

Canadian
Operating
Room *Nursing*
Journal

Volume 12, Number 1, March/April, 1994

OR Nurse

Perioperative Nursing
Practice

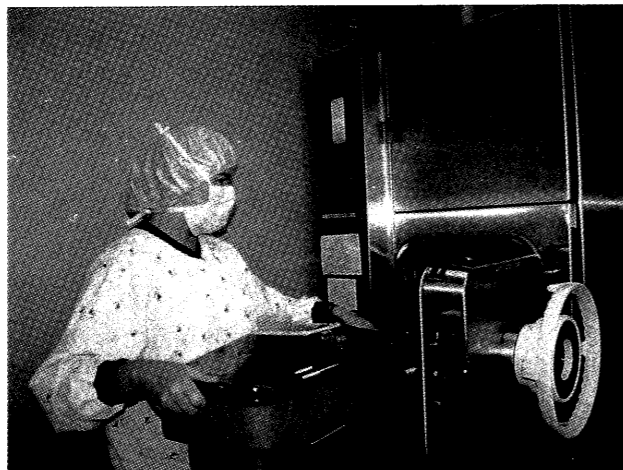
Anaesthesia

Surgery

Expanded Role
of the OR Nurse

Flashpak Closed Flash Container

- Maintains Sterility for 24 hours
- Avoid Risk of Contamination
- Solution to Mobile Sterile Field



Endopak

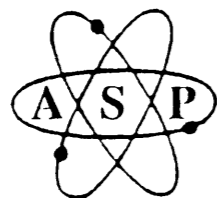
Protection for storage and processing of your costly Lap-coly instruments.
Can be processed by Steam, E.T.O. Gas, or Cold sterilant.
Variety of sizes to meet all your requirements.



CLASSIC
Surgical

(EAST)
L T D.

1-800-268-2202
(Ontario)



ADVANCED
SURGI-PHARM
AVANCÉE INC.

(514) 393-9535
(Québec)

CLASSIC
Surgical

L T D.

1-800-663-6575
Western Canada

Canadian Operating Room Nursing Journal

Published for the Operating Room Nurses
of Canada by Health Media Incorporated.

Volume 12, No. 1, March/April, 1994

Editor: Agnes Forster

Editorial Board:

Sandra Betts, R.N. (Chairperson)
Saint John, New Brunswick
Eva Marie Lessing (Co-Chair & Secretary)
Winnipeg, Manitoba
Geraldine McEvoy, R.N.
Kirkland, Québec
Josette Forest
Lévis, Québec
Hilda Gatchell, R.N.,
Secretary (ORNAC)
Oshawa General Hospital, Oshawa, Ont.
Loretta Thomas - Aasen, R.N., B.S.N.,
President-Elect (ORNAC)
Weyburn, Saskatchewan

Ron Forster
Publisher & Advertising Manager
Sherri Cannon - Subscriptions Manager

**Canadian Operating Room
Nursing Journal,**
14453 29A Avenue
White Rock, B.C.
V4P 1P7
Phone: (604) 535-7933
FAX: (604) 535-9000

Subscription Rates: 1 Year 2 years
Canada \$ 17.00 \$27.00
United States \$ 22.00
Other Countries \$ 26.00
Single Copy orders \$ 5.00
Add GST @ 7% to all orders. R102310323
Canadian Operating Room Nursing Journal is in-
dexed in *Index Medicus*, the Cumulative Index to
Nursing and Allied Health Literature.
I.S.S.N. No.-0712-6778
Publications Mail Registration No. 5934

- 5 **ORNAC's Mission, Values and Vision Statements**
By Jackie Waisman, ORNAC President
- 6 **The New Code of Ethics: Implications for Perioperative Nurses**
By Corina Balcom
- 9 **Professionalism**
By Shirley Gallant, Carol Anne Howe and Donna Wheaton
- 12 **Expanded Roles - OR Nurse**
A letter to Ontario nurses to support the ORNAO's proposed expanded roles
By Judi Tyndall
- 14 **ORNAC's Research Committee Report**
By Loretta Thomas-Aasen
- 15 **2nd National Survey Report**
On the Expanded Role of the OR Nurse
By Gloria Stephens
- 22 **Nurses' Perception of Desirable Qualities/ Characteristics of a Good Leader**
By Brenda-Lee Kingdon
- 28 **Workload Measurement Tool for an Integrated OR/PACU**
By Cynthia A. McLennan

ORNAC's Mission, Values and Vision Statements

By Jackie Waisman

As a result of the October, 1993 ORNAC Board meeting, a task force consisting of the ORNAC President, Chairmen of Research, Certification and Standards met to revise the existing Philosophy and Mission statements of the Association. Incorporating these existing statements and feedback from the Board of Directors, the Mission/Values/Vision statements were completed. At the April Board meeting the Goals of the Association for 1994-95 will be established. These will be an extension to the Mission/Values/Vision. Should you have any questions or comments, please do not hesitate to contact the President of ORNAC. The Executive and Board of Directors look forward to your feedback.

Mission, Values, Vision and Goals

An overview of the key components of a strategic plan including Statements of Mission, Values, Vision and Goals will be described in the following paragraphs.

- A mission statement describes what an organization is and its purpose.
- Statement of values reflect the basic beliefs that are most important to an organization. Values drive the organization.
- Vision statement identifies who or what an organization wishes to become.
- Goals refer to what an organization hopes to accomplish and are detailed statements that when accomplished will help the organization achieve its vision.

Mission Statement

The Operating Room Nurses Association of Canada is an organization of Registered Nurses dedicated to:

- The promotion and advancement of excellence in perioperative patient care.
- The professional and personal enhancement of operating room nurses.

Values Statement

These values reflect the basic beliefs that are most important to the Operating Room Nurses Association of Canada:

Knowledge: We recognize and are committed to education and research as essential components guiding our practice.

Collaboration: We will collaborate with nurses within our specialty organizations/agencies and other disciplines that impact our practice.

Respect: We will recognize the worth, quality, diversity and importance of each other and the patients we "care" for.

Professionalism: We will work together to promote and advance our specialty.

Continuous Quality: We will strive to achieve excellence in perioperative practice and activities influencing our association.

Vision Statement

The Operating Room Nurses Association of Canada will be a strong, unified association striving to maintain, enhance and advance perioperative nursing practice.

Author

Jackie Waisman, Nurse Manager, Operating Room and Recovery Room, Red Deer Regional Hospital, Red Deer, Alberta, is President of ORNAC.

discover



Joseph Lister was the inventor of the Carbolic Acid Spray in 1865. It was Lister's determination

and utmost desire to develop and improve surgical techniques, that led him to his invention, which in its time, was inspired and revolutionary.

1865


Downs Surgical and Lister are very alike in the way they work, in that Downs Surgical are persistent in their search for advancement and progression within the medical field. It is this knowledge that gives surgeons assurance when using Downs Surgical instruments and in turn makes Downs Surgical one of the leading names in the medical field today.

Parkway Close,
Parkway Industrial Estate,
Sheffield, South Yorkshire
S9 4WJ England.
Tel: +44 742 730346
Telex: 547667 DOWSURG
Fax: +44 742 701840



Downs Surgical is a part of
AESCULAP LTD

DISCOVER  DISCOVER QUALITY

For further information of the products and services offered by Downs Surgical, contact , your local distributor.
50 Steeles Ave. E., Suite 15, Milton, Ontario L9T 4W9 Tel: (905) 878-4400 Fax: (905) 878-5044

The New Code of Ethics: Implications for Perioperative Nurses

By Corina Balcom, R.N., B.N.

History

Nursing has advanced since the time of Florence Nightingale to become a highly specialized profession. "The categorization of an occupation as a profession has traditionally been based on fairly standard criteria, developed by persons with expertise in the study of professions" (Kerr & MacPhail, 1991, p. 24). As Kosier and Erb (1988) state, "The standards of training and practice for the profession are determined by the members of the profession, rather than outsiders" (p. 6). It is in the area of standards of practice where ethics becomes a professional responsibility.

Hendrickson and Deloughery (1991) describe ethics as, "...the branch of philosophy that deals with the dynamics of decision making concerning what is right and wrong" (p.178). Nursing ethics are specifically designed to meet the needs of the nursing profession.

The Code of Ethics for the nursing profession evolved out of a need. Nurses have always been taught to promote the well being of clients, family, and the public, but historically this concept was often overlooked. Many nurses were told by physicians to accept

Abstract

This article will look briefly at the historical development of the Code of Ethics for Nurses and then critique the New Code of Ethics. From there, aspects of the Code will be applied to perioperative nursing.

The Canadian Nurses Association (CNA) revised its Code of Ethics of Nursing to all its members in November, 1992. Nurses can be guided by this document in ethical issues which they must face in their work. Perioperative nurses encounter specific situations daily, for which the Code of Ethics can be a guide.

and follow their orders without question. This meant nurses also had to ignore procedures they felt to be inappropriate, unnecessary, or which caused harm to the patient. Consideration was seldom given to the nurse's personal values which could be in sharp contrast to a physician's or an employer's.

A final circumstance during World War II, as Kerr (1991) tells us, was, "Unacceptable experimentation on and treatment of human beings during the war led to the Declaration of Universal Human Rights in 1948, and the health professions focused attention on the necessity of protecting individuals from unscrupulous, unethical, and incompetent practitioners" (p. 191). As a result, the International Council of Nurses (ICN) developed a Code of Ethics in 1953 which could be used as a standard for measuring nurses conduct.

The CNA generally accepted and used this code until 1980 when the first CNA Code of Ethics was developed. Kerr (1991) explains, "disagreement about the wording of the initial Code resulted in the development of a new Code, adopted in 1985" (p 27). Presently the CNA has seen the need to review the Code and is mandated to do so every five years.

Hendrickson and Deloughery (1991) tell us that recent developments in society have increased nurse's ethical awareness. These advances include the following:

1. Technological advances such as transplants, artificial organs, amniocentesis, and respirators have allowed for prolonging life. They have also prompted

Author

Corina Balcom, R.N., B.N., is staff nurse in the operating room and recovery room at the Newcastle Facility of the New Brunswick Region 7 Hospital Corporation, Newcastle, N.B.

questions as to which is more important, quality or quantity of life.

2. The Rights of all patients have been recognized and health care workers are obliged to respect these rights.

3. Legal intervention in malpractice cases has brought awareness of ethical issues to everyone.

4. Finally, the lack of resources, such as new machines, trained personnel, donor organs, and money result in ethical problems. (Hendrickson and Deloughery, 1991).

Critique

One of the positive aspects of the new CNA Code of Ethics for Nursing is that it is a very readable document. The index is well set up so that anyone looking for specific information can quickly access it without searching the complete document. The point form format makes information findable and understandable as each point can stand on its own or be viewed in the larger context in which it is used. It is advisable for nurses to read the Code often so as to review expected professional behaviours as well as to be reminded of their continuing ethical obligation to clients and the profession.

Nursing practice is defined at the beginning of the Code. This serves as a consistent guide for all Canadian nurses rather than relying on other definitions or even a nurses own interpretation of what nursing is. The definition in the new Code is very broad and allows for the whole scope of nursing practice to be included whatever the direction of the nurse theorist, the work setting, or focus of care.

The significance of having a Code of Ethics is addressed throughout the document. The preamble states, "the nurse, by entering the profession is committed to moral norms of conduct and assumes a professional commitment to health and well being of clients" (p.1). It goes on to emphasize this in relations with clients, other nurses, other health care workers, and the greater society.

The moral norms of conduct are listed in terms of values. The Code and its interpretative statements, which explain the obligations, provide behavioural direction for nurses as they perform nursing activities with high quality nursing care and ethical obligations as the outcome.

The CNA, as stated earlier, had mandated to review the code every five years. A concern is that this time period may in the future have to be decreased. If technology continues to advance and accelerate as it

has in the recent past, eventually a two year or maybe even a yearly review will be required to keep up with ethical issues under study at present and in the future, issues we can't even imagine.

Dunphy and Mercer (1992) mention several areas of the Code where more explanation is required. For example, although they feel nurses should have structures in their workplace where they can voice complaints, these structures are not explained. Dunphy and Mercer (1992) also warn, "specialty nurses should be wary of modifying the Code for their own area" (p. 21).

The Code and Perioperative Nurses

The code of Ethics applies to nurses in all practice settings. The operating room (OR) and recovery room (RR) are no exception. Two ethical concerns which face us daily in our practice are advocacy and refusal to care for patients.

Advocacy

Dunphy and Mercer (1992) comment on the new CNA Code as remaining fairly constant in its main points. They do, however, point out some of the significant changes. They say, "One of the changes in the new Code lies in the nurses role as patient advocate" (p. 19). Kosier and Erb (1988) say, "an advocate pleads the cause of another or argues or pleads for a cause or proposal" (p. 18). Perioperative nurses are in a unique position to advocate for the patient.

One of the roles of an advocate is to "inform patients of their rights and options and of the consequences of these options" (Kosier & Erb, p.18). A client who requires a surgical procedure has the right to be informed about the risks, benefits, and expected and potential outcomes. Basically this is a medical responsibility. However, OR nurses in preoperative assessment are able to determine fears and anxieties which the patient and/or family members may have and their need for information about their procedure.

This information, as stated previously, is learned during the assessment phase of the preoperative (pre-op) visit which ideally is conducted the day before surgery for hospitalized patients. With the recent increase in Day Surgery and Same Day Surgery these interviews must be arranged individually with clients prior to their surgery. The nurse is able to give information which reinforces and supplements that given by the surgeon and anaesthesiologist. The nurse's relationship with client and family, addresses Value I of the Code which shows, "respect for needs and

values of clients" (p.1).

The rapport established during the pre-op visit can help the patient confirm that the nurse will be his advocate, protector, and caring professional during the time when he/she is unconscious or sedated. The patient at that time is in a powerless position, unable to make a decision concerning his well being. The circulating nurses role is to "control the physical and emotional atmosphere in the room...for the safety and welfare of the patient" (Atkinson, 1992). The tasks of the circulator reinforce the advocacy role and some of these are listed as follows.

1. The circulating nurse provides an atmosphere that is warm and quiet.

2. She/he must insure proper positioning of the patient and have available items to pad and protect bony surfaces, prominent nerves and blood vessels.

3. The circulator must also protect the patient from electrical hazards by using only approved and properly functioning equipment. The importance of proper grounding is also a responsibility of the circulating nurse.

4. As well, respect must be shown for a patient's religious and cultural beliefs and their right to privacy.

5. The circulating nurse is also responsible to have supplies and personnel ready in order that surgical time is as short as possible.

The preceding nursing functions allow the perioperative nurse to follow the obligations of Value XI of the Code. That value states "The nurse advocates the interests of clients" (p.21).

Refusing to care for patients

Nursing is a caring profession and its main focus is on the client and his/her well being. However, the nurse also has established norms, values, and beliefs. These ways of thinking have been developed from birth with religious and societal influences to create a unique person. From time to time a nurse will face situations which are in contrast to norms, values and beliefs of patients and employer.

One issue is that of abortion. Hendrickson and Deloughery (1991) say, "If ethically opposed to abortions, the nurse is usually excluded from participating in activities considered morally repugnant. The nurse should also realize however, that the woman having an abortion has ethical views on the issue that may differ from that of the nurse, and as a person and a patient deserves respectful care" (p.206).

The Code can be used to prevent this dilemma from happening in most cases. This situation can be de-

scribed as ethical distress which according to the Code says occurs when "nurses are ethically obliged to provide particular types of care despite their personal disagreement or discomfort with the course of treatment prescribed" (p. iii). Nurses have the right to refrain from participating in abortions in the facilities where they are performed, due to their beliefs. Value V, of the Code, under limitations says, "A nurse is not ethically obliged to provide requested care when compliance would involve a violation of their moral beliefs" (p. 10). However, the nurse is also obliged to make this known to her employer at the time of employment. The Code also guides the nurse's behaviour according to obligation number 2 of Value V which states, "In seeking or accepting employment, nurses must accurately state their areas of compliance as well as limitations" (p. 9).

Atkinson (1992) also explains that in cases of emergency where the life of a mother is threatened, the nurse could be required to participate. Again the Code is very clear in one of its first statements. Obligation number 1 of Value 1 states, "the client's perceived best interests must be a prime concern of the nurse" (p. 1).

These examples show how perioperative nurses are guided by the Code of Ethics in their workplace. It can help to achieve a balance between what is right and wrong for peace of mind of the nurse and the best interests of the patient.

References

- Atkinson, L. (1992). *Berry & Kohn's operating room technique* (7th ed.). Toronto: Mosby Year Book.
- Canadian Nurses Association (1991). *Code of ethics for nursing*. Ottawa: Author.
- Dunphy, E., & Mercer, M. (1992). The revised code of ethics. *The Canadian Nurse*, 88 (10), 19-21.
- Hendrickson, F., & Deloughery, G. (1991). Ethical influences on nursing. In G. Deloughery (Ed.), *Issues and trends in nursing*, (pp. 177-217). St. Louis Mo.: C.V. Mosby.
- Kerr, J. (1991). The practicing nurse and the law. In J. Kerr, & J. MacPhail (Ed.), *Canadian nursing issues and Perspectives*. Toronto: Mosby Year Book.
- Kerr, J., & MacPhail, J (Ed.). *Canadian nursing issues and Perspectives*. Toronto: Mosby Year Book.
- Kosier, B., & Erb, G. (1988). *Concepts and issues in nursing practice*. Don Mills: Addison Wesley.
- Merriner-Thomey, A. (1989). *Nursing theorists and their work* (2nd. ed.). Toronto: C.V. Mosby.

Professionalism

By Shirley Gallant, Carol Anne Howe & Donna Wheaton

The Shorter Oxford English Dictionary defines professionalism as:

1. professional quality, character, method or conduct; the stamp of a particular profession.

2. the position of a professional as distinct from an amateur; the class of professionals 1884.

Sec. 63-7-103 of The Tennessee Nurse Practice Act now states that the practice of professional nursing means, "the performance for compensation of any act requiring substantial specialized judgement and skill as the basis for application of the nursing process, in wellness and illness care". The judgement and skill must be based on knowledge of the natural, behavioral and nursing sciences and the humanities.

The term "professional" is much used and much abused. It is both an adjective and a noun applied to every occupation from repairing automobiles to playing football. How often one hears the expression: "He/she is a real professional".

Six major characteristics of a profession as described by Peter M. Blau and Richard W. Scott are:

1. Professional decisions and actions are governed by universal standards that derive from a body of specialized knowledge.

2. Professional expertise is very specialized; problems dealt with are limited to the specialty area.

3. Client relationships are characterized by affective neutrality; i.e., there should be no emotional involvement with the client.

4. Professional status is achieved by individual performance.

5. Professional decisions must not be based on the practitioner's self-interest.

6. The profession controls itself, and external regulation is unnecessary.

Professions must have a service orientation, and the needs of clients should be placed above the

professional's personal desires.

As an occupation moves toward professional status, the occupation is upgraded. Greater income, prestige and power accrue to the professional; and these rewards, in turn, attract higher calibre people into the profession.

Professionalization also leads to the establishment of roles, and with acceptance of the "professional role" come certain preconditioned behaviours that are "expected of the professional".

Professional nursing includes the following:

- responsibly supervising patients, which requires skills, observation of symptoms and reactions, and accurate recording of facts;

- promoting, restoring and maintaining health or preventing illness of others;

- counselling, managing, supervising and teaching others;

- administering medications and treatments as prescribed by a licensed physician, dentist, podiatrist or nurse authorized to prescribe treatment;

- applying nursing procedures that involve understanding of cause and effect; and

- nursing management of illness, injury, or infirmity including identifying patient problems.

Why is professionalism so important to the operating room nurse today? What can we do to foster an image that reflects what the operating room nurse truly stands for?

Authors

Shirley E. Gallant, R.N., is an OR staff nurse; Carol Anne Howe, R.N., is an OR staff nurse; and Donna Wheaton, R.N., is the head nurse in the operating room, Miramichi Region Hospital, Chatham Facility, Newcastle, New Brunswick.

The first step in presenting oneself as a professional is having a firm understanding of just what professionalism is. Professionalism requires that a discipline possess its own body of knowledge, that it control its own level of entry and qualifications and that it set its own standards and quality of work.

Professionalism implies such pre-requisites as basic education, the pursuit of on-going education, the ability to understand one's own role and the role of others in the performance of their duties and responsibilities.

Last, but not least, is image. We must be aware of our image, as it is a reflection of all our preparations, experiences and values.

As Mrs. Jeanine Pelland, president of the Order of Nurses of Quebec said, "Image needs to be constantly nourished in order to be renewed. It is in this way that our professional image is renewed".

The Perioperative Nurse and Professionalism

Operating room nurses have been challenged by change. As operating room nurses, we have been called upon to keep abreast of the latest developments in technology and health care. The changes occurred in a number of areas including the following: (1) Education (2) Multi-disciplinary approach (3) Research (4) Quality Assurance (5) The Nurse Consultant (6) Continuing Education (7) Primary nursing (8) Standard Care Plans (9) Staff development (10) Nursing Calendars (11) Evaluation (12) Central orientation (13) Parallel professionals (14) Nursing Grand Rounds, and (15) Problem identification

We, as nurses and professional women of the 90's, must look carefully at the above list and identify those areas where we have to reinforce ourselves collectively and individually on an on-going and regular basis.

As operating room nurses, some of the rewards we share with professionals include:

- (1) Respect by and for colleagues
- (2) A fair salary
- (3) A healthy balance in work and personal life
- (4) Recognition of achievement and opportunities for growth
- (5) Supporting our peers and colleagues involved in regional, provincial and national organizations whose efforts are beneficial to the profession
- (6) On-going education
- (7) Participation in research

(8) Never being satisfied with the status quo

If our goal is to maintain our professionalism, we have to carefully assess our personal and work lives and be aware of ourselves as professionals and individuals on a regular basis.

What approach is to be taken if one is to successfully present oneself as a professional?

In answering this question, we must stress the importance of setting an ultimate goal for ourselves.

We must be very clear in the professional perception of our role, otherwise frustration, conflict of interest and disintegration will occur. We must know not only our own roles, but those of others in order to have a reliable frame of reference.

We must experiment, keep searching and attempt to direct ourselves toward a positive professional potential and we must be committed to the nursing process in order to be more effective in our role.

To be more professional, we must first overcome three unprofessional characteristics: (1) passivity (2) low self-esteem (3) poor unit organization

In our pursuit for professionalism, we should take a close look at the connection between learning and being professional.

Learning is viewed as a lifelong process of adaptation in which effective learning plays a central role. Nursing is a challenge as well as a profession. We must strive personally to develop our careers. We should stay on top of new ideas, technological changes, new procedures and equipment. We must learn to survive in our area of nursing practice.

Maintenance of Professionalism

It is necessary for nurses to continue their education to keep abreast with the advances in the health field today and to meet the demands of a changing society.

We must readily support and promote quality assurance, performance appraisal and reinforce and develop our skills in professional judgement. In our daily performance as operating room nurses, we must be willing to help create a professional and working environment where patient care is carried out according to appropriate sterile techniques performed by a qualified staff who maintain skills profession.

If we believe our skills are going to be developed, we will be more satisfied in our jobs and thus less tendency for discontent in the workplace will be present.

We must make it a personal responsibility to establish a personal development plan for ourselves. We

must update credentialing programs; i.e., CPR - Provincial Registration, I.V. recertification annually in terms of practice domain.

Experiential and educational help support our professional growth. We must readily research activities necessary for continued development through on-going education and monitoring the proper function of equipment.

We must be able and willing to perform our functions and responsibilities competently and responsibly to learn new knowledge and skills that are required in our daily work. We must come to work regularly and punctually. We must be willing to stretch professionally.

Operating room nurses must function as close co-workers. We must form a professional bond with our fellow workers. We must share our knowledge, support our colleagues and upgrade our profession.

We should never assume that we will learn something if we happen to be at the right place at the right time. We must make learning and training our priorities. Better trained nurses can contribute significantly to improved patient care. Options for continued professional growth can increase morale and job retention among staff nurses and nurse managers alike.

Our nursing environment today is one of tradition and history. We have so much to give and so very much to gain.

To maintain our professionalism, we must be assertive, responsible and accountable. We should be active in committees; i.e., Quality Assurance, research, etc. We must develop a business-like professional attitude; i.e., that we are not just doing a job but a professional career and self-choice.

Nursing in the operating room occurs whenever there is a surgical patient who comes to our area for whatever procedure. The nurses in the operating room must act as collaborators to provide quality nursing care with the emphasis on wellness.

Collaboration is the most significant indicator of the evolution of professionalism in nursing. It is absolutely essential for us as operating room nurses.

The sharing of responsibility through collaboration by means of negotiation with nursing colleagues is an absolute must if we are to say we provide quality nursing care in our hospitals. Collaboration with our co-workers can create a positive self-esteem and professional unity in the operating room.

Achieving success in our professionalism must be well planned. How well we implement the intent of any plan directly determines if the outcome will be a

success or a failure. We, as professionals, must enjoy our work. We should be developing our personal growth by improving ourselves daily. We could improve our reading and listening and communication skills. We must invest in ourselves, associate with positive, optimistic people with goals, purpose and a direction in their lives.

We must guard our health. We should be well rested and in good physical shape. We must think of ourselves as professional role models.

Collegiality is a critical factor in achieving the goals of respect and trust. The ability to share and defer judgements are contingent on collegiality. This is essential if we are to reach the highest level of professionalism in the operating room.

Renewal of Professionalism

Nurses, as professionals, need to renew contact with nursing's rich heritage and history. By connecting with that history, nurses could develop a sense of belonging to a continuing process rather than seeing only their particular moment in the development of the profession.

A positive self-concept leads to behaviours that are productive and successful. Individuals with confidence are more likely to take risks. Nurses will recognize that they are legitimate professionals and develop self-confidence in their ability to influence change. They can acknowledge their uniqueness and measure their merit against their own standards, instead of attempting to meet an externally imposed standard.

When nurses reflect on their professional experience, they will recognize their value and how they will be affected by their social conditioning. With that recognition, they will begin to revolt against the status quo and leaders will emerge from the grassroots. They will be role models for skills appropriate to leadership in their profession.

References

- Austin, Charles J. Ph.D., Redefining professionalism in health administration. *Hospital Progress* pp. 70-73.
- Barr, Norma J., Desnoyer, Janet M. (1988 - March/April) Career development for the professional nurse: A working model. *The Journal of Continuing Education in Nursing* pp. 68-72
- McEvoy, Geraldine (1990 February) Professionalism and the operating room nurse. *Canadian Operating Room Nursing Journal* pp. 6-11
- McKay, Sheila A. (1993, April) Powering up our professional image. *The Canadian Nurse* pp. 35-37

Ontario's OR Nurses Need to... "Actively Support" the Expanded Roles - OR Nurse

By Judi Tyndall
President-Elect - ORNAO
and ORNAC Research Committee Memembr

The Operating Room Nurses Association of Canada (ORNAC) has given national approval for each province to pursue the expanded role of the Operating Room Nurse. The two major directions are:

Perioperative Nursing Practice - Anaesthesia

Perioperative Nursing Practice - Surgery

Manitoba already has an anaesthetic role in place, Alberta has approval and is developing a curriculum for surgery and anaesthesia. Quebec is actively progressing towards the Perioperative Nursing Practice - Surgical Role.

The Operating Room Nurses Association of Ontario has formed a committee and drafted a proposal (see Appendix 1) which has been submitted to the Ministry of Health, College of Nurses, Canadian Nurses Association and the Registered Nurses Association of Ontario.

The proclamation of Regulated Health Professional Acts (Dec. 31, 1993) has provided the opportunity for expansion of the operating room registered nurse role. Other disciplines are aggressively pursuing the present role of the OR Registered Nurse as well as some aspects of the proposed expanded role. (The Respiratory Technologists (R.T.) through Michener Institute (Toronto) have a course in place for the R.T. to be first assistant to the Anaesthetist.) The O.R. Registered Nurse plays a vital role in the care of the Perioperative patient. This role must be expanded in recognition of present day demands.

As an Ontario OR Nurse we would ask you to actively support the proposed expanded role. Please share this with your colleagues, surgeons and anaesthetists. Elect a contact person within your operating room to report any comments, questions, suggestions to any of the following committee members:

Committee Members:

Laurel Hopwood-Jones...FAX 905-575-2591 or
... (905)-527-4322 E3639
Alaine Young..... (905)-527-4322 E3689
Judi Tyndall..... (905)-527-4322 E2023

c/o Henderson General Hospital, Operating Room,
711 Concession St., Hamilton, ON, L8V 1C3

By now, all hospitals will have received information regarding the ORNAO Conference this April in Ottawa. We urge you to attend as this conference will provide updates on the status of this proposal.

(Appendix 1)

Expanded Perioperative Nursing Practice

Introduction

The operating room registered nurse functions in the unique role of patient advocate in the perioperative setting. As a result of significant changes in the health care system, the operating room registered nurse must now expand this role. The two major directions for expansion are the Perioperative Nursing Practice - Anaesthesia and the Perioperative Nursing Practice - Surgery.

Recommendations

Recent health care reforms have provided the impetus for the redefinition of the scope of perioperative nursing practice. To ensure efficiency and continuity of patient care, there is a need to recognize the unique role of the registered nurse in the Perioperative settings. The definition of the Operating Room Nurses Association of Canada (ORNAC) for Perioperative Nursing Practice will be used as the foundation for the

delivery of the appropriate standard of patient care.

"Perioperative nursing practice can be defined as those professional and clinical nursing activities which focus on identifying and meeting the individual needs of the surgical patient" (ORNAC Recommended Standards of Perioperative Nursing Practice, Jan. '93, p 8).

The increased patient acuity, the impact of an aging population (with underlying system problems), the diminishing human resources in surgery and anaesthesia, and the decreased financial resources have all contributed to the need to expand the unique role of the operating room registered nurse.

The two major directions for this expansion are:

1. Perioperative Nursing Practice - Anaesthesia

The function of this position will be to provide advanced clinical nursing care preoperatively, intraoperatively, and postoperatively to surgical patients undergoing an anaesthetic procedure. Specific responsibilities of the role will include:

- completion of Pre-anaesthetic patient assessments and preoperative preparation
- participation in Pre-anaesthetic Clinics
- assisting the Anaesthetist in administering the anaesthetic procedure
- completion of postoperative followups
- participation in anaesthesia rounds
- participation in clinical research projects
- teaching nursing and support staff
- performing other related duties

2. Perioperative Nursing Practice - Surgery

The requirements for this role have arisen as the result of shorter or nonexistent preoperative lengths of stay, the decreased numbers of surgical residents and interns in medical programs and the need to obtain skilled, professional assistance in both smaller urban or regional and outlying facilities.

The function of this position will be to provide advanced clinical nursing care to patients undergoing a surgical intervention. This expanded perioperative nursing practice will include:

- coordination of the preoperative care of the surgical patient (i.e. physical examination and history)
- ordering diagnostic tests according to preset parameters
- initiating discharge planning
- conducting preoperative teaching for patients and their families
- communicating pertinent information to the facility to individualize and streamline patient care on the day of surgery

- acting as a surgical assistant in the OR
- completing postoperative followups
- participating in clinical rounds
- participating in research projects
- performing other related duties

The operating room nurse would complete further education and clinical requirements prior to assuming the expanded nursing role.

Conclusion

In these times of diminishing resources and increasing consumer demands, it is critical that health care professionals use all available resources appropriately. This is important to ensure that quality patient care is maintained and that a more cost effective system is developed. It is within this climate of change that the role of the operating room nurse must expand.

The expanded Perioperative Nursing Practice roles have evolved as a natural progression of perioperative nursing practice. The education, funding and process for the development of these roles require further discussion within our professional associations and institutions across the country.



Announce

Le comité de traduction de l'A.I.I.S.O.C. recrute des membres pour la révision de documents traduits afin de fournir aux infirmiers et infirmières de langue française, les mêmes informations que reçoivent leurs consoeurs et confreres de langue anglaise. Dans le but de respecter cette mission, nous sommes a la recherche de personnes désireuses de donner bénévolement de leur temps pour la bonne interprétation des documents. Veuillez adresser vos coordonnées a:

Mariale Lapierre
34-302 rue Thibault
Lévis, PQ G6V 2J7

Translation

The translation committee of ORNAC recruits members for the translation and revision of documents to provide French speaking nurses the same information received by their English colleagues. For this purpose and to respect our mission, we are researching nurses prepared to volunteer their time for the good interpretation of documents.

Research Committee Report

By Loretta Thomas-Aasen

During the January 28, 1994 weekend the Research Committee conducted its first annual meeting as a group at St. Paul's Hospital in Vancouver, B.C. The warm British Columbia weather was wonderful, even the flowers were blooming.

Two B.C. members, Gloria Stephens and Marnie Simon, showed us the beautiful sites and superb eating establishments of Vancouver and Burnaby. Even though we took some time to appreciate the sites and sounds of Vancouver and area, we still managed to complete our weekend goals and objectives. Indeed, we had a very productive meeting. Thanks to my Committee Members for a great meeting! Meeting highlights include:

- ORNAC to fund a Registered Nurse in Graduate studies (can be non-nursing) to attend the International Research 94-95 Conference.
- Development of Anaesthesia Skills List for Registered Nurses. This information will be submitted to the Canadian Anaesthetists' Society Task Force on Anaesthesia Assistants.
- Discussion and revisions to our display posters and promotional materials.
- Revisions and acceptance of our 1994-95 Research Committee budget.
- Discussion on the availability of funding for perioperative nursing practice research.
- To communicate to O.R. provincial newsletters thereby encouraging members to perform perioperative nursing practice research.
- Research Committee to purchase a display board to be utilized at upcoming provincial and national conferences.
- Shirley Thorn developed the following documents: The Research process includes the Role of Research and Stages in the Research Process and Questionnaires includes: collecting information, types and design. This information will be reviewed and ready for distribution in April, 1994.
- Development of the Certification Survey Questionnaire, completed by Shirley Thorn with presentation to Anna Kristoff (Certification Chairperson).
- Revisions to the Committee Terms of Reference. Revisions to the following definitions: Perioperative Nursing Practice, Anaesthesia and Surgery.
- Development of our Scope of Practice for perioperative nursing for presentation to the Board of Directors.

- Research Committee Members to attend the Canadian Anaesthetists' Society Annual Meeting, June 17-21, '94 in Edmonton, Alberta.
- L. Thomas-Aasen and Shirley Thorn are scheduled to present a session on research to delegates attending the ORNAO Conference in Ottawa this April.
- Our next meeting is scheduled for April, 1994 in Ottawa, Ontario, during the ORNAO Conference.

Committee Members include: Loretta Thomas-Aasen, Chairperson, (SK), Gloria Stephens (BC), Marnie Simon (BC), Judi Tyndall (ON), Shirley Thorn (MB), Jack Kress (MB), Donna Prokopczak (AB).

Canadian Anaesthetists' Society (CAS) Meeting Highlights: - January 8th '94

Committee members include: Jackie Waisman (ORNAC President), L. Thomas-Aasen (ORNAC Research Committee), Susan Dunnington and David Gillett (Canadian Society of Respiratory Therapists, Dr. John Atkinson (Chair), Dr. Peter Duncan (CAS) Dr. Serge Lenis (CAS), Ann Andrews (Staff, CAS) and Dr. Ian White (CAS, invited guest)

This Committee is planning to complete the following prior to the June, 1994 Canadian Anaesthetists' Society Annual meeting in Edmonton, Alberta:

- Development of a task analysis of the perceived position of the anaesthesia assistant, both in and out of the O.R. environment.
- Preparation of a job description showing skills required in the function.
- Identification of the professional relationship that might exist between the assistant and the physician.
- The development of a training curriculum.

Our next meeting is scheduled for March 19, '94 in Montreal.

We will continue to keep you posted with regards to our progress. However, if you have any concerns or questions please contact me at: (306) 842-6991 (Telephone) or FAX (306) 842-4453.

Author

Loretta Thomas-Aasen, R.N., B.S.N., is President-Elect of ORNAC and Chairperson of the ORNAC Research Committee.

2nd National Survey Report Expanded Role of the Operating Room Nurse

By Gloria Stephens

Background

The second National Survey was conducted to take advantage of the large attendance of staff nurses at the National OR Conference held in Quebec City 1993. The survey questions were the same as the first survey of November, 1992. The survey was not conducted for the purpose of a comparison, but to gather more data in order to determine the 'scope of nursing practice' in the operating room.

Results were printed in the *Canadian Operating Room Nursing Journal*, September/October, 1993.

Research Question:

1. What is the current practice, throughout Canada, of operating room nurses?
2. What might the future be for operating room nurses if the role is not expanded?

Methodology

The questionnaires were divided between the Provinces which corresponded to the percentage of responses for the national survey conducted in November, 1992:

- for ease of identification the questionnaires were coloured for each specific Province.
- as the delegates picked up their registration package they also picked up a survey according to their Province colour, until the required number of questionnaires were gone. Only staff nurses participated.
- the delegates were requested to complete and return the survey before leaving the conference site.

1. Key Points in the Data Analysis

Approximately 89% of the O.R. staff nurses are ORNAC members and appear to be mostly situated in the mid-sized hospitals. 70% of the respondents were

staff nurses with an average of 17 years experience in ORs. Nurses over 45 years of age made up 30% of the respondents. Of these 21% had taken a post basic O.R. program of six months duration. The highest level of education of the respondents broke down to: 81% diploma, 16% BScN, 1% non-nursing, 1% masters.

2. Findings - Current Practice

Twenty six questions were asked with regard to the O.R. nurse's general, preoperative, induction, interoperative, and immediate postoperative responsibilities in both the circulating and scrub nurse roles.

General Responsibilities:

- promoting and maintaining standards of practice 83%
- complying with legal requirements 82%
- identifying and rectifying unethical practices 62%
- exemplifying role model characteristics 76%

49% of respondents indicated that the circulating nurse is and should be responsible for patient assessments, nursing care plans, patient teaching and family teaching.

The circulating nurse provides comfort measures in relation to vital functions 91% and is with the patient 82% at induction. The OR nurse (84%) receives, identifies and admits the patient to the operating room.

Combinations of many OR staff members were found to be responsible for the anaesthetic equipment. For recording activities and drugs during a cardiac

Author

Gloria Stephens, is a Clinical Instructor, Operating Room, St. Paul's Hospital, Vancouver, B.C. She is the Immediate Past President of ORNAC and a member of the ORNAC Research Committee.

arrest (Circulating Nurse 66% Respiratory Technician 4%). The respiratory technician was found to be primarily responsible for the anaesthetic equipment (25%).

The survey showed that the circulating nurse did not have primary responsibility to monitor the anaesthesia patient - the exception being in the case of monitoring local anesthesia (77%).

81% of the hospitals do not have a designated RN whose role it is to assist the anaesthetist, and only 16% of those who do assist received extra training from an organized anaesthetic program, and 41% received on the job training.

The majority, 57%, indicated that the scrub nurse performs a surgical assistants function when additional assistance is required and only when there is no surgical assistant available. This would not be considered a "transfer of function". 90% reported the scrub nurse was expected to perform both roles consecutively.

3. Vision of Future Goals

84% indicated that they could see an expanded role for the scrub nurse to include that of RN First Assistant. Respondents stressed the importance of advanced education and experience here. They felt this should be a separate function and not shared with other responsibilities. As well, some felt they were already accomplishing this task.

66% envisioned an expanded role for the circulating nurse to that of First Assistant to the anesthetist. Again, advance education was stressed and the role should be a separate function. Similarly, some respondents felt they were presently fulfilling this task.

84% agreed that additional remuneration should be given to these roles.

The most popular affiliation responsible for preparing operating room nurses to assume these functions was ORNAC. A close second (20%) was the hospital and 3rd (19%) Educational Institutions.

81% of the respondents agreed that there will be an increased role for the nurses in the operating rooms of Canada over the next five to ten years.

Summary of Each Section

Section A: Operating Room Facilities and Personnel Highlights

84% of the hospitals that responded are located in the city with the majority utilizing between 250 and 500 beds per hospital. The majority, 30%, will use on

average 4 to 5 operating room theatres on weekdays between September and June. Approximately 36 operations are done per day, or 168 per week on average.

On average there are 22 fulltime, 7 part-time, and 4 casual registered nurses employed in the O.R. per hospital. This would obviously vary with the size of the hospital.

There OR staff nurse most often alternates between scrub/circulating (98%) nurse duties. 94% of the hospital assist the Anaesthetist and 41% of the hospitals have their staff nurse work in the recovery room, relieve the managerial positions (69%) and do other duties such as cleaning, supplies, leader, etc. (46%).

Section B: Operating Room Registered Nurse Responsibilities

This section is broken up into the following sections:

- General
- Preoperative Phase - Circulating Nurse
- Induction Phase - Circulating Nurse
- Intraoperative Phase - Circulating Nurse
- Intraoperative Phase - Scrub Nurse

For the most part respondents agreed that the nurse has responsibility for these activities. This section will only touch on the exceptions worth noting.

Preoperative Phase - Circulating Nurse

A significant number of hospitals in British Columbia, Nova Scotia and Quebec are not currently making the Circulating Nurse responsible for performing preoperative patient assessments but feel they should be. The overall outcome indicated that 49% of Circulating Nurses perform preoperative patient assessments. 70% of Circulating Nurses receive, identify and assess patients.

Only 23% of the respondents agreed that the Circulating Nurse is accountable for preparing individual perioperative nursing care plans. Another 40% agreed that they should be responsible.

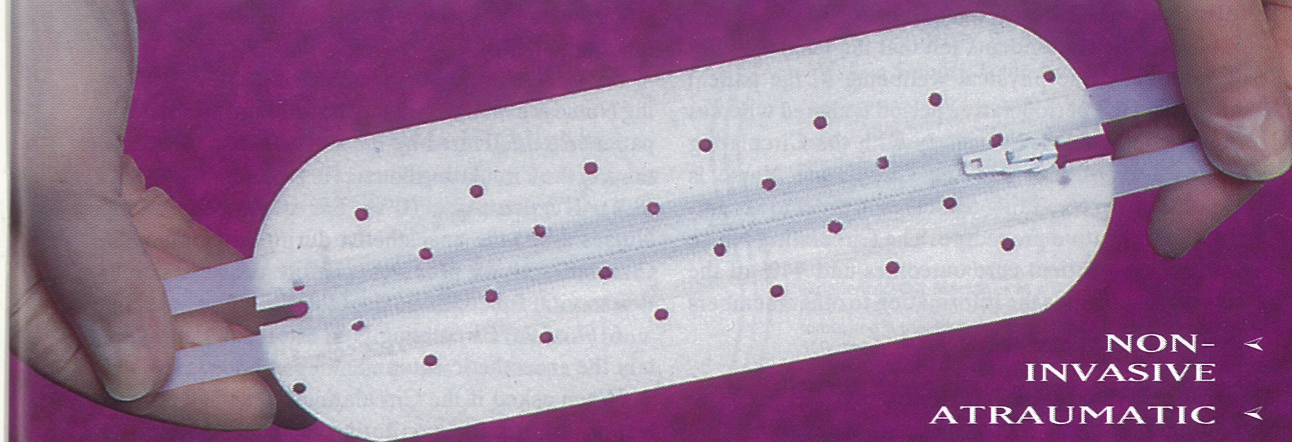
Only 4% currently are participating in perioperative family teaching. 34% feel they should be responsible for this and 28% are sharing this with other staff. This sharing is found mainly in larger hospitals (30%).

Induction Phase - Circulating Phase

Analysis shows that 36% of the hospitals are sharing the responsibility for preparing and maintaining anaesthetic equipment; 23% always do and 25% never.

Three Provinces indicated (100%) that the Circulating Nurse assist the Anaesthetist during induction.

A Better Way To Nurse A Wound



NON-
INVASIVE
ATRAUMATIC

Woundmate™

CLOSURE WITHOUT SUTURES for SURGICAL and ACCIDENTAL wounds.

Clinically Tested with Thousands of Patients

Now there's an exciting new approach to the treatment of cuts and incisions that is much less traumatic - for both you and your patients.

For Patients

Woundmate is a painless, non-invasive alternative to suturing and clips. It's fast and easy to apply, with dramatic cosmetic results.

For You

You'll be impressed by Woundmate's significant reductions in infection. You'll appreciate saving valuable time in O.R. You'll be pleasantly surprised by Woundmate's simplicity and easy aftercare. And you'll have one less risk of needle stick injury to be concerned about.

PAINLESS APPLICATION AND REMOVAL - IN SECONDS

Aggressive silicone based adhesive maintains optimum immobilization yet allows easy painless removal. No traces are left on the skin.

Woundmate is available in 14 lengths from 4cm to 50cm to accommodate virtually every procedure.

- > SUPERIOR APPROXIMATION OF WOUND EDGES
- > MINIMAL SCARRING
- > REDUCED POTENTIAL FOR INFECTIONS
- > HYPOALLERGENIC ADHESIVE
- > SAVES VALUABLE TIME
- > HIGHLY COST-EFFECTIVE



Simply apply open Woundmate to each side of the wound. (Suture subcutaneously if necessary). Grasp loop and slide zipper closed.

Here's a trial close...

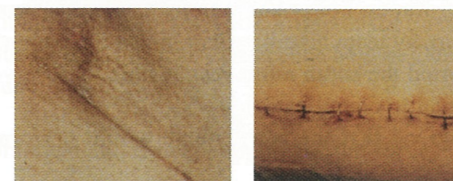
To receive a free sample of the AN HAACK Woundmate, call AN HAACK Medical in Oakville, Ontario at 905-842-4500 • Fax 905-842-5677

Discover for yourself the surgical solution to wound closure that finally has some teeth in it.

AN HAACK Woundmate - Worldwide patents.



THERE'S A FINE LINE Between Stitches and the Surgical Zipper



After closure with Woundmate

Sutures

The other Provinces were high in % with the exception of the P.Q. with 28%.

Intraoperative Phase - Circulating Nurse

Half of the respondents felt that the responsibility of monitoring the physical wellbeing of the patient throughout the perioperative period is shared whereas the other half felt it lies solely with the Circulating Nurse. 89% of the time the Circulating Nurse is responsible for providing resources in order to accomplish the operative procedure. The Circulating Nurse evaluates the patient care outcomes and 44% of the time communicates the information to other members of the health care team.

Intraoperative Phase - Scrub Nurse

With regard to preparing, and maintaining the technical equipment for surgical procedures, 53% responded that this responsibility was solely the Scrub Nurse's. Another 36% responded that this role is shared.

SECTION C: Perioperative Activities Undergoing Change

Most perioperative nursing activities are documented through integration in the Operative Record and 34% use separate nursing record.

Bio-Pscho/Physical Assessments are usually done on admission to the OR in the Presurgery Areas (59%).

Before surgery most patients are assessed (72%).

The OR registered nurse is found (84%) of the time to receive, identify, and admit the patient to the O.R. The anaesthetist, Respiratory Technician and Receptionist rarely ever are responsible for this. It should be noted that the Anaesthetist does receive, identify and admit 31% of the time in hospitals that have greater than 1000 beds.

A response of 58% indicated that Circulating Nurse administers medication for intravenous use. With exception, a large majority of the respondents within the provinces of British Columbia, Manitoba, Nova Scotia, and P.E.I. indicated that this activity is not performed by the Circulating Nurse.

59% responded that the Circulating Nurse would not perform anaesthetic agents intravenously.

Although the majority of the responses, (68%) indicated that the Circulating Nurse would record the narcotics used by the Anaesthetist in the drug register, the other 40% indicated negatively. (Alberta, Nova Scotia, Saskatchewan and mid-size hospitals held the majority in the NO answer). The remainder of the

questions asked with regard to the Circulating Nurse's anaesthetic responsibilities were answered positively. 67% of the time narcotics are dispensed by the Circulating Nurse and 87% apply monitoring devices, equipment to patients.

56% of the respondents indicated that the Circulating Nurse is usually assigned to assist and facilitate the patient care delivered by the Anaesthetist. Combinations of the Circulating Nurse, Respiratory Technician (8%), Nursing Aide (0%). 8% of the Circulating Nurses assist the anaesthetist during induction. The Circulating Nurse provides comfort measures in relation to vital functions 96% of the time.

61% of the Circulating Nurses prepare and maintain the anaesthetic equipment.

When asked if the Circulating Nurse has primary responsibilities for monitoring the anaesthetized patients, the answers were diverse. A large number of staff nurses, although still not majority, revealed that the circulating registered nurse always assumes primary responsibility for monitoring the anesthetized patients jointly with the anaesthetist as opposed to 9% on the previous survey. These responses changed from the First survey in New Brunswick and Ontario as well as hospitals with less than 250 beds.

77% answered "always" when asked if the Circulating Nurse has the primary obligation during local anesthesia and records findings.

The Circulating Nurse is usually chosen as being primarily responsible for assisting the Anaesthetist (66%):

- to perform specific duties during extubation/conclusion
- to record the activities and drugs given during a cardiac arrest/emergency situation
- to accompany the anaesthetist and patient to the recovery room.

60% responded that both verbal and written charts are used as a means of communication for patient information between the Circulating Nurse and the recovery staff.

Greater than 95% of the responses indicated that the Scrub Nurse has responsibility in observing and reporting activities that could cause injury. With exception, Quebec answered in majority that the Scrub Nurse was not responsible for observing and reporting restricting drapes, heavy/sharp objects and inadvertent pressure by team members leaning on the patient. 93% reported the scrub nurse responsible to observe and respond to complications.

90% agreed that the scrub nurse would perform

scrub nurse functions, as well, when performing surgical assistant activities. 96% responded that this would not be considered a "transfer of function" and only 13% agreed that when formulating the "transfer of function" activities, operating room nurses were involved in the decisions (ie. small hospitals).

Section D: Future Trends Highlights

84% agreed that they could envision an expanded role of the scrub nurse to include that of RN First Assistant.

66% responded that they could see the circulating nurse expand the role to that of RN First Assistant to the Anaesthetist. British Columbia, was the only province to respond negatively to this question.

Comments

- The certification process is necessary especially in the rural areas
- Post basic courses need to be more available throughout Canada ie. Long Distance Education
- Legislation is need to cover legal aspect of expanded role

Survey Quotations worth noting:

"Certification of the OR nurse would enable perioperative nurses to acquire first assist recognition. ORNAC must play a major role in this development. I commend this questionnaire as ORNAC appears to have begun this process".

"I feel nurses should do all the jobs involving patients and not have so many sub-specialities in the OR because it is too expensive and these other individuals cannot do other duties."

81% agreed that there will be an increased role for the nurses in the operating rooms of Canada over the next five to ten years.

Summary

In summary, with only very minor differences in the results between the two surveys, ORNAC can feel very confident that these results are highly valid.

Acknowledgement:

The ORNAC Research Committee wishes to thank all those staff nurses who completed the questionnaire during the National Conference held in Quebec City, June, 1993.

Gratitude to the 3M Canada Company for their practical and timely support for the survey.

OPERATING ROOM MANAGER

New Mexico

Make a Smooth Transition to the U.S.

As a Canadian-owned organization, the advantages of consulting with Synergy Recruitment and Immigration Specialists are clear. We provide the unique knowledge and support you need in making a career transition to the U.S. We will guide you through the issues regarding relocation, from visas and green cards to family relocation, certification and community reviews.

Currently, we have a challenging opportunity for an experienced **OR Manager** in a busy Southeastern New Mexico medical center. This facility offers a stimulated 8 theatre OR with a staff of 30 and up to 350 cases a month. The qualified candidate will have a BSCN degree and a minimum of 3 years' OR experience which must include experience at the management level.

Also available are **Staff Nurse Positions** at a wide variety of locations, ranging from urban teaching facilities to rural community hospitals in Arizona, Florida, Louisiana, Mississippi, Nevada and Texas.

The above positions offer excellent salary and benefit packages, including relocation assistance, tuition reimbursement and career ladder programs. For additional information, call us toll-free today.

1-800-667-5499
Vancouver, B.C.



Recruitment and Immigration Specialists, Inc.
Promoting Canadian Professionals...Internationally



Purchase the "New"
**ORNAC "Recommended Standards
for Perioperative Nursing Practice"**

- Professional • Clinical Standards and
- Competencies of an Operating Room Nurse as established by the Operating Room Nurses Association of Canada

Cost - \$35 which includes handling. Cheques or money orders should be made payable to The Operating Room Nurses Association of Canada.

Direct your orders and payment to:
Jane McClain
Box 525
Lethbridge, Alberta
T1J 3Z4

The ORNAC Standards are Copyright and should not to be photocopied or duplicated in any form.

MICRO-TOUCH* LATEX SURGICAL GLOVES

Trusted Protection. Now More Sensitive.

MICRO-TOUCH Surgical Gloves have long been the leading brand. Now they're more sensitive, flexible and comfortable.

• **SENSITIVITY**

Advanced latex formula provides greater tactile sensitivity.

• **PROTECTION**

Look for the Johnson & Johnson stamp of quality on every glove. It's your assurance of superior protection.

• **FLEXIBILITY**

Low modulus latex formulation reduces hand fatigue.

• **COMFORT**

Curved fingers and adequate finger length make movement easy.

• **PLUS ...**

NEW PACKAGE

Impervious poly material minimizes latex deterioration, clear seal turns opaque if compromised and thumb notch makes opening easier.



Johnson & Johnson
MEDICAL PRODUCTS

1421 LANSDOWNE STREET WEST, PETERBOROUGH, ONTARIO K9J 7B9
WESTERN & ATLANTIC PROVINCES: 1-800-668-9045 • ONTARIO: 1-800-268-5577 • QUEBEC: 1-800-668-9067

*Trademark

Did you know

that gases escaping during laparoscopic surgery may place you in danger?

Danger of exposure:

infectious pathogens such as hepatitis B¹ & C³, HIV DNA², tuberculosis^{1,3} and other bacteria contained in body fluids can be active in the air for up to 14 days².

Universal Precautions

are safety practices recommended for your protection from sprayback of gases escaping through trocars during instrument changes.

Get the protection you deserve!

**Find out how –
ENDOPATH™**

Trocars patented 45° flapper valve and double gasket system provide you with the best protection⁴ available from sprayback!

Ethicon Endosurgery

representatives will be pleased to demonstrate safety you can see.



¹Eubanks, S et al. Reduction Of HIV Transmission During Laparoscopic Procedures. Surgical Laparoscopy And Endoscopy Vol 3. No. 1, 1993.

²Baggish, M. S et al. Presence Of Human Immunodeficiency Virus DNA In Laser Smoke. Lasers In Surgery And Medicine 11:197-203, 1991.

³Fry, D. E.: Reduction Of HIV Transmission During Laparoscopic Procedures. Surgical Laparoscopy And Endoscopy Vol 3. No. 1, 1993.

⁴Data on File.

Danger You Can't See.



Safety You Can.

Johnson & Johnson
MEDICAL PRODUCTS

1421 LANSDOWNE STREET WEST, PETERBOROUGH, ONTARIO K9J 7B9

SIMULATED SPRAYBACK

Nurses' Perception of Desirable Qualities/Characteristics of a Good Leader

By Brenda-Lee Kingdon, R.N., B.Sc.N

Introduction

The purpose of this paper is to compare and contrast nurses' perception of what they considered to be desirable characteristics of an effective leader. The perceptions of characteristics for an effective leader to be discussed will include: communication, motivation, delegation, performance skills, knowledge, proactivity, flexibility, setting of objectives, role model and participating partnership. Current and relevant literature will be integrated into the discussion to substantiate the nurses' perceptions. Strengths, weaknesses and recommendations will be made at the conclusion of the paper.

Question

The interview question was developed according to the criteria set out for this project's objective. The criteria met was an open ended and concise question. The question was as follows: What do you consider to be desirable characteristics of a leader?(Appendix A)

Method

Design

In order to interview the nurses, a contract for registered nurse participation was developed (Appendix B) and sent out to medical wards in an acute care urban hospital. Seven registered nurses replied signifying their participation. The contract outlined the intent of the interviewer, time allocation, the outcomes and guaranteed anonymity of the nurses. The nurses participating were referred to in this paper as respondents. The respondents perceptions were collected in a qualitative data format and then they were objectively analyzed.

Definition of Terms

Certain terms were identified as being essential to the process undertaken. These terms are defined as follows: a) Leader - refers to a person who leads, and that can be a managerial position, or a staff nurse. b) Leadership - from the definitions reviewed in the literature, leadership in this paper means an interpersonal process influencing the actions of an individual and/or group toward accomplishing goals in a given situation. Lawrence & Lawrence, (1988) defined leadership as "an interaction between people and the ability to lead. It is the process of influencing the activities of an organized group towards goal setting and goal achievement" (p 173). c) Characteristic was used because by definition it means personality traits or distinguishing features about a person.

Environment

The environment in which the interviews took place was an allocated private office. The environment was non-stressful, free from interruptions and away from any of the clinical areas. The interview took approximately thirty minutes.

Analysis

An objective analysis was used to create a bridge between characteristics respondents' considered to be an effective leader and relevant literature. The analysis

Author

Brenda-Lee Kingdon, R.N., B.Sc.N., is Unit Manager of the Operating Room and Recovery Room, Brandon General Hospital, Brandon, Manitoba.

sis process took the following steps:

1. The author read relevant literature in order to become familiar about the concept of leader and leadership characteristics.

2. The author studied the interview assessment notes, where each respondent's impressions of an effective leader were obtained.

3. The author compared the respondent's comments to the Hersey & Blanchard (1988), Situational Leadership Model of effective leader behaviour or styles. The data collected from the respondents was integrated and compared to the tri-dimensional leader effectiveness model (Appendix C).

4. The respondents data was examined and analyzed as to how it fit within other identified leader styles in the reviewed literature. The majority of the respondents (6 out of 7) described an effective leader as having a democratic style of leadership as opposed to autocratic or permissive style (Appendix D).

Results and Discussion

From the data obtained, the key characteristic of an effective leader as identified by the respondents are now discussed.

Communication

The respondents strongly stressed the importance of a leader being able to maintain two-way communication. Two-way communication was important for the leader and team as it led to improving lines of communication and interaction among staff relationships. Hartlebury (1990) stated that a leader, "must ensure good communication in all directions to encourage feedback, working together and discussion" (p 35).

The respondents felt that the ability of a leader to communicate effectively held the group together. Hersey & Duldt (1989) stated communication congruency is believed to help people function together to achieve unity ..., it enables feedback in a rational, logical manner with minimal emotional overtones and the followers can learn that ... one's own behaviour ... determines how the leader will respond" (p 7).

Motivation

The respondents felt an effective leader must form a team of people who are responsible for the various jobs. Leaders could accomplish this through incentive and rewards for successful work. One of these rewards could be promotion and another is a letter to communicate to the rest of the team letting them know about one's good work.

The respondents realized, although staff nurses could not actually promote a colleague, they could influence the discussion in this area. Most importantly, they could thank a co-worker as a way to reward successful work. The respondents felt an effective leader must understand what motivates the team.

The respondents felt that, if a leader is able to motivate staff personally, the job will be carried out with more effectiveness. This results in staff feeling better about themselves as individuals and as a team member. It was felt that staff would put more energy into their assigned tasks rather than wasting time being frustrated. Marriner & Tomey (1988) identified that, "work motivators include achievement, growth, responsibility, advancement, recognition and the job ... if satisfied with [the] job, ... and employee can be motivated by ... challenging work in which they assume responsibility" (p 233).

Delegation

The respondents felt a leader must be able to analyze activities and make decisions. Then the effective leader must divide the activities into jobs and assign appropriate staff to those activities. The respondents stated that a leader was responsible for the allocation of work and in so doing ensuring that completion of work occurs.

However, the leader should not do it all or make all the decisions. Capable nurses are employed and the leader should encourage staffs' responsibility to develop competence in their work. The leader should also know their staff so as to delegate tasks to the appropriate person. Sullivan & Decker (1992) saw these behaviours as that of a directive leader who lets subordinates know what they are expected to do, give guidance and support.

The respondents felt a leader should be able to delegate work. It was an appropriate behaviour for a leader. A leader could delegate, which would provide educational opportunities as well as professional growth for staff. Hartlebury (1990) identified that, "delegation is a tool for leaders to get the most from their teams. It enables the leader to devote time to a number of issues at any one time and develop individual manager skills of [the] staff" (p 35). Performance Skills re: Technical and People.

All respondents stressed the need for an effective leader to have acquired a set of skills during their practice as a professional nurse. These acquired skills recognized the leader as an expert or a good role model. Those identified performance skills ranged

Concerned About Glutaraldehyde & EtO?

After all, chemicals that
make instruments safe for use
should not be unsafe
for you to use.



That's why we developed **STERIS 20™**, our proven, safe, and effective sterilant formulation for use in the **STERIS PROCESS™**.

No toxic fumes or emissions, and no disposal restrictions.

Even expensive, delicate scopes, cameras, and other reusable minimally invasive instruments can be rapidly and safely sterilized and ready for use in less than 30 minutes—Just In Time for each patient procedure.

The **STERIS PROCESS**
The Proven Process
Just In Time

STERIS®



ULTRAMED, INC.
50 Steeles Avenue East ■ Suite 15
Milton, Ontario ■ L9T 4W9 ■ Canada
Tel: 416-878-4400 ■ Fax: 416-878-5044

The Leader In Site-Of-Use Sterile Processing Systems.

from being competent in techniques, procedures and the use of tools. Douglass (1988) labelled this skill as "Technical skills" (p 221) where the leader had the ability to use tools, techniques and procedures in a specialized manner and was recognized as an expert.

The second performance skill respondents identified was the people skill. They felt leaders must have the ability to deal with people effectively. It was essential that a leader must meet the human needs of the staff and the patients.

Blankenship, Wilhoit & Blankenship (1989) stated that, "for a leader to be effective, they must be responsive to the self-perceived needs of all personnel. Some need structured leaders, while others need the freedom to do self-directed work" (p 81). Douglass (1988) stated that, "the leader needs to have the ability to select, motivate, work with and lead employees ... and to be effective ... know how to assess and recognize abilities in self, and others" (p 225).

Knowledge

The respondents felt that a leader must demonstrate knowledge of all aspects of the delivery care. They saw a leader as having knowledge of the latest techniques and an understanding of legal and ethical issues that confront the practice of nursing today. An effective leader must be able to supervise and direct the nursing care of the patients in an acceptable standard in accordance with Manitoba Association of Registered Nurses' Standards of Care.

Knowledge of functions such as planning, organizing, staffing, directing and controlling are essential to the leader role (Dunham & Fisher, 1990, p 1 - 7). Stevens (1985) identified leadership characteristics as being knowledgeable, having integrity, communication skills ... and planning skills.

Proactivity

The respondents felt that a leader must be able to come up with strategies to help future planning. This was necessary in order to implement the changes in the health care system. They felt to be "super nurse" a leader must anticipate problems and be able to handle them effectively.

Some of these problems may be ones never before encountered, or anticipated. With today's health care reform a competent leader must be on top of all the changes and be able to offer knowledgeable solutions. The respondents felt that leaders must be able to take on new roles.

They identified that leaders are encountering the

shift of power and authority from vertical lines of decision making to horizontal. The respondents recognized that leaders are being proactive through greater group participation in determining end results. The democratic method of leadership was seen to be beneficial, in that it permitted consultation and involvement in managing the nursing unit. Sullivan & Decker (1992) discussed the democratic style of leadership as a participative approach to leading. The approach focused on people oriented and effective team work. The interaction between leaders and staff had to be open and there had to be a trusting relationship for this type of leadership.

However, the respondents felt that there were still situations when the authoritarian style of leadership was needed. Sullivan & Decker (1992) confirmed what respondents identified in that the authoritarian style of leadership is effective in crisis situations where highly specialized skills are required and where options for facilities are limited.

Flexibility

The respondents stated that an effective leader must be flexible. With this characteristic the leader would diagnose the situation and adapt a behaviour to fit the demands presented. If impossible to adapt a behaviour then a leader must develop a means to make a change.

They felt the effectiveness of confronting and solving the demands was dependant upon the leader, the staff and the situation. Douglass (1988) stated that, "if [leaders] are relatively inflexible in their leadership style, then they will function well only in certain situations, [and] such limitations hamper an individual" (p 28).

Sets of Objectives

The respondents generally felt that a leader should be able to determine and guide staff in setting objectives. Further, a leader in conjunction with the staff should be able to write clear goals to meet those objectives. Leaders must be able to facilitate achievement of those objectives.

Leaders need to encourage staff to accomplish objectives perhaps by demonstration. They should not ask staff to meet objectives a leader is not prepared to meet. The respondents felt a leader must be visionary, and be able to share their vision with the staff through common, challenging, and achievable goals and objectives.

Unclear goals result in staff not knowing how to accomplish the objectives. Achieving common goals

was felt to improve and attain high levels of performance (Sullivan Decker, 1990). Hein & Nicholson (1990) stated that, "a leader must have the capacity to communicate one's vision of a desirable future state of an organization" (p 72).

Role Model

The respondents felt that it was important for an effective leader to be a role model. The expectation would be that staff would emulate the leader's values in caring for patients. The respondents described the leader with a strong value system as: accountability, fair, honest, caring, a listener, influence and possessed a sense of humor.

Participative Partnership

The respondents felt very strongly about a leader using a participatory approach in sharing of information and decision making. They felt an effective leader needed to use a participating behaviour more than a task oriented leader behaviour. Hersey & Blanchard (1982) confirmed two types of behaviour that the respondents identified as behaviour for an effective leader.

These identified behaviours are as follows:

1. High-task/High relationship behaviour is referred to as "selling" because with that style most of the direction is still provided by the leader. The leader also attempts through two-way communication and socio-emotional support to get staff to "buy into" decisions that have to be made.

2. High relationship/low-task behaviours is the "participating" style where the leader and staff share in decision making through two way communication. Much facilitating behaviour comes from the leader since the staff have the ability and knowledge to do the task.

Summary and Conclusion

In summary, there were definite similarities between the respondent's description of desirable characteristics of an effective leader and the literature reviewed. The respondents themselves stated that there was not one characteristic that should be included in a definition for a leader, nor should all the identified characteristics be required. They felt some characteristics should be present the majority of the time. Leaders must use communication, motivation, delegation, performance skills, knowledge, proactivity, flexibility, set objectives, role model and have a participative partnership with staff to be effective.

The results of contrasting and comparing respondent's descriptions of a leader have led to possible future recommendations for leaders using these characteristics in their performance. The use of the identified characteristics could result in the following:

1. Leaders using them could develop a tool for performance reporting.
2. Use in continuing education programs to help develop leadership skills in potential leaders.
3. Further development of leaders roles.
4. Criteria for selecting future leaders.
5. Define and understand the role of a leader.

In conclusion, it was realized that the acts of a leader are a continuous challenge. For a leader there must be a behaviour between accomplishing the work and meeting the human needs. A leader can be effective if they know their staff well enough to meet the ever changing abilities and demands placed on them.

The respondents felt that being a leader was a taxing, and complicated series of functions that guide both people and physical resources toward positive results for the patient, the facility, and the individual. "Getting things done through others" requires many flexible characteristics. The respondents found it difficult to isolate each characteristic, because each one blends with another in the process of being an effective leader.

With these identified characteristics, moving towards excellence in leadership should be a leadership goal for all professional nurses.

References

Blankenship, M., Wilhoit, L. & Blankenship, C. (1989). Leadership: Do it with style. *Nursing Management*, 20 (2), 81-82.

Douglass, L.M. (1988). *The effective nurse manager* (3rd Ed.). St. Louis: C.V. Mosby.

Dunham, J. & Fisher, E. (1990). Nurse executive profile of excellent nursing leadership. *Nursing Administration Quarterly* 15 (1), 1-8.

Hartlebury, M. (1990). Teamwork and leadership. *Nursing Times*, 86 (16), 35-38.

Hein, C.E. & Nicholson, M.J. (1990). *Contemporary leadership behaviour* (3rd ed.). Toronto: Little Brown.

Hersey, P. & Blanchard, K.H. (1988). *Management of organizational behaviours: Utilizing human resources* (5th ed.), Englewood Cliffs, N.J.: Prentice-Hall.

Hersey, P. & Duld, B.W. (1989). *Situational leadership in nursing*. Norwalk, CT: Appleton & Lange.

Lawrence, S.A. & Lawrence, R.M. (1988). Leadership: What it is and how to teach it. *Journal of Nursing Education*, 23 (4), 173-176.

Marriner - Tomey (1988) *Guide to nursing management* (3rd ed.). St. Louis : C.V.Mosby.

Stevens, B.J. (1985). *The nurse executive* (3rd Ed.). Rockville, M.D.: Aspen.

Sullivan, E.J. & Decker, P.J. (1992). *Effective management in nursing* (3rd Ed.). Don Mills: Addison-Wesley.

Webster Dictionary (1992). *New expanded Webster dictionary*. Miami, Florida: P.S.I. and Associates, Inc.

Bibliography

Becker, H.S. & Greer, B. (1969). Participant observation and interviewing: A comparison. In G.J. McCall & J.L. Simmons (Eds.), *Issues in participant observation: A text and reader* (p.p. 322-331). Reading, M.A.: Addison-Wesley.

Blake, R.R., & Morton, J.S. (1982). Grid principles versus situationalism: A final note. *Journal of Applied psychology* 7 (2), 211-215.

Bonaquist, P.A. (1986). What is leadership? *Nursing Success Today*, 3 (1), 9-13.

Chenitz, W.C. & Swanson, J.M. (1986). *From practice to grounded theory: Qualitative research in nursing*. Menlo Park: Addison-Wesley.

Davis, M.Z. (1986). Observation in natural settings. In W.C. Chenitz, & J.M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 48-65). Menlo Park, Ca: Addison-Wesley.

Everly II, G.S. & Falcione, R.L. (1976). Perceived dimensions of job satisfaction for staff registered nurses. *Nursing Research*, 25 (2), 346-348.

Halpin, A.W. & Winer, B.J. (1957). A factor study of leader behaviour descriptions. In R.M. Stogdill & A.E. Coons (Eds.), *Leadership behaviour: Its description and measurement* (pp 39-51). Columbus, Ohio: Ohio State University.

Hambleton, R.K. & Gumpert, R. (1982). The validity of Hersey and Blanchard's theory of leader effectiveness. *Group and Organizational Studies*, 7 (2), 225-242.

Hersey, P. Angeline, A.L. & Carakushansky, S. (1982). The impact of situational leadership and classroom instruction on learning effectiveness. *Group and Organizational Studies*, 7 (2), 216-224.

Moloney, M. (1979). *Leadership in nursing: Theory, strategies, action*. St. Louis, Mi C.V. Mosby Co.

McClosky, J.C. & Molen, M.T. (1987). Leadership in nursing. In J.J. Fitzpatrick and R.L. Taunton (Eds) *Annual review of nursing research* (volume 5) (pp. 177-202). New York: Springer Publishing.

Novak, J.D. & Gowin, D.B. (1984). *Learning how to*

learn. Cambridge: Cambridge University Press.

Pryer, M.W. & Distefano, M.K. (1971). Perceptions of leadership behaviour, job satisfaction, and internal-external control across three nursing levels. *Nursing Research*, 20 (6), 534-537.

Smith, H.L. & Mity, M.W. (1984). Nursing leadership: A buffering perspective. *Nursing Administration Quarterly* 8 (3), 43-52.

Yukl, G.A. (1989). *Leadership in organization* (2nd Ed.). Englewood Cliffs, N.J.: Prentice-Hall.

Appendix A

ASSESSMENT INTERVIEW GUIDE

1. What does being a good leader mean to you?

Appendix B

A contract letter mailed to nurses inviting their participation in this study.

Appendix C

A three dimensional graph illustrating the Leadership Profile. Available from the author. Send a written request enclosing a postage-paid addressed envelope.

Appendix D

Comparative summary of democratic, authoritarian and permissive styles of leaders identified by respondents:

Democratic	Authoritarian	Permissive
Respondents described characteristics of this leader as:	Respondents felt this type of leadership style was only required in crisis situations where highly specialized skills were required, and options were limited.	No Respondents described characteristics of this style of a leader.
- participative		
- two way communication		
- knowledgeable		
- motivating		
- facilitating		
- open		
- sets objectives		
- group goals		
- encouraging		
- trusting		
- reward		
- recognition		
- cooperation		
- moves forward		
- flexible		
- delegator		
- people oriented		
- team worker		

Workload Measurement Tool for an Integrated OR/PACU

By Cynthia A. McLennan

The 1990's and the resulting budgetary downsizing have reinforced the need to have objective data that will reflect both staffing patterns and accurate nursing workload measurement. How to translate case length into potential workload becomes the issue that this article will address. Staffing patterns and quantitative analysis of workload measurement (WLM) makes resource allocation obvious and justifiable.

Our two theatre three (3) bay OR/PACU does not enjoy the benefits of a computerized scheduling system so all WLM is performed manually. As in all operating theatres statistics are maintained and periodically analyzed for workload trends. In this time of fiscal restraint nurse managers must rely on objective statistical analysis to reinforce staffing requirements. Our surgical suite at Renfrew Victoria Hospital incorporates the Post Anaesthetic Care Unit. Therefore, our inclusion of WLMS and for both OR and PACU proved to be a challenge.

Literature available for manual WLMS analysis is minimal. A common reference however, was always made toward the fact that OR/PACU nursing is influenced significantly by other factors and the WLMS must account for support services that influence the surgical procedure. As in every Operating Room the nurse is only one member of the OR team, and most often other team members, and situations influence the nursing WLMS.

Prior to developing this WLMS tool certain objectives were established. The system had to be user friendly, inclusive of all required data, and easily evaluated.

The nurses in the OR/PACU were required to determine the standard nursing care hours for each case. Support care times were also factored. The end result was the determination of standard times for each case passing through the OR/PACU. These times were evaluated and certain case mix groupings based

on time similarity were observed. The length of time a case takes to complete is directly proportional to the amount of nursing care hours necessary to provide the required OR nursing care.

Over one thousand surgical cases were analyzed and case times were assigned accordingly. Case categories progress from level one (1), minor cases, to level five (5) for our most complex procedures. Corresponding average lengths of time are assigned to each category based on the research into average length of time per case through the OR and subsequent PACU recovery periods. All times are calculated by the hour and documented as such.

We arrived at these individual category times by defining certain terms as well as amending the OR record to facilitate easy data collection.

Total Nursing Care (TNC) is the nursing workload per case based on the total time accumulated from when the patient is admitted to the OR hallway, until he/she is discharged from the PACU. At Renfrew Victoria Hospital we are an all RN staff so immediate case clean up is a task that the RN staff absorb.

Support care given by others is defined as time assigned to a case for activities that could be carried out by non-nursing personnel. Our CSS attendants currently reprocess all items used in each surgical case, as well as carrying out the environmental maintenance for the unit.

Our OR nursing record documents patient entrance to the OR hallway, admission to the OR theatre, the time skin was cut by the surgeon, dressing application, and when the patient exited the theatre. Our PACU records indicate time of arrival and discharge. We determined the scrub nurses time as: Case set up until

Author

Cynthia A. McLennan, R.N., is OR/PACU Nurse Manager, Renfrew Victoria Hospital, Renfrew, Ont.

case termination and the dismantling of the surgical case equipment used in that procedure. The circulating nurses time is determined from when the nurse begins the pre-operative checklist in the OR hallway, until the patient is transferred postoperatively into the PACU.

The PACU nurses' times are from patient admittance until discharge from the PACU and transport back to the nursing unit. Post anaesthetic care unit duties also include the pre-admission clinics and the post-operative telephone discharge program. These times are documented separately on the daily record.

To tabulate the PACU nurses total nursing care, the Renfrew Victoria Hospital Tuesday afternoon pre-admission clinic times must also be documented. The average length of time the PACU nurse takes to attend to each patient is 0.75 hours. This time is used to pre-admit the patient in a clinic setting prior to their same day OR admission for major surgery. In addition to discussing the patient information brochure and any other concerns the nurse tries to provide a hospital tour if time permits. The nurse completes the following forms: perioperative patient profile, nursing data base and pre-anaesthetic patient questionnaire. If the nurse has assessed the patient and feels pre-operative treatment intervention is necessary she contacts the anaesthesiologist or surgeon to confirm her diagnosis. For example, a patient scheduled for major surgery may be consuming an anticoagulant and the nurse will inform the patient to discontinue this drug prior to surgery after consultation with the surgeon. It is very surprising to review the number of times the RN has assessed a patient problem and their actions have resulted in a smooth perioperative course for the patient. The WLMS allows for documentation of the clinic under the pre-admit column on the daily record.

The PACU nurse also completes the post-operative telephone follow up of all our clients. This telephone program allows us to keep in touch with our clients so that we may identify and act upon any potential problems at a very early stage. Contacting our clients by telephone at home has proven to be an excellent risk management and continuing quality improvement tool. Our clients genuinely enjoy the contact as does the nursing staff. The post operative telephone program is recorded on the WLM sheet under telephone and .10 hour per client is the average time for each call.

Support care given by the nurses while helping the CSS attendant may also be documented on the WLMS form. As we work as a team in the surgical suite it is difficult at times to categorize daily unit tasks. It is

however, interesting to document the exact extent of total nursing care.

The category number assigned to each case represents the hours of nursing care per patient, thereby reflecting case complexity. The categories are as follows with examples of cases included:

Category	Hours Nursing Care/Pt.	Example
1	0.3	- cysto-local
2	0.7	- cystoscopy-neuro - colonoscopy-neuro - gastroscopy-neuro
3	2.0	- lesion excision - carpal tunnel - haemorrhoidectomy - vasectomy - radical toenail excision - breast biopsy - appendectomy - diagnostic laparoscopy - laparoscopic tubal ligation - D&C - hemorrhoidectomy
4	3.50	- mastectomy - laparoscopic chole cystectomy - caesarian section - reduction mammoplasty - abdominal hysterectomy - open cholecystectomy - laparotomy - panniculectomy
5	4.50	- bowel resection - laparoscopic assisted vaginal hysterectomy - Richards Hip Pinning

Most metropolitan operating surgical suites operate on a WLMS that accounts for 24 hour monitoring. At RVH we concentrate most of our day in an 8 hour block. Our efficiency in this time frame is the most significant to our administration. The integrated OR/PACU charting methodology makes our manual tracking of all data readily available and easily interpreted.

Pure nursing care is defined as direct hands on patient care. Calculation of the pure nursing workload in the OR/PACU can be accomplished by determining

**Personal Commitment = Capital Gains
Professional Collaboration**

3rd Provincial Conference

Operating Room Nurses Association of Ontario

April 25 - 27, 1994
Ottawa Congress Centre

Sunday: April 24, 1994 - Workshops

- 1600 - 1900-Pre Registration
- 2000 - 2230 - Welcome Cocktail Reception

Monday: April 25, 1994

- 0715 - 0815 - Registration
- 0815 - 0915 - Opening Ceremonies
- 0915 - 0945 - Keynote Address: The Capital Gains of Radical Changes in the OR - **Muriel Shewchuk**
- 0945 - 1015 - Coffee
- 1015 - 1115 - O.R.N.A.O. Information Meeting
- 1115 - 1130 - Opening of Exhibits
- 1130 - 1500 - Viewing of Exhibits / Lunch
- 1500 - 1600 - Simultaneous Sessions:
 - Computerization in the O.R./Case Costing Project
- Speaker - **Lynn Nagle**
- Risk Management in the O.R. - **Ann Tapp**
- Substance Abuse in Nurses - It's Identification and Treatment - **Dr. Graeme Cunningham**
- 1800 - 2030 - J.J.M.P. Present * **Ethicon Night**

Tuesday: April 26, 1994

- 0730 - 0830 - Registration
- 0830 - 0945 - Simultaneous Sessions:
 - Latex Allergy - The Patient, The Employee.
- Speakers: **Shirley Brown, Susan Smith, Judi Tyndall, Alaine Young**
- Implementing New Technology: The Theory and the Reality - Speaker - **Claudette Sobers.**
- Celebrating Conflict, Speaker - **Angela Jackson**
- 0945 - 1015 - Coffee
- 1015 - 1130 - Simultaneous Sessions:
 - Latex Allergy - The Patient, The Employee.
- (repeat) **Shirley Brown, Susan Smith, Judi Tyndall, Alaine Young.**
- Vision 1995, A Client Centered Accreditation.
- Speaker - **Pat Wallace.**
- Celebrating Conflict. (repeat) **Angela Jackson.**
- 1130 - 1500 - **Viewing of Exhibits**

- 1500 - 1600 - Simultaneous Sessions
 - Nursing Research. Speaker to be announced .
 - Ethics, Speaker - **Dr. David Roy**
 - Advanced Role of the Registered Nurse. Speakers ✓
 - **Jane Fulton, Jackie Waisman**
- 1830 - 1930

*** Exhibitors Cocktail Reception 1830-1930**

*** Capital Adventure - 1930 - 0130**

Dinner/Karaoke/Line Dancing

Dress: Informal / Casual

Wednesday: April 27, 1994

- 0730 - 0830 - Registration
 - 0830 - 0945 - Simultaneous Sessions:
 - Empowerment Means Speaking - Are You Ready? Speakers - **Barabara Crim, Ann Hood**
 - Self Esteem - Speaker to be announced .
 - Too Many Roles - Not Enough Time, Speaker - **Terry Howard**
 - 0945 - 1015 - Coffee
 - 1015 - 1130 . Simultaneous Sessions:
 - Empowerment Means Speaking - Are You Ready? (repeat) **Barabara Crim, Ann Hood**
 - Empowering O.R. Nurses. **Sharon Frank**
 - Nursing Diagnosis in the O.R. **Judi Tyndall, Annabelle Watson.**
 - 1130 - 1400 - Viewing of Exhibits /Lunch
 - 1400 - 1600 - Building the Health Care Team- He Said / She Said - **Patricia Heim**
 - 1600 - 1630 - **Closing Ceremonies**
 - Draw For All Expenses Paid (maximum \$2500.00)
 - Trip to National Conference in Vancouver in 1995. Winner must be present at time of the draw.
- (Program details continued - page 33)

ORNAO Registration:

- * Early Bird Registration: Received up to and including April 8, 1994 Daily Fee - \$60.00
- 3 Days- \$175.00
- * No Early Bird for Non-Members.

After April 8, 1994.

- Daily Fee -Member - \$ 70.00
- Non-member \$90.00
- 3 Days - Member- \$ 200.00
- Non- member - \$ 250.00
- Banquet Tickets - \$50.00

ORNAO Conference

Inquiries May Be Made To:

- Publicity:**
Janet MacCullouch,
27 Forestgate Drive,
Hamilton, Ontario, L9C 6A4
- Exhibitors: Carole Starr,**
39 Terraview Heights,
Peterborough, Ontario, K9L IM7
- Registration: Wilma MacDonald,**
280 McClellan Rd. #57,
Nepean, Ontario, K2H 8P8

Ottawa to host 3rd provincial conference of the Operating Room Nurses Association of Ontario



ORNAO Conference Committee members - Back row (left to right) Rosemarie Atwell (Hospitality), Hilda Gatchell (Secretary), Wilma MacDonald (Registration), Araina Clark (Hostesses), and Betty Anne Fawcett (Treasurer). Front Row (left to right) Sharon Ball (Program), Vija Hay (Chairperson), Judi Tyndall (Co-Chairperson) (Protocol/Publicity), and Mindy Shinoff (Program). Committe members not present during the photo session - Carole Starr (Exhibitors) and Janet MacCullouch (Publicity).



Left to right: *Betty Audain, Unit Manager, Surgical Suite, The Moncton Hospital; Mary Clark, who delivered the graduates' address; Sharon MacKnight, who had the top average; and Susan Poirier, Education Coordinator, Education Department, The Moncton Hospital, Moncton, New Brunswick.*

NB's launches Post Basic Perioperative Nursing Program

Eight nurses from The Moncton Hospital graduated recently from the province's first specialized education program for nurses who work in the operating room environment.

The program, which was designed by the hospital's staff educators, is called the Post-Basic Perioperative Nursing Program. A self-directed learning modular program, it is the first of its kind in New Brunswick and maybe the first in Canada.

It took graduates 2,000 hours of study on their own

time over a two to three year period. This is a major contribution of time, considering that 1,950 hours is a full year of work.

Congratulations to those students who have shown motivation, discipline and dedication to their professional development.

The first graduates of the program are Mary Clark, Celia Cobbett, Carolyn Dinan, Myra Folkes, Catherine Holmes, Sharon MacKnight, Margaret (Peggy) Vautour and Linda Hooper.

J&J Medical's OR Bursary Application Deadline is April 15

The Johnson & Johnson Medical Products Bursary is offered to financially assist members of ORNAC in furthering their education in areas that will enhance perioperative nursing practice.

Three bursaries will be awarded in 1994, one for \$1,000 and two for \$2,000.

Applications (available from your Provincial Presidents) are invited by ORNAC for the Johnson & Johnson Medical Products Bursary for 1994. Submit your application to:

Elizabeth A. Kent
Chairperson, Awards Committee
54 Foley Court
Fredericton, N.B.
E3B 2R8
Telephone (506) 457-9613
FAX (506) 457-2077

Johnson & Johnson Medical Products Bursary awarded to two OR nurses

The ORNAC Board of Directors is pleased to announce the first recipients of the Johnson & Johnson Medical Products Bursary. The bursary is given to operating room nurses wishing to further their studies in a program that will enhance their perioperative nursing career. Through the generosity of Johnson & Johnson, ORNAC is able to offer three bursaries yearly to nurses who qualify under the criteria set down by the ORNAC Awards Committee. In 1993, there were two outstanding recipients.

Deborah Roberts

The first winner is Deborah Roberts from Prince Edward Island. Deborah is a staff nurse in the operating room at the Queen Elizabeth Hospital in Charlottetown, P.E.I., and is currently pursuing her Baccalaureate in nursing studies on a part time basis. She is married and has two children. Deborah has been very active in ORNPEI and has represented the province on the ORNAC Board of Directors 1987-1989.

Deborah also finds time to be active in her community and to enjoy various hobbies and interests.

Lorraine Varner

The second recipient is Lorraine Varner from Kelowna, B.C. At the time of receiving the bursary, Lorraine was the Director of Nursing - surgery at the Kelowna General Hospital. Lorraine is in her final year towards her master of science in nursing degree from Gonzaga University, Spokane, Washington. Since 1977, Lorraine has been active in the provincial operating room nurses' associations in Alberta and in B.C., and presently represents B.C. on the ORNAC Board of Directors. She is currently the Director of Ambulatory Services at the Kelowna General Hospital. As well as a demanding professional life, Lorraine enjoys a very busy family life with her husband and young son.

On behalf of the ORNAC Board of Directors, I congratulate both Deborah and Lorraine and wish them well in their endeavours. In addition, may I extend to the company of Johnson & Johnson Medical Products our sincere thanks and appreciation for their generous support of operating room nursing.

Elizabeth A. Kent,
Chairperson -ORNAC Awards Committee



Deborah Roberts (left), is presented with the J&J Medical Products \$2,000 Bursary. Marlene Hill, past president of the PEI OR Nurses Group and Board member of ORNAC makes the presentation.



Lorraine Varner, RN, BN, (left) is the second recipient of the J&J Medical Products Bursary Award. Shirley Hemerling, President of the BCORNG, made the presentation on behalf of the ORNAC Award Committee Chairperson, Elizabeth Kent.

CALENDAR

British Columbia Operating Room Nurses Group

14th Annual Conference

June 2nd - 4th, 1994
Silver Star Mountain Resort,
Vernon, B.C.

Accommodation: Single, Double and Group Condo
accommodation available, plus Meal Plan.

Keynote speaker: **Herb Dixon**, BSc, MEd, noted
speaker and educator who has 25 years of administra-
tive and educational experience. He is committed to
helping people reach their potential for productivity
and job satisfaction.

Plenary Session: **Dr. Jane Fulton**, a dynamic and
entertaining speaker who is well versed in the health
care issues of B.C. and Canada. She will speak on
"Working Through the Ethical Issues". She has ap-
peared on the Phil Donahue Show and recently was a
consultant to Hillary Clinton on Canada's Health Care
System. Dr. Fulton is an associate professor of strate-
gic management and ethics at the University of
Ottawa.

Other speakers include: **Carol Ann Fried** on
"Laughing Matters"; **Dr. Evo Olivotto** on Breast
Cancer Progress; **Barbara Bolding** on Endoscopic
Instrumentation; **Dr. Warren Bell**, "Global Perspec-
tives on Recycling & Reusing"; and a session on
"Pediatric Urology" with **Dr. K. Prestage** and
Dr. T. Kinahan.

Closing Address will be delivered by **Judy Rebbick**.

Contact: **Trish Allen**
4108 14th St., Vernon, B.C.
V1T 8B9
Phone: (604) 542-2418

Operating Room Nurses Association of Ontario 3rd Provincial Conference

April 25-27, 1994
Ottawa Congress Centre, Ottawa, Ontario

Conference Chairman: **Vija Hay**.
Theme: "Personal Commitment + Professional
Collaboration = Capiital Gains"

Exhibitors Contact - **Carole Starr**
Fax: (705) 876-5105
Bus Phone: (705) 743-2121

Registration Contact: **Wilma MacDonald**
Staff Nurse OR, Queensway Carleton Hospital,
NEPEAN, Ontario
Tel: (613) 721-2000 Ext. 2900
(See Page 32 for more details)

Operating Room Nurses of Alberta 16th Annual Conference

October 19-22, 1994
Lethbridge Lodge Hotel
Lethbridge, Alberta

Theme: Standing Tall in the Winds of Change
Program Content Outline: Latex Allergies; Dis-
posables vs Reusables; Health care packaging issues;
-Environmental Safety Guidelines; Laparoscopic Sur-
gery - How Far Can It Go? Magic or Medicine? The
Dependent Adult and Advanced Nursing Practice.

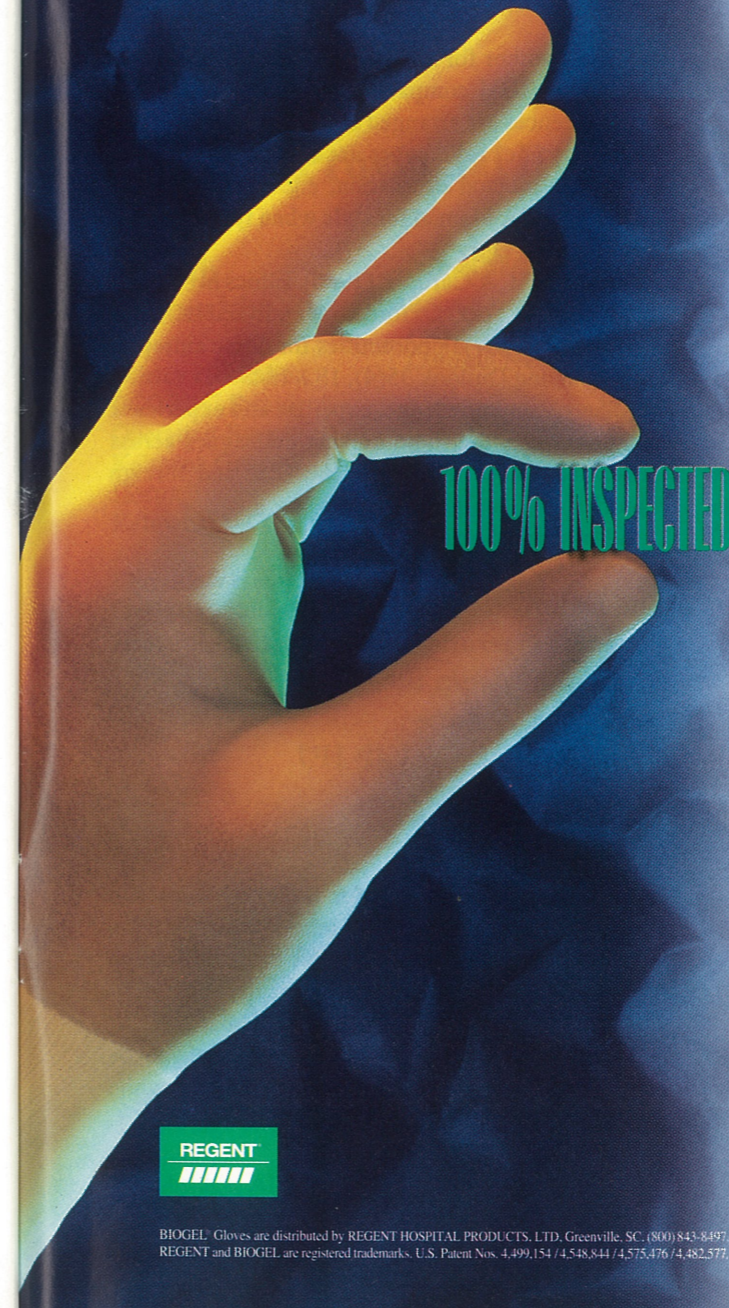
Contact: **Gloria Nemecek**, Chairman,
Box 122, Picture Butte, Alberta. T0K 0V0
(403) 732-4667

1995 & 1997

ORNAC '95 - 14th National Conference
Vancouver, B.C. May 8-12, 1995
ORNAC - 1997 Conference - Ontario

World OR Conference
September, 1995 Sponsored by the AAORN
Hamburg, Germany

Why there's safety in numbers.



Biogel® Gloves are setting
the standards for safety,
and we have the figures
to prove it.

NEW RISKS. NEW STANDARDS. A few years ago, price and
comfort were the primary considerations in selecting surgeons'
gloves. But today, with the ever-present threat of deadly HIV and
HBV, dependable barrier protection is more crucial than ever.
That's why Biogel® Gloves are 100% air inflation-tested and physi-
cally inspected. Our commitment to total quality is responsible for
an in-use failure rate that is three to five times lower than that of
competitive gloves. While some manufacturers claim "greater tensile
strength" based on their own lab testing, Biogel Gloves have proven
themselves time and time again in actual surgical procedures.

TRULY DERMA-COMPATIBLE. Biogel has also assumed the
leadership role in tackling latex-related skin problems by
drastically reducing their causes. Through the patented Biogel
manufacturing process, comprehensive rinsing and leaching
reduces levels of highly allergenic extractable latex proteins.
According to a recent study using the new ultra-sensitive Guthrie
LEAP© assay method, Biogel Gloves were found to have nearly
undetectable levels of these proteins. And Biogel Gloves are
made without adding potentially harmful chemicals such as
thiurams, used by other glove manufacturers in the curing
process. In addition, the patented Biogel lining buffers the wearer
from direct contact with the latex. These factors make Biogel
Powder-Free Gloves truly derma-compatible and hypoallergenic.

POWDER-FREE. PYROGEN-FREE. In addition, post-op
problems caused by powder and other particulates, as well as
those associated with pyrogens, have been virtually eliminated.
This is the direct result of the unique process and the clean room
conditions in which Biogel Gloves are produced and packaged.
In fact, Biogel Gloves surpass the rigorous guidelines set by the
U.S. Government for making the claim "pyrogen-free."

Modern surgeons' gloves must meet higher safety and performance
standards than ever. Regent is proud to take the lead in setting
highly stringent clinical criteria, and we challenge other gloves to
try to measure up. These days, the stakes are much too high for
compromise.

For outstanding barrier protection, comfort and performance,
depend on the full line of Biogel Gloves—Biogel Surgeons' for
surgery, Biogel M for microsurgery, and Biogel Diagnostic for
non-sterile procedures.

For FREE glove samples or more information, call (800)763-6364.

Biogel®

THE WORLD'S FINEST SURGEONS' GLOVES.™



BIOGEL® Gloves are distributed by REGENT HOSPITAL PRODUCTS, LTD., Greenville, SC, (800) 843-8497. Made in Malaysia by LRC Products Limited, London. Subsidiary of London International Group plc.
REGENT and BIOGEL are registered trademarks. U.S. Patent Nos. 4,499,154 / 4,548,844 / 4,575,476 / 4,482,577. ©1993 Regent Hospital Products Limited. All rights reserved.

Descriptions of new surgical techniques and new technologies needed

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

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

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

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

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

sent to the author for approval. If possible, submit a copy of your IBM-compatible or Macintosh disk.

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

Benjamin M. & Curtis, J. (1986). Ethics in Nursing (2nd ed). New York: Oxford University Press.

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

Share your knowledge, expertise and experience with your operating room nursing colleagues across Canada and those nursing in the U.S. and foreign countries.

Address all correspondence to:

**The Editor,
Canadian Operating Room Nursing Journal
c/o Health Media Inc.
14453 29A Avenue
White Rock, B.C., V4P 1P7
Phone (604) 535-7933
FAX: 604-535-9000**

Please allow six weeks for the acceptance and review of your manuscript. Authors will receive a letter from the publisher on receipt and a follow-up letter announcing acceptance and possibly some revisions suggested by the editorial review board.

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



Canadian Operating Room Nurses Association of Canada Executive and Board of Directors - 1993-1994

President
Jackie Waisman
Nurse Manager, OR, RR
Red Deer Regional
Hospital Centre
Red Deer, AB

President-Elect
Loretta Thomas-Aasen
9 McLelland Bay
Weyburn, Saskatchewan
S4H 2V3

Past President
Gloria Stephens
Nurse Clinician
St. Paul's
Hospital
Vancouver, BC

Vice President
Vija Hay
President ORNAO
Nurse/Manager, OR/RR/DS
Queensway Carlton,
Ottawa, ON

Secretary
Hilda Gatchell
Nursing Unit Mgr.,
Surgical Suite,
Oshawa General
Hosp., Oshawa, ON

Treasurer
Marlene Hill
President ORNPEI
OR, Queen Elizabeth
Hospital,
Charlottetown, PEI

Provincial Representation - 1993-1994

British Columbia

Shirley Hemerling
BCORNG President
Operating Room
Kelowna General
Hospital
Kelowna, B.C.

Lorraine Varner
Operating Room
Kelowna General
Hospital
Kelowna, B.C.

Alberta

Dahlia Robinson
President ORNAA
OR Clinical Coordinator
University Hospital
Edmonton, AB

Jane McClain
Past President ORNAA
Lethbridge Regional
Hospital,
Lethbridge, Alberta

Saskatchewan

Anna Kristoff
President SORNG
Clinician Nurse Educator,
Staff Nurse,
Regina General Hospital
Regina, SK

Phyllis Arnst
St. Paul's Hospital,
Saskatoon, SK

Manitoba

Karen Schuster
President- MORNA
Seven Oaks General
Winnipeg, MB

Karen Steindel
President-Elect MORNA
Operating Room
Children's Hospital
Winnipeg, MB

Ontario

Judi Tyndall,
President-Elect ORNAO
OR Clinician
Henderson Div., Hamilton
Civic Hospital, Hamilton.

Carole Starr
Unit Supervisor, OR
Peterborough Civic
Hosp., Peterborough ON

Quebec

Jane Percy
President, SO/OR
Operating Room
Queen Elizabeth Hosp.
Montreal, PQ

Josette Forest
President Elect, SO/OR
Ste.Foy, P.Q.

New Brunswick
Elizabeth Thompson
President, NBORNG
OR, Dr. Everett Chalmers
Hospital, Fredericton, NB

Corina Balcom
Pres.Elect.NBORNG
OR, Region 7 Hospital
Corporation,
Newcastle, NB

Nova Scotia

Donna Farid
NSORNG President
Victoria General Hosp.
Halifax, NS

Shelly Zareski
NSORNG President-Elect
Operating Room
Isaac Walton Killam
Hospital, Halifax, NS

Newfoundland

Angelia LeMoine
Past-Pres., N&LORNA
Western Memorial
Regional Hospital,
Corner Brook, NF

Lillian Budden
President, N&LORNA
OR, Dr. Charles A.
Janeway Hospital,
St. John's, NF

Prince Edward Island

Rosemary Moase,
Vice President, ORNPEI,
Prince County Hospital
Summerside, PE

Concern about ozone layer depletion by chlorofluorocarbons (CFCs) is accelerating their elimination.

If you use 12% ethylene oxide (EO)/88% CFC gas to sterilize instruments, consider replacing with the STERRAD™ Sterilization System now.

BETTER FOR EMPLOYEES AND PATIENTS

STERRAD is a low-temperature plasma sterilization process that eliminates the EO health and safety concerns.

BETTER FOR BUDGETS

The system saves money. The low cost, 75-minute cycle reduces need for duplicate instrument sets.

BETTER FOR THE ENVIRONMENT

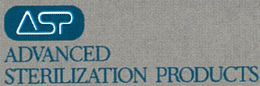
The STERRAD Sterilization System eliminates another big disadvantage of 12/88 EO: ozone layer depletion from CFC emissions.



STERRAD™

STERRAD technology was developed to address sterilization of heat- and moisture-sensitive instruments. It's safe, economical and effective.

For instrument sterilization that's "Better All Round", talk to Johnson & Johnson Medical Products about the STERRAD Sterilization System.



THE FIRST STERILIZATION BREAKTHROUGH IN FORTY YEARS IS HERE.

BETTER ALL ROUND



Johnson & Johnson

MEDICAL PRODUCTS

1421 LANSLOWNE STREET WEST, PETERBOROUGH, ONTARIO K9J 7B9 • PHONE (705) 741-6100