Canadian Operating Room Nursing Journal

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RN First Assistant dominates Vancouver conference

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of practice.
My mandate

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Canadian Operat

Laparoscopic Transperitoneal Nephrectomy
- P. 21

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Volume 13, No. 2, May/June, 1995

...ild be innovative.

Peter Drucker defines innovations as "change which creates a new dimension of performance." As we move into new dimensions, let us not forget our roots and the focus on OR Nursing, but let us regain the momentum to move us forward in the excellence of practice.

My mandate is to provide support and leadership

I begin my term of office on a high note – the CNA Certification Program for Perioperative Nursing is a reality! Over 500 candidates have registered for the certification examination on June 3, 1995, the highest number ever. As I write this message on the eve of certification, I am proud and assured that we are moving forward in the excellence of perioperative practice.

Vija Hay is the Director of Nursing Services, Queensway Carleton Hospital, Nepean, Ontario

14th National Conference Planning Committee. Seated left to right: Vicky Dabbs, Exhibits Chair; Susan Kerr, Program Chair; Sandra Grimwood, Conference Planning Coordinator; Wayne Barry, Entertainment; Lynn Walters, 1st Assistant, Hostess; and Sheena Wallbridge, 1st Assistant, Registration. Standing left to right: Margaret Mellan, 1st Assistant, Exhibits; Helen Sleep, Hotel Rep; Cory Both, 1st Assistant, Program; Lynda Magnuson, Sec./Treasurer; Helen Calveley, Hostess Chair; Gladys Jarvie, 1st Assistant, Publicity; Jean Chambers, Publicity Chair; and Susan Wynne, Registration Chair.

ORNAC Executive. Seated left to right: Newly elected President Vija Hay, Immediate Past President Jackie Waisman; and Gloria Stephens. Standing: Treasurer, Marlene Hill; and Hilda Gatchell. Both Hilda and Gloria Stephens leave the Board this year after many years of service to ORNAC.

On behalf of the Planning Committee, I would like to thank all the delegates and exhibitors who took part in "Tradition and Beyond", the 14th National ORNAC Conference. The conference was a success because the delegates attended educational sessions, showed an interest in the technical displays and networked with colleagues. Exhibitors provided their support to our organization, and their participation in a time of financial constraint is a positive indication of their commitment to perioperative nursing.

The future of ORNAC depends upon nurses who care about professional development and the promotion of excellence in perioperative nursing. This conference proved that we can move forward with confidence.

- Sandra Grimwood, Vancouver Conference Planning Coordinator

ORNAC Executive and Board. (Seated, L to R): Hilda Gatchell, Vija Hay (President), Jackie Waisman, Gloria Stephens and Marlene Hill. Standing: Donna Farid (NS), Karen Steindel (MB), Judi Tyndall (ON), Monique Parazzelli (PQ), Nora Slater (NB), Sandra Giles (NF), Lillian Budden (NF), Corina Balcom (NB), Lorraine Varner (BC), Anna Kristoff (SK), Shirley Thorn (MB), Jossette Forest (PQ), Marg Farley (SK), Shelly Zareski (NS), Dahlia Robinson (AB), Paula Dyer (PEI), Gloria Nemecek (AB), Rosemary Moase (NF), Faye Meuser (BC), and Sharon Ball (ON).

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Transitions
New Roles - New commitments

By Vija Hay

As I begin my term as President of ORNAC, I reflect on the past and the future, and therefore my words from the closing ceremonies at the National Conference in Vancouver may be appropriate to repeat.

I thank the founders of this Association for having the vision and the determination to make ORNAC a reality, and I thank the past executive and board members for their dedication and hard work to advance ORNAC to the high level it has achieved in the very short years it has been in existence.

As we move into an uncertain future, we will individually and as an organization face the most challenging tasks and times in our careers. Many of you will seek guidance to manage the change. We have to be strong as individual OR nurses and as an organization to develop new and/or expanded skills and manage proactively. We should focus on what is going well, believe in our abilities, seek new opportunities and be innovative.

New ORNAC Executive: Seated left to right - Jackie Waisman, Imm. Past President; and Vija Hay, President. Standing left to right - Marlene Hill, Treasurer; Donna Farid, President-Elect; and Corina Balcom, Secretary.

Peter Drucker defines innovations as "change which creates a new dimension of performance." As we move into new dimensions, let us not forget our roots and the focus on OR Nursing, but let us regain the momentum to move us forward in the excellence of practice.

My mandate is to provide support and leadership and to ensure that ORNAC serves the needs of all levels of OR nurses. I want to involve you as partners in dealing with the new issues and new roles to keep ORNAC in the forefront of changes that affect OR nursing and to realize our vision of a STRONG, UNIFIED Association.

At this time of transition in ORNAC's Executive, I would like to acknowledge Gloria Stephens, past President and Hilda Gatchel, Secretary, who have left the executive on completion of their term of office. Both Gloria and Hilda have made significant contributions to their respective Provincial Associations and ORNAC. A special farewell and recognition was given to Gloria as she retires from her work at St. Paul's Hospital, Vancouver. We wish Gloria much happiness and enjoyment in the future.

Congratulations and welcome to the newly elected Executive members Donna Farid, President-Elect and Corina Balcom who assumes the chores of Secretary.

I begin my term of office on a high note – the CNA Certification Program for Perioperative Nursing is a reality! Over 500 candidates have registered for the certification examination on June 3, 1995, the highest number ever. As I write this message on the eve of certification, I am proud and assured that we are moving forward in the excellence of perioperative practice.

Vija Hay is the Director of Nursing Services, Queensway Carleton Hospital, Nepean, Ontario

RN First Assistant

The Perioperative Role of the Future

By Dr. Jane C. Rothrock, RN, MSN, BSN, DNSc

Let me begin by stating that the role of the Registered Nurse First Assistant is not the only perioperative role of the future. It is a vitally exciting potential role of the future, one rich with varied opportunities. There are lots of other things that perioperative nurses could be doing in the future, also very rich and varied in their potential. We call this role changing the transforming and recreating of ourselves, that is 1995 language. It is re-engineer, restructure, rede… and transform.

An RN first assistant and a… one day and having a philoso… whose profession was the o… "well, in the beginning God t… created Eve; obviously God … RN first assistant thought abo… turned to the surgeon and … remember also in the begi… confusion, turmoil and disar… created order; obviously Goc…

The world that we are livi… is constantly changing, and i… feel incredibly uncomfortable. … and it's coming so fast we really haven't time to truly anticipate it.

Very recently some Canadian OR nurse managers were interviewed in *OR Manager*, and some Canadian vice-presidents of nursing were interviewed in *Nursing Economics*. From these articles I gather you are going through changes almost exactly like we are in the United States. Some of these changes happened to you even more quickly than they happened to us because you have a federal health system that is able to tell you what you are supposed to do tomorrow, with the expectation that you would have finished it yesterday. The U.S. federal health care system takes at least four years to figure out what we should be doing tomorrow and they change their mind the day after that. Nonetheless, the changes are coming at us from the local level and the state level, and it is extremely confusing. The messages are not always the same, but some of the messages are pretty universal and some of the messages are pretty consistent. We will look at messages later in this article. But, in the midst of all of this change and chaos there are incredible opportunities. I call them strategic opportunities because many of those opportunities require us to have ourselves

ght: Newly elected t President Jackie ng: Treasurer, Mar- Hilda and Gloria fter many years of

ference. The conference was a su… because the delegates attended educ… al sessions, showed an interest in the… nical displays and networked with… leagues. Exhibitors provided their su… to our organization, and their particip… in a time of financial constraint is a… tive indication of their commitme… perioperative nursing.

The future of ORNAC depends u… sional development and the promoti… nursing. This conference proved that… dence.

- Sandra Grimwood, Vancouver C…

we have given thought and questions that are going to complications that we are g contentious debate that ursing community. They the opportunity that we ally have now as you are tion of the role of the RN You have the opportunity urselves in places where e what kinds of things are e things that we have had very exciting to know that within weeks to begin an RNFA program in cardiac surgery in Quebec, and so it has begun. It has begun and it will continue.

I have talked with people from Canada seriously for four years about the RN first assistant - the Canadian Nurses Association, many, many people from Quebec, the people that are behind this whole thing, and have brought it to fruition. We have become friends as well as allies and colleagues as we have worked together and worked through how the RN first assistant fits into perioperative patient care. One of the reasons that we haven't had RN first assistants from Canada in programs in the United States or perioperative nurses who are looking to that as part of their future career development is because you haven't had a place to come home to and practice the role.

There is no easy solution to all the problems that we are experiencing in the health care system, but nursing has a lot of the solutions, and that is part of the opportunity that we have, especially in terms of the evolution of the RN first assistant role. So, let us begin by clearly understanding that as we look at opportunities we can be brave about this whole thing. We can be brave, we can harness our power and we can really talk among ourselves freely as we hash out the complex issues of how this role is going to evolve.

Dr. Jane C. Rothrock is Professor and Program Coordinator, Perioperative Nursing and RNFA Programs, Delaware County Community College, Media, Pennsylvania. Dr. Rothrock was president of the American Operating Room Nurses Association, 1994-1995. In addition to this abridged lecture she was Keynote Speaker, delivering the Valerie Shirreff Memorial Lecture at the 14th National ORNAC Conference in Vancouver in May, 1995

Don't Kill The Messenger

The other advice that I would give you as you move into these kinds of dialogue… …AC and within the provincial assoc… messenger, and this is not ju… could be the hospital admin… Surgeons are often misinfo… talking about in terms of an… can be incredibly collaborati… supportive but that is only … them. Often in the beginning… they feel very threatened, … threatened because this pot… issue, and they feel also pro… that here is a nurse who is goi… of that intellectual stuff that p… footing when they are both together at that OR bed at the patient's side. So we have to promise that we won't kill the messenger and that we won't kill the message when the message is one of resistance, when the message is one of confusion. You will not necessarily have the same contentious raging debates that we had in the U.S., but some of them will be somewhat the same. The last thing that we always do at the end of any kind of discussion with someone is make sure we have given that person our message, so whether it is a hospital administrator that is taking it back to the CEO group, whether it is a surgeon who is taking it back to the medical staff committee, whether it is a perioperative nursing director who is taking it back to the nursing executive committee, or whether it is a colleague who is going to be taking it back to our peers, we have to make sure that we keep on giving people our message.

Barriers to Practice: Reimbursement

Now I want to address three substantive issues. In the U.S. we have a system of federal health insurance. We are not nationalized. We have a lot of private health insurance and it is very confusing. We have two kinds of national health insurance, neither of which reimburse for the services of an RN first assistant. They reimburse the hospital and part of that reimbursement is for nursing care, or nursing service delivered. So when we try to talk with this group about getting reimbursement for the nurse as assistant at surgery, it is their contention they are already paying for that. You see the nurse is bundled, the nurse is included in whatever that fee is they give the hospital for taking care of a surgical patient. Now somebody figured this out once and said it was about 88 cents for the nurse to assist at surgery. That is pretty impressive, isn't it? So one of the barriers to practice is that federal insurance will pay surgeons to first assist at surgery, …physicians who are credentialed as a physician's assistant. You …nada, do you? I have not read …literature. So, you do not have …r non-physician provider. But …ibility in the future. It is some- …thinking about as you develop …entials and responsibilities for …terms of what is left that is still … because whenever there is a …cy in reform is going to be to …eap to fill that service gap. So …look at with role evolution and description, is to begin with the broadest possible role you can. It doesn't mean that every nurse who is an RN first assistant in Canada is going to fulfil that role in its broadest implications, but you want to look at the biggest possible picture and describe what that biggest possible picture is. From there you can credential down within institutions and put limits on scope of practice and institutional privilege for the RN first assistant. Look big and hard to ensure there are no service gaps and you obviate the risk of having other non-physician providers try to create themselves to fill those service gaps, otherwise you'll find you are out of part of the role, or that you have competition that you never wished to have.

So, how are you going to get your health service to pay for an RN first assistant? How are we going to get

U.S. Medicare to pay for an RN first assistant? To us we have a serious barrier and it is a legal barrier because it is illegal to bill Medicare for an RN first assistant's service. So that is a huge barrier that we have to overcome. We also know in our country, and you are much better at this than we, we have been focused on specialization. You have been a country that has done a much, much better job of primary care. Most of our physicians are specialists. You have a huge population of generalists, primary care physicians or family doctors. We don't, so we have ended up with a huge glut of surgeons and with surgical residencies that are taking up space when we should really be educating primary care physicians. We are going to change that. So one of the things that we have had to look at as we look at barriers to practice is as the number of surgical residencies go down, and they will, our government has told us that, the slots for surgical residents are going to decrease, the slots for primary care physicians are going to increase. That means a service gap. That means that what that surgical resident ordinarily does...now think about what a surgical resident ordinarily does...admitting, history and physicals, preoperative rounds, physical assessment, review of laboratory and diagnostic studies to make sure the patient is adequately and safely prepared for the surgery, and safely in terms of hemodynamic status and electrolyte status, and all of the other things you and I are concerned about. That resident comes up to the OR and assists at surgery, does postop rounds, discharges the patient and gives the patient a prescription. As we look at what is going to happen in the future and what are the strategic opportunities, one of those strategic opportunities is for the RN first assistant to move into the service provider roles that residents have previously filled. Now for us that means advanced practice.

I was not a bit surprised to hear the results of ORNAC's survey on advanced practice for the surgical nurse and advanced practice for the nurse in anesthesia.(See National Survey Report, page 31 of this issue). For us the advanced practice nurse and advanced practice role is different. It almost unilaterally requires a master's degree and we have categories of advanced practice nurses:

- nurse practitioner,
- clinical nurse specialist,
- certified nurse midwife, and
- certified registered nurse anesthetist.

They are the four recognized groups of advanced practice nurses in the United States. So for us , part of our debate is about where the RNFA fit into the advanced practice role. It is not a raging and contentious debate, but it is passionate and that is healthy, that is wonderful, that we can engage in debate in the community of nursing. Because if the RNFA fits into advanced practice, they have to get a master's degree and they are going to be able to do all of those things, they are going to do the admitting histories and physicals, and in fact in one of our hospitals in New York, our nurse practitioners have admitting privileges. In rural parts of the U.S. nurse practitioners who assist at surgery, master's prepared, perioperative nurses who assist at surgery, who are also RNFA's, not only get paid by Medicare but also have privileges to do minor surgery. Why? Because it is rural, other people don't want to work there, it is sometimes an undesirable place to be, and that is how we have gone about things, obviously not an ideal system. We have taken nurses, nurses willing to go to places where no one else wants to go, and we treat them pretty well. We make sure they get reimbursed and we make sure they have decent privileges so they can provide the services that are required by their patient population. If you work anywhere else, you can't do any of those things because guess what?...that place is full of physicians and they get first shot. So when we talk about legal barriers to practice, for us and maybe even for you, one of the things that is under consideration and that we have debated in the nursing community is, should we go for a federal practice act?

National Practice Act

Should Canada go for a national practice act so that instead of having this spotty, this often inadequate structure that grows up from the local level, depending on what is required at the local level, and therefore becomes absolutely different all over the country. That is the situation that we are living with. You can be an RN first assistant in one state and do certain things, and move to another state and you are not allowed to do them anymore. Or you can be an RN first assistant in one state and have been required to have X, Y, and Z as part of your educational preparation, and then move to another state and they require something else as part of your educational preparation. So it is very confusing, it is very difficult for nurses who are in advanced practice roles or in an evolving role like the RNFA to have mobility across the country and know they are not always going to be able to do the things that they have done in the past.

I will give you an example. Until recently, one of

the states said RN first assistants could do everything that we consider normal intra-operative behaviours except for suture. Well, you know an RN first assistant loses an awful lot of value at the surgical field if they can't suture, and yet if you move to that state they won't let you put a needle holder with a needle in your hand and put it in somebody's tissue. It wasn't allowed. In other states, RN first assistants in cardiac surgery harvest the vein. They have been doing that for quite a while. They are starting to harvest the radial artery as a conduit in bypass surgery. RN first assistants are doing that. They do it, they do it well, and we have even begun some research on how you can identify patent veins when you go to assess what leg, what vein you are going to take as an RNFA. Nonetheless, in one state you can perform a specific function and it is written into the *Practice Act*, yet in another state it is denied. So what you have been permitted to do somewhere for years, suddenly you move, and you are no longer permitted to do it. So this is an option then, to get rid of all of these changing circumstances and changing rules and what you are allowed and not allowed to do based on where you live in the country.

Now there are a lot of down sides to such an option, but it certainly is a consideration and it is something during health care reform that our nursing community spent a good two years dialoguing over and we finally decided **not** to go for it. In Canada you have your provincial Health Professions Act. What we decided to go for was supporting state level, or for you provincial level, licensure and scope of practice and privilege decisions. However, with strong federal incentives to see that these were under the jurisdiction of the Board of Nursing. You see for RN first assistants and others who practice in an area where our roles overlap that of medicine, sometimes decisions about what we can and cannot do are made by the Board of Nursing and the Board of Medicine. My experience is that the Board of Nursing and the Board of Medicine are committees. One is made up of nurses and the other is a committee made up of surgeons. You give them each something to decide separately and they come back with two totally different answers. So it is not easy when you have joint jurisdiction over this role of the first assistant who does perform some delegated medical tasks, as well as many, many nursing tasks. Who decides what they get to do? We would like to move with total nursing jurisdiction over this role, to get rid of some of the restrictions, to get nursing speaking together, to get all of those boards from all of those states to come together because they do have a national board, to come together and work through practice decisions.

So this is going to be one of the barriers to the practice of the RN first assistant in Canada. You may wish to at least play out whether it even a possibility to have a federal practice act, and if not...what can you do then to see that nursing has most of the jurisdiction in the province, to get medicine working with you, but to give nursing the authority to make the practice decision rulings. It is a strategic position that you want to get in so that you don't have to go through the things that we have gone through. I would strongly urge you that while I sense a federal practice act won't work, I also know that the best thing to do is to get nursing in control of all of the decisions about the role, and again that means working with different messages and different messengers.

Prescriptive Authority

Now, prescriptive authority. Surgical resident discharge patients and give them prescriptions. There are institutions in our country where the RN first assistant has a role that is very similar to that of the surgical resident but without a master's degree. Some institutions in the U.S. have a latitude within a broad scope of practice, they have latitude in describing role responsibilities, and there are some institutions that are looking to develop a formulary, a list of the things that the RN first assistant could prescribe. It would be some kind of protocol for the surgical patient that was being discharged. Some people get pretty alarmed about that, that a nurse is actually going to write a prescription for an antibiotic! I admit we have not done a good job with giving our advanced practice nurses prescriptive authority. It makes no sense for these nurses not to have prescriptive authority. It duplicates services and it drives up costs. Canada can learn our lessons, so that as you look at what the Canadian role is going to be, look at the big picture, where will the service gaps be, and how are you going to ensure they are met and they are filled. If you choose that it is not part of your role, that is your choice, but you won't have positioned yourself without having given consideration to another service requirement.

Physician Supervision

Now what about physician supervision. When the Association of Operating Room Nurses came up with our very first official position statement on the RN first assistant in 1983, that position statement very clearly said that the RN first assistant works under the direct supervision of the surgeon. Now we know what that was interpreted to be in many institutions. The surgeon could not leave the room while the RNFA was finishing closing the wound. Even if there were only four skin sutures left, the Surgeon was supposed to be directly supervising. That kind of language became very limiting. You don't have anybody to compete with you yet, so as you create yourselves think about using language that is going to allow you to constantly evolve, to constantly transform and to not be in the situation that we were where a surgeon would say:

"I have got to stay in the room the whole time the RNFA is there. Once we get on skin, I want to drop out. I want to go talk to the family, I want to go dictate, I want to go have a coffee and get ready for the next patient. Now if I have an RNFA in the room and I have to stay in the room, I can't do those things, so baby get me somebody else. Get me a non-physician provider like a PA that doesn't live with all of those rules that I, the surgeon, can control. I am the master."

The surgeon is often the master of a non-nurse. It is nursing with all of its rules and regulations that the surgeon cannot intervene in and say, oh sorry we are not going to follow that rule today, they can't do that. And so you need then to think about what kind of supervision are you going to require. Are you going to use words like 'direct supervision'? We changed our statement in 1994 and it now says "collaborates with", we rid ourselves of all the statements about supervision and direct supervision so that one can't infer that the surgeon has to stay in the room.

How much physician supervision is required? Is it required by direct presence or can a physician, surgeon, be somewhere in the hospital by beeper in order to supervise and answer a question or a concern. Can supervision be carried out by protocol? Can you have protocols written? California, interestingly enough, requires protocol for certain things. So a RNFA in California has to function under protocols for certain nursing behaviours. They have protocols for achieving hemostasis and protocols for suturing. Those protocols are broad guidelines, they kind of give a directive as to what can be sutured, when it can be sutured, and what kind of hemostatic adjunct the RNFA can apply. Can the RNFA just tie knots? Can she just put a hemostat on or can she put a hemostat on and tie a knot, can she put a hemostat on and buzz it with the ESU, can she use the Argon beam coagulator on it ? How do we define hemostasis? In some states we have protocols, and you could have protocols for specific functions in Canada. Here is one of the favourite questions:

What are you going to do if the surgeon drops dead? And you only have another RN, you know, just a nurse. Just an RN first assistant is in that room at that OR bed and the surgeon drops dead. Now you know when people ask me that question, I usually say to them- "well .... you really ought to worry about what happens if the anesthesiologist drops dead".

Because I am a director of an educational program I am often asked, "What will happen if a surgeon drops dead, will the RN first assistant finish the surgery?" I love to answer these questions. And I say to them, "now if the anesthesiologist drops dead, one of my perioperative nurses will bag you, will see that you aren't oxygen-deprived, and will maintain you in a living semi-comatose state, they will even talk to you while you are asleep because they have read the research that patients can hear under general anesthesia, so they will comfort you during this crisis while everyone is running around during the code, they are going to let you know that everything is going okay, everything is alright until another anesthesiologist gets there". And then I say to them, "but ... if the surgeon drops dead, my RNFA will not finish the surgery, but, if you are bleeding I promise they will stop it. If they are in the middle of an anastomosis, I promise you they will try to get things back together, they will throw a wet sponge on, they will keep you stable, physiologically they know exactly what to look for until another surgeon comes in". And then I conclude with "now what you really should worry about is, what if the perioperative nurse dropped dead!". That is called being in deep do-do! You don't really think that there is anybody else in the room that can do all the things that OR nurses do. There isn't. Do you think the anesthesiologist could run around and open all the supplies, know what the female and male adapter look like, and be able to find the last two? The surgeon would have no idea where the equipment is stored or how to operate them. When lap choles were started there were these wonderful one week courses that the surgeons went away to, right? They came home and overnight by a miracle that nobody talked about, you had to know how to operate the equipment. Now nobody sent us away for a week, did they? But the next day let's talk about coherent light, let's talk about trouble-shooting, let's talk about what camera can be replaced with this piece of equipment and what video we could steal from what room so we could do lap chole #2 since we only had one working video

system. It was a miracle, wasn't it, but you and I learned to do all that and survive. So when people ask me this big question, I say to them "hey you know what, easy, let's just write a protocol for what happens if the surgeon has a heart attack during surgery". We'll write a protocol for it and we will have general broad guidelines and then nobody has to worry about that question any longer. So again, think about physician supervision, how much, when, in what situations, and how are you going to handle it so that there isn't a huge service gap and so that you don't make the RN first assistant a person who can't best fill in for another physician assisting, because obviously we want the RNFA to be in the best possible position to substitute for, to replace another physician who would ordinarily have assisted at that surgery.

Reimbursement

Let's go back to reimbursement and finance issues. Obviously we have a problem with federal insurance and getting reimbursement. We have not won that battle yet, and frankly I am not sure if we will. I am not sure if we are going to win it with the system that we have right now. If you have read anything about health care reform in the U.S., you read that we say Medicare is a stand-alone program, it will not be folded into health care reform. However, you know we are also working on things like balancing our budget (what a concept), balancing our budget, and in order to do that, we are looking at saving money in Medicare. So while we say that Medicare is not part of health care reform, other committees are looking at balancing the budget and saying "well, we are not going to raise taxes so where are we going to get this money?". Well, we had better be able to save some from Medicare. Medicare is our flagship federal program...and it is an embarrassment; it is an inequity and it is wrong that our flagship federal program does not treat service providers equitably.

Now we also have private payers, as we talk about reimbursement. The majority of private payers, 16,000 of them you know, so every time we go for reimbursement for the RN first assistant, it is like we deal with insurance company "A", we finally win that battle and now let's deal with insurance company "B", and it takes you your whole life to deal them all. It is battle after battle, like the war that will never be won. However, the good news is that many of our private insurance companies pay RN first assistants. We have RN first assistants who have their own businesses, they contract with hospitals and they contract with physicians, they bill the insurance companies themselves and they support themselves

Now to the question of "how much should we charge?". Think about strategically positioning yourselves and get these debates out of the way. Talk about them now and come to a consensus now because one of the questions you are going to ask is the same question that we have asked. Well, let's see now this is pretty simple. Same service, same pay. Well, if a physician assists at surgery and we provide the same service that that physician provided, shouldn't we get paid the same thing? A very interesting and a very complex question. Certainly equal pay for equal work is a philosophy that has enormous appeal. On the other hand, I caution you that as you process the worth and value of an RN first assistant, you also look at what is happening in your external environment. Your external environment is into cost-containment.

It is incredible the things that we do and the kind of patient assessment and the nursing diagnoses that we make. If a hospital administrator or a consultant looked in a door and saw you slapping a sticky pad on somebody's thigh, hooking a piece of equipment to a table, they would have no understanding of the intellectual processes that you engaged in when you made the decision about where to put that ESU pad. You never put on that pad without a thorough assessment but, it doesn't look like you are doing an assessment. You go to get the patient comfortable and you may say to the patient, "I am going to put my hand on your thigh", you lift up the blanket or the sheet that is on the patient, you take a look at the skin there, you determine what kind of contour, what kind of muscle mass, whether it is oily, whether it is hairy, all of the other things, scar tissue, that you need to know, everything is fine—boom, put the pad on. The person that is watching you saw you move a patient onto an OR bed, rip open a gel-pad, take off its back and stick it on somebody's thigh. They assume they can get somebody else to do that. That is how they see our role, they see it as very mechanistic. So yes, I think that this rumour is one that we need to be extremely concerned about in OR's across the world, not just in Canada and the U.S., because the move is on. I believe also that what we are going to have to do is start quantifying events that occur to patients because lesser qualified people were taking care of them. Now that is going to require courage.

Canadians probably read about the hospital in the United States where they took the wrong leg off a patient. A week later they operated on the wrong knee.

They unhooked the wrong patient from a respirator. Now this is all in the same hospital. Pretty unbelievable isn't it? They almost lost their license to operate. In the OR, part of their corrective action plan in order to be allowed to resume doing surgery was hiring more OR nurses. You hear that message!! That is what we have to quantify. And that is what I am sorry and afraid is going to happen. Those kinds of errors are going to take place and then we will get the nurses back. So what we need to do is grab those stories, grab that information, and when your hospital administrator suggests that you do this, honey you march in and say: "I feel obliged to share with you what happened in this hospital in Florida", and say "I hope we don't have to go through the same kinds of things here". Again, data, data, data...data talks. So let's not make it our own tragic data, let's bring somebody else's tragic data and show the administrator.

The RNFA Program

The RNFA course I teach is one year long. Now, it is two academic semesters. However, it is almost all long distance learning. So while I was not able to persuade the college to do teleconferencing, I was able to persuade them to do very nontraditional education. Students reside in Pennsylvania with me at the college for only six days. If you were to start in September of 1995, by August '96 you would have received in the mail all of your assignments that have to be complete before you show up for your six days. You have about thirteen papers to write and they have everything to do with nurse practice acts, scope of practice issues, with pain assessment, etc. and they are very in-depth assignments that have to be completed. You receive your first anatomy and physiology exam in the mail and it is mailed back to the college. Then you come for six days of very intense course work, you have about three or four books to read before you get there so that you are very well prepared to sit through nine hours of very intense lecture with a physician-nurse team-taught course. You go back home, you finish up the rest of your course work by December. The following January you start your internship. You must complete 200 hours of assisting, so that means for five months (that's how long the next semester lasts from January through May), you have to have 200 hours at the OR bed and you keep logs of every single procedure you assist at, you develop some of your own objectives as well as have competencies you must meet by the college, you have to be rated on those competencies for every single surgical procedure and then you have about another fifteen assignments. You have to do rounds, write sample postop notes, go to the surgeon's office and pick up a patient, do a complete case study, and follow a patient through their surgical experience and back either to the surgeon's office or to their home. So it is two academic semesters or what we consider one academic year but very, very non-traditional. They are held all over the United States.

Comment from the Convention Floor:

> "At the Toronto Hospital, there is an RNFA employed by a cardiac surgeon to harvest the vein for CABG or CABS (however you refer to it), she is a graduate of a postdiploma OR program, she is very good, and trained in RNFA by the surgeons. She has been employed for a year and a half and is doing well. She also has her BScN, and she is the first that we know of in Toronto".

How wonderful, now is this not a good model for role evolution? When you think of who this person is going to be and what is this person going to look like, this RNFA, we have one. We have someone who didn't go to a formal program—why?—there wasn't one. But the person went through a post-basic program in perioperative nursing, was trained by the surgeons, has a Bachelor's Degree, so is doing a lot of things right, again so that people can't say, "gee, you went away to school for two days and you are a two-day wonder; who died and made you queen that you can suddenly, do this". This is someone that you might want to talk about, you want to be able to connect with that nurse in Toronto. This is how we begin forming our RNFA networking groups. We find this nurse, find out what her job description is, and then we start growing and going on a new adventure together. I support very strongly the RNFA role, but we need to start our debate. We have to ask the hard questions among ourselves, we can't afford to get out there in public and have people ask us hard questions that we haven't thought about answers to.

I am very concerned about the future of perioperative nursing when most of the college/university courses have dropped perioperative content. Look at the mean age of nurses here today, how depressing. What we need to remember is what attracts people to nursing in the first place. What attracts people to nursing is often the opportunity for an autonomous role, the opportunity for continued clinical growth. If we look at how we are going to attract nurses to the OR, what better than to tell them there is a new clinical role, and that you need to be an experienced perioperative nurse to move into it. Let's assume you wanted to go get a master's degree, was there any place for you at the bedside in the OR? Not usually. You got transferred right out and right away from the bedside. You became a manager, you became an educator, you became a QA person, you became whatever...but you didn't have a chance for clinical

growth. It was scrub or circulate and that is all its been for a long time. We will now attract people into perioperative nursing with the RNFA program.

What are the legal implications of and RNFA assisting with surgery if he/she is not properly certified? In Canada you are just getting into certification for perioperative nursing. You will also have to deal with certification for RN first assistants at some point in time and ensure they are properly educated and credentialed according to whatever the province or jurisdiction says is required.

First of all, in an emergency situation, in the U.S. almost all State's have a clause for what is called 'a delegated medical act'. What that means is if you are in a situation where you need to assist during an emergency, the physician in that situation may delegate medical acts to you to have you assist and that is perfectly within your scope of practice as a nurse and perfectly within the physician's scope of practice as a physician. Now, what the physician can't do is routinely delegate those medical acts to you in a way of getting around the requirements for an RNFA.

No 'Specialized' RNFAs

Are there specialized RN first assistants? Well, yes there are but let me tell you our program doesn't prepare them that way, not in the didactic part of their course. They hate it because of course all the cardiac perioperative nurses have to learn about gallbladders and where the cystic artery is, and where the cystic duct is and the node of Calais. All they want to do is hearts. Well guess what, that is not all they are going to be tested on in their certification exam and so it is a generalist's course. They are allowed to specialize in their internship and yes of course many of them assist in just one specialty, that is a very risky thing to do. We are talking about re-engineering here, restructuring, we are talking about career security. The perioperative nurse of the future will be multi-competent generalist/specialist, which means you don't just do hearts, and my message to my RNFA's is get out of that heart room, get yourself able to assist in other things because as we go through mergers and acquisitions, what if they get rid of the hearts in one of those hospitals that just got acquired and merged, and all you can do is hearts. You don't have a job. You need to be career-secure and I say be a generalist/specialist, your general specialty is perioperative nursing, but be a specialist within that field in a number of areas, not just one.

How much is it? Let's just say the maximum for somebody from out of the country would be $200.00 U.S. dollars. So it is six credits at $200 each and then of course you have to think about books, telephone because you to talk to your faculty facilitator during your internship every two weeks. Also you would have to fly or drive, stay in a hotel

The final message is that we need to cooperate, we need to collaborate, but we will not capitulate. We will cooperate with our physician colleagues, we will cooperate with our colleagues on jurisdictional boards of nursing, we are extremely well positioned. The question we have to keep asking ourselves is - can we move? Can we move, are we ready to move? We can't sit still. To progress is to choose, but to choose is very difficult. Many of you may have heard of Mia Angelo, poet laureate in the United States. Now this is what Mia has to say from one of her stunningly meaningful books called *Wouldn't Take Nothing For My Journey Now* and it is called *New Directions.*

> "Each of us has the right and the responsibility to assess the roads which lie ahead and those over which we have travelled and if the future road looms ominous or unpromising and the roads back uninviting, then we need to gather our resolve and carrying only the necessary baggage, step off that road into another direction. If the new choice is also unpalatable, without embarrassment, we must be ready to change that as well. You and I have to commit to not paving the cow path. You know what is behind us that didn't work, that was bumpy. That is not where we want to spend our time, paving our road. And if it means that we have to find our new path and create new roads, we can and we will. Together we can do anything."

The other thing that we have to remember is that we are the only group of people in the whole world that can do something like this and feel incredibly proud of it. Now if you can do that and be proud of it, you can create any road, follow any path and find any place that you wish to find. I just can't tell you how many times I have talked, maybe this is the third time, about the RN first assistant with you, ORNAC, to watch your growth, to see the things that have happened, I just cannot...and I say to you again with the most humble sincerity, I am so privileged to have been a part of you, to learn these lessons, to watch you grow and to go a little bit of this journey with you, I am so proud of you. I hope that you are proud of yourselves. You have done something that is so important for the future of health care in Canada. It is not just for the future of the perioperative nurse, it is for the future of perioperative nursing care. You are well on your way to the place that you want to be, to see that you give quality, safe, cost-effective care. There is no better place to be. ■

The ORNAC Legacy

Reflections on the association's roots with an eye to the future

By Joan Donald, R.N., B.Sc.N.

Introduction

Many operating room nurses are struggling these days to keep up their enthusiasm and faith in our health care system when so many difficult changes are underway in our hospitals.

The question remains, is our health care system being threatened or simply being streamlined? There are as many answers to that question as there are people and the one true answer will lie with the future. Lately, it seems politically dangerous to offer an opinion. But are there traditions that will provide us with better insights and courage to face the future, whatever lies beyond? I believe there are and I believe that they are here in our own organization and in our own people, both past and present. I have called this presentation "Our legacy" - a time together to reflect on our roots as we prepare to branch into the future.

The metaphor of a tree has certain appeal when attempting to look at "Tradition and Beyond" in the Operating Room Nurses Association of Canada (ORNAC). The pioneers of the past have provided the basis for our traditions and roots. The sap, which runs from the roots to the branches, can be likened to the spirit of operating room nursing. This in turn feeds the branches as they reach for the sky and beyond. Branches go in many directions which can be compared to our nursing practice which is constantly evolving and changing. Just as each leaf is a unique creation of nature, so too each nurse is a unique creation, depending on their heredity and life experiences.

Just as a tree has its fresh, green foliage, so too nurses have fresh, new, and innovative ideas. Leaves change colour in the Fall and the tree becomes a display of vibrant colour - a mosaic - a kaleidoscope of brilliant tones. Nursing is made up of nurses who provide vibrancy and diversity. Each has a different personality, different point of view, and a different approach to patient care. But each and every nurse contributes to the well-being of the organization. Just as a leaf brings breath and nourishment to the tree, so too each operating room nurse brings life to OR nursing and to ORNAC. No one nurse is more valuable or less valuable than another.

As the leaves age or drop from the tree they return to the earth valuable nutrients that are taken up in the root system. The circle of life for the tree is complete. As nurses retire or move on from ORNAC, they leave behind valuable gifts that provide essential elements for the growth and development of the organization. We may not always recognize or appreciate these gifts, but we are the richer for them. Our circle of life is complete.

Traditions or Roots

Reflecting on our roots could take us back a very long way and involve many people. For fear of omitting someone, I will not attempt to name the many pioneers of the past. ORNAC is a mere child of 12 years. Not even a teenager, yet. However, national conferences were held in various centers across Canada for many years prior to ORNAC's beginnings. The national conference (planning) committee was comprised of nurses from various provinces who planned and organized national conferences. These nurses were just as confident, capable, dedicated, and committed as national committees have been since 1983.

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They established a national network that provided the foundation for the formation of our organization.

As we sat around the table at the national conference meeting in Winnipeg in 1982 and discussed the wisdom of becoming a formal, structured organization, there was cautious optimism. Much has transpired since then and as the saying goes "The rest is history" - and what a proud history it has been !

We must remember the people who have influenced our lives, and examine what we have inherited from them and what our responsibility is for the future.

Family

While reflecting on our roots, we need to identify the people who have contributed to our beginnings, our growth and development. We'd be remiss if we neglected to start with our families. Can you remember those special moments in your childhood when mum said "Wait until your father gets home!" In addition to our parents, our brothers and sisters, all relatives contributed to our growth as a unique human being. A special influence is that of our immediate family - our husband or wife and our children.

One of the many professors who have made an impact on me this past year is Clive Beck. He emphasizes the contribution that our children and our students make to us. He says that when we try to teach values to others - students, patients, fellow community members and our own children - we should use a "dialogue" approach as much as possible. Most importantly, we should recognize that we can learn as much from our "students" as they can from us. Each of them has had a life-time of experience and reflection which is a great resource. If we don't take advantage of their insights, listening to them as much as they listen to us, we will miss out on a major learning opportunity for ourselves and also hinder their learning. In addition, the relationship that evolves is better as a result. He further states "I have always learned as much from the "students" in my adult values class as they have from me."

Teachers, mentors, and colleagues

Our teachers and mentors have given us special tokens of their knowledge, skills, and talents. We learn so much from so many. Some of these have been our colleagues and coworkers.

How well I remember, as a student nurse, my first experience in the Operating Room. Terrified as I was, as the temperamental surgeon threw a haemostat across the room, hitting the circulating nurse in the shin with it, I vowed that this experience would not be the memorable highlight of this rotation. Rather, I would remember events that were special to me - such as the lady who had a full placenta previa and was bleeding to death before our eyes. I remember how the OB and I frantically wheeled her to the OR. How we insisted that the anaesthetist come from the theatre out into the hall and provide some form of anaesthesia while the surgeon opened the belly and we (me with my limited, but adequate for the moment, OR experience) delivered a live baby and saved a mother's life.

My operating room experience ended up being the most significant part of my training, so much so that I went on to specialize in OR nursing. I credit much of this to one special OR nurse who encouraged me, taught me, and who became my mentor. Her name was Joyce and I later nursed her dying father. When I graduated, Joyce gave me a Hummel figurine which still sits proudly on my dresser as a reminder of a special nurse who definitely influenced my life.

What do you recall of your early operating room experience? Do you remember your instructor, a certain doctor, or perhaps a staff member who was especially patient and good to you? Were there times when you nearly quit or left the OR but something drew you back? Someone challenged and encouraged you and that was all you needed.

I chose to be in OR Nursing. It chose me to stay.

Leadership

What of nursing leadership today? Is it an elusive or disappearing commodity? Admittedly, there are pockets of strong leadership evident in various areas of Canada. But what of other nursing leaders? Are they an endangered species? Are you as concerned as I am? One has to question their impact or role in health care reform. Are they providing a leadership and mentoring role or are they barely visible; seldom heard; almost insignificant as leaders? Has there been too much concern with pleasing administrators, boards, or politicians? Nursing's voice at the management table appears to be less and less audible. Nursing leaders have been stripped of their power. I am told that right here in Vancouver, one facility appointed an administrator whose acknowledged mandate was to disempower nursing and, it happened.

Dorothy del Bueno said in 1993 that "there is a loss of nursing oversight and influence on patient care when none or few of the administrators are nurses. Even if nurses are aligned through professional practice councils, their ability to influence policy and financial decisions relating to patients will be limited. Thus, nurses may have gained a forum, but lost their voice".

Have we been caught dozing? Have we created an elitist group who are so focused on nursing models, theories, and nursing only, that we are being left behind? We must "mainstream" - get involved in the political arena, business world, and volunteer to be a team player. The literature increasingly tells us of the value of degrees outside of nursing such as sociology, business, education, and management. If we are to be valued in the mainstream of health care, we have to broaden our perspectives. Yes, we have to have nursing knowledge, but we can bring other knowledge and skills to the table also. Get involved, speak out, show the world your leadership skills. As Jane Fulton said to the ORNAC/Vancouver Conference, we need to have a broader outlook and tell the world what we are about.

OR nursing groups have a tradition of strong leadership. How can we convince these leaders to take this tradition beyond? Beyond the doors of the Operating Room and into the board rooms of Canada's hospitals. I have often heard "but I couldn't do that - I don't have what it takes". In the words of Jonathan Swift:

> *Although men are accused of not knowing their own weakness, Yet perhaps few know their own strength. It is in men as in soils, where sometimes there is a vein of gold which the owner knows not of.*

The vision, talent, and ability are all present in our OR leaders. What is needed is the spirit of commitment - commitment to the bigger picture of nursing management. This is not for everyone as many OR nurses would never be satisfied outside the Operating Room. Having a position which allowed time in both areas would be the ideal. OR nurses have so much to contribute and nursing leadership lies wanting and in need. OR nurses are capable of meeting that need.

What did these folks from the past give us? Is there anything of substance, something we can identify? Something we can point to and say we inherited this or that? Or is it like beauty; only in the eyes of the beholder? I think it is both. The items of substance are many and can be listed. The list includes:

"ORNAC" - a highly respected organization which is recognized internationally. An organization with a vision, a mission statement, goals and objectives, an executive and a board of directors.

ORNAC has a bank account, standards, position statements, and guidelines for national conferences. We have awards, a chain of office, a national journal and a national exhibitors advisory committee (NEAC) whose contribution is considerable. The list could go on and on. Have we something of substance? There is no question - the list is impressive! Are there other legacies that we have inherited?

Those who went before us left something even more important than these tangibles. They left us spirit. Although spirit is something less discernable than a bank account, it is no less important. They left us a spirit that is undaunted in the face of adversity.

Spirit of Excellence

We learned at an early age how to care with compassion and understanding. We remember when mum soothed the tears produced by a scraped knee. The seeds of caring were planted then, when, as children, we were surrounded by love and tenderness. I believe this spirit grew and blossomed into something even grander - a spirit of excellence.

Regardless of the massive restructuring of our health care system, OR nurses continue to be committed and dedicated to quality patient care. OR nurses never waiver from giving their best. Even when hospital funding is not available for attending educational conferences, OR nurses make the sacrifices, find the money and attend. When you are called upon to work through the night to save a life, you don't question it, you just do it. Right? You don't do those things unless you have spirit that won't quit.

Once again I draw from my studies with Clive Beck. Emotion is an important source of motivation as it affects what we do. Because of this, we need to build up a rich emotional life with a wide range of emotions. People who are unusually alive with fun, energy, wit, and good humour, "Live more fully because they're able to use more of themselves."

We need practice in being affectionate, fearful, and angry in appropriate ways. To have emotions and express them takes courage. If we do not express our emotions we will not know what the consequences will really be and will not learn how to deal with the resultant conflict. One author says that "conflict is inevitable, the source of all growth, and an absolute necessity if one is to be alive". Beck believes that "conflict is another thing we must 'learn to do' through experience, acquiring the skill of remaining connected despite conflict". Trying to remain connected despite conflict is a challenge for everyone.

We rarely know for certain that we are making the best possible decision or even a good one. Accepting

the rough and tumble of life, constant change, mistakes, uncertainty - is essential for well-being. Human life has never been and never will be perfect. It is when we stop insisting on the perfect that we are able to attain the good.

Mark Phippen, when accepting the award for excellence at AORN, remarked that he had made lots of mistakes along the way and that he was by no means perfect. Receiving this award made him realize that he didn't have to be perfect - just excellent. Our leaders aren't perfect, not many of us are perfect, and the comforting thing is that we don't have to be. We just have to be excellent. A spirit of excellence has been established by the pioneers of the past and perpetuated by our leaders of the present.

What is excellence?

I especially like Aristotle's definition:

We are what we repeatedly do. Excellence, then is not an act, but a habit.

Have you ever thought of excellence as a habit? Think of it - the many things that you repeatedly do every day. Preparing lunches for the family, organizing your day, and getting to work on time. Preparing the equipment for surgery, completing the pre-op checklist, and efficiently managing the surgical procedure. You do these things repeatedly. You do them well and with excellence. Every nurse in this room could qualify for an award of excellence !

I don't say this to minimize the significance of such an award, I say this to emphasize that you need to believe that you are worthy - you must give yourself permission to believe that you are excellent. Believe this with all your heart and every day of your life. Especially on those days when things get you down and you need a "pick me up". If you remember nothing of this article, remember to tell yourself from time to time "I am excellent!"!! You have a God-given right to believe this because you have inherited a spirit of excellence.

Spirit of Curiosity

We have also been left a spirit of curiosity, a quest for knowledge, for life long learning. There is likely not another area of nursing that has been so bombarded by changing technology and advances in pharmacology as operating room nursing. Do OR nurses resist or shy away from these changes? No. They go to educational sessions, they practice, they proudly display their certification papers and then they provide leadership to others. We are a curious lot and enjoy the challenge of learning something new. A commitment to life-long learning is part of our heritage and it is not restricted to work issues. OR nurses are known for their varied talents, abilities, and interests.

Last year I attended the AORN congress held in New Orleans. While we were there, one of the great jazz musicians of the era died and a state jazz funeral was planned. Everyone was talking about it - our bus drivers, the hotel people, shop keepers - and, naturally, curiosity took over. We found out its location and waited in anticipation along the street with the gathering crowd. Before we could see anything, we could hear "The Old Rugged Cross" being played by the band in the distance. As the Grand Marshalls led the casket and the pall bearers down the centre of the street, the crowd swelled in numbers. As they neared the cemetery, the chosen Marshalls performed the dirge - an elegant, graceful and proud stroll. The music was sombre, quiet and dignified. Only special guests were allowed into the cemetery, but an elderly black man explained to us what was taking place. As the service ends they lower the casket into the grave, the pastor says "Cut him loose! Cut him loose ! " and with that, the deceased is off to heaven - cut loose of his earthly ties. He is now in heaven and everyone is happy for him. Let the celebrations begin !

It is now that the band breaks out with "Oh When The Saints Go Marching In" as they dance and play and lead the crowd down the middle of the street to continue the celebration. What a way to go! This time of jubilation is to celebrate the life of one who has gone on. There is no longer sadness, there is joy in the fact that this man lived, loved, and shared his gift of music.

For me, this was a wonderful learning experience. I learned something of the culture of the people of New Orleans, and, on reflection, I learned something even greater. It was this spirit of curiosity that led us to that place; a spirit which I inherited and for which I am grateful. Somehow, I knew that those who have gone before us would have approved. This leads me to the last of our traditions - a spirit of fun.

Spirit of Fun

Another area of study for me this past year was related to culture. According to Edgar Schein "Culture has been defined as the outcome of 'group' learning. When a number of people simultaneously face a problematic situation and have to work out a solution together, we have the basic situation for culture formation". I now believe that the culture of nursing is a very real one. Schein also explains something called *shared understanding* which I also think is pertinent to nursing, but especially to OR nursing. The application of the five elements of *shared understanding* to OR nursing demonstrates our common language and our common bond.

Schein	OR Nursing
1. Common Anxieties	Discovery of similar anxieties and tensions, e.g., responses in emergency situations
2. Common Emotional Responses	To strong external threat, e.g., replacement of the RN with less qualified personnel
3. Common Overt Action	Joint activity to deal with the threat
4. Common Emotional Release	Joint activities that have symbolic meaning and emotion, e.g., attending the funeral of a patient.
5. Common Emotional Regression	Joint emotional release-dancing, athletics, party, feeling of sharing, self-disclosure, vulnerability, interdependence.

Having fun is an important factor in the life of the OR nurse. When we get together we chat about things of common interest and laugh at things that some folks wouldn't even understand, let alone think were funny. In our work we see things that make us appreciate life. With a heightened awareness of the fragility of life comes an increased sense of one's own mortality. As a result, social activities are important in the lifestyle of OR nurses. "Live each day to the fullest" is a motto worthy of adoption. The sharing of social time with OR friends has great value.

All of this is possible because we have been conditioned by those nurses who established the protocols for meetings and conferences. Can we even imagine a conference without the fun that accompanies the educational and working sessions? Hardly, and who would want to? We have inherited a spirit of fun with all its joy, laughter and comraderie - a tradition to be preserved.

As we reflect on our roots, I will summarize the traditions that I believe we have inherited from the pioneers of the past

1. The Operating Room Nurses Association of Canada (ORNAC)
2. A Spirit of Excellence
3. A Spirit of Curiosity
4. A Spirit of Fun

These traditions are a legacy, which is by definition "Something handed down from one who has gone before". What does one do with a legacy, something handed down? Do you ignore it? Do you try to be nonchalant and say "that's nice but I didn't ask for it so I don't have to do anything about it"?

Just as a seed which is planted requires care and nourishment in order to grow into a tree, so too does the legacy of ORNAC require care and nourishment in order to grow and flourish. It needs you to support it, to contribute to it, to participate in its endeavours, and - most of all - to cherish it.

Never before has nursing been so under siege, so threatened. Never before has there been such an urgent need for dynamic, insightful, and strong nursing leadership. ORNAC is capable of such leadership. The leaders in ORNAC need each and every member behind them. We must never underestimate the power in an organization such as ORNAC. Being involved has its rewards. I gave many years to ORNAC and I don't regret one moment of it - it had its rewards. Continue to cherish ORNAC, Respect its power, and give them everything you've got!

Spirit of Excellence

Have you every stood back and watched your child or a young friend or relative and wondered, "Where did they learn to do that?" Or said to yourself "What a kind and thoughtful gesture. My kid did that ?" Where do you think they learned those things? From whom did they inherit their abilities and talents? From you. You taught them to be kind, to want to do well, and to be excellent. Just as you have done for students and colleagues in nursing.

Remember my mentor Joyce, remember those that you have had and remember the many times that you have done the same for others. All too often we have run into someone who possesses great knowledge and ability who has no intention of sharing this. It's as if their professional image is diminished as a result of enhancing someone else's.

You've heard "love isn't love until it's given away". I think the same can be said for excellence.

As you help to bring a new life into the world, or care for a sick child, or return a parent to their family, or ease the pain of a dying patient, you are caring and

you are sharing your spirit of excellence. Each task you perform for your family and loved ones, each lesson you hear, and each tear you dry is an example of caring and sharing.

It is said that if you want to be a better tennis player, you should play with someone who challenges you or who is a better player than you are. When it comes to excellence, hang out with people who bring out the best in you and make you be your best.

Nurture your spirit of excellence. Like a fresh acorn, polish it, be proud of it, and share it.

Spirit of Curiosity

It is said that the only constant today is change. Such change requires constant learning. A commitment to life-long learning will enable you to keep pace with the changes occurring in our world. Is there anyone who can foresee with absolute certainty, how we will guarantee compliance to standards in these changing times? Maintaining professional competency will become increasingly important for ensuring quality care to our patients.

When I sit down to do something on the computer and I need help, I ask my son. Many OR Nurses can identify with that.

Researchers tell us that kids have a natural curiosity which, unfortunately, becomes stifled and begins to wane in kindergarten. We should encourage that spirit of curiosity in our children, our students, and our colleagues. These words attributed to John F. Kennedy demonstrate this spirit.

"Some people see things as they are and ask "why"? I see things that aren't and ask "why not"?

This legacy, this spirit of curiosity, also needs to be valued and shared. In your quest for lifelong learning, learn first to ask Why? Then, ask Why not?

Spirit of Fun

We all have special memories of experiences, even conferences, when we really had lots of fun. A time when you laughed a lot, shared good times, and, as the Jasper conference taught us, you hugged a tree. Can you remember the last time you had fun - lots of fun ? Hopefully, you will remember events of this conference week. But if you try to go back beyond that, how do you do? Can you recall making plans to just have fun - making an appointment to have fun! We should all take the time to plan time for fun.

We often tell others to "take time to smell the flowers, or "hug a tree, but are we good at following our own advice? Don't let the "if onlys" creep into your life. Make every moment count. You have inherited a spirit of fun. Enjoy it, share it, and "go for the gusto! Don't let those precious moments slip by. Don't live with regret.

What is Success?

To laugh often and love much,
To win the respect of intelligent persons and the affection of children;
To earn the approval of honest critics and endure the betrayal of false friends;
To appreciate beauty;
To find the best in others;
To give of one's self without the slightest thought of return;
To have accomplished a task, whether by a healthy child, a rescued soul, a garden patch or a redeemed social condition,
To have played and laughed with enthusiasm and sung with exaltation,
To know that even one life has breathed easier because you have lived;
This is to have succeeded.

Ralph Waldo Emerson

OR nurses "have played with enthusiasm and sung with exaltation" this week. Throughout their professional lives, OR nurses have an unrelenting devotion to their work as they seek to know that even one life has breathed easier because they have lived. This is success. Tradition and beyond - we have reflected on our roots and hopefully, I have given you some thoughts to guide you as you branch into the future. We have been left a legacy - a wonderful gift of ORNAC - the organization, and spirit. It is now yours to cherish, enjoy, and hand on to the next generation. Only by sharing it with others can we ensure a measure of our own immortality. Just as the pioneers of the past have become immortalized in us, so too will we become immortal as we pass our legacy on to the generations to come. Just as the tree completes the cycle of life, so too can we grow from our roots, nourished with our spirit to blossom into something grand and beautiful. From tradition and beyond — beyond into our tomorrows and our future.

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Laparoscopic Transperitoneal Nephrectomy

By Lorette Krivak, RN

With the introduction of laparoscopes an evolutionary field has been opened to operating room nurses. At Concordia General Hospital, Winnipeg, Manitoba, the nurses experienced a surgical procedure that we would like to share with perioperative nurses across Canada. This was the first laparoscopic nephrectomy to be performed in the province. June 9th, 1994 was our target date and the excitement in the O.R. increased as the day approached.

Our staff urologist Dr. Martin Rifkin, M.D., FRCS (C), was very informative during the inservice describing the procedure. "The candidate for such a procedure has to be well selected to avoid unnecessary complications", he said. In an effort to decrease the morbidity associated with open renal surgery, laparoscopy is applied. By decreasing incision size morbidity is greatly reduced.

Our patient was a 74 year old female with a six year history of recurrent urinary tract infection, left pylonephrosis associated with left flank pain. Thorough investigation revealed scarred left kidney. Multiple courses of antibiotics were persued and the patient continued with persistant infections.

Indications

1. Any benign disease of the urinary tract which requires surgical removal for cure (renovascular hypertention, chronic infection not responsive to medical therapy, chonically obstructive symptomatic nonfunctioning kidneys, mulicystic displastic kidneys.)

2. Kidneys containing small tumors are being removed laparoscopicaly. These are confined to small (<5cm mid to lower renal) tumors. The use of laparoscopy to remove malignant kidneys is somewhat controversial, however preliminary studies demonstrate feasibility.

Abstract

This article will provide an overview of a Laparoscopic Transperitoneal Nephrectomy, including operational procedure and O.R. setup as performed at Concordia General Hospital in Winnipeg, Manitoba.

Contraindications

Abdominal wall sepsis, intestinal distention, incarcerated inguinal hernia, uncorrected coagulopathy, cardiorespiratory impairment, severe obesity, large hiatus hernia, significant adhesions, kidneys containing large tumors.

Preoperative Preparation

Informed consent addressing possibility of open laparotomy. Internal risks of open surgery are duplicated with with laparoscopic approach, i.e., bowel injury, splenic or hepatic injury, pancreatic injury, life threatening hemorrhage.

The patient is informed that laparoscopic approach will involve placement of five 5mm to 12mm incisions, each of which has the potential to cause discomfort or become infected. The patient is also informed

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of the possibility that an open laparotomy may need to be performed if the procedure cannot be properly or safely completed, or if a significant complication occurs.

Type and cross match for at least two (2) units of blood.

Mechanical bowel prep is done.

Instruments for Laparoscopic Nephrectomy

7f 11.5 ureteral occlusion baloon catheter
.035 Amplatz super stiff guidewire
Sterile plastic bag
Five Trocars: 3 5mm, one 12mm, and one 10/11mm
One 5mm curved scissors
One 5mm Maryland dissector
Multiple 5mm **atraumatic** and traumatic grasping forceps
10mm multiload clip appliers: Both 11mm and 9mm should be available
5mm endo-babcock to retract ureter
One 5mm irrigator/aspirator
One Cook Surgical Entrapment Sack (5x8)
One 10mm Cook electrical tissue morcellator
Trocar reducers: 10.5mm and 4.5mm
Umbilical tape in the room
One ring forceps
10mm fan retractor in the room
Endopath Vascular stapling device (1 vascular load)
Sutures: Vicryl-0x2 and Vicryl-3-0x2
Dressing steristrips and tincture of benzoin
Nephrectomy and Cystoscope instrument trays.

Operating Room Set Up

The surgeon stands on the opposite side of the table from the kidney to be removed.

The camera assistant stands next to the surgeon.

There are 2 video carts: the primary one is above the 1st assistant, the secondary video cart is behind the surgeon.

The sterile covered set-up for laparotomy must be in the room and ready to go in case of rapid hilar bleeding.

The morning of the surgery the patient was taken to I.C.U. where the nurses assisted the anesthetist with the insertion of an arterial line and a Swan Ganz catheter. Meanwhile the O.R. nurses prepared the surgical suite, opening bundles and necessary supplies for our first laparoscopic nephrectomy. The patient was then transferred to the operating room on a glass table, anesthetized and put in a lithotomy position for the first step in the procedure - having a ureteral catheter and a super stiff guide wire inserted for better identification of the ureter during the laparoscopic nephrectomy. Following this a naso-gastric tube was inserted.

In consultation with the anesthetist, it was decided to do the cystoscopy and insertion of ureteral catheter under fluroscopy in a general room. A foley catheter was also inserted. Both catheters were placed in a sterile plastic bag. The patient was then transfered to a regular O.R. bed on a Vac-pac ready for lateral positioning (70 degree). The patient was secured to the bed with chest and leg safety straps.

The table was then rotated away from the surgeon (40 degrees). The patient's temperature was monitored and all I.V. and irrigation solutions used were warm.

The following is a full description of the procedure as presented to us by Dr. Rifkin.

After the insertion of the catheters a full abdominal skin prep is done, which includes the entire abdomen from the xiphoid process to the symphysis pubis and from just lateral to the contralateral rectus muscle to the posterior axillary line on the ipsilateral side. The sterile plastic cover is removed from the catheters and the perineum and shaft of the catheters are prepared and separately draped thus ensuring ready access to the ureteral catheter throughout the procedure.

Operative Procedure

There are 5 port sites. One 10/11mm port is placed in the periumbilical area. A 12mm port is placed in the ipsilateral midclavicular line (MCL) immediately subcostal. A 5mm ipsilateral MCL port is placed 3-4cm below the level of the umbilicus. Two 5mm ports are placed in the ipsilateral anterior axillary line (AAL). The surgeon operates the two MCL ports, the first assistant operates the two AAL ports. The periumbilical port (camera site) is operated by the second assistant. All trocars are directed towards the renal pelvis. *(Refer to Figure A.)*

Procedure

1. Pneumoperitoneum is acheived by introducing the 14G Veress needle in the periumbilical incision insuflating the abdomen to 20mm HG. The 10/11mm port is placed and the abdomen is inspected. The 12mm port is placed below the costal margin. The laparoscope is then placed through the 12mm port, inspecting the initial port site. Next, a 5mm MCL port is placed about 3 to 4 mm below the level of the umbilicus. Now, the table is tilted back to the level position so the patient is back to full flank position from an oblique position. At this point, two 5mm AAL ports are placed, at the tip of the 12th rib and at the level of the umbilicus.

2. Incision of the line of Toldt: A 5mm reducer is placed on the 12mm MCL port. The surgeon retracts and incises through the two MCL ports while the assistant retracts tissue through the AAL ports. Incision is made from the common iliac artery to the ipsilateral colonic flexure. The peritoneal incision is continued medially until the colon can be completely swung medially away from Gerota's fascia. Care must be taken at level of attachments between Gerota's fascia and spleen and lienorenal ligament. These attachments may be secured with 9mm clips or electrocautery.

3. Securing the ureter: Looking at the area of retroperitoneum above the iliac vessel, the scrub nurse moves the ureteral catheter back and forth within the ureter to help identify the ureter at this level. The assistant retracts tissue lateral to the ureter through the AAL port. The surgeon retracts tissue medial to the ureter via the upper MCL port, while tissue over the ureter is cut and cauterized freeing the ureter up. The ureter is dissected in one plane - until a window around it is created. A 5mm endo-babcock clamp is passed through the lower AAL port to secure and retract the ureter laterally, thus providing for rapid ureteral dissection. The gonadal vein will be identified alongside the ureter and is carefully dissected and clipped and transected. The left gonadal vein can be used to lead to the main renal vein.

4. Dissecting the upper and lower poles of the kidney: After the ureter is dissected to the UPJ, the lower pole and lateral surface of the kidney are cleared of surrounding tissue. The renal capsule is identified along the upper pole of the kidney and the surrounding retroperitoneal tissue including the adrenal gland is pushed cephalid off the renal surface. Dissection is continued medially until the entire medial surface of the upper pole is exposed.

5. Securing the renal vessels: Through the lower AAL port, the assistant holds the ureter, through the upper AAL port the assistant passes 5mm forceps over the medial surface of the upper pole of the kidney and the forceps are then used to retract the upper pole of the kidney laterally and upward placing the renal hilum on stretch. The surgeon uses the atraumatic grasping forceps and scissors to dissect the hilum. By carefully moving along the ureter and UPJ, the renal vein is usually identified first. Perihilar tissue is carefully dissected from the renal vein anteriorly, superiorly and posteriorly. The renal artery should then be identified and dissected similarly. Via the upper MCL port, a muliload clip applier is placed. Five 9mm clips are placed on the artery, and the artery is transected. The vein is similarly treated, however the vein may be too wide for clips. 11mm clips may be used or a vascular endo GIA may be used.

6. Incising the ureter: After controlling the artery and vein, the remaining attachments of the kidney should be taken down sharply and bluntly. The 7F occlusion balloon is deflated and the guidewire is removed. Two 9mm clips are placed on the mid ureter and the ureter is incised.

7. Passage of entrapment sack: The 5x8 inch sack is rolled into its introducer. The drawstrings of the sack are carefully laid down along the body of the sack and rolled into it. The sack is introduced via the upper MCL port. Using atraumatic graspers, the sack is pulled into the abdomen. The sack introducer is then

Figure A

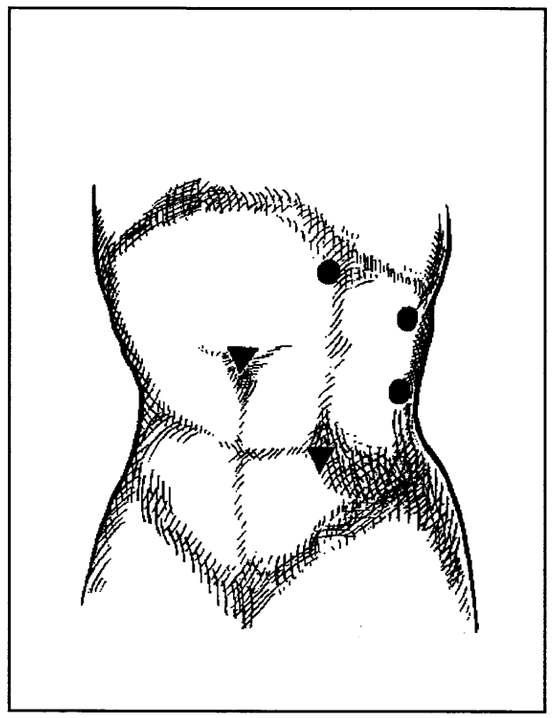
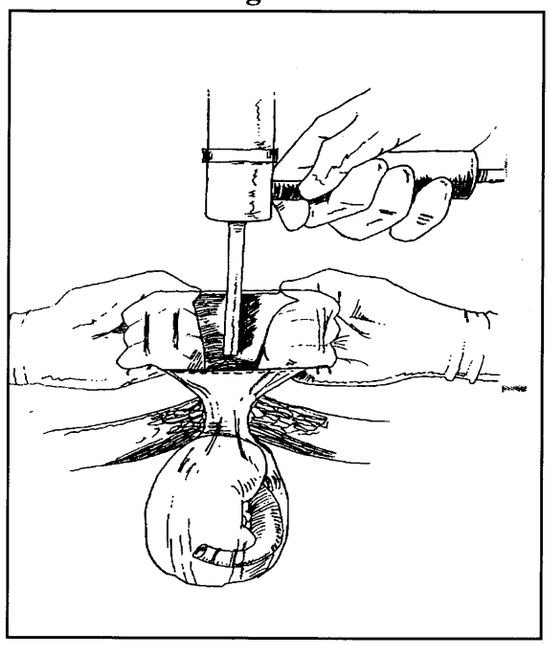


Figure B



removed from the port. The laparoscope is then placed in the upper MCL port and the sack is opened with three (3) graspers. The laparoscope is passed into the depth of the sack to open it up. The assistant uses the upper AAL port to grasp UPJ and manoeuvre the kidney into the sac. The laparoscope is moved to the periumbilical port and the drawstrings of the sac are drawn into the 12mm sheath. The intra-abdominal pressure is reduced to 5mm and a check for hemostasis is performed.

8. Tissue removal: The patient is returned to the oblique position. The laparoscope is maintained in the periumbilical port. The drawstings of the sac are pulled through the 12mm MCL as far as possible thus drawing the neck of the sack into the sheath. The drawstrings are released from the forceps, and the forceps and the 12mm sheath are removed from the abdomen.The drawstings should now rest on the abdominal wall. The drawstring are grasped and pulled by the surgeon until the neck of the sack is delivered onto the abdominal wall. The tissue morcellator is plugged in, and the handle of the morcellator is connected to suction, and the valve of the suction is in the off position. The 10mm barrel of the morcellator is firmly introduced into the sack until it contacts renal tissue. The neck of the sack is pulled up by the assistant. The morcellator is activated by depressing the foot pedal while the morcellator is moved rapidly back and forth into the renal tissue. As the renal tissue is fragmented the pieces are rapidly aspirated into the handle of the morcellator. After about 5 minutes, the morcellator is removed, the suction is turned off and the handle is removed to scrape off tissue. The process continues until all the tissue is fragmented. The empty sac is removed from the abdomen and the incisions are closed. *(Refer to Figure B.)* The fascia from the larger skin incisions are closed with Vicryl - 0 UR5 and Dexon 3-0 CE4 for skin, steri strips and mepore dressings are applied.

The patient was then transferred to I.C.U. after the 8 and 1/2 hour procedure. She was monitored very closely for 48hrs then transfered to the ward. The patient was discharged seven (7) days later and is presently doing very well.

Endoscopic surgery is the way of the future. The technique is excellent; pain management is improved, the need for hospitalization is reduced dramatically, morbidity can be avoided, and the patient is able to resume normal daily activities in a very short period of time. At Concordia Hospital, we are looking forward to advances in other laparoscopic procedures in the very near future. ■

Position Paper of the Ordre des infirmières et infirmiers du Québec

Perioperative Nursing Care

The Function of the Nurse as First Assistant

Position

The Ordre des infirmières et infirmiers du Québec, in concert with various nurses associations and certain health care settings, is in favour of the recognition of the nurse's function as first assistant. The nurse who assumes the function of first assistant during a surgical procedure is practising in the field of perioperative care, and is acting within the framework of her professional practice. The majority of the first assistant nurse's activities are conducted in the presence of the surgeon, in interrelation with him, and under his direct supervision. The nurse thus provides the clinical and technical assistance necessary for the surgeon to operate safely, and in the best interests of the user.

Report

Scientific and technological change, the development of the nursing profession, budgetary constraints, regional shortages of doctors, and quotas on residents at university hospitals all have an impact on professional practice, and on the overall work environment, particularly in the operating room.

At present, several health care institutions and numerous surgeons are making urgent demands that nurses assume the function of first assistant during the course of various types of surgery. The pressure is increased by the fact that many nurses are already faced with situations where they must provide such assistance to the surgeon. In Quebec, this situation is now common, and is tending to become widespread. A recent poll, carried out in March 1993 by the Association des infirmières et infirmiers de salles d'operation du Quebec (SOOR), confirmed that 86.6% of respondents were frequently alone with the surgeon during major operations. Moreover, 88.8% acknowledged having taken on the role of scrub nurse and first assistant simultaneously. The latter situation is deemed precarious; it could affect the quality of nurses' interventions, and endanger user safety.

Several North American groups have adopted a position in favour of recognizing the function of the nurse as first assistant. As of 1983, with the support of the American College of Surgeons, the Association of Operating Room Nurses (AORN) the largest such association in the United States made its position official. It believes that the function of first assistant is part of perioperative nursing care, and is inherent in the practice of nursing. The majority of State Boards of Nursing in the U.S. have since ratified the AORN position. In addition, the results of the recent national survey carried out by the Operating Room Nurses' Association of Canada (ORNAC), in which 361 hospitals from ten Canadian provinces participated, reveal a strong trend toward recognizing the role of the nurse as first assistant. (See National Survey page 31).

In Quebec, nurses practising in the field of perioperative nursing care, and particularly those who work in the operating room, have over the years acquired an unequalled expertise, bringing to light their specific contributions to this sector, which could be described as a nerve centre of hospital operations.

Nurses are present in every Quebec hospital where surgery is performed. Their contributions to the success of operations and to the prompt recovery of patients are indisputable. Their great versatility also allows them to intervene at different stages of the care episode, and in a variety of situations, ranging from

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Note: The position described herein was adopted by the Bureau of the Order at its regular meeting, September 29 and 30, 1994. The feminine pronoun is used in this document, without prejudice.

current and habitual care to care in emergency situations.

The knowledge and know-how of nurses are undeniable, particularly in the operating room, where they are highly valued by the surgical team, whether they be used to ensure internal service, external service, or surgical assistance.

Confident in its mission to protect the public through the monitoring of the profession by its members, and mindful of its responsibility regarding the quality of nursing offered to the population, the Order has decided to support the recognition of the function of the nurse as first assistant in the area of perioperative nursing care.

Perioperative Nursing Care

At the present time, across North America, there is an overall trend toward the development of perioperative nursing care. The concept of perioperative nursing care covers the entire care episode, during the preoperative, peroperative, and postoperative periods; the concept allows the nurse to get a global picture of the user's experience throughout the episode.

In order to manage the care episode properly, ensure the provision of quality services, and achieve the best results for the user, several Quebec nurses have taken the lead in the area of case management for target clienteles; they are convinced that they can, and indeed must, improve the organization and quality of health care. Thus, the nurse becomes the coordinator of various activities in the care episode.

Experiments in clinical case management already begun in several Quebec hospitals have given convincing results, and testify to nurses' invaluable contribution. Whether it be for clients undergoing a liver transplant, a bone marrow transplant, cardiac surgery, or a hip fracture arthroplasty, the results are the same: reduction in the length of stay, fewer consultations and laboratory tests, fewer radiology tests, improvement in the continuity of care and services, an increase in both users' and care providers' satisfaction, and improvements in care quality. In short, this approach provides an answer to the increasing costs of the health care system as well as enriches the nurses' traditional role.

In the case-management context, the nurse clinician in perioperative care is integrated into the team in order to ensure the follow-up of patients in a given specialty. Her interventions are varied, covering a range of care activities offered during the preoperative, peroperative, and postoperative periods.

In the preoperative period, among other activities, the nurse conducts a clinical assessment and a physical examination in order to identify the user's needs. She provides preoperative education and, with the user, begins to plan the care episode, including the conditions related to the user's discharge.

During the peroperative period, the nurse assumes various functions, such as those of scrub nurse and circulating nurse, and even that of first assistant. Whatever her function, the nurse's interventions are always based on the assessment data she has gathered. She is able to recognize potential risks associated with, for example, the user's position on the operating table, and to evaluate the user's condition just prior to his transfer to the recovery room.

In the postoperative period, in the spirit of continuity, the nurse ensures the communication of information relevant to the user's condition to the recovery room team. She is also responsible for postoperative education, family counselling, and the assessment of the user at discharge, as well as for follow-up in an outpatient clinic or even at the user's home.

Thus, the role of the nurse clinician specialist in perioperative care is called upon to evolve, even though, in Quebec, there is currently no established practice of nurses who, as clinicians, ensure the entirety of care during the preoperative, peroperative and postoperative periods. The Order has, however, been informed of two university hospital projects that favour integrating the nurse clinician specialist into perioperative care. Nevertheless, given the urgent necessity of responding to current needs associated with the peroperative phase, the Order is now pronouncing itself in favour of recognizing the function of the nurse as first assistant in the context of perioperative care.

The Function of the Nurse as First Assistant

The nurse who assumes the function of first assistant during an operation is practising in the field of perioperative care; she is thus acting within the framework of her professional practice. The nurse first assistant carries out the majority of her activities in the presence of the surgeon, in interrelation with him, and under his direct supervision. The nurse thus provides the clinical and technical assistance necessary for the surgeon to operate safely, and in the best interests of the user.

The nature of the activities included in the function of surgical assistance varies according to setting, type of surgery, available resources, services offered, and so on. For example, the operations performed at the Montreal Heart Institute are different from those done at the Montreal Neurological Institute or the Centre hospitalier de Montmagny. Thus, the definition of these activities must be sufficiently flexible to allow surgeons, nurses, and the health care institution the latitude necessary to act in an appropriate manner and in the best interests of the user during the course of a surgical procedure.

The duties involved in assisting must necessarily be determined by each individual institution, and governed by the rules of practice and administration of the various bodies involved. Properly speaking, the activities of assistance are numerous, diverse, and do not all need to be mentioned here. Consequently, the tasks listed below are those that currently are often carried out by nurse first assistants, or by nurses who are in the position of assisting. They are specified below for the sake of information.

- Positioning the user.
- Daubing and preparing the skin.
- Draping.
- Performing hemostasis using mechanical and thermal methods; clamping vessels, cauterizing, ligating vessels, etc.
- Ensuring the exposure of organs and tissues: suctioning, sponging, placing and holding retractors, irrigating the operating site, cutting tissues identified by the surgeon, placing sponges around the operating sites.
- Suturing facia, subcutaneous tissues, and skin.
- Selecting sutures and needles, suturing, cutting threads, tying knots.
- Using any instrument at the request of the surgeon: manipulating the laparoscope, tapping the osteotome, etc.
- Applying postoperative dressings.

When she assumes the function of first assistant, the nurse carries out highly sophisticated and specialized care activities, using technical skills and exercising the clinical judgment inherent to the practice of her profession. During an operation, for example, the nurse who acts as first assistant is always in a position to assess, detect and prevent problems related to the progress of the operation; she is also in a position to act effectively and, when necessary, take corrective or emergency measures.

Training Requirements and Qualifications

It goes without saying that the function of the nurse first assistant requires appropriate training programs. In the absence of training programs in educational institutions, and while waiting for such programs to be developed, some health care settings have established programs that are at once theoretical and practical; they are designed for nurses who have operating-room experience and who wish to take on this function.

Prior to assuming the function of first assistant, a nurse must meet certain training and experience requirements in order to ensure the quality and safety of her interventions. These requirements must be specified by the health care setting and must meet the criteria listed below, among others.

- Knowledge of professional standards, laws and regulations, policies and procedures that may bear on the function of nurse first assistant.
- Special training provided within the framework of a structured program that includes both theoretical study and practical traineeships.
- Knowledge of the responsibilities inherent in the function.
- The ability to carry out all the tasks required during the course of an operation, in an appropriate and effective manner.
- Extensive experience as a scrub nurse and circulating nurse in the operating room, corresponding to a number of years, usually five.

Methods of Implementation

In order to ensure the development and implementation of the role of first assistant in a given setting, several mechanisms must first be put into place by each centre. These mechanisms should be deployed after an agreement between the director of nursing care (DN), the council of physicians, dentists, and pharmacists (CPDP), the council of nurses (CN), and the institution's board of directors has been reached. The mechanisms are related to the following elements.

- Methods for the selection, training, and recognition of nurses likely to act as first assistants:
- skills required;
- experience required;
- evaluation of knowledge, etc.
- Methods of quality control and assessment:

- continuous assessment;
- annual assessment of performance in the context of a quality-control program

put forward by the director of nursing care.

- Rules of nursing care:
- rules governing nursing care should be established in agreement with the DN

and the CN.

- Rules of medical care:
- rules governing the surgeons who have recourse to a nurse first assistant.
- Administrative policies.

Nature of Responsibilities

The general principles and the nature of the civil and penal responsibilities pertaining to the nurse who assumes the function of first assistant are no different from those of a nurse practising in another field. Just as a physician who acts as first assistant is acting within the framework of his field of practice, the nurse who assumes the role of first assistant does so within the context of her own field of practice, giving clinical and technical assistance to the surgeon.

The surgeon remains responsible for the entire surgical intervention, and directs its progress. The nurse, in turn, assumes the function of first assistant, and carries out the majority of her interventions at the request of the surgeon, and under his supervision. However, taking into account the full extent of the autonomy conferred on her by her field of professional practice, the nurse who acts as first assistant remains fully liable for any errors that fall within her area of competence. She must therefore assess all orders she receives in the light of her knowledge. She must also conduct her interventions in an appropriate manner, using the necessary skills and exercising sound professional judgment under all circumstances.

Conclusion

The Ordre des infirmières et infirmiers du Québec considers the function of nurse first assistant to be situated in the evolving context of professional practice; it is a response adapted to the population's needs in health matters, as well as to the demands of the health and social services system in the province of Québec.

(**Legal deposit:** Second quarter 1995. Bibliotheque nationale du Québec National Library of Canada ISBN2-89229-192-5. 1995, Ordre des infirmières et infirmiers du Québec)

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English translation
Services d'edition Guy Connolly

Plein Feux Sur I.I.P.A.

(Infirmiers, Infirmières Premiers (ières) Assistant (es)

Par Claude Marcil, BScN

En 1992, les Infirmières et Infirmiers des salles d'opération du Québec créaient un comité Ad Hoc sur l'Infirmière première assistante.

C'est alors, que le comité allait entreprendre une grande aventure.

C'est lors d'un Congrès Provincial des I.I.S.O,Q. tenu précédemment que les infirmières nous demandaient de se pencher sur la question puisque particulièrement en région éloignée, la pénurie d'assistant chirurgical amène l'infirmière a jouer ce rôle.

De plus, dans les grands centres urbains, la diminution de résidents en chirurgie cause une problèmatique de plus en plus importante au niveau de l'assistance opératoire.

Le 27 mars 1992, la première rencontre avait lieu à l'hôpital Ste-Justine de Montréal.

La décision de travailler avec notre corporation professionnelle (l'Ordre des Infirmierès et Infirmiers du Québec) fut unanime dans la perspective d'une planification stratégique.

Le processus de reconnaissance de la fonction d'infirmière première assistante s'engagea avec l'O.I.I.Q.

Avant de parler de Premier Assistant, il fallait définir la réalité des soins périopératoires et le rôle de l'infirmière comme étant la professionnelle de choix pour oeuvrer dans cette discipline.

Par la suite, une enquête provinciale fut entreprise en collaboration avec l'O.I.I.Q. pour mettre à jour un premier sondage réalisè en 1989 et qui nous permettait de connaître la réalité de la pratique infirmière en soins périopératoires.

Ainsi 86.6% des répondantes nous confirmaient qu'ils leur arrivaient d'être seules avec le chirurgien lors d'une chirurgie majeure et 88.8% reconnaissaient jouer le rôle du service interne et de première assistante simultanément.

Avec l'arrivée de la nouvelle technologie (chirurgie laparoscopique), une opportunité pour les infirmières de jouer un rôle plus élargi en soins périopératoires se présentait.

Par conséquent, 87.8% nous disaient qu'elles seraient intéressées à s'inscrire à un programme universitaire de premier cycle advenant qu'un tel certificat soit mis sur pied.

La conclusion de l'enquête stimula le comité à continuer notre démarche.

Madame Jane C. Rothrock

Par la suite, un plan d'action fut établi entre nos deux organismes. Madame Louiselle Bouffard, consultante aux services professionnels de l'O.I.I.Q. de même qu'une avocate du bureau firent la visite de quelques blocs opératoires pour voir les infirmières à l'oeuvre. En juin 1993, lors d'un congrès national qui se tenait à Québec, les représentants de la corporation eurent un entretien avec Madame Jane C. Rothrock Docteur en nursing et qui est une pionnière du dossier premier assitant aux Etat-Unis.

Auteur

Bacheliers "es science", Claude Marcil est infirmier-chef, responsable de l'unité des soins périopératoires du Centre Hospitalier de Lachine , P.Q.

M. Marcil est Vice-président provincial des Infirmières et Infirmiers des Salles d'opération du Québec, il est responsable du comité AdHoc sur l'infirmière première assistante.

Madame Desrosiers, nouvelle Presidente de l'O.I.I.Q., conférencière d'honneur lors du Congrès National pris contact avec l'ampleur de notre organisation et démontra beaucoup d'intérêt à notre cause.

Pour que notre dossier puisse évoluer rapidemment, le regroupement des directeurs de soins infirmières du Québec étaient informés de nos démarches.

En décembre 1993, l'Ordre produisait trois documents de travail: l) La fonction d'infirmières premières assistantes. Un pas vers les soins infirmiers périopératoires avancés. 2) Le cadre légal de la fonction d'infirmière première assitante. 3) Cadre de référence des projets-pilotes, "fonctions d'infirmières premières assistantes."

Prise de Position de l'O.I.I.Q

L'étude et la révision des documents de travail permirent de produire un document qui fut présenté aux membres du bureau de l'Ordre les 29 et 30 septembre 1994, et qui expriment la position officielle de la corporation. Ce document qui s'intitule: "Prise de Position de l'O.I.I.Q." sur la fonction d'infirmière première assistante statue que:

> "L'ordre des infirmières et infirmiers du Québec, en concertation avec divers groupes d'infirmières et certains milieux de soins, prend position en faveur de la reconnaissance de la fonction d'infirmière première assistante. L'infirmière qui assume la fonction de première assistante au cours d'une chirurgie exerce dans le domaine des soins périopératoires et agit dans le cadre de l'exercice de sa profession. C'est en présence du chirurgien, en interrelation avec lui et sous sa supervision directe que l'infirmière première assistante accomplit la majorité de ses activités. L'infirmière apporte alors l'aide clinique et technique dont le chirurgien a besoin pour procéder de facon sécuritaire à l'intervention chirurgicale, et dans les meilleurs intérêts de l'usager."[1.]

De plus, l'ordre dans son document établit un constat sur la problématique de l'assitance opératoire, exprime sa vision des soins périopératoires, définit la fonction de première assistante, discute des exigences en matière de formation et de qualification, de modalité de mise en place de ce nouveau rôle dans nos établissements et explique la nature de la responsabilité de l'infirmière dans la pratique du premier assistant.

Conclusion

En conclusion:

> " L'Ordre des infirmières et infirmiers du Québec considère que la fonction d'infirmières premières assistantes se situe dans un contexte évolutif des pratiques professionnelles et est une réponse adaptée aux besoins de la population en matière de santé, ainsi qu'aux exigences du système de santé et des services sociaux dans la province de Québec." [2.]

Fort de cette prise de position officielle par l'O.I.I.Q. nous avons commencé à entreprendre des démarches avec certaines Universités. Josette Forest, Présidente provinciale de l'I.I.S.O.Q. et membre du comite AdHoc a préparé un document qui est présenté aux responsables dans les différentes Universités, un plan de cours basé sur le "Core of Curriculum" des infirmières premières assistantes aux Etats-Unis a été élaboré.

Dans l'attente de la mise sur pied du programme universitaire, certains Centres hospitaliers, dans l'objectif de combler immédiatemment le besoin d'infirmière première assistante, ont élaboré un programme dans leur Centre où une partie théorique et une partie pratique permettent de préparer les infirmières à jouer leur rôle de première assistante.

Au Québec, nous sommes au tournant d'un nouveau rôle, l'infirmier et l'infirmière premiere assistante.

Il reste beaucoup de travail à faire mais la volonté des infirmières à voir ce rôle reconnu stimule le comité à atteindre son objectif.

References

1. O.I.I.Q. 1994 Prise de Position.
2. O.I.I.Q. 1994 Prise de Position.

National Survey Report on the PNA and PNS roles

By Gloria Stephens,
Chairman,
Advanced Nursing Practice Committee

The National Survey completed March, 1995 was conducted to determine :

1. Interest of Operating Room Nurses to support The Operating Room Nurses Association (ORNAC) in the pursuit of the Perioperative Nurse Anaesthesia (PNA) and Perioperative Nurse - Surgery (PNS) roles.
2. Potential job duties and the relationships of the PNA and PNS roles with the nursing staff.

The Advanced Nursing Practice Committee is an ad hoc of ORNAC. Membership consists of: Josette Forest (PQ), Jack Kress (MB), Rosemary Morse (PEI), Dee Robinson (AB), Marnie Simon (BC), Judi Tyndall (ON), and Gloria Stephens (BC).

Basis of the Questionnaire

Changes in job function and categories of workers are occurring because of financial restraints, advancing technology and complex surgical procedures. As a result it is time for operating room nurses to seriously determine their 'scope of practice' and advance with the changing times. ORNAC was prepared to take a stand and promote the PNS and PNA roles but first needed to know how the membership felt about the roles. Hence, the survey was conducted. The survey of 1992 determined the current practices and possible future trends for operating room nurses.

A random selection of names of OR nurses was made from each province and a total of 590 questionnaires were distributed.

Key Points in the Data Analysis

The national response rate of 48% provided a high statistical validity to the survey and an encouraging support to ORNAC to actively pursue the two roles - PNA and PNS. The primary positions responding were: staff nurses 63%, head nurses 12%, other categories 15%.

Every province had a high percent of support for the PNA role ranging from 80% in New Brunswick to 25% in PEI, except Quebec which had a 27%"no" response. The main reasons stated by Quebec respondents for the no was that the position is already held in Quebec by respiratory technicians. Another common remark on the PNA role was: "... OR nurses are already doing this role, why develop another category?"

The PNS role received a very strong support by a 71% national response.

These two roles, PNA and PNS, to be successfully performed require an advanced education program and there was a national survey support of 45% for a six-month program and a 22% support for a one year program. A frequent concern expressed was the job potential following graduation from such a program.

"How would PNA/PNS roles fit into the staffing pattern", was a question on the survey. The national response was 47% for the roles to be combined with the regular staff, but have specialized functions.

The complete Provincial results may be obtained through each Provincial President as space in this article prevents a more detailed reporting.

The survey covered the following areas with the choices: Yes, No, should be, should not, always, never, shared, and recent. The **highest national responses** to the questionnaire in percentages are indicated in bold face type.

Gloria Stephens retired from the ORNAC Board and St. Paul's Hospital, Vancouver this Spring after an outstanding and highly honored nursing career.

Perioperative Phase - Circulating Nurse

• Responsible for participating in perioperative patient teaching. **31% Should be**

• Responsible for participating in perioperative family teaching. **41% Should be**

• Responsible for Receiving, Identifying and Assessing the status of the surgical patient. **77% Always**

Induction Phase - Circulating Nurse

• Responsible for remaining with the patient and providing supportive care during preinduction and induction of anesthesia. **85-89% Always**

• Provide physical comfort measures specific to each surgical patient in relation to vital functions. **90% Yes**

• Apply monitoring equipment to the patient. **88% Always**

• Responsible for preparing and maintaining the anesthesia equipment. **58% yes** **50% shared**

(Shared included - circulating nurse, nursing aide, anesthesia nurse, respiratory technician, central service, bio-med.)

• Responsible for Assisting the anesthetist during induction. **81% Always**

• Administer medication for intravenous use. **61%** occasionally (only if emergency) **23% No** **11% Yes**

• Dispense narcotics used by the anesthetist. **65% Yes**

• Record the narcotics used by the anesthetist in the drug register. **68% Yes**

• Responsible for assisting the anesthetist with preparation for the reversal of the anesthetic. **92% Yes Always**

Intraoperative Phase - Circulating Nurse

• Responsible for providing resources necessary for the surgical team to function efficiently. **91% always**

• Responsible for monitoring the physical well being of the patient throughout the perioperative period. **44% shared**

• Responsible for documenting nursing activities. **93% always**

• Responsible for accompanying the anesthetist when transporting the patient from the OR to the Recovery Room. **76% Always**

• Responsible for communicating patient information to the Recovery Room Nurse. **51% Always**

Intraoperative Phase - Scrub Nurse

• Responsible for performing scrub nurse role. **86% Always**

• Responsible for preparing and maintaining technical equipment for the surgical procedures. **60% Always** **34% Shared**

• Responsible for performing surgical assistant activities **60%** when there is no surgical assistant **81%** of the time when additional assistance is required.

• 88% responded that when performing surgical assistant activities the scrub nurse is also expected to perform the scrub nurse functions as well.

Since the May, 1995 ORNAC Board Meeting the chairmanship of the Advanced Nursing Practice Committee was assumed by Jackie Waisman, Immediate Past President, as the board wishes all chairmen of committees to be board members.

There will be an important meeting this June between the Canadian Anaesthetist Society and ORNAC, therefore more activity should stem from the discussions of this meeting.

ORNAC has also been corresponding with the NAFTA Anesthetic Committee and will probably be sending a representative to the August, 1995 meeting in Chicago. The Quebec OR Nurses group are making great strides in developing the PNS role and the Ontario OR Nurses are well organized for the PNA role. The details of all these activities are not ready for publication, but keep reading the Journal for further developments.

I wish to take this opportunity to thank the committee and all the respondents to the National Questionnaire for taking their time to answer and return this survey. We've come a long way and there is still a great deal of work to be done, but I am very confident the goals will be reached. ■

The Diversified Future of Perioperative Nursing was the focus of 14th National ORNAC Conference

Vancouver. There was something for everyone at ORNAC's 14th National Conference, May 8 to 12, 1995. For a full week over 700 OR nurses from across Canada, the U.S. and UK, participated in a full range of educational and technical sessions. The social functions were outstanding and the food at every sitting was first class. Plan now for ORNAC's 15th National.

The topic of RN As a First Assistant dominated the conference, and several of these conference papers are presented in this issue. In future issues of this Journal many of the 30 major lectures will be presented.

RNABC commends OR Nurses

Arlen Bruce, President-Elect of the Registered Nurses Association of British Columbia, spoke at the conference opening ceremonies.

"I have been a perioperative nurse for the past 14 years, and though my professional involment in nursing organizations has taken me on a more generalist path, I acknowledge and share, with pride in the accomplishments, my collegues, here today, have made. I remember the first BCORNG convention I attended! Three things stand out for me as I recall this event. I remember the awe after seeing one of my first plays, the Man from La Mancha at the Queen Elizabeth theater in Vancouver. Secondly, the sense of pride I came away with as professional nurse; and the third thing, the theme of the convention: "How operating room nurses are pacesetters in our profession"! This is very evident today in the following:

1. In ORNAC's development and use of standards

2. A move towards standardized levels of competencies (Canadian Nurses Association certification in Nursing Specialties)

3. In the development of futuristic roles in perioperative, advanced nursing practice, such as Perioperative Nurse Anaesthesia and Perioperative Nurse-Surgery.

Using ORNAC's published Recommended Standards as the basis for providing quality care is our Insurance, as nurses, that the public receives the high level of care they deserve.

The RNABC commends operating room nursing visionaries. Once again I am reminded with pride, of how the family of nursing is working towards the same goal: caring and protecting the public. "

OR Nurses set a record at CNA

Yves La Fortune of the Canadian Nurses Association stated at the Opening ceremonies he would be taking back to Ottawa a copy of ORNAC's '95 Conference Program as an example of a dynamic conference for the planning committee of the CNA Biennial. The program featured everything from trauma management to new reproductive technology, from fire safety to Latex Allergy.

"Over 500 OR nurses sat for the CNA Certification Exam in Perioperative Nursing this June, 1995. The was a record number in a specialty exam for the CNA and a proud record for Canada's perioperative nurses. Congratualtions to all those candidates"

Mr. Lafortune said it had been a busy and challenging year for all nurses across Canada.

" The CNA has initiated a number of key projects to respond to an unsettled environment. The CNA has initiated a national nursing competency project, a review of the code of ethics and it is also preparing to host the World of Nurses at the ICN Congress in Vancouver in June 1997.

The CNA Certification Program remains a fundamental part of our support of Canadian nurses and I am pleased that we are able to offer the first certification exam in perioperative nursing this June.

On behalf of the CNA I would like to thank ORNAC and all the nurses who assisted in developing the certification exam, for taking the time, for your effort and your dedication. Our certification exams are truly developed by nurses for nurses. "

Editorial Award

The winners of the ORNAC Johnson & Johnson Medical Products Drake-Thompson Writing Award are **Gloria Stephens** author of "Perioperative Nurse Anesthesia", and **Jack Kress** of St. Boniface General Hospital, Winnipeg, MB, for his article "The RNAA Program Enhances the O.R. Team". Both articles were published in the *Canadian Operating Room Nursing Journal*, May/June, 1994, Vol. 12, No. 2.

The $3000 cash award will be shared by the two winners. (See photo of presentation on page 37).

Isabelle Adams Award
Excellence in Perioperative Nursing

At the Closing ceremony, following the lecture of Joan Donald on 'ORNAC's Legacy', see page 15, Shelly Zareski, chairperson of the ORNAC Awards Committee provided delegates with an explanation on the Isabelle Adams Award for Excellence in Perioperative Nursing. The selection is by the vote of OR nurses from across Canada. There is no monetary value to the award, it is an honor to be named and highly prestigious. The recipient joins the ranks of previous OR Nurses of Excellence, the late Val Sherriff, Toronto; Gloria Stephens, Vancouver; Muriel Shewchuk, Calgary; and Jacqueline Craig, Montreal.

Shelly Zareski continued:

"The person that was chosen for this award is an efficient motivated individual, especially known for her ability to make decisions and lead by example. She has been a nurse for over 25 years and has worked in a variety of positions in the health care field.

After receiving her diploma in nursing she aspired to continue her education and make learning a life long pursuit. She is recognized for accomplishments both provincially and nationally and has held executive positions at both levels of our operating room associations.

She has not only made a significant contribution to the nursing profession but is involved with many community agencies as well. She has been a speaker at the local, national and international level.

If I told you that she is a people person with the ability to bring interdisciplinary groups together in order to focus on mutual goals and achievements, would the name Joan Donald come to mind ?"

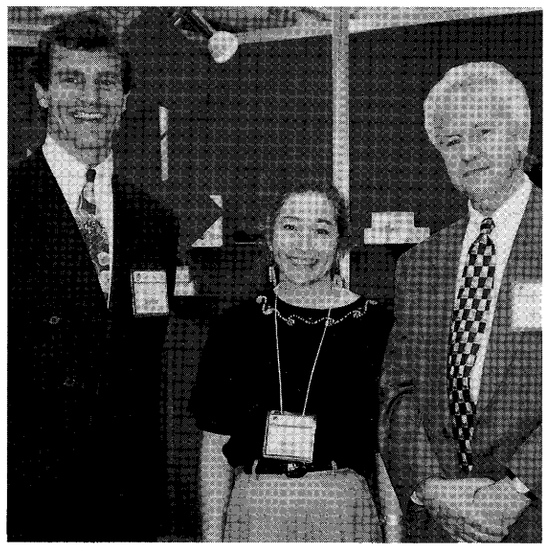
With the announcement of Joan's name the delegates squeeled with delight and applauded their approval. Joan was stunned and unbelieving.

Jackie Waisman, ORNAC Immediate Past President made the presentation of the medal.

Joan Donald, RN, BScN, BEd, MA(Ed) is a charter member of ORNAC and served as President 1988 - 1990. She was previously Director of Ambulatory Care, The Moncton Hospital, Moncton, NB. She is presently enrolled in doctoral studies in Education at the University of Toronto.

Joan Donald, recipient of the Isabelle Adams Award for Excellent in Perioperative Nursing.

Fern Watson from Chedoke-McMaster Hospitals, Hamilton, ON, at the '95 National Conference in Vancouver with Jeff Somerville, Manager Davis & Geck's Ontario Region (left) and Jim Miller, Sales Rep. (Rt). Fern was the lucky winner of the Davis & Geck educational trip draw made at the closing ceremonies of the '94 Ontario Provincial OR Conference.



Speaker Lorna Murphy (far left) and delegates. Arden Bruce, (above) President-Elect, RNABC.

Dave Patterson of Johnson & Johnson presents the Editorial Award to Gloria Stephens for 1994. She shares the award with Jack Kress of Winnipeg.

Jane McClain of Lethbridge moderates a conference session.

Conference committee members - Helen Calveley(front) and Bob Bothwell of MDT with Susan Kerr (left) and Cory Both. MDT sponsored the daily Fitness Program.

Speaker Estlle Davison-Crews. Her lecture will be featured in a later issue of this Journal.

ORNAC 14th National Conference - Vancouver

Yves Lafortune of the Canadian Nurses Association, Ottawa.

Opening ceremonies of ORNAC 1995 Conference

Over 700 OR Nurses registered for the Conference.

Dr. Hedy Fry, a Vancouver physician and Member of Parliament apologized for all physicians who ever kept OR nurses waiting.

Lorraine Varner of Kelowna, B.C. spoke of rituals and research in the OR. Watch to see her paper in the September Journal.

The Squamish Band of five drummers with leader Chuck (photo below) and his Talking Stick at the colorful and exciting Opening Ceremonies.

OR BURSARY

The ORNAC/Johnson & Johnson Medical Products Bursary is offered to financially assist members of the Operating Room Nurses Association in Canada (ORNAC) in furthering their education in areas that will enhance perioperative nursing practice.

Applications are invited by ORNAC's Awards Committee yearly. Deadline for submission is March 15th. Bursary application forms are available from:

Shelly Zareski
Chairperson
ORNAC Awards Committee
5572 North Ridge Road, #1206
Halifax, Nova Scotia
B3R 5K2
Telephone (902) 454-0463
Fax: (902) 428-3214

CALENDAR

World Conference of OR Nurses - IX
September 10-15, 1995, Sponsored by the AAORN, Hamburg, Germany.

October 20 & 21, 1995
Operating Room Nurses' of Hamilton & District 11th annual conference presents "Saving Our Sanity". Sheraton Fallsview Hotel & Conference Centre, Niagara Falls, ON. Come for a few days of laughter and learning.
Contact: Chalene Smith (Registration), (519) 853-2538
Milton District Hosp. (905) 878-2383 Ext. 2318

October 27 & 28, 1995
Operating Room Nurses Association of South Central Ontario present 'Thriving, Not Just Surviving'. Pinestone Inn, Haliburton, ON. A few days of education and rejuvenation. Direct inquiries to: Kathy Bruce, c/o Whitby General Hospital. (FAX: 905-430-3421) or phone 905-668-6831 Ext. 1284.

May 6-8, 1996
Operating Room Nurses of Ontario 4th Provincial Conference, International Plaza Hotel, Toronto. Sharon Ball, Exhibit Chair, Janet MacCullouch, Publicity Chair.

ORNAC '97
15th National ORNAC Conference Ottawa,ON.

Correction

to ORNAC's Recommended Standard #8
"Scrub, Gown , Glove"
Section 8.13 should read:

If a glove becomes contaminated or sustaines a pin hole, the glove shall be changed as soon as the situation permits by one member of the sterile team regloving the other member. If not possible, by open glove method.

Rationale:
Once the original gloves are donned, the gown cuffs are considered contaminated.

Wanted

ORNAC is trying to locate copies of the May, 1986 *Communiqué.* If you have a copy or know of someone who has an extra, please forward it to:

Ms Vija Hay
ORNAC President
1195 Richmond Road, Suite 607
Ottawa, ON K2B 8E4

Alaska Cruise

After the Conference 41 delegates, relatives and friends boarded *Sky Princess* for a seven-day Alaskan Odyssey which included stops at Juneau, Skagway and Sitka. The delegates enjoyed a variety of activities and shore excursions, including: helicopter and airplane flights to Mendenhall & Taku Glaciers, Salmon Bakes Wildlife Sightseeing, Historical Bus Tours, A train tour on the White Pass & Yukon Railway to the great continental divide near Skagway, whale watching boat tours, kayaking, visits to local sites and native displays. If any group were to win a prize for the most tours taken during a cruise, that award would be won hands down by the ORNAC delegates. They did it all! Only an OR nurse could muster up the stamina to continue the non-stop activity for a full seven days.

While on the Sky Princess, the "love boat", the delegates also found the time and energy to take in many onboard activities that the cruise line offered: line dancing - karoake singing - horse racing - bingo champagne waterfall building & tasting - cocktail parties - dancing - duty free shopping professional entertainment featured every evening in the show lounge. Again, the group was tireless. Some even work out in the gymnasium while others worked on the midnight buffets. A great time was had by all.

Gloria Stephens and her husband Tim were part of this group celebrating Gloria's retirement after 30 years from St Paul's Hospital. The cruise was a retirement gift from her many friends at St. Paul's Hospital.

The tour organizer and escort, Mary Raikes-Tindle, was a OR nurse for 29 years with the Vancouver General Hospital. Report&photo credit to Mary.

Photo: On the Cruise (ltoR) Carol & Gerry Starr, Peterborough, ON; Mary Raikes-Tindle; Marie White, Peterborough, and Hilda Gatchell, Oshawa, ON.

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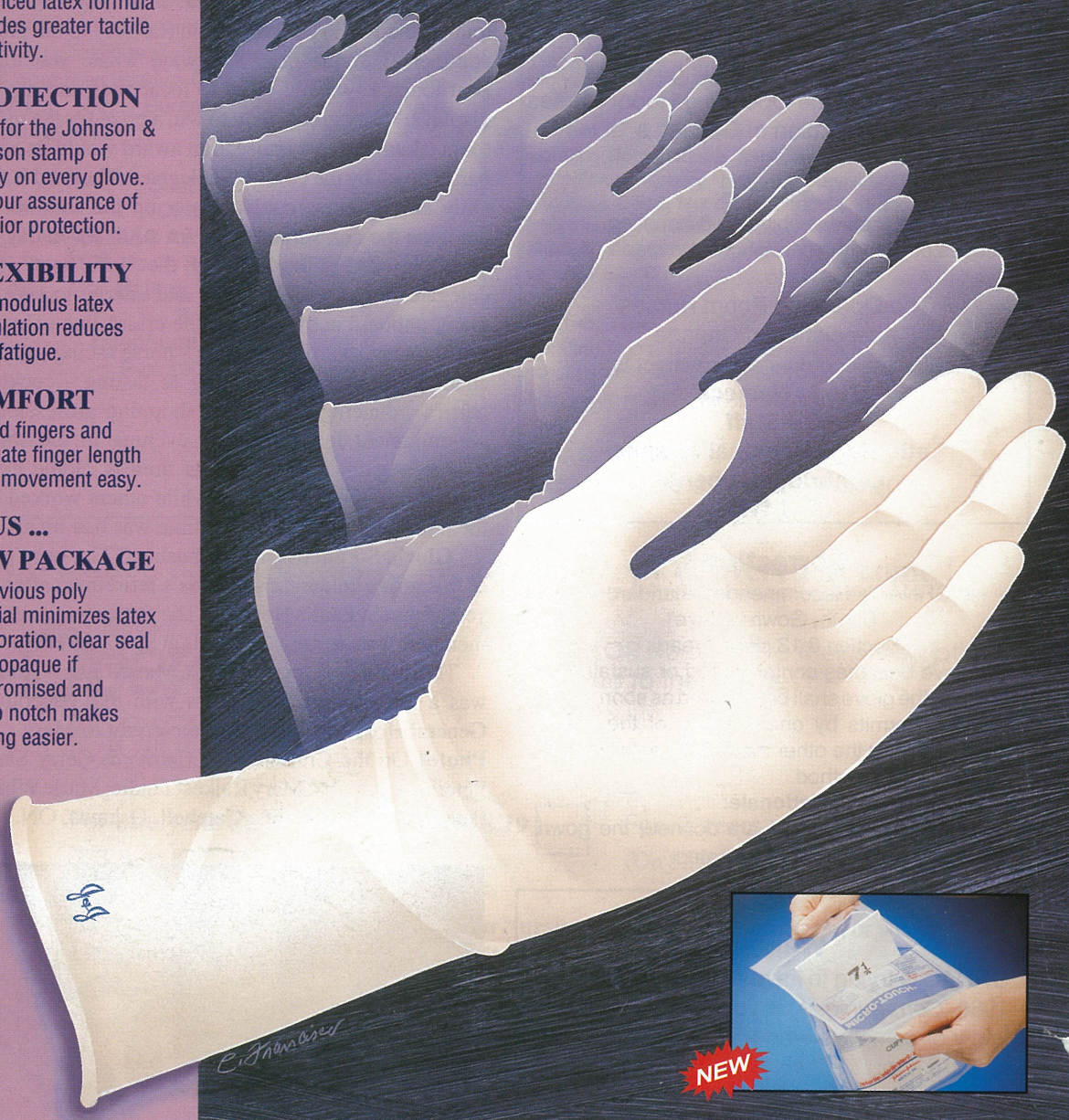

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