiar with the care we provide for them and they know they can place their trust in us.

Beverley P. Giordano, Editor of the AORN Journal, expressed my sentiments exquisitely in the Sep-

tember, 1997 issue when she stated:

"As technology advances, the tools that perioperative nurses use to care for patients may change, but the fundamentals of nursing care (i.e. knowledge, skill, judgement) are timeless. These fundamental nursing values are the basis of the quality care that surgical patients have relied on in the past - and will expect in the future. This is the message for perioperative nurses to convey to the public".

Giordano went on to quote Virginia Henderson who wrote, "The essence of nursing is to do for others what they would do for themselves if they had the strength, the will and the knowledge".

As National Perioperative Nurses Week (the week of November 14th) draws near, Giordano suggests that instead of our usual demonstrations of OR Settings in public areas, demonstrating instrumentation, showing videos of surgical procedures, think of how we can send another message - how we care for our patients (by keeping them warm, safe from harm, staying by their side, listening to their concerns, offering support and easing their anxiety, while all around them bustling preparation and invasive monitoring takes place).

ORNAC has prepared a promotional video, which after you have viewed it, leaves you with a feeling of pride in your chosen profession of perioperative nursing. Show that. Also, a pamphlet is being developed explaining in simple terms "Why You Deserve a Registered Perioperative Nurse". When they are ready, we will send them to each provincial OR nurses organization for distribution to the public.

If the public is convinced that you are the best person to provide quality care pre, intra and postoperatively, they can become invaluable allies in influencing those who make decisions about staffing our operating rooms. Perioperative Nurses Week is your opportunity to participate in delivering the right message to the right people.

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.

Protecting Your Future

By Susan R. Guerra, RN & Carolyn Rose, RN

Introduction

Have you recently had any reason to believe your job may be in jeopardy? If you answered "no" to this question, you may want to reconsider your answer! What is your response to the following questions: Has the budget been cut in your operating room? Is your hospital merging with any other area hospital? Have hospitals in your area closed now or will they close in the future? Have any positions been eliminated in your O.R. recently? And have RN's been replaced with alternative personnel? If you answered "yes" to any of these questions, it's time to sit up and take notice! Your job may be on the line.

There may be nothing we can do as perioperative nurses to stop some of the chain of events taking place in our environment right now. However, when administrators look at slashing budgets, we want to make sure we are part of the solution rather than part of the problem. One of the ways we can protect ourselves is to look for ways in which we can impact cost savings for our department. By instituting some creative ideas, perhaps we can stave off future threats.

Examine Draping Practices

One of the first areas in which to look for cost savings is draping. Recently, in this journal, an article was published addressing some of the practices of over draping for surgery. Use of approach sheets and squaring off the incision area (depending on the draping system utilized) may no longer be warranted. Standardizing draping techniques among physicians reduces variability and in turn, cost. For example, when surgeons perform dilation and curettage procedures in their clinics, they may only use towels to drape the immediate area. And yet, in the operating room we persist in using leggings, a sheet under the

buttocks, and a sheet over the abdomen. This is quite a contrast compared to the two towels used to drape in the surgeon's clinic!

Eliminate Wastage

An additional area which can drive significant cost savings is by simply eliminating wastage. How frequently are items opened "just in case" or "just because the surgeon *may* ask for it," only to discard those items at the end of the case? If there are items listed on the surgeon's preference card that are not used 100% of the time, wait to open those items until they are specifically needed and requested. To avoid the potential mishap of opening items that will not be used, ensure the surgeon's preference cards are up to date and accurate. This will also assist the next RN who prepares for this procedure and is not as familiar with the surgeon's preferences.

At times, surgeons will insist that certain items and sutures be opened for the procedure. If this is the case and items are opened and not used, save these items in a plastic bag for a month or two. At the end of this specified time frame, determine the cost of these wasted items, tally the total, and present the results to the surgeon. Surgeons respond very well to data and the dollar total may encourage them to reconsider some of their unnecessary requests.

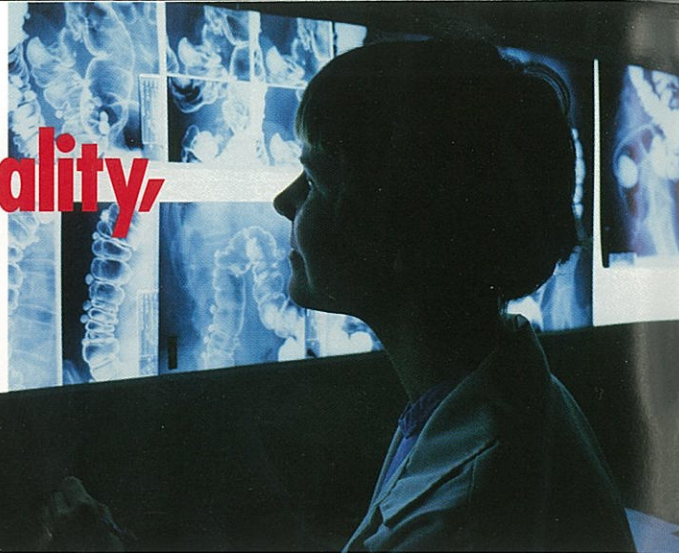
The use of an event-related sterility system rather

Author

Susan R. Guerra, RN, is a Surgical Services Consultant, and Carolyn Rose, RN, is a Nurse Consultant with Allegiance Healthcare Canada Inc.

This article was first presented at the 15th National Conference of the Operating Room Nurse Association of Canada, Ottawa, May, 1997.

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than a time-related outdated system can also save many dollars per annum in reprocessing and packaging costs. Consider the time utilized to check for outdates, deliver the outdated supplies to the central processing department, unwrap the supplies, rewrap/package the supplies, resterilize, and then return to storage. This is a very costly venture, especially when the item is likely to be sterile if there has been no untoward occurrence with the item.

Standardize

Standardization of supplies can save hundreds of dollars in supplies and associated costs. The associated costs may not appear to amount to much at first glance until the entire supply link is analyzed. The circle of inventory control includes checking the storage area for needed items, submitting needs list to purchasing, creating a purchase order, phoning the vendor to order the supply, receiving the items at the receiving dock, distributing the paper work to the appropriate departments throughout the hospital, and delivering the item to the ordering department. If too many items are ordered and not used right away, the item may become obsolete, damaged or soiled, lost, and at a minimum, occupy valuable storage space. The more items, the greater the cost to the system.

There are many areas in which standardization can occur. The first is to standardize draping practices (as discussed previously) and other supplies utilized for a procedure. Instrument trays offer opportunities for standardization. Are five different varieties of curved clamps really needed on each instrument tray? Another area ripe for standardization are the common supplies used by most of the staff in the operating room. Many hospitals support wide variation in hats, masks, scrub brushes and solutions, and gloves. Some variation is necessary due to allergies, etc. However, much seems to stem from personal preferences. The question to ask staff members and physicians is: "Are these products selected because you prefer them or are they necessary to address a particular need?" The key is to determine clinical acceptability rather than ensuring all personal preferences are satisfied.

Create Physician and Nurse Awareness of Costs

It is easy to be lulled into the false thinking that surgeons and nurses are fully aware of the cost of all the items they use on a daily basis for surgery. The fact is that many probably don't know costs because the

money for the items usually does not come out of their own pocket or that of their department. Money typically comes from the operating room budget. To create fuller awareness on the part of surgeons and nurses of item costs, several techniques can be employed. First, simply post the price of items in locations unavoidable to the surgeon; surgeons will begin associating actual costs with their supply consumption. Prominent locations ideal for posting include the locker rooms, the door exiting the locker room, the supply room, and the wall above the scrub sinks where they must stand for at least a few minutes. Some hospitals have employed the "post one item per week" methodology so that a constant rotation of supplies and related expenses are displayed.

Another example of how surgeons can drive supply costs is through the accuracy of their surgical bookings. How many times has the discovery been made that the procedure a surgeon has booked is not the actual procedure that will be performed? The supplies are pulled and opened for the procedure and then when the patient arrives, the site of a procedure is different, additional sites are added, etc. Next time this occurs, save any wasted and unused supplies, tally the total cost and present this to the surgeon. Mention that the money lost on these wasted supplies might have been spent on other patients.

Question Everything You Do and Use

After working in the operating room for a period of time, many everyday practices become second nature, unquestioned. The days of continuing in the status quo are over! No longer can the system afford to continue routine behaviours without examining their effectiveness and looking for more cost-effective alternatives. What kind of table is used as a back table? Is a special drape or multiple drapes required to create a sterile field on this table? Is it necessary to create a sterile field to set up the patient skin prep? Must the Mayo tray be wrapped and sterilized or can it simply be placed in the stand and draped as one unit? Scrutinizing these everyday activities may result in many cost saving alternatives.

Examine Dinosaur Practices

Sheer habit may dictate what is worn and/or used in the operating room. Yet there is abundant research available which demonstrates that some of these habits are not contributing to the ultimate outcomes previously thought. Surgical masks are a good example of an item that may be overused in an effort to

decrease operating room contamination. Many research studies show that masks are not effective in reducing surgical infections and may actually increase environmental contamination.¹ Does this mean surgical masks should be eliminated for the purpose of protecting ourselves from splashes and from breathing in harmful particles? Probably not. It does mean that it may not be necessary to wear masks in corridors, workrooms, and empty operating rooms when there is no potential for exposure.

Eliminating shoe covers represents an additional opportunity for cost savings. Once again, research has failed to demonstrate a positive impact of use of shoe covers on reduction of contamination in the operating room environment.² Should shoe covers be eliminated entirely? Shoe covers can serve the purpose of keeping shoes clean during surgical procedures with moderate fluid exposure. Procedures with high fluid exposure potential may actually require more protection including fluid impervious shoe covers or boots. Cost savings may be realized by eliminating the requirement of shoe covers in all areas of the operating.

Cover gowns and lab coats are also up for grabs. Do cover gowns/lab coats really help reduce contamination of scrub suits and the operating room environment? Studies conducted on use of cover gowns to reduce environmental contamination and infections in patient populations have shown cover gowns to be ineffective.³ Another study resulted in lack of statistical significance that bacterial counts on scrub clothes was reduced through use of cover gowns.⁴ Consider establishing parameters and locations that are acceptable to visit without wearing cover gowns. Eliminate the need for staff members to journey outside the operating room environment through methods such as arranging for food service in the staff lounge. Many hospitals have actually eliminated the requirement for cover gowns and lab coats and report no change in infection rates while experiencing significant cost savings.

Finally, sterile prep sets may soon become obsolete because they may not contribute to the reduction of microbial counts during skin preparation. There are many, many practices that deserve evaluation as to their effectiveness. Seek research and conduct research which supports these queries.

Learn to Sell Your Ideas

Not sure where to start in implementing all these ideas? Start first by seeking other individuals who will support the ideas - fellow colleagues, charge nurses, managers. Ask them if they would be willing to help

the cause. Second, seek literature and other sources that provide support and documentation. Conduct literature searches on different topics or ask to meet with the infection control practitioner to discuss practice changes. Volunteer to participate on committees and task forces that address cost issues. Begin to associate with these types of efforts and the appropriate individuals will begin to recognize you as part of the solution.

If All Else Fails...

What happens when even after making these wonderful efforts toward cost reductions, job security remains an issue? Reality dictates that with all the changes in the health care environment, threats to security will persist far into the future. Now what? Consider alternative ways to apply the knowledge and skills that come with being a perioperative nurse. There are many career options available for those with nursing backgrounds and the list grows daily. Industry is seeking more and more the clinical background because they are discovering that it may be easier to teach a nurse sales and marketing skills than it is to teach a non-clinical person the details of the operating room and hospital environment. Jobs with industry include not only sales and marketing but also computer software development and implementation, product or other expert consulting and teaching. Industry and other institutions conduct research projects that require individuals with nursing backgrounds for project management.

The difficulty nurses generally have is learning to articulate the skills already possessed that are useful in other settings. Nurses are masters at handling stress, multiple tasks simultaneously, and dealing with difficult situations and personalities. Learn to capitalize on these strengths when selling the value of a nursing background.

While some skills are inherent to perioperative nursing, other skills are not and must be acquired. Additional education may be warranted in the form of obtaining a degree or other training. Computer literacy and expertise is a must and can also be acquired with additional training. Most positions of this nature require written reports and letters and thus keen writing skills are of the essence. Finally, in Canada particularly, being bilingual in French and English is a real plus.

The largest hurdle nurses must overcome to venture outside the doors of the operating room is having the courage to do so. The comfort of familiar environment and fear of the unknown make for a paralyzing

combination at times. A gentleman named Raymond Lindquist stated that courage is "the power to let go of the familiar." Let go of the familiar and begin to seek the unlimited opportunities available. ■

References

- ¹Beck, W.C. The surgical mask: another 'sacred cow'? *AORN Journal* 55:4 (Apr. 1992) 955-957.
- ²Hambraeus, A. Malmborg, A. "The influence of different footwear on floor contamination," *Scandinavian Journal of Infectious Diseases* 11(3)(1979) 243-246.
- ³Birenbaum, H.J.; Glorioso, L.; Rosenberger, C.; Archad, C.; Edwards, K. "Gowning on a postpartum ward fails to decrease colonization in the newborn infant." *AJDC* 144:9 (Sept. 1990) 1031-1033.
- ⁴Mailhot, C.B., Slezak, L.G., Copp, G., Binger, J.L. "Cover gowns researching their effectiveness." *AORN Journal* 46:3 (Sept. 1987) 482-490.
- Belkin, N.L. "Personal protective equipment in aseptic technique and universal precautions." *Today's O.R. Nurse* (June 1992) 15-20.
- Copp, G., Mailhot, C.B., Zalar, M., Slezak, L., Copp, A.J. "Covergowns and the control of operating room contamination." *NursingResearch* 35:5 (Sept./Oct. 1986) 263-267.
- Donowitz, L.G. "Failure of the overgown to prevent nosocomial infection in a pediatric intensive care unit." *Pediatrics* 77:1 (Jan. 1986) 35-38.
- Humphreys, H., Marshall, R.J., Ricketts, V.E., Russell, A.J., Reeves, D.S. "Theatre over-shoes do not reduce operating theatre floor bacterial counts." *The Hospital Infection Society* 17(2) (February 1991) 117-123.
- Lovitt, S.A., Nichols, R.L., Smith, J.W., Muzik, A.C., Pearce, P.F. "Isolation gowns: a false sense of security?" *American Journal of Infection Control* 20:4 (Aug. 1992) 185-190.
- Mathias, J.M. "Experts discuss merits of surgical masks." *O.R. Manager* 9:11 (Nov. 1993) 1, 8-10. 2.
- Nystrom, B. "The contamination of gowns in an intensive care unit." *Journal of Hospital Infection* 2 (1981) 167-170.
- Pelke, S., Ching, D., Easa, D., Melish, M.E. "Gowning does not affect colonization or infection rates in a neonatal intensive care unit." *Archives of Pediatric Adolescent Medicine* 148 (Oct. 1994) 1016-1020.
- Raju, T.N.K. "Gowns, caps and masks in neonatal units: are they necessary?" *The Indian Journal of Pediatrics* 55:5 (1988) 669-674.
- Ritter, M.A., Sieber, J.M., Calson, S.R. "Street shoes vs. surgical footwear in the operating room," *Infections in Surgery* (January 1984) 81-83.
- Rush, J., Fiorino-Chiovitti, R., Kaufman, K., Mitchell, A. "A randomized controlled trial of a nursery ritual: wearing cover gowns to care for healthy newborns." *Birth* 17:1 (Mar. 1990) 25-30.

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Evidence-based Practice in Perioperative Nursing: a Literature Review and Suggestions for Change

By Sara K. Smith, RN, BScN

Nursing is fundamentally caregiving, certainly the public view of nurses is that they are bedside caregivers. However, the social context of nursing is changing. Traditionally nurses have been viewed as being "practical rather than academic, subservient and, in Florence Nightingale's day, saintly, sanitary and feminine" (Hicks, 1996). Now, as education in nursing and nursing professionalism have developed there is an increasing recognition that nurses need evidence that their nursing care procedures are based on fact not tradition. Nurses need evidence that their procedures are effective and are the most appropriate, and in these days of fiscal restraint are also the most economical (Hicks, 1996).

Evidence-based practice, that is, practice that is based on objective research, is now widely recommended to the nursing profession (Barnsteiner, 1996; Beyea & Nicoll, 1997a; Hicks, 1996; Kitson et al., 1996; Cavanagh & Tross, 1996, Mottola, 1996;

Simpson, 1996; Thomas, 1996). It may seem obvious that nurses should use procedures that are well established and rational, and yet it has been identified (Hunt, 1996) that sometimes nurses do not use well established research results, and that, at the same time, nurses support practices and developments that have no sound research base or have even been shown to be detrimental to patients. This indicates that attention must be given to the knowledge gap that exists between nurses' good intentions and actual day-to-day practice (Thompson, 1996). This paper will present an overview of the research utilization process, with specific attention given to suggestions for encouraging evidence-based practice within the perioperative environment.

Role of the Perioperative Nurse

The perioperative nurse has responsibilities that have been clearly defined as those nursing duties carried out by the professional nurse in the three phases of surgical patient care: preoperative, intraoperative, and postoperative (Gillette, 1996; Von Post, 1996). The general public may still hold the image of perioperative nurses as surgical technicians or as handmaidens to surgeons, focusing on positioning, draping or prepping of the surgical patient (Gillette, 1996). Although the technical tasks are duties of the

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Abstract

Evidence-based practice (nursing practice that relies on information generated from the results of scientific research) is widely recommended as the method of nursing practice of the future. This is particularly the method of choice in perioperative nursing. In this article the literature on evidence-based practice is reviewed with particular emphasis on the role of the perioperative nurse, research utilization, and barriers to evidence-based practice. Suggestions for change to promote evidence-based practice are also outlined.

perioperative nurse there is also an extensive knowledge base required on the provision of patient-centered care as well as explicit roles and responsibilities for perioperative nurses in regard to evidence-based practice (Beyea & Nicoll, 1997a; Gillette, 1996; Simpson, 1996). Introducing "evidence-based" into practice involves new responsibilities:

1. A responsibility to improve procedures based on evidence.
2. To gather evidence by evaluating current practice and also new procedures.

Nurses, by virtue of the fact that they are doing nursing work, are in the best position to recognize nursing problems. In addition, nurses are deeply interested in solving nursing problems (Baumgart, 1996). However, there are some important elements involved in getting staff nurses to become aware of or to utilize research (Castledine, 1996). Staff nurses, such as the perioperative nurse, require a level of education (i.e. baccalaureate degree) or exposure to special training course in the understanding and application of research (i.e. a post registration course or staff development program) that teaches the nurse how to read critically and evaluate research studies (Lacey, 1996; Mottola, 1996). Often nurses at an undergraduate level are not sufficiently prepared in critiquing research reports to provide informed judgments about using research findings for nursing practice (Mottola, 1996). Armitage (1990) also found that nurses required significant preparation before they had the skills to implement evidence-based practice.

"Nursing staff still lack certain required skills before research utilization can take place. Education in these areas is of vital importance. A questioning attitude needs to be fostered, together with critical reading skills. Where there are differences of opinion, nurses sufficiently familiar with research material have the confidence to argue their point with others." (Armitage, 1990, p. 13)

Increasingly more staff nurses have gained exposure to research either through undergraduate education or through continuing education courses enabling them to translate research findings into practice protocols (Baumgart, 1996; Barnsteiner, 1996; Mottola, 1996). Most countries have implemented the initiative of "project 2000" in which the objective is to promote a higher education in nursing, and the hope is that this will introduce into the workplace scholars with a critical attitude (Baumgart 1996; Mulhall, 1997). However, there is a danger that the "research-practice gap" (Mulhall, 1997) causes nurses educated within

the university system to quickly revert to non critical and non discerning behavior once in the workplace (Mulhall, 1997). The more hopeful outlook is that as more highly educated nurses enter the workplace the gap will close and a discerning attitude will become common.

Research Utilization

Nursing research has been cited by many authors to be vital to the development of expert nursing practice as well as to the provision of quality care (Castledine, 1996; Lacey, 1996; Mottola, 1996; Thompson, 1996). Utilizing research is complex and not just a simple task, initially, the nursing unit must have a positive attitude towards research and interest from the staff (Cavanagh & Tross, 1996). A number of components are needed to establish a research-based practice within nursing care. Components described by Barnsteiner (1996) are: work settings promoting the use of knowledge, structures and systems that encourage and support nurses in accessing knowledge, and nurses who consider alternatives to current practice. Cavanagh and Tross (1996) suggest that nurses must be able to read and critique research, review and identify research in their own practice area to obtain a research knowledge base, to take that research knowledge base and create a protocol that is useable in the clinical area and to evaluate the protocol assessing whether it is being used as expected. Thompson (1996) stated that there is a significant gap, "a culture gap" (p. 191) between practicing nurses and nurses in academia and Mulhall (1997) refers to a similar gap. For example, many practicing nurses do not read academic journals (Cavanagh & Tross, 1996). This is a reason, one of perhaps many, that influences the acquisition of knowledge about research findings. Suggestions to narrow the gap between theory and practice include: time and resources to facilitate learning, access to library data bases, links to academic support, and a stronger leadership within nursing units that encourages critical appraisal, change management, and implementation of technology skills (Thompson, 1996).

Barriers to Evidence-Based Practice

For change to happen examination of the barriers inhibiting the utilization of research information in clinical practice is important. There are several barriers cited throughout the literature (Cavanagh & Tross, 1996; Hicks, 1996; Hunt, 1996; Mottola, 1996; Simpson, 1996). The barriers encompass issues including lack of available time to access the informa-

tion, lack of available research findings and lack of administrative support. Simpson (1996) groups these barriers into terms of attitudes, resources and support. Attitude includes all beliefs and assumptions nurses have about evidence-based practice, this may include the professional nurses' role and their ability to find, read and use research evidence in practice (Simpson, 1996). Resources are all those barriers that include time, availability, usefulness and access to information. This may include resources in the form of support groups, education or consultants to help nurses to improve their understanding of research material and ultimately perhaps to use the information in practice (Simpson, 1996). Lastly, support refers to the institutional and administrative cooperation to facilitate the use of evidence-based practice (Simpson, 1996). Included in this would be time needed during the working shift to implement evidence-based changes and to evaluate those changes.

Although implementing the use of evidence-based practice seems to be the preferred road to the future, one must also apply such an approach with a little caution (Newman, 1996). The results of a given piece of research cannot be assumed to be applicable across cultures or countries; some evidence may have little or no relevance to specific recipients of care (Newman, 1996). However, this does not mean that nurses should not embark on projects to utilize relevant research findings. Maintaining the status quo, continuing to implement non-researched procedures, may be a greater risk than those that may be encountered by directing good research into practice. Using poor research results or non-researched opinions is hazardous to the patient who may be subjected not only to harm but also to the loss of effective care as nurses use their energy and resources in wasteful or inefficient directions (Hunt, 1996).

The shift in practice from one that is based on tradition to one that is based on evidence is bound to be a difficult one for nursing (Simpson, 1996; Hicks, 1996). Nursing has been a profession valued for its doing rather than for knowing, for its rituals rather than for critical evaluation, and it is a fact that the majority of nurses function well without the direct and ongoing benefit of research results (Simpson, 1996). It must also be recognized that the value of evidence-based practice is a fashionable assumption. Nevertheless, it seems logical that it is better to work on the basis of evidence than on the basis of opinion.

There is also a risk that evidence-based practice will be taken over by new more fashionable trends before the nursing community has had the time to

properly establish a way of working that is evidence-based (Hunt, 1996). Hunt also stresses the need for practitioners to be able to assess the utilization and relevance of evidence-based practice, it is necessary that "we as individuals and the organizations we work in understand and overcome the barriers to research utilization so that we do not have the same barriers as we have had in the past" (Hunt, 1996).

Suggestions for Change

The following suggestions for change are developed from the literature as well as from personal involvement during a six week special studies course in perioperative nursing. The objective of all suggestions is to encourage the spirit of inquiry in nurses, and to help nurses become accustomed to thinking about health research literature and how it might be applied to their practice.

All nurses, whatever their field of specialty have a responsibility to value and recognize research. All nurses do not need to do research on a formal level; however, all nurses should be able to read and interpret relevant research concerning their area of expertise as well as to identify areas in which development or research is needed.

Nurses must be taught how to use research. Many authors have pointed out that nurses need to be taught evaluative techniques and to understand statistical treatments that are used in research reports (Beyea & Nicoll, 1997b; Cavanagh & Tross, 1996; Csokasy, 1997; Thompson, 1996). A nursing area such as the O.R. can creatively encourage such an educational milieu by implementing a few innovations. A number of innovations have been documented to lead to positive changes in knowledge and nursing practice (Barnsteiner, 1996; Cavanagh & Tross 1996; Csokasy, 1997; Mottola, 1996) these are:

1. A journal club or seminar series.
2. Research newsletters.
3. A research bulletin board.
4. Nursing administration and clinical nurse specialist support in the areas 1-3 above.
5. Access to the Internet, especially to online journals such as The Online Journal of Knowledge Synthesis for Nursing published by Sigma Theta Tau International.

Journal clubs create an arena for reading, discussion, critiquing and exploration of research publications. This is important since the first step to translating research knowledge into practice is learning how to read research reports (Beyea & Nicoll, 1997b). The

weekly inservice meetings at the University of Alberta Hospital for example are very well attended by the O.R. staff; such a forum as this is an excellent opportunity to allow staff to read research articles. For example, a 20 minute presentation of relevant topics from research publications with a 10 minute discussion can be presented by nurses on a rotation basis.

An accurate and informed interpretation of research reports is essential; to achieve this, access to experts to assist with the reading and the critique of health literature would be useful. Expert opinions may be obtained from an advanced practice nurse or a clinical nurse educator, or through partnering with local faculty (Barnsteiner, 1996; Csokasy, 1997; Mottola, 1996).

Most nursing units have computers, but there is no access to the Internet. Internet connection would allow online journals to be read, and searches to be made of the journals available on any data base. Access to the Internet at the nursing unit would also allow nurses to use features such as *Listservs* which allow one to pose practice questions and offer information on new nursing practices (Barnsteiner, 1996).

Conclusion

In a fiscal climate of severe restraint and downsizing it is important that nursing adopts practices that are efficient and based on evidence. There is no area of nursing in which this is more important than in the O.R. If the perioperative nurse cannot work at the evidence-based level then she/he may well be replaced by single-function technicians. It is to be hoped that the suggestions for encouraging evidence-based practice will advance perioperative nursing.

Acknowledgment

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References

- Armitage, S. (1990). Research Utilization in Practice. *Nurse Education Today*. 10(1), 10-15.
- Barnsteiner, J. H. (1996). Research-based practice. *Nursing Administration Quarterly*. 20(4), 52-58.
- Baumgart, A. J. (1996). Promoting nursing practice

through research. *International Nursing Review*. 43(2), 45-48, 57.

- Beyea, S. C. & Nicoll, L. H. (1997a). Research-based practice provides the foundation for perioperative nursing's preferred future. *AORN Journal*. 65(1), 118-119.
- Beyea, S. C. & Nicoll, L. H. (1997b). Research utilization begins with learning to read research reports. *AORN Journal*. 65(2), 402-403.
- Castledine, G. (1996). All nurses are responsible for implementing research. *British Journal of Nursing*. 5(12), 764.
- Cavanagh, S. J. & Tross G. (1996). Utilizing research findings in nursing: policy and practice considerations. *Journal of Advanced Nursing*. 24(5), 1083-1088.
- Csokasy, J. A. (1997). Building of perioperative nursing research teams part 1. *AORN Journal*. 65(2), 396-401.
- Hicks, C. (1997). The dilemma of incorporating research into clinical practice. *British Journal of Nursing*. 6(9), 511-515.
- Hunt, J. M. (1996). Barriers to research utilization. *Journal of Advanced Nursing*. 23(3), 423-425.
- Gillette, V. A. (1996). Applying nursing theory to perioperative nursing practice. *AORN Journal*. 64(2), 261-268.
- Kitson, A., Ahmed, L. B., Harvey, G., Seers, K. & Thompson, D. (1996). From research to practice: One organizational model for promoting research-based practice. *Journal of Advanced Nursing*. 23(3), 430-440.
- Lacey, E. A. (1996). Facilitating research-based practice by educational intervention. *Nurse Education Today* 16(4), 296-301.
- Mottola, C. A. (1996). Research utilization and the continuing/staff development educator. *The Journal of Continuing Education in Nursing* 27(4), 168-175.
- Mulhall, A. (1997). Nursing research: Our world not theirs? *Journal of Advanced Nursing* 25(4), 969-976.
- Newman, N. (1996). Evidence-based practice: Apply with a little caution. *Australian Journal of Advanced Nursing* 14(2), 4.
- Simpson, B. (1996). Evidence-based nursing practice: The state of the art. *Canadian Nurse* 92(10), 22-25.
- Thompson, D. (1996). Getting research into practice. *Intensive and Critical Care Nursing*. 12(4), 191-192.
- Thomas, B. (1996). Appliance of Science. *Nursing Times* 92(8), 69.
- Von Post, I. (1996). Exploring ethical dilemmas in perioperative nursing practice through critical incidents. *Nursing Ethics*. 3(3), 236-249.

Orderlies and Aides Merging into O.R. Attendants

By Susan Carver, RN, CPN(C)

In the 80's we saw the beginning of new technology in anesthesia and surgical techniques in the Operating Room. The Canadian Anaesthetic Society (CAS) has set high standards for noninvasive monitoring of the anesthetized patient for safe anesthesia. The new drugs used during anesthesia have the ability to provide excellent pain control with shorter recovery time both in the post anesthetic care unit and at home. In surgery, laparoscopic techniques have also decreased the time spent in the recovery phase post operatively.

The Pre-op Clinic has reduced stress for patients coming to the OR by streamlining their preparation

Abstract

It was always my belief that perioperative nurses should be in the operating room performing nursing duties, not in the role of cleaning instruments and picking tables. New technology introduced over the past decade required longer schedules for nurses and the introduction of additional support staff. Because of the longer schedules, it became more cost effective to hire support staff to assist nurses in non-nursing functions. Recently, I was involved in a program which reorganized one aspect of our OR department and merged two existing support positions into one.

Using ORNAC standards, CAS standards and CSS standards, I accepted the challenge of organizing the supplies of the department, merging orderlies and aides into one support group, training and documenting the important assignments given to this group and orienting staff to this new role.

time for surgery, allowing the Day Surgery Unit to admit and have them available for their surgery time within minutes of arriving at the hospital.

Post Anesthetic time has also been reduced, and all these new developments have been very beneficial for the patient, who is our primary concern, regardless of how it has affected the OR environment and staff.

Our elective list reached its maximum with all these advances in place, and we've had to look closely at our limitations and how to improve our situation.

In the past, during our elective schedule, nurses picked tables, processed instruments, cleaned rooms, and ordered supplies. Support staff worked only Monday to Friday, and only from 0700 to 1500hrs.

Monitors, televisions, microscopes, and lasers are quickly occupying valuable space. Operating rooms built in the fifties have run out of space in the nineties, (our OR was built in 1957). Also, a department called Biomedical Engineering has become very important to us, since our old wrench won't fix today's complex problems.

With each new procedure comes more equipment and intricate instrumentation. We have been bombarded with all of this, and when one looks around, one wonders when it all started and where it all came from. We've been so busy learning about the various new technologies, we didn't see the overall massiveness of it sneaking up on us.

We can now see how new technology has affected

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our OR environment. It has increased the volume of cases, limited our space, demanded more knowledge of equipment and instrumentation, and has given more responsibility to support staff.

Nurses are now working in the rooms and are unable to fill in those places where support staff can be more beneficial and cost effective. We have found it necessary to hire more support staff and to evaluate their job descriptions.

In the 80's, the support staff consisted of orderlies and aides. Orderlies were responsible for cleaning rooms and anesthetic equipment, stocking of supplies, and setting up rooms. Aides were responsible for cleaning instruments, picking tables and stocking supplies. Both groups were basically doing the same job, caring for the OR environment, and yet their responsibilities were never amalgamated. These two groups have now been merged to become known as *OR attendants*.

Functions of the OR Attendant

The OR attendant working in the operating room of the 90's does more than wash instruments and clean floors. This position has progressed into a highly technical area of expertise, caring for and handling very expensive instrumentation, storing and cleaning equipment such as televisions and microscopes, and the carts that house them, the care and handling of anesthetic equipment, restocking supplies, decontamination, disinfecting, and sterilization. The attendant is responsible for making sure that instruments and equipment in his/her care meet with certain standards, and therefore every individual should be oriented to all current and new components. The OR attendant is also responsible for maintenance of a safe, clean environment for themselves and their clients.

In certain procedures they will assist in the transfer and positioning of patients, under direct supervision of a Registered Nurse or Physician. There is a great need for flexibility, team work and good communication skills in order to make everchanging times and events flow with as little disruption as possible in routines of the department.

In June of '95, the timing was right for our department to define the role of OR attendants. Physical restructuring of the patient holding area and sterile supply room had relocated supplies and equipment. There was apparent need for staff documentation of traditional daily tasks. New technology demanded some training guidelines. We also needed at that time to question how well our cleaning methods were working, because we were developing a

serious problem with rust on our instruments.

OR Attendants are responsible for the operating room environment. The overall list of tasks performed by this group is quite lengthy, therefore I will condense the job descriptions into the main areas of shift-related responsibilities, thus demonstrating that all the tasks were non-nursing functions.

We learned together and taught each other as we went through the learning process for the new role. Today the position is still evolving with the involvement of the CSS.

Two attendants arrive early, obtaining the charge nurse's schedule for the day with the room assignments. The attendants have been taught room set-up for Malignant Hyperthermia, Laser, Cat Scan, Latex Allergy, ENT, Plastics, Dental, Gynecology, General surgery, Vascular, Orthopedics, Ophthalmology, and Urology. The first table is checked for supplies and is left in the room. One attendant is designated to two rooms and is responsible to the nurses in these rooms for equipment, change-over and supplies. They also attend report.

The decontamination room attendant's duties include cleaning instruments in the department as well as sending anesthetic supplies to CSS for pasteurization. Large items such as basins and orthopedic implant instrumentation pans are also rinsed off and sent to CSS for further cleaning and sterilization. The attendants have been instructed on how to protect themselves while in the decontamination room and on the importance of removing bioburden from the instruments.

Two relief attendants care for the sterile supply area where the trays are processed. An instrument book with pictures and familiar names has been successful in the training of organizing the basic instrument sets. These attendants are also responsible for ensuring a stretcher, ICU bed or ward bed is outside the room for the case that is in progress, and that missing supplies from the pick sheets are put on the next table.

An evening attendant is responsible for picking the next day's tables and assuming the duties of the other attendants as they leave for the day. This attendant also assists PACU staff with their transfers back to the patient's floor.

Attendants are required to take the CSS course as well as all hospital mandatory reviews.

As a resource person, I became an OR attendant for several months. Slowly and deliberately, we examined storage areas for convenience and availability of supplies. Any instrument that could not be sal-

vaged or that had not been used in a number of years was disposed of appropriately. We tried to simplify storage and then we labelled, labelled, labelled.

New easy-access plastic storage bins replaced old cardboard boxes. To increase floor space, an unused scrub sink was removed, and peg boards were hung for additional storage space on the available wall space.

We tried to keep change-over time simple by having attendants remove dirty items used for the previous case. Nurses would replace these with clean items for the following case. This is where flexibility and communication became important.

We catalogued instrument trays with pictures and names familiar to our staff. Another book was started to document tasks assigned to each shift, because the staff eventually grew in number and worked extended hours during the week and on the weekends.

An orientation program was prepared emphasizing "on the job training," for as we trained the new staff, we too were learning how to work together, combining these two positions. All of us were assimilating our new responsibilities as a team.

Computer print out sheets for pick lists have

now invaded our domain. These have facilitated supply/case match-ups. However, one still has to learn the language.

Ongoing in the process is a basic "how to" book, as well as updating computer print out sheets, meetings and questionnaires that confirm we are indeed all learning the same things together.

There was total cooperation and participation between the attendants and nursing staff for this process to have happened. Enhanced communication skills and good team work were also part of the success. It was definitely not an easy year, and at times it was very stressful for everyone in the department. Empowerment to change our environment to suit our needs certainly made it worthwhile. To be responsible for the changes certainly gives staff a feeling of ownership of the daily routine in their work environment.

In less than six months we had become more comfortable with the position of OR attendant. The process of teaching and learning has been exceptional, and we have all developed an overall sense of teamwork.

OR attendants are a terrific group of caring individuals, and I applaud them for what they have accomplished so far. Their future can only continue to improve for them and their clients. ■

Cervical Plexus Block for Carotid Endarterectomy: A Nursing Care Plan

By S. June Hill, RN, CPN(C)

Recent interest in cervical plexus block (CPB) used for carotid endarterectomy surgery has become "the topic of conversation" at St. Boniface General Hospital (SBGH), in Winnipeg, Manitoba. No longer are the rhythm of the respirator and beat of the monitors the only sounds heard in the theater during this major surgery. As the surgeon applies the carotid cross clamp, what appears to be a casual social conversation ranging from grandchildren to gardening is actually an intraoperative assessment tool for monitoring changes in patient speech pattern or neurological status.

Historical

Traditionally at SBGH, carotid endarterectomies were performed only under general anesthesia. Late in 1996, SBGH anesthetist Dr. Matthew Cohen, incorporated use of the cervical plexus block technique which he acquired while training under Dr. Matthew Posner & Dr. Patrick Sullivan at Ottawa Civic Hospital. Shortly after, other SBGH anesthetists also began providing this alternative anesthetic method for the carotid patient.

The use of local or regional cervical block is not a new concept in vascular surgery. The first carotid endarterectomy was performed by DeBakey in 1953, under local anesthetic. (Shah et al., 1994). The use of cervical plexus block was first performed by Halstead in 1884 at Bellevue; however, it was Labat who popularized the technique in America. Within the past decade, the popularity of CPB has reemerged as regional techniques provide the optimal method for monitoring continuous cerebral function during carotid endarterectomy surgery (Masters, Castresana, & Castresana, 1995).

Advantages/Disadvantages

Traditionally, general anesthesia for carotid endarterectomy has been advocated for its cerebral protective effects with the use of selected anesthetic agents. However, general anesthetics may imply a greater

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Abstract

Historically, carotid surgery is identified in the operating room as a major surgical procedure. Although the surgical intervention remains the same, a regional anesthetic technique calls upon perioperative nurses to utilize their assessment and planning skills astutely preparing innovative nursing interventions that enable successful patient outcomes.

The key to a successful nursing care plan for a carotid endarterectomy performed under cervical plexus block is an awareness of the patient's physiological needs as well as the environmental influences they may be experiencing.

As the administration of regional anesthesia for major surgery become more prevalent, there is a resurgent demand for traditional holistic nursing interventions in the operating room. The perioperative nurse must couple technical expertise with intuitive assessment skills and administration of compassionate nursing care.

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perioperative blood pressure lability and longer surgical intensive care unit stay postoperatively. (Ombrellaro, Freeman, Stevens, Goldman, 1996).

The ability to monitor the intraoperative neurological status of the patient undergoing carotid endarterectomy is the major advantage to using the regional block. There is a potential for decreased need of shunt insertion which in itself potentiates the risk of thrombus or air embolism related stroke. (Wilke, Ellis, McKinsey, 1996). Reduced need for postoperative ICU invasive monitoring contributes to a shorter hospital stay associated with use of regional anesthesia. Patients undergoing carotid endarterectomy at St. Boniface General Hospital are now considered for "Assess in Recovery Room" status as an alternative to routine Surgical Intensive Care Unit admission. Thus, patients may be discharged earlier providing potential hospital utilization savings.

Anatomy of the Cervical Plexus

The cervical plexus is formed from the first four cervical spinal nerves, C-1 through C4. The first cervical nerve is considered to have no sensory components and only minor motor components. The spinal nerves emerge from the intervertebral foramina and pass posterior to the vertebral artery and vein in the gutter formed by the anterior and posterior tubercles of the corresponding transverse process of the cervical vertebrae (Figure 1). All but C-1 divide into ascending and descending branches that form a pattern of three loops, hence, the plexus formation (Masters, Castresana, & Castresana, 1995). Cranial nerves X, XI, and XII communicate with the vagus (C1, C2), the hypoglossal (C1, C2) and the accessory (C2, C3, C4) nerves, thus explaining potential side effects from the cervical block technique. Deep branches of the cervical plexus provide motor innervation to muscles of the neck, including the phrenic nerve (C3, C4, C5).

Superficial structures to be cognizant of include the external jugular vein, which crosses the supraclavicular muscle at approximately the C4 level.

Method of Administration

Approximately ninety minutes prior to surgery, patients should have a topical anesthetic cream (EMLA® 50 grams) applied generously to the surgical site. Protected by a clear occlusive dressing, the cream will provide analgesia to a depth of 3 - 5 mm (Figure 2). This provides comfort during needle placement for local injection and during initial incision

(Sullivan, Posner, 1995). In the operating room theater the clear dressing is removed immediately prior to block insertion.

A sterile regional administration setup with control syringe and three 22 gauge regional needles are required. Warmed prep solution is applied to a wide area encompassing the operative site. Using palpation of landmarks with the patient's head turned away from the side to be blocked, the anesthetist marks neck areas corresponding to transverse processes of C2 to C4.

In the deep cervical plexus block, the nerve roots are anesthetized at a point before the motor and sensory nerves separate. This provides anesthetic to the muscles corresponding to the cervical vertebrae and transverse processes of C-2, C-3, and C-4, allowing deep block for surgical retraction.

The deep block is performed prior to the superficial block so as not to distort the surface anatomical landmarks thus creating difficulty with initial needle positioning.

The first regional needle is inserted at C4, followed by C3 then C2, using C4 as guide placement (Figure 3). With all three needles in position, 8 ml of 0.375% Bupivacaine with 1:200,000 epinephrine is first injected at C2, as this is the most difficult site to establish. This procedure is repeated for the C3 then C4 sites, removing each needle individually after injection.

A superficial cervical plexus block is used to supplement the deep block. Cephalad and caudal infiltrations are performed along the posterior border of the sternocleidomastoid muscle (Figure 4). Local anesthetic is also infiltrated directly into the sternocleidomastoid muscle to facilitate analgesia during muscle retraction. (Figure 5)

Supplemental local infiltration of Xylocaine 1% plain is injected intraoperatively at the carotid bulb (Figure 6) prior to surgical manipulation as nausea, bradycardia and hypotension may occur when the carotid sinus is manipulated. (Sullivan, Posner, 1995)

Potential Complications

Syringe aspiration is performed prior to each injection to ascertain the needle is not intraarterial (vertebral artery) or intrathecal (spinal). Anesthetizing the phrenic nerve results in temporary paralysis of the ipsilateral diaphragm (Sullivan, Posner, 1995). This may be a concern in patients with severe lung disease or contralateral phrenic nerve palsy. Hoarseness (temporary recurrent laryngeal nerve palsy) may develop from local anesthetic injected too anteriorly,

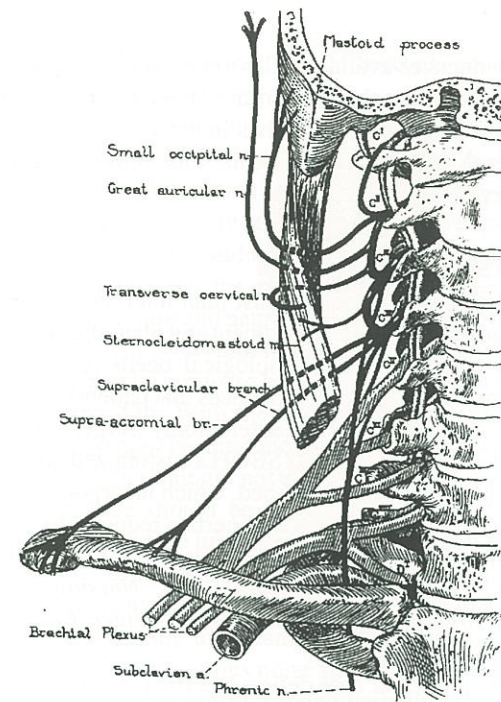


Fig. 1. Semischematic representation of the cervical plexus and phrenic nerve shown in relation to the transverse processes which are threaded by the vertebral blood vessels. Note: From "Blocking of Spinal Nerves" by John Adrian, MD, 1985, *Labat's Regional Anesthesia Techniques and Clinical Applications*, p 246. Copyright 1985 by Warren N. Green, Inc. Reprinted with permission.

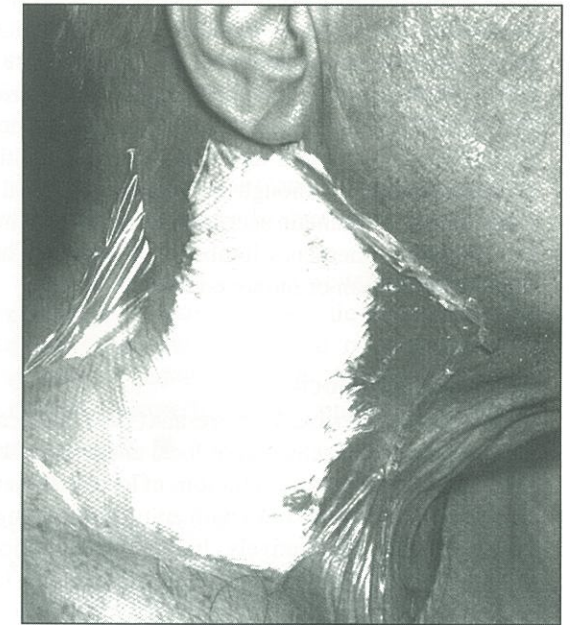


Fig. 2 EMLA® Cream application preoperatively. Figures 2 to 7 are Reprinted with Permission from "Cervical Plexus Block for Carotid Endarterectomy," P. Sullivan, MD, M. Posner, MD, Editors, University of Ottawa, 1995.

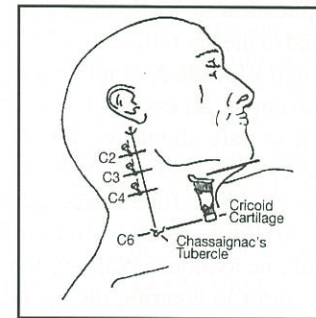


Fig. 3. Needle Placement

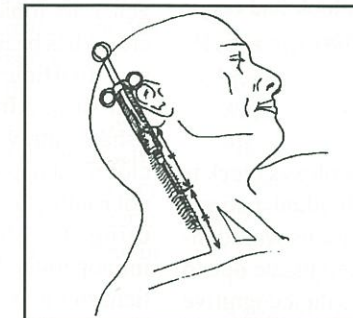


Fig. 4. Superficial Infiltration

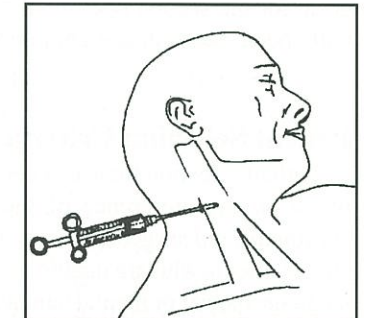


Fig. 5. Injection into the Sternocleidomastoid Muscle

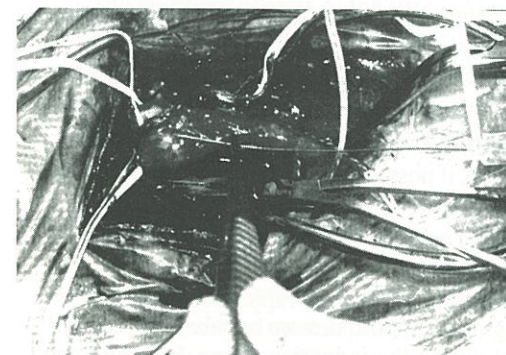


Fig. 6. Intraoperative carotid sinus nerve block at carotid bulb.

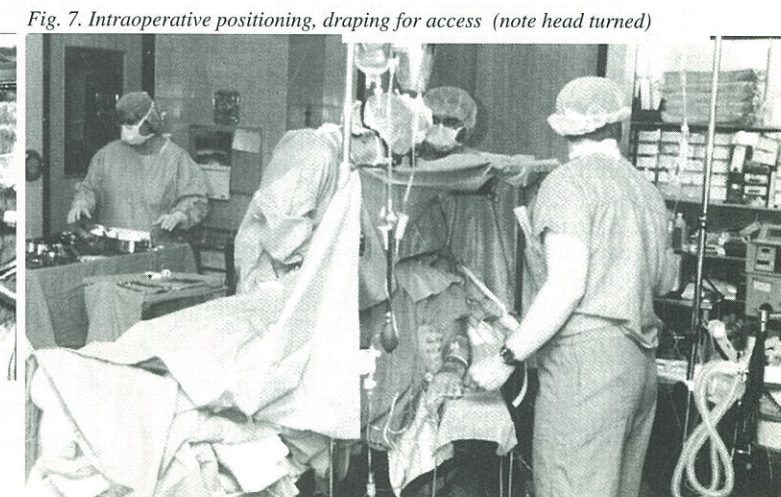


Fig. 7. Intraoperative positioning, draping for access (note head turned)

or as a result of retractor pressure during surgical dissection. This would be a concern in patients with a contralateral recurrent laryngeal nerve palsy. Care is taken not to inject the external jugular vein during superficial block as seizures or loss of consciousness occur from intravascular injection of large quantities of local anesthetic. Although uncommonly required, it is imperative to maintain accessibility to the patient's airway should emergency intubation be required during block insertion or intraoperatively.

Duration of Block

Masters, Castresana & Castresana (1995) advocate two alternatives to selection of local anesthetic used. One choice is lower concentrations of local anesthetic (Lidocaine or Bupivacaine) with epinephrine using a larger volume. Alternatively, higher concentrations with lower volume without use of epinephrine. The addition of epinephrine prolongs the block and allows lower concentrations of local anesthetic to be used.

Duration of block averages four to six hours. Sullivan and Posner, (1995), report reexploration of the wound for a hematoma which developed in the postoperative period, using only supplemental analgesic for the second operation. The block had originally been established eight hours prior.

Patient Selection Criteria

Patient selection for use of cervical plexus block is based on the preference of the individual patient, anesthesiologist and surgeon. Contraindications would include patients who are unable to communicate due to language barrier or mental handicap as their cognitive function would be difficult to assess intraoperatively. Generally, patients on antidepressants require monitoring for post anesthetic disorientation.

Physiologically unsuitable candidates include patients with obesity, respiratory disease, or difficult airway access due to potential for respiratory compromise. Difficulty land marking, rapid desaturation and inability to lie flat contribute to life threatening complications which could preclude use of regional block. Skin infection at the operative site or allergy to local anesthetic also constitutes a contraindication (Sullivan, Posner, 1995).

Cervical plexus block provides an alternative for patients with concurrent carotid and coronary artery disease. For patients with both unstable carotid stenosis and unstable ischemic heart disease, Wilke, Ellis & McKinsey, (1996), mention alternative surgi-

cal sequences available. Carotid endarterectomy under cervical block with coronary revascularization to follow avoids the negative inotropic effects of a general anesthetic in patients with limited cardiac reserves.

Nursing Implications

Perioperative nurses must plan interventions that utilize their intuitive assessment and planning skills to meet their patients physiological needs as well as control environmental influences that patients experience during carotid endarterectomy surgery under cervical plexus block. At SBGH a customized nursing care plan has been developed, which incorporates the compassion and technical expertise required to meet the specific needs of patients undergoing carotid surgery by cervical block. (See - *O.R. Nursing Care Plan for Carotid Endarterectomy under Cervical Plexus Block*).

Six phases of care define specific patient needs:

1. Pre-Op: During first contact with the patient, neurologic status should be assessed to have a baseline reference before cross clamp. At this time, reassurance and emotional support should be developed, to alleviate potential patient anxiety. Assurance that a generous topical application of EMLA® anesthetic cream has been applied to the operative site within the specified time frame will alleviate discomfort at injection sites. After intravenous access has been established, intravenous flow rate should be monitored closely at approximately 30 cc per hour. As a Foley is not routinely inserted, excessive fluid intake contributing to bladder distention and discomfort intraoperatively should be avoided. Walking the patient to the bathroom prior to entering the operating room is feasible as pre-op sedatives are not routinely ordered.

2. Establishing the OR Environment: Priorities are temperature and noise control. A warm operating room provides comfort for the apprehensive patient. A calm, unrushed atmosphere should prevail. It is desirable for the circulating nurse to provide the patient with uninterrupted attention during the induction process; therefore, if possible the scrub nurse should be set up prior to patient entry to the operating room. This allows time to comfort the patient and provide a calm relaxed atmosphere.

3. Induction: With good rapport established, the circulating nurse should devote her attention toward the patient during the induction phase. Ensuring patient comfort and providing assistance to the anesthesiologist by maintaining patient's position and administering

narcotic or antihypertensives as directed, assists in expediting the induction process.

4. Draping: Draping should be adapted so that towels do not cover the patient's face. A small laparotomy sheet tented over a raised mayo stand which is taped securely at its base, provides exposure of the patient's face and torso. The anesthesiologist should have total view of the patient's body to facilitate monitoring motor and neurologic functions during the procedure (Figure 7). Suction tubing should be strategically placed so as **not** to be within the patient's view.

5. Intra-Op: With the procedure under way, the patient's senses become more acute as they lay motionless. As a reminder not to turn their head, a safety strap or tape should be secured over the patient's forehead with face turned toward the anesthesiologist, facing opposite to surgical side. Under the drapes and lights, the patient may become very warm therefore room temperature and blankets should be regulated accordingly. Extraneous noise should be limited. Encouraging the patient to respond verbally provides a valuable tool to assess for slurred speech and impaired cognitive function due to decreased intraoperative cerebral perfusion. Placing "Patient is Awake" signs on the operating room doors inform theater traffic of patient status. Supplies for shunt insertion should be immediately available pending patient manifestations of neurological deficits during cross clamp.

6. Post-Op: Upon completion of the procedure, care should be taken to turn off the operative lights prior to removing the drapes as lights will be directly facing the patient's face. Report to the Recovery Room (or SICU) should include a neurologic status report, conveying the patient's status as "awake and in control of all body functions".

Conclusion

The technical aspects of the surgical procedure do not require modification. An intraarterial monitor is still established upon entry to the operating room. Instrumentation requirements and sequence of surgical events proceeds as documented for removal of carotid artery debris.

On average, the actual operative time has decreased and patients are routinely being transferred to Recovery Room rather than Surgical Intensive Care Unit. Patients are transferred to the ward earlier and regain their independence more rapidly.

Familiarity and confidence with the cervical plexus block technique provides an exciting alternative to carotid endarterectomy surgical management by a co-

ordinated interdisciplinary perioperative team. The anesthesiologist, who adeptly administers regional anesthetics has an ongoing assessment of the adequacy of cerebral perfusion. The surgeon, lowers patient risks and decreases case cost by not routinely using a shunt. The nurse provides holistic perioperative patient care. Together the team delivers a progressive alternative to carotid endarterectomy surgical management.

At St. Boniface General Hospital, use of cervical plexus block as choice of anesthetic for carotid endarterectomy, provides renewed opportunities for perioperative nurses to couple their compassionate and technical expertise to accomplish successful patient outcomes. ■

Acknowledgements

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References

- Adriani, J., (1985). Blocking of spinal nerves. *Labat's Regional Anesthesia Techniques and Clinical Applications* (4th ed.). St. Louis, MO: Warren H. Green, Inc.
- Masters, R.D., Castresana, E.J., Castresana, M.R. (1995). Superficial and deep cervical plexus block: Technical considerations. *Journal of the American Association of Nurse Anesthetists* 63 (3), 235-243.
- Ombrellaro, M.P., Freeman, M.B., Stevens, S.L., Goldman, M.H. (1996). Effects of Anesthetic Technique on Cardiac Morbidity Following Carotid Artery Surgery. *The American Journal of Surgery*. 171. 387-390.
- Shah, D., Darling III, C., Chang, B., Bock, D., Paty, P., & Leather, R. (1994). Carotid endarterectomy in awake patients: Its safety, acceptability, and outcome. *Journal of Vascular Surgery*. 19 (6), 1015-1020.
- Sullivan, P., Posner M. (Eds.), (1995). *Cervical Plexus Block for Carotid Endarterectomy*. University of Ottawa. [educational manual] 1 -15.
- Wilke, H.J., Ellis, J.E., McKinsey, J.F. (1996). Carotid Endarterectomy: Perioperative and Anesthetic Considerations. *Journal of Cardiothoracic and Vascular Anesthesia*. 10 (7), 928-949

O.R. Nursing Care Plan for Cervical Plexus Block for Carotid Endarterectomy

Problem	Expected Outcome	Nursing Actions
<p>#1 FEAR, ANXIETY:</p> <p>Related to: - conscious awareness of surgical procedure being performed - powerlessness over loss of control</p>	<p>PATIENT WILL:</p> <p>- cooperate with regional induction process - experience minimal apprehension and fear - be able to verbalize fears</p>	<ol style="list-style-type: none"> 1. Remain with patient throughout induction and be available intraop 2. Explain all procedures prior to their initiation 3. Verbal and nonverbal communication during induction: -soft voice; gentle touch; hold patient's hand 4. Monitor room noise: -"PATIENT IS AWAKE" sign on doors - Limit room traffic only to staff involved - Soft music in background - incidental noise kept to minimum (trays/pkges opened quietly) 5. Have scrub nurse set up prior to patient entering room, so you can give full attention to the patient 6. Arrange pre-op visit where applicable
<p>#2 PAIN:</p> <p>Potential pain related to: - several injections during regional induction - intraop deep manipulation</p>	<p>PATIENT WILL:</p> <p>- not express pain - will remain calm and cooperative</p>	<ol style="list-style-type: none"> 1. Stay with patient providing emotional comfort and support during induction 2. Check time EMLA cream applied to surgical site (1 1/2 to 2 hrs preop) 3. Be prepared to administer analgesic as required while anesthetist inserting block 4. Ensure local anesthetic is available on surgical field intraop. 1% Lidocaine plain 5. Pre-op ward nurse teaching re: timing and amount of EMLA application
<p>#3 SKIN INTEGRITY:</p> <p>Potential for impairment of skin integrity: related to: - immobility intraop</p>	<p>PATIENT WILL:</p> <p>- not express discomfort of pressure points - will not be restless intraop</p>	<ol style="list-style-type: none"> 1. Pillow under patient's knees intraop 2. Confirm with patient if tucked arm on operative side is padded comfortably 3. Pad arm rest on non operative side 4. Prewarmed gel pads on O.R. bed 5. Pad gel roll beneath shoulders 6. Ensure tape across forehead is not pulling hair or skin
<p>#4 SENSORY INPUT</p> <p>Potential for patient to experience unpleasant sensory input: related to: Claustrophobia, weight of surgical drapes, face covered.</p>	<p>PATIENT WILL:</p> <p>- communicate in calm, cooperative manner intraop -patient's view will not be exposed to unpleasant stimuli</p>	<ol style="list-style-type: none"> 1. Inform patient when drapes will be applied 2. Use elevated mayo stand to keep drapes off patient's face (Tape stand securely at base so it will not slide down onto patient) 3. Fold face towel in 1/4 when draping 4. Direct suction tubing away from patient's view 5. Turn O.R. lights off prior to removing drapes
<p>#5 TEMPERATURE</p> <p>Potential for fluctuations of patient comfort temperature: related to: INDUCTION: cool environment INTRAOP: heavy blankets, warm OR lights</p>	<p>PATIENT'S TEMPERATURE WILL: - core body temperature will remain between 36.5 to 37degrees.</p>	<p>DURING INDUCTION: 1. Warm room to 23 degrees 2. Warm gel pads on bed 3. Cover patient with warm blankets upon entering O.R. PRE & INTRAOP: 1. Prewarm prep solution (no more than 30 minutes.) 2. Inform patient re: coolness when applying cautery pad 3. Remove warm blankets prior to prep 4. Place a single light sheet on patient during prep 5. Lower room temperature intraoperatively</p>
<p>#6 FLUID BALANCE</p> <p>Potential for fluctuations of fluid balance related to: - intra op IV fluid replacement, - usually no indwelling urinary drainage catheter intraop</p>	<p>PATIENT'S FLUID:</p> <p>- volume will be maintained - patient will not complain of bladder discomfort intraop</p>	<ol style="list-style-type: none"> 1. Ensure patient does not receive excessive IV fluids pre-op 2. Ensure patient voids prior to entering O.R theater
<p>#7 NEUROLOGICAL DEFICIT</p> <p>Potential for neurological deficit intraop related to: - cross clamp of carotid</p>	<p>PATIENT WILL - be alert, fully oriented and moving all limbs purposefully post op - will not require shunt placement intraop</p>	<ol style="list-style-type: none"> 1. Obtain accurate baseline neuro assessment preop 2. Position O.R bed so anesthetist has full view of patient's body intraop (to assess motor function) 3. Assure room is quiet during cross clamp time, to be able to identify impending neurological deficits (assess patient's cognitive function and note slurred or incoherent speech) 4. Initiate clock counter when clamp is applied to record length of cross clamp of carotid 5. Have shunt supplies ready if complications develop. Open them if patient is high risk
<p>#8 NURSING ACTIVITY</p> <p>Potential for knowledge deficit of nursing activities related to: - new method of anesthetic technique for carotid surgery</p>	<p>NURSES WILL</p> <p>- apply appropriate amount of EMLA cream at correct timing - nursing activities will be organized during procedure - smooth transfer of nursing care to Recovery Room or SICU team</p>	<ol style="list-style-type: none"> 1. Teach ward nurses rationale for timing and amount of EMLA cream to apply 2. Provide thorough reports to Recovery Room (or SICU) nurses, including: <ol style="list-style-type: none"> a. That surgery was done under regional block b. That patient is awake c. Neuro status of patient pre & post op d. Vascular access lines (IV and arterial line) e. That patient may not necessarily have a Foley catheter f. Hemovac drainage system

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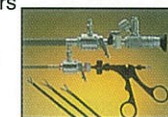
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The French Patient

By Wendy Walsh, RN & Joyce Landry, RN

This article was originally a booklet, a working tool formatted for easy use as a reference for communication with the French patient in the Operating Room. Most questions are posed for a "yes" or "no" response, with juxtaposed English/French translations.

In English, there are many different ways to make statements or ask questions. The questions are de-

signed to have words used that are similar to English and French; to "mimic" each other. The additional list of words are included to assist when asking the questions.

This article was originally published to assist French speaking patients from St. Pierre Miquelon in the operating room.

Suggestions:

The following phrases could be included with your introduction to the patient.

- | | |
|--|--|
| 1. Je parle un peu français. | 1. I speak a little french. |
| 2. Si vous parlez lentement, je peux mieux comprendre. | 2. If you speak slowly I'll understand better. |
| 3. Répondez aux questions par "oui" ou "non" si possible. Ça sera plus facile de comprendre. | 3. Answer questions by simply "yes" or "no" if possible. That will make it easier to understand. |

Patient Waiting Area

French

1. Je m'appelle _____.
2. Je suis une infirmière (ou un infirmier).
3. Comment vous appelez-vous? ou Quel est votre nom, s'il vous plaît?
4. Avez-vous assez chaud? ou: Avez-vous froid?
5. Je vais vous poser des questions.
6. Répondez aux questions par oui ou non, s'il vous plaît.
7. Est-ce que je peux regarder votre bracelet d'identification, s'il vous plaît?
8. Avez-vous mangé ou bu quelque chose depuis minuit hier soir?
9. Mâchez-vous de la gomme?

English

1. My name is _____.
2. I am a nurse.
3. What is your name, please?
4. Are you warm enough? or Are you cold?
5. I am going to ask you some questions.
6. Please answer the questions with yes or no.
7. May I look at your arm band, please?
8. Have you had anything to eat or drink since midnight last night?
9. Are you chewing gum?

Authors

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Acknowledgement

For translation and preparation of the original booklet, thanks to Joyce Landry and Sharon Dominic.

French

10. Avez vous des allergies : a) a nourriture? b) aux médicaments? c) au latex / au caoutchouc?
11. Portez-vous des dentiers?
12. Avez-vous des couronnes sur les dents?
13. Avez-vous des dents qui branlent? ou Avez-vous des dents qui bougent?
14. Portez-vous des bijoux?
15. Portez-vous des verres de contact? ou des audiophones (prothèses auditives)? ou des sous-vêtements?
16. Quelle opération subissez-vous?
A) Montrez-moi l'endroit où vous allez avoir votre opération? (Optionnel) B) Le côté droit ou le côté gauche? (Optionnel)
17. Qui est votre chirurgien?
18. Avez-vous des questions?

1. Avez-vous parfois des brûlures d'estomac?
2. Est-ce que vous fumez?
3. Souffrez-vous du diabète?
4. Est-ce que vous régurgitez votre nourriture?

English

10. Do you have any allergies :
a) to any food? b) to any medications?
c) to latex / rubber?
11. Are you wearing false teeth?
12. Do you have any caps on your teeth?
13. Do you have any loose teeth?
14. Are you wearing any jewellery?
15. Are you wearing any contact lenses or hearing aids or underwear?
16. Do you know what operation you are having done?
A) Point to that area on your body?
B) The right side or the left side?
17. Who is your surgeon?
18. Do you have any questions?

1. Do you ever have any heartburn?
2. Do you smoke?
3. Do you have diabetes?
4. Do you regurgitate your food?

Patient Nurse

1. Je m'appelle _____.
2. Comment vous appelez-vous?
3. Je suis votre infirmière (ou infirmier).
4. Nous allons maintenant dans la salle d'opération.
5. Il y a deux autres infirmières dans la salle.
6. Je vais vous mettre des draps chauds.
7. Pouvez-vous bouger vers l'autre lit, s'il vous plaît?
8. Mettez vos bras proches de chaque côté et placez-vous au milieu du lit.
9. Je vais placer une ceinture de sécurité au-dessus de vos jambes.
10. Je vais placer des électrodes de surveillance cardiaque sur votre poitrine.
11. Je vais mettre un appareil de tension artérielle sur votre bras.
12. Vous allez sentir beaucoup de pression la première fois que l'appareil gonfle.
13. Je vais placer sur votre doigt un appareil qui mesure l'oxygène dans le sang.
14. On doit vous faire une intraveineuse dans la main ou le bras.
15. La piqûre faite par l'aiguille peut être inconfortable.
16. Prenez de grandes respirations dans le masque, s'il vous plaît. C'est seulement de l'oxygène.

1. My name is _____.
2. What is your name?
3. I am your nurse.
4. We are going into the Operating Room, now.
5. There are two other nurses in the room.
6. I am going to put warm sheets over you.
7. Can you move over to the other bed, please?
8. Place your arm by each side and place yourself in the middle of the bed.
9. I am placing a safety belt over your legs.
10. I am placing EKG pads on your chest.
11. I am placing a blood pressure cuff on your arm.
12. You will feel the blood pressure cuff getting quite tight, the first time it inflates.
13. I am placing an apparatus on your finger to measure the oxygen in your blood.
14. It is necessary that we start an intravenous in your hand or arm.
15. You will feel a small amount of discomfort with the prick of the needle.
16. Take some deep breaths through the mask, please. It is only oxygen.

French

17. Vous allez peut-être avoir de beaux rêves une fois endormi.
18. Vous allez peut-être vous sentir étourdi. C'est normal.
19. Avant de vous endormir vous allez avoir un mauvais goût dans la bouche. C'est normal.
20. Si l'acide dans l'estomac monte à la gorge, c'est important qu'il ne descende pas dans les poumons. Il est donc nécessaire que j'appuie sur le cou jusqu'à ce que vous vous endormiez.
21. Vous allez dormir maintenant.
22. Vous allez dormir bientôt.

English

17. You may have some pleasant dreams while you are asleep.
18. You may feel dizzy now. This is normal.
19. Before you go to sleep you will have a bad taste in your mouth. That is normal.
20. It is important that **if** your stomach acid rises to your throat, it is prevented from entering your lungs, therefore it is necessary that I place pressure on your neck as you're going to sleep.
21. You will be going to sleep now.
22. You will be going to sleep soon.

Post Operative

1. Votre opération est terminée.
2. Nous allons bientôt enlever le tube dans votre gorge.
3. Prenez de grandes respirations.
4. Ouvrez les yeux, s'il vous plaît.
5. Tout s'est bien passé.
6. En vous réveillant, vous serez à la salle de réveil.

1. Your operation is finished.
2. We will take the tube out of your throat, soon.
3. Take some deep breaths.
4. Open your eyes, please.
5. Everything went well.
6. When you wake up you'll be in the recovery room.

French

L'ABDOMEN
LA CHEVILLE
LE BRAS
LE DOS
LA VESSIE
LE SANG
LE CORPS
L'OS
LE CERVEAU
LE SEIN
LE MOLLET
LA JOUE
LA POITRINE
L'OREILLE
LE COUDE
L'OEIL/ LES YEUX
EPIGASTRIQUE
LE VISAGE/ LA FIGURE
TROMPE DE FALLOPE
LE DOIGT
LE PIED
LE FRONT
LA VÉSICULE BILIARE
LES CHEVEUX
LA MAIN
LE COEUR
LA HANCHE
L'INTESTIN
LA MÂCHOIRE

English

ABDOMEN
ANKLE
ARM
BACK
BLADDER
BLOOD
BODY
BONE
BRAIN
BREAST
CALF
CHEEK
CHEST
EAR
ELBOW
EYE/ EYES
ÉPIGASTRIC
FACE
FALLOPIAN TUBES
FINGER
FOOT
FOREHEAD
GALLBLADDER
HAIR
HAND
HEART
HIP
INTESTINE
JAW

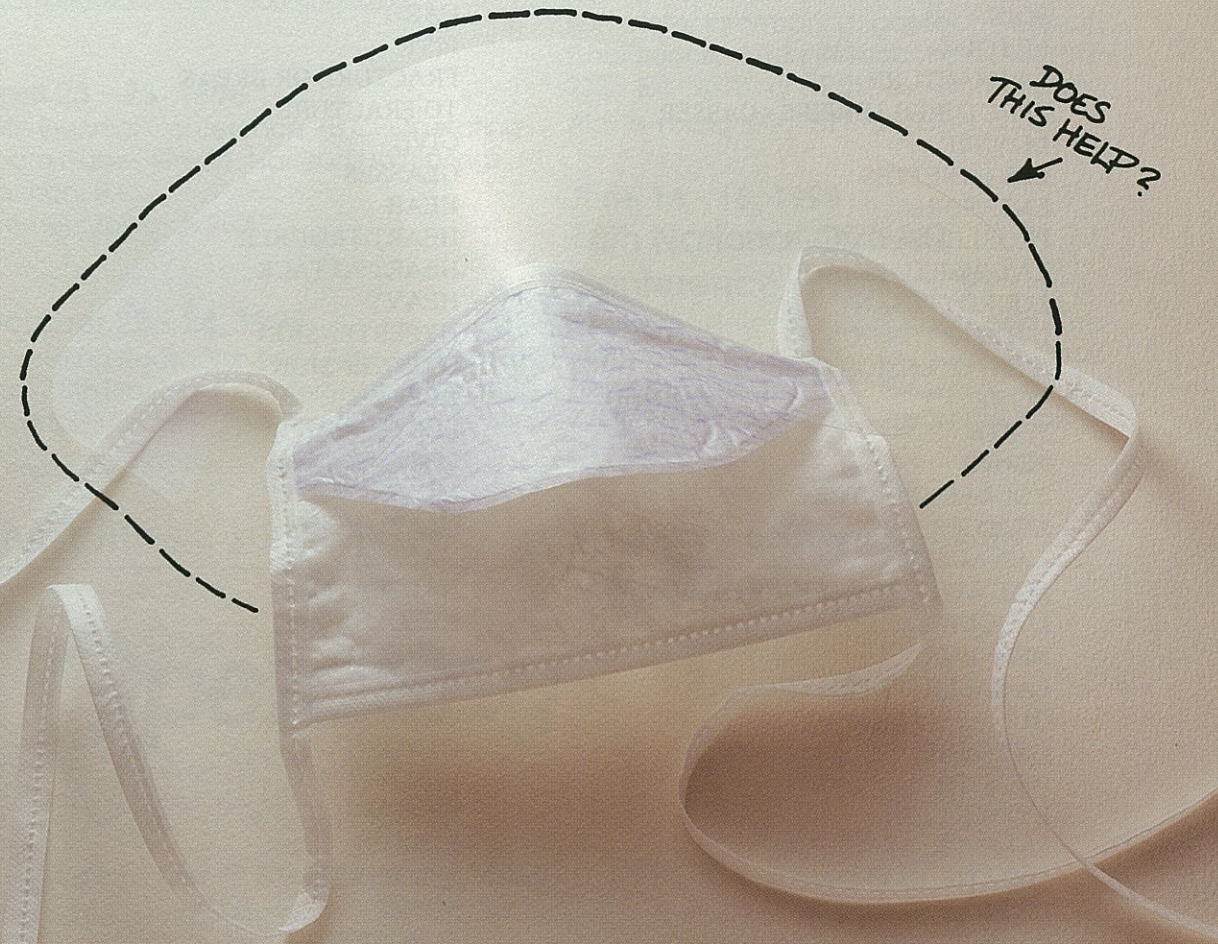
French

LE REIN
LE GENOU
LE LARYNX
LA JAMBE
LA LÈVRE
LE FOIE
LE POUMON
LA BOUCHE
LE COU
LE NEZ
LES OVAIRES
LA PAUME
LE PANCRÉAS
LA CÔTE
L'ÉPAULE
CÔTÉ
LA PEAU
LA RATE
L'ESTOMAC
LA CUISSE
LA GORGE
LE POUCE
L'ORTEIL
LA LANGUE
L'UTÉRUS
LA VERTÈBRE
LA VOIX
LE POIGNET

English

KIDNEY
KNEE
LARYNX
LEG
LIP
LIVER
LUNG
MOUTH
NECK
NOSE
OVARIES
PALM
APNCREAS
RIB
SHOULDER
SIDE
SKIN
SPLEEN
STOMACH
THIGH
THROAT
THUMB
TOE
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VERTEBRA
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French

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 L'ANESTHÉSISTE
 L'ANGINE DE LA POITRINE
 BILATÉRAL / LES DEUX CÔTÉS
 PROCHE
 LA COUVERTURE
 LA RESPIRATION / SOUFFLE
 SOIN
 LE POING
 LA FRACTURE
 FRACTURER / BRISER / CASSER
 DONNER
 LES LUNETTES
 ENTENDRE
 PROBLÈMES CARDIAQUES
 LA CRISE CARDIAQUE
 LOURD / PESANT
 L'HYPERTENSION (F)
 L'HYPOTENSION (F)
 TENIR
 PERTE
 PERDU
 BOUGER / METTRE
 NOMMER
 LA NAUSÉE
 MAL AU COEUR / ENVIE DE VOMIR
 L'AIGUILLE
 NERVEUX
 LA SALLE D'OPÉRATION
 OU
 OXYGÈNE
 POUSSER
 L'OREILLER
 ENLEVER
 SÉDATIF, CALMANT
 LE DRAP
 LA CHIRURGIE
 CHIRURGICAL
 DOUX (M), DOUCE (F)
 ARRÊT
 FORT
 LA SOIF
 LA TUMEUR
 ESSAYER
 LA VEINE
 LE VOMISSEMENT
 FAIBLE
 PESER
 OÙ
 FAUX (M), FAUSSE (F)

English

ARTERY
 ANESTHETIC -Local / -General
 ANESTHETIST
 ANGINA
 BILATERAL
 BESIDE
 BLANKET
 BREATH
 CARE
 FIST
 FRACTURE OR BREAK
 TO FRACTURE
 GIVE
 GLASSES
 HEAR
 HEART TROUBLE
 HEART ATTACK
 HEAVY
 HYPERTENSION
 HYPOTENSION
 KEEP
 LOSS
 LOST
 MOVE
 NAME (VERB)
 NAUSEA
 NAUSEATED
 NEEDLE
 NERVOUS
 OPERATING ROOM
 OR
 OXYGEN
 PUSH
 PILLOW
 REMOVE
 SEDATIVE
 SHEET
 SURGERY
 SURGICAL
 SOFT
 STOP
 STRONG
 THIRST
 TUMOR
 TRY
 VEIN
 VOMIT
 WEAK
 WEIGH
 WHERE
 WRONG

Conference Calendar

Canadian Nurses Association Perioperative Nursing Certification

Next Exam Date: **April 4, 1998.**
 Deadline for application: **November 21, 1997.**
 To obtain candidate information for the next exam date Phone 1-800-450-5206

April 20 - 22, 1998

Operating Room Nurses Association of Ontario - 5th Provincial Conference. Sheraton Fallsview, Niagara Falls, Ont. "Images & Influence '98" Increase your Confidence & Credibility. Prepare for the 21st Century. For more information contact: Publicity Chairperson - Audrey Macdonald (905) 878-2383 Ext. 2310, or 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"

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.

October 22 - 24, 1998

Operating Room Nurses of Alberta Association - 18th Provincial Conference - Red Deer, Alberta. Theme - "Speaking Out."

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