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Cost-Effective Nursing Practice

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Contents

Cost -Effective Nursing Practice: Cost -Awareness and Empowerment

By Patti Fisher, R.N.

The unlimited resources allocated to health care in the past, no longer exist. While health care purse strings are tightening, technology continues to advance with alarming speed and a high price tag.

In order to continue providing quality care to their client population health care facilities and their employees must direct their focus towards cost-containment and cost-reduction. An extension of this primary focus will be the use of efficient and cost-effective processes throughout the facility.

Improvement of quality by ongoing change and measuring outcomes, while at the same time containing costs, are necessities. Institutions must also be effective, efficient, and adaptable. Both external and internal factors require examination.

Abstract

Cost-effective nursing practice is essential to succeed today as resources allocated to health care are declining. Realizing that any change poses a threat to our security, it is imperative that stakeholders be permitted to participate in decision-making processes affecting their work. An honest, open exchange of ideas towards cost-effective practices should be encouraged. Cost-effective behaviours are influenced significantly by negative attitudes with reagrd to loss of human resources, increased workload, and potential pay cuts. This article describes innovative strategies which could promote successful cost-effective nursing practice, including working smarter, not working harder. Topics addressed are attitude, awareness and empowerment.

Two of the factors which have led to the limiting of resources allocated to health care are the economy and the provincial deficit. Even though, according to several economists, the economy is stabilizing, it will be some time before an upward swing is visible. Health Care is not alone; other institutions and numerous industries (automotive, electronics, communications and chemicals) are also being curtailed by the economic situation.

Administrative management and boards of institutions are responsible for developing strategies to deal with both external and internal issues. There must be organizational transformation at all levels in order to survive the decrease in funding. It could mean the reduction of types of services made available, structural reorganization such as reducing the number of managers, and/or moving towards team management and shared governance. These are decisions over which the majority of employees have no control. Internally there has been a push to decrease both the average length of hospital stay and the number of admissions. Staff reductions and bed closures have become necessary in most health care facilities to meet the tight budgetary demands. Once these decisions have been made and presented to the employees they must find ways to adapt and work within the new structure. For nursing this means a focus on problem-solving, decision-making, providing quality care, doing more with less, and according to Blaney and

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Hobson, working smarter not harder (Blaney, 1988).

Environmental issues have also recently impacted on health care facilities. One of major concern is handling of biohazard waste materials, not only within the facility, but also regarding the transportation and costly disposal at an acceptable landfill site. Governmental policies have prevented a facility's ability to utilize incineration as a means to dispose of waste products. The increased use of disposable, single use only items has placed an added burden on waste disposal.

Many factors have been mentioned over which few employees have control; however, there are those things under the domain of influence that all employees have control over. It is within this domain that nursing has the ability to impact positively on health care. All nurses can influence attitude. Important components linked to attitude are awareness and empowerment.

Attitude

Cost effective behaviours are influenced significantly by attitudes towards the issue in general. A nurse's attitude toward cost-effectiveness is a function of her beliefs about this issue and its consequence for nursing (Blaney, 1988). Nurses are in a central position, interfacing with the physicians, other hospital departments, and the client. Nurses can no longer "bury their heads in the sand" and believe that someone else will worry about costs (Blaney, 1988). Ignoring the need for cost-containment will only lead to mediocrity and reduced quality.

Frequently the biggest stumbling block, and occasionally the greatest obstacle to cost-effectiveness, is its association with negative factors such as: staff reductions, pay cuts, working longer and harder, reduced resources and decreased quality care. The above factors generally lead to a less than positive attitude towards these issues.

Implications Regarding Cost-Effectiveness

According to Blaney and Hobson (1988) negative attitudes lead to negative outcomes and also affect and/or possibly block efforts to improve behaviour. Prior to implementing any cost-effective strategies or trying to improve behaviours they recommend an assessment of the prevailing nursing attitudes. They developed a reliable and valid measurement tool which could be utilized to accurately measure nursing attitudes toward cost-effectiveness. Should the results of the attitude assessment scale indicate negative attitudes a concerted effort by management and education is necessary to improve attitude prior to any attempts to improve behaviour toward cost-effectiveness.

Strategies

People are the key to effective implementation of cost-effective systems. Frequently, negative attitudes are formed due to incomplete, questionable accuracy of information. Ignorance and fear of the unknown lead to distorted perceptions. Success is greatly dependent upon whether people resist or accept the intended strategies. Blaney and Hobson recommend managers and educators utilize the following message characteristics (Blaney 1988).

1. Factual, complete, relevant, current information.
2. Simple, well organized, straight forward structure.
3. Two-sided presentation: both advantages and disadvantages.
4. Frequent repetition of the basic message.

To increase the chance of being successful with implementing strategies to improve attitude the following is recommended (Blaney 1988):

1. Utilize nurses' knowledge base.
2. Give the impression of honesty - not hiding anything.
3. Deal with misconceptions and allow for venting.
4. Repeat the message in different ways - using different media
5. Be persuasive, plan and implement with care.
6. All participate in decision making
7. Point out the fact that someone else may make decisions if they're not successful.

The vital issue, the driving force behind the need for strategies to improve attitude and ultimately cost-effectiveness is this: if the game isn't played, if nurses don't become active participants the organization's ability to succeed, to come on 'line" with budgetary demands will fail (Blaney 1988).

I. Awareness

Awareness includes both self-awareness and awareness of the outside world. By utilizing one's five senses, sight, hearing, smelling, tasting and touching, one develops a perception of the external world. It is important to cultivate that awareness and enhance it with one's intuitive sixth sense; look at the consequences and the implications of nursing practice as it is presently applied. What is the current return? What might it be? Is it, or could it be more 'value-added" for the client, facility and employees?

Medical supplies is an area over which nurses exert a great deal of discretionary control (Blaney 1988). Misappropriation or abuse of medical supplies may occur due to the following:

- Lack of awareness of a problem
- Convenience
- No responsibility - less than positive attitude
- Lack of motivation/ incentives
- Laziness
- Confusion over who has control
- Lack of/poor communication between provider and user (manager/service manager, and nursing)
- Too many "similar" products to choose from.

It is imperative that potential causes be examined and appropriate strategies be implemented to improve such situations. All staff need to be made aware of the importance and inordinately high cost associated with misuse of supplies. This must be supported by all levels within the organization including the provision of a forum for discussion and exchange of ideas.

The following questions will determine familiarity with awareness (Blaney 1988):

1. How much do you think instances of misuse of supplies cost the unit?
2. How does this problem affect you, your unit, and the hospital?
3. Is anyone familiar with a specific situation in which nursing supplies were used in a less than optimum manner?
4. Why do we have problems with inefficient use of supplies?
5. Do most nurses know how much patient care supplies cost?

Another strategy would be to look at areas where duplication of tasks occur, or where variances occur in client needs. Take a look at those "sacred cows", those practices that have been in place forever without regard for changes in clinical practice.

Look at a small change/cost-effective strategy first, then lead into the bigger one(s). Taking small practical steps allow the staff to see a positive impact in a relatively short span of time. This approach is likely to make them more receptive to a larger cost-effective strategy where the overall impact may take longer to visualize and be felt.

Realizing that each department or area has concern regarding its own budget first, it is imperative that one does not lose sight of the global cost, which is the facility's bottom line. For Example: a surgical client requires intraoperative catheterization and a generic drainage bag is attached. The client is transferred to Post Anaesthesia Recovery Room where hourly urine output is ordered. The previously connected urine bag is inadequate for this type of measurement and a new bag with hourly output measurement capabilities has to be attached. The cost of a generic drainage bag ranges from $3.60 - $3.70 while the hourly output measurement bag ranges from $10.25 - $10.30 dependent upon quantities ordered. $3.00 wasted for one item in one procedure.

Another area which could be examined carefully, with the potential to save costs is the use of Intravenous (IV) solution administration sets. Many clients come to the operating room with an IV in place. The solution administration set is often, unnecessarily a blood administration set regardless of the fact that the client may not have had a blood crossmatch ordered by the physician. The difference in cost between a regular solution administration set and a blood set can vary between $2.00 - $3.00 depending upon company supplier and anaesthesia demand. These are just two situations, there are numerous others that could be examined. Networking and collaborating with departments where client care overlaps can only benefit all. Assessing policies and procedures on an annual basis to determine their application to present clinical practice could have a major cost savings impact.

Utilizing appropriate hospital committees could be extremely effective in dealing with issues that impact on several departments. Rather than each department/ unit addressing similar issues, if such issues were tabled at a hospital wide 'Nursing Practice Committee" then resources could be allocated appropriately to examine such issues. A task team/subcommittee of interested members could collect critical data, plan strategies, present a formal report, obtain approval by majority consensus and finally, implementation of the most acceptable strategy. This has the potential to exhibit tremendous cost savings by reducing the amount of time spent on certain issues, reducing duplication of tasks, and reducing the number of employees involved. A value-added benefit would be the provision of more consistent quality of care throughout the facility.

Awareness is the first step of implementing strategies to improve cost-effective nursing practice. The second step, although no less important is empowerment of nursing staff.

II Empowerment

Before defining empowerment it is important that an overview of "power" definitions be given. Power has several definitions, many of which have less than positive connotations. It is those in power, or those who don't exercise their power to influence others, and the associated outcome which may be seen by others as good or bad (Blaney, 1988). Power is not static: it is a resource in our society which changes as individuals and group relations change (Kidder, 1989).

In an organization, power is also based on a philosophy and a system of ideas which generally include a vision statement, goals and objectives developed by management with input from staff. By ignoring power relationships and failing to use power strategies nursing is often ignored or manipulated by other groups in the organization (Kidder, 1989). As Kidder states: action rather than reacting offers the individual the opportunity to plan participation rather than be manipulated by other power holders (Kidder, 1989).

Empowerment also has various definitions. Empowerment is essentially a process arising from valuing other people (Chavasse, 1992). It is the act of building, developing and increasing power through cooperation, sharing and working together (Voigt, 1990).

Empowerment as opposed to power means that power, through interacting with others results in an increase in power for all involved.

Voigt and Murrell identify several forms of empowerment: education, effective leading, providing and structuring (Voigt, 1990). These forms are described below.

The intended function of education is that, beyond the basic information sharing, the intent is such that basic information will be expanded and built upon in order to create and develop more useful information. Knowledge and information allow for a more accurate understanding of the situation and thus a more thoroughly informed decision will be made.

Managers who believe in abilities of their staff facilitate the organization in profiting from a broader base of talent. This allows employees the opportunity to identify and solve problems on site at the time and place the difficulty occurs. Management must not lose sight of the fact that their staff will not necessarily move forward at the same pace.

Even in light of tightened budgetary belts, empowering employees does mean supporting them with appropriate resources necessary to provide quality client care. Resources include the shared "vision" of the organization and developmental sessions in order that staff may understand the changes occurring, the process, and how to be more efficient. Empowerment, for staff nurses, does come with an expense attached. That expense is one of ownership, responsibility and accountability for any decisions made and acted upon. Management alone cannot be blamed for situations and decisions made with empowered staff.

The structure of the organization including the policies, procedures, job descriptions, and job analysis should allow for growth and development of all employees in order for the environment to be conducive to empowering. For empowerment to take place there must be a commitment throughout the organization. Voigt and Murrell (1990) describe several factors which will impact on an organization and its employees' ability to empower/ or become empowered. There must be a fundamental belief and trust in people, clearly defined organization values, wide availability of information, a climate of collaboration, humanness and enjoyment, open communication and ongoing feedback in a non-threatening environment.

Look to nursing peers for advice and guidance, for solace, support and encouragement. Recognize the value of independence but also know the wisdom of coming together (Baetz, 1991). Rather than remaining an isolated individual faced with a seemingly unsurmountable problem, alternatives for dealing with difficult situations are much easier to find when collaborating with peers. Valuing others, being able to incorporate others' ideas or solutions as well as build upon them, is a great venue for professional growth and development. Demonstrating responsibility towards others, having a positive approach, and showing evidence of credibility lead to empowerment. Growth and development, including the acquisition of knowledge all lead to higher self-esteem and thus empowerment. No one grows with only an image of themselves (Baetz, 1991).

It is apparent that cost-effective practice and continued provision of quality care will not exist without motivating factors. Nursing staff must be made aware of overuse or abuse of supplies and equipment, and alternative choices. They must be shown both the outcomes and the impact those outcomes have on both their ability to provide quality care as well as their actual jobs.

Change is most often seen as a threat to both security and stability. Established routines, long taken for granted are now being questioned. Productivity may also be questioned in search of inefficiencies and ineffectiveness. Being "busy" does not always liken to being productive. With reduced resources, measurable positive outcomes are crucial in order to justify the continuance of certain functions or activities. There is a need to get on with dealing with the present changes by moving beyond the theoretical planning and actually doing something about the changes already in place.

Proactive planning, assessing methods of practice and conscientious efforts in cost-containment and cost-effectiveness will place "nursing" in a sound position in the fight for financial resources. Input from both management and staff on what they do, how it benefits the client, and how the staff can improve/ increase efficiency and effectiveness are goals which need to be developed collaboratively. From management's perspective, there is a need to determine appropriate utilization of staff. Are their assigned tasks appropriate and productive or do these tasks belong to another group or department? Nursing literature searches, as well as the utilization and application of clinical research will provide a solid base to initiate cost-effective measures at the same time as initiating improved nursing practice.

Communication cannot be overly stressed even when attitudes towards cost-effectiveness are positive. Information regarding reasons for change, and intended outcomes, staff input, empowered decision-making and the ongoing timely method of feedback are all necessary if there is to be a collaborative effort toward ensuring that cost-awareness will lead to cost-effectiveness. Networking with other centres, including specific departments in order to examine their strategies will not only be insightful but may also reduce the amount of valuable time and effort placed on planning strategies. People who can be explicit about their needs increase the chances of their needs being met (Baetz, 1991).

Success is more achievable if there exists an organization and environment of cooperation, communication, active participation, trust, and high expectations from all managers, staff and administrators (Mayberry, 1991).

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Downsizing
Recognizing the Effects and Taking Control

By Jemma Lynch R.N., M.N.

The first part of this article will address the effects of displacement or bumping on staff, the second part will outline some strategies which have been found helpful in organizational downsizing, and the final part will describe Layoff Survivor Sickness as outlined in *"Healing the Wounds"* by David Noer.

My information is based on a phenomenological study I carried out in a Calgary, Alberta, hospital where a Unit was closing and staff received position elimination notices and subsequently bumped onto other units. Interviews were carried out with the staff who were bumping off the Unit as well as Nursing Managers and staff who were receiving staff onto their Units. Information has been added from literature review which includes a study done by Alice Sears (1992 Unpublished) *"Understanding the Psychological Impact of Displacement: A Study of Stress, Hope and Coping."* It is hoped that by presenting this information, it will help to validate the feelings of those affected by downsizing, and facilitate the necessary grieving that is necessary to make a paradigm shift in their thinking in order to grow from this process. For those who have not been directly affected by downsizing, consider the broader picture and contemplate on the downsizing of health care services in Alberta as well as the other provices of Canada.

Personal Stressors for Staff

1.Concern for Patient Care.

As nurses we are first and foremost concerned with safe and efficient patient care. When bumping occurs into and out of Units, there is a concern that because those with expertise are leaving and those bumping in do not have the desired experience, that patient care may be jeopardized. This may be especially true of specialty areas such as the Operating Room.

2. Different Patient Focus.

Staff stated that going from a Unit where they were comfortable in their knowledge and skills to another Unit where the patient population was different was very stressful.

3. Fear of not being accepted on new Unit.

This fear has since been validated by a Occupational Health Nurse who said the fear ranges on a continuum from nurses being unable to work for as long as a year because they felt they had not been accepted by their peers or manager to those who feared they would not be accepted but worked through it when they got to their new Unit.

4. Loss of contact with colleagues.

When you work with certain people for months/ years, friendships develop and support and encouragement is reciprocal. In the Operating Room, this is not only true for your fellow nurses but you also have a close working relationship with the surgeons. Being bumped creates a fear of loss of cohesiveness.

5. Having to comfort colleagues.

We tend to empathize with our friends who are being bumped and feel guilty on seeing their grief.

6. Fear of loss or decreased income.

Many of the staff affected by bumping are single wage earners. With the coincidental downsizing in business and industry, there are many nurses whose partners are unemployed. There is a fear of having to go from a full - time position to a part - time position, depending on the availability of positions and the seniority of the person affected.

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7. Feelings of loss of control over the situation.

Many nurses expressed feelings of desperation and of not being in control of their own destiny.

8. Inability to take early retirement.

At the time of my study, early retirement "packages" were not being offered. However, even with the hospitals offering packages to those who wish to retire, there is still the possibility of having to take a penalty on their pension if they do not have the required age and years of service.

9. Physical ability.

Staff found it stressful to contemplate on going to areas where the physical requirements for lifting etc. were greater. In the Operating Room, the requirements for assisting with specific types of surgery e.g. total joint replacements may vary, as well as long standing time required for some surgeries.

10. Felt "like starting all over again".

A nurse who had over twenty years of general surgical nursing experience stated that she felt like a student nurse again. Many nurses felt they were going from expert to neophyte when bumping to a new area.

11. Re-evaluation of personal and professional values.

Although this is thought to be a positive exercise, at a time of downsizing and bumping, it tended to bring out a sense of disillusionment and nurses found themselves discouraged with the profession of nursing . For some, past anger and resentment resurfaced from their personal lives also.

Stressors for Staff within the Department of Nursing

1. Rumours.

Dealing with the many rumours that abound during downsizing is stressful for staff. Physicians are famous for spreading rumours so you are particularly vulnerable working in the Operating Room.

2. Position denial.

Nurses who had attempted to bump into certain positions and who were denied, found this to be extremely stressful. It affected their self - esteem and they were faced with the dilemma of whether to grieve the decision or be content with another position.

3. Waiting for verification of position.

Nurses found the uncertainty of not knowing if they had been accepted for a position to be stressful. They also worried about getting bumped again.

4. Rotations not available on new Units.

As we all live by our calendars, not knowing time off especially around Christmas and special holidays is stressful.

5. Lack of information/communication.

Staff felt that they did not know what was happening and that they depended on rumours and hearsay. This was mentioned by all the staff interviewed.

6. Hearing of misfortunes of persons bumped.

Many of the staff expressed a discomfort with having to bump someone out of a line but the stress was increased when they heard of the misfortunes of those they had bumped - staff member having chest pain or that her husband lost his job, etc.

7. Inconvenient, yet necessary, Collective Agreement.

This specifically refers to Article 15 in Alberta (position elimination clause) where nurses expressed a great deal of discomfort with the actual bumping process, but felt the clause was necessary for some degree of job security.

8. Decrease in "Casual" shifts.

Casual /relief staff had no hope of getting a part - time or full-time job. With the present increase in number of layoffs and the "recall" system, the potential for casual staff to obtain work is even more limited.

9. Lack of visibility of Administration.

Many of the staff interviewed expressed annoyance at the lack of visibility of senior Administration staff on the Units during downsizing. This appeared to increase their sense of being devalued.

Stressors for Staff from outside Department of Nursing

Stressors from within Department of Nursing and without are differentiated to denote those which we can rectify versus those we have little control over.

1. Lack of longterm planning.

Staff blamed senior hospital administration as well as Government for a lack of long term planning resulting in the downsizing of health care services

2. Lack of alternative cost-saving measures.

Nurses cited many examples of poor bed utilization, unnecessary tests performed on patients and inappropriate purchases within the hospital.

3. Blaming of Nurse's wages for strain on budget.

Nurses noted that the local newspapers had frequent articles suggesting that nurse's wages were to blame for the high cost of health care.

4. Downsizing in industry.

Coinciding with layoffs in health care services is the general downsizing in business and industry

which resulted in many nurses having unemployed partners thus the situation is even more stressful.

It was interesting to find validation of these themes in the study done by Alice Sears in Edmonton (1992, unpublished) as she found the three worst things for nurses during displacement were

(1) **Uncertainty/Rumours,**

(2) **Administration/Poor communication**,and

(3) **Displacement/ the Bumping Process.**

Sears had compared staff who received position elimination notices on a Unit which was closing and staff from a Unit which was being relocated to another (sister) hospital and found that having no choice (relocating to another hospital) caused more stress than receiving position elimination and being able to bump into other positions of choice.

Management Strategies

The following themes emerged from the interviews with the Nursing Managers:

1. The need for information

2. The need for quality control

3. The need for support

1. Providing Information

Administration needs to give information on the external and internal forces - the rationale behind downsizing such as: the Federal deficit in excess of $40 billion; the decrease in transfer payments to the Provinces; the potential for regionalization; HPI (Hospital Performance Index); trends in health care - the shortened length of stay because of advances in technology and the increase in laproscopic surgeries thus decreasing the need for inpatient beds. The proposed changes in the Alberta Legislation regarding the Health Professions Act toward more collaborative and cooperative relations with other disciplines leading to "Patient Focused Care" delivery models and perhaps cross-training of disciplines is an area we as A.A.R.N. members need to be cognizant of and lobby for the interests of registered nurses. Pat Mandy (1992) described the Regulated Health Professions Act of Ontario in her keynote address to the Operating Room Nurses Association of Ontario and gives many helpful suggestions for operating room nurses.

Managers felt that there was a need for overcommunication at the time of downsizing. They suggested that Senior Administration be visible on the Units to talk informally with staff as well as having newsletters, forums, videos and a medium to address "facts versus rumours". Extend invitations to your Senior Administrator to visit in the O.R. - they are pleased to be invited.

2. Champion Quality Control Effort.

All the staff interviewed spoke of the lack of a thorough orientation. It takes at least two to three months for new staff to diffuse their anger. Staff may be functioning at an expert level on the Unit they leave, but revert to a neophyte role on the new Unit. It is worthwhile to provide new staff a proper orientation both for quality patient care and team building .

It is essential to provide a forum for staff to express their feelings - acknowledge the hardships imposed on them. Managers, charge nurses and clinicians may need to steer the discussions toward positive solutions and attitudes and discourage these discussions in holding areas where patients are awake.

Managers need to be flexible with the rotations at time of downsizing - creativity is needed to provide for safe coverage e.g. staff for "on call" until new staff are orientated.

This is a time when managers may need to reaffirm their quality control responsibilities and the expectations of their staff and have them articulate what they expect of you as a Manager/Charge Nurse. Diane Miller (1991) stresses this aspect of quality control and personal and professional development.

For Managers /Charge Nurses, this is a time when you need to re-establish the tried and true methods of time management - the "to do" lists, time in your office with the door closed to get caught up on your work.

Team Building is essential for quality patient care. Staff need time to adjust to new areas. They are hard on themselves when they move from an area of expertise to another area. Diane Miller (1991) describes a four-quadrant cycle for staff who start a new job which is also applicable to staff who bump into a new area:

Level 1: 0-18 months - need direction, need to know the what and why, likes lists, somewhat rigid

Level 2: 18-36 months - critical thinking begins, become competent.

Level 3: 3-4 years-proficient, on committees, preceptors

Level 4: 4 years and up - The "gold", the experts, we tend to overuse.

Miller jokingly refers to Level 1 staff as "the Guppies" and Level 4 staff as "the Barracudas" and suggests that the guppies sometime get eaten by the barracudas! It is especially important for managers to be sensitive to the needs of the staff bumping into a Unit (the guppies) and redirect the energy of the barracudas into positive behaviors in accepting the newcomers.

3. Need for Support.

For Managers, Clinicians, Charge Nurses and Clinical Nurse Specialists, your traditional role will change at times of downsizing and bumping to that of counsellor, advisor and stress management personnel. You need support also. You may be losing valuable staff. Get the support from whoever you can - boss, family or friends.

Managers suggested a task force or committee be set up to dovetail the interests and priorities of management and union during downsizing. This committee should have representation from management, unions, Human Resources and Occupational Health to offer consistency and support throughout the transition. Employee Assistance Programs are valuable at these times of change and staff should be encouraged to seek help.

Inservices/workshops tend to be postponed at times of drastic change. This is when they are needed most. Stress management workshops, forums for expression of feelings and workshops on empowerment are essential. It is important to have debriefing sessions after each major wave of downsizing to discuss problems encountered, ways of improving the process and getting suggestions and support from each other. You need to reinforce to yourselves and to each other that you do make a difference.

Personal Strategies.

Because anxiety is greater when we feel a lack of control, at times of downsizing we need to focus on areas where we do have control. We should all have a contingency plan to deal with the threat of downsizing, displacement and possible unemployment.

1. Acknowledge your feelings.

In his book on "Healing the Wounds" (1993), David Noer gives the analogy of a family to illustrate the need for acknowledgement of feelings - for those who are left behind after downsizing as well as those who leave. Imagine a family - father, mother and four children. They are a close family. They eat breakfast together every morning before going off to work and school. One morning the children notice something is different. The parents look very grave. The father finally says " Children, your mother and I have gone over our budget and we have discovered we are unable to make ends meet with all of you four children. We have decided that two of you must leave - you two must go to live with your aunt and uncle. You children who are left here with us will have to study and work hard and we will be a closer and better family." Noer suggests the following exercise to facilitate the acknowledgement of feelings - write down the feelings the children who left might have had, the feelings the children who stayed might have had and the possible feelings of the parents.

2. Take regular inventory of your skills - write up your resume.

This increases your sense of having options and control. Become aware of other job opportunities. Continue on with your Resolution to the A.A.R.N for Advanced Nursing Practice to provide anaesthetic/surgical assistance. Be mindful that you are in one of the four sectors which are considered to be the driving forces of the economy (computers, instrumentation, communication and) health care according to Nuala Beck, (1992). This sector includes drugs, biomedicine, surgical and medical equipment and supplies. You are advantaged working in the O.R. and being nurses - you have the communication skills, you constantly deal with new technology and equipment and you are emersed in the health care system! Develop plans to acquire the skills you will need. The future is a lot brighter than you think.

3. Commit to a lifetime of learning.

Peter Drucker (1993) in his book "Post Capitalist Society" states that "...the world that will emerge from the present rearrangement of values, beliefs, social and economic structures... will be different from anything anyone today imagines... and it is certain that its primary resource will be knowledge." Your own philosophical statement from your Recommended Standards for Perioperative Nursing Practice (1993) also includes a definition of life long learning as " an active process through which the learner acquires knowledge, skills and attitudes. The needs of society are ever changing, therefore, learners must continue their education all through life." A lifetime of learning does not necessarily mean going back to school to acquire more formal education - it means any way you can learn how to do your job better, or how to do another job which will make you enjoy your work better or give you a passion for your work.

4. Decrease your debt and set money aside.

This is another practical way of giving you the feeling that you have control over your life, that you are adapting and preparing for unforeseen changes.

5. Lower your expectations.

This can be difficult. Have you ever gone house-hunting - for a smaller house? It's very discouraging. You may also want to rethink your expectations for vacations, new car etc.

6. Consider other family members.

This type of stress affects our whole family. We need to remember to praise our children more than usual and to continue with positive family activities. If you have an unemployed partner you may want to take advantage of the Employee Assistance Program in your organization or seek out some counselling. If your organization does not have an EAP, check your excess medical insurance - it may cover some counselling sessions.

7. Participate in volunteer activities or non-profit organizations.

This can facilitate socialization and networking as well as increasing self-esteem. Peter Drucker (1993) also mentions in his book that this is going to be necessary in our post-capitalist society to maintain viable communities.

8. Maintain job performance.

You need to do this for your own self worth and a feeling of autonomy - not just for quality control.

9. Physical activity.

Physical activity is necessary to deal with anxiety. Exercise provides a constructive outlet for metabolizing the neurotransmitters released during times of stress. Breathing exercises, positive thoughts, music, biofeedback and prayer can achieve a restful state.

10. Work together toward a common goal for health care.

We need to be more instrumental in influencing and developing our health care system. Lobby your MLAs. Write letters expressing your ideas. Write in your Journal (a Journal you should be proud of - one of the few Canadian Nursing Journals) for your colleagues across the country - a great way of communicating and uniting.

11. Look for opportunities for growth.

Direct Access is promising. The AARN is presently lobbying the government to re-allocate funds from an acute care system to a community based system and to fund the services of registered nurses. You have excellent skills - you can provide pre and post op teaching, prepare teaching pamphlets /videos for patients and families, set up and manage clinics. In New York, physicians and nurses and other disciplines are forming community Network Clinics in response to the changing health care needs. Continue your efforts for Advanced Practice. Network with physicians and explore the work possibilities for the future.

Layoff Survivor Sickness

It may happen that the people who remain after layoff and bumping do not get the attention they need. This results in what David Noer (1993) calls the Layoff Survivor Sickness and is described as a set of attitudes, feelings and perceptions that occur in employees who remain in an organization following involuntary employee reduction. People suffering from this sickness are said to have a reduced desire to take risks, a lowered commitment to the job, and a lack of spontaneity. Some of the other survivor sickness symptoms include: codependency with the organization, job insecurity, a feeling of unfairness, depression, stress, fatigue, distrust and betrayal, wanting it to be over, thirst for information, survivor blaming, denial, lack of strategic direction, lack of management credibility, short-term profit orientation, non-reciprocal loyalty. Feelings of optimism and continuing commitment as well as justification and explanation are likely to be expressed by management staff only.

Most of the above symptoms are familiar to us. If we consider the analogy of the family letting two of their children go, we realize the feelings of the remaining family members are as significant as those who left. The concept of codependency with an organization, as one of the symptoms of survivor sickness, needs further clarification. Noer (1993) describes employees as codependent with an organization to the extent they index their self worth by their success in that organization - their sense of value and identity is based on pleasing or often controlling, not him or herself, but someone else. Hospitals promote this codependence, with the best of intentions, through social functions, benefit plans, group insurance, tuition reimbursement etc. Units promote this codependency through the development of a specific unit culture and cohesiveness, social activities, specific knowledge base by virtue of the particular patient population. As nurses, we are traditionally excellent team players as opposed to individual practitioners and so are more vulnerable to becoming codependent.

Coping Strategies for Layoff Survivor Sickness

The following are some strategies suggested by Noer to cope with or prevent survivor sickness.

1. Manage the layoff (bumping) process.

This is a time for overcommunication and working together (union and management).

2. Facilitate the necessary grieving.

Use the analogy of the family. A facilitator may be helpful to assist people express their feelings and move them to positive attitudes and solutions.

3. Break the dependency chain.

Staff need to break away from organizational/unit codependency and feel self-empowered. When we are self-empowered we have personal power over our self-esteem and sense of importance and this helps to keep us somewhat immune to survivor sickness. It is important that staff maintain internal control, keep their personal power and love themselves without making this love and acceptance conditional on organizational or Unit approval.

One way to prevent organizational or Unit codependency is through "detachment" where you no longer index your self-esteem and identity by your success in the workplace. If who you are is where you work, you will do anything to hang on.

Quality work will assist you to detach. Quality work starts internally - you want to do a good job. It is an outward manifestation of your own internal gifts, talents and skills.

Having varied social and professional networks helps staff not to rely on the hospital or Unit to nurture various aspects of their lives. Take stock of your own dependency scale. How much do you depend on your Unit or hospital for a measure of your self-worth? Do you need to cultivate other social, professional or spiritual networks?

4. Building a new employment relationship.

This can be very difficult for us as hospital employees. When (most of us) graduated as nurses, job security for life was taken for granted. Noer compares the old employment relationship with the new in the following way:

(a) Old employment relationship - employment seen as long term. New - employment relationship situational. Outcome: flexible workforce;

(b) Reward - promotion from within - fixed job descriptions. New - reward is acknowledgement of contribution, self-directed work teams (self-governance) Outcome: motivated work force;

(c) Old relationship - management is paternalistic. New - management is empowering, no "taking care of employees", employee autonomy is encouraged. Outcome: empowered work force;

(d) Old employment relationship - loyalty means staying with same organization. New - Loyalty means responsibility and good work, non-traditional career paths (here is an opportunity for your Advanced Practice - Anaesthetic /Surgeon Assistant). Outcome for new employment relationship - responsible, autonomous workforce; and

e) Old employment relationship - lifetime career a given. New - No assumptions of lifetime caretaking, short-term job planning, explicit job contracting. Outcome-Employees and organization are bonded around good work.

The new employment relationship is undoubtedly unfolding in health care. We can either attempt to hold on to the past or move into the future and develop our own sense of self-worth and control. You have excellent critical care skills. Take advantage of this time of transition to unleash your potential in whatever area you have a passion for in either your present work situation or a new one. Allow yourself to envision the possibilities, the autonomy, the feeling of self-worth and accomplishment and above all - a sense of control over your own destiny.

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"Do not define yourself as an assistant to anyone..."

Says AARN President-elect Barb Shellian to OR Nurses

I note with interest that your conference theme focuses on energy and if there is a way I would attempt to describe Operating Room nurses - the word energy would definitely come to mind! I admire and respect Operating Room nurses and the contribution they make to patient care in this province and this country.

The involvement of the Operating Room Nurses Association of Alberta in AARN activities has been valuable in this current climate of relentless change and reformulation in the Health Care System. You are the AARN and your concerns and issues are the business of the AARN.

The AARN has established two pivotal priorities for 1993 - 1995: Health Care Reform and Research based nursing practice. I notice that the presentations at this conference are closely linked with these two priorities, for example: sessions related to these changing times, nursing research, downsizing, new technology and therapies, and the future of OR nurses.

It is a reality that we cannot continue to do things the way we have in the past. It is a reality that health care dollars must be allocated more wisely. It is a reality that community care and community based decision-making is the way of the future. It is a reality that registered nurses will have an important role to play in the restructuring of the health care system.

One of the major initiatives of the AARN in the past two years has been the activities related to increased direct access to services provided by registered nurses. The goal of the direct access proposal is this: that the full range of nursing services be recognized and integrated as part of basic health services in Alberta so the public can choose to go directly to a registered nurse for nursing services. This position strongly advocates for a patient centered choice driven" health" care system rather than the provider driven "illness" focused system that currently exists. Increased direct access to nursing services means affordable, cost effective quality health care for the citizens of Alberta.

That is not to say that Albertans will not become ill and require nursing services in acute care settings, but we also recognize the reality of changes in technology, shorter lengths of stay in hospital with the corresponding need for increased community based nursing services and the need to utilize all health care professionals effectively and appropriately.

"...It is absolutely essential that patients undergoing surgical procedures have the benefit of the critical thinking and clinical expertise of registered nurses".

What will the future hold for OR nurses? Hospitals and operating rooms will continue to exist for patients requiring that specific expertise and level of care - if anything the care in the operating rooms will become more complex and demanding. In my view, it is critical for OR nurses to clearly articulate their unique and distinctive contribution to patient care in the OR. Do not define yourself as an assistant to anyone - define yourself in terms of nursing practice and articulate why it is absolutely essential that patients undergoing surgical procedures have the benefit of the critical thinking and the clinical expertise of registered nurses.

To emphasize this point. I would like to quote from the AARN Scope of Nursing Practice document:

"The strength of nursing lies in the nurses' ability to identify, relate, interpret and integrate the patient's various needs, taking into consideration the input and contributions made by others concerned with the client's care. As early as 1893, Florence Nightingale noted that nursing's purpose, whether caring for the sick or the well, was to put people in the best possible condition for nature to restore or preserve health, and to prevent disease or injury , (very applicable to operating room nursing). Further, Nightingale believed that health is not only to be well but to be able to use well every power we possess. Nurses respond directly to the needs of clients to enhance health. Nursing care is comprehensive, innovative, flexible, readily available and cost effective. The depth and breadth of the scope of nursing practice places nurses in a position where they can make a significant contribution to health care".

The AARN is your professional association - a vehicle for each registered nurse to deal with issues related to professional nursing practice and concerns related to the safety of the public we serve.

The OR Nurses have achieved a great deal in this climate of change, with much more work still to be done. I would like to leave you with some thoughts from the poet Robert Louis Stevenson on achievement to stimulate your thinking.

To have lived well
To have laughed often and loved much
To have gained the respect of honorable persons and the affection of children
To earn the appreciation of honest critics and endure the betrayal of false friends
To appreciate beauty and to find the best in others
To leave the world a better place either by a flourishing garden or an uplifting poem or a redeemed social condition
To know that even one life breathed easier because you lived
This is achievement ! ■

Barb Shellian, President Elect of the Alberta Association of Registered Nurse brought greeting from the (AARN) to the 1993 conference of the Operating Room Nurses Association of Alberta, in Calgary, Alberta, October 20-23, 1993.

The Imposter Phenomenon:

If I'm So Successful, Why Do I Feel Like A Fake ?

By Jean Rankin, BScN, MHSc

The Imposter Phenomenon is a psychological syndrome or pattern, and it is based on intense, secret feelings of fraudulence in the face of success and achievement. If you suffer from the imposter phenomenon (I.P.), you believe that you don't deserve your success and you're a phoney who has somehow "gotten away with it." You aren't the person you appear to be to the rest of the world.

But there is far more to the imposter phenomenon than that. The sense of being a fraud is only one part of it. Victims of the imposter phenomenon are caught up in a cycle of emotions, thoughts, and actions that can virtually control their lives. Although they are often people who are driven to achieve, they live in fear that each new success will reveal them as fakes. They are sure that when this happens, everything they have laboured so hard to build will be destroyed.

Although the imposter phenomenon is not a new problem, it wasn't until 1974 that the syndrome even had a name. The term "imposter phenomenon" was coined by two psychologists at the Georgia State University, Dr. Pauline Clance and Dr. Suzanne Ines. They had been observing this phenomenon for several years, studying 150 highly successful female students and career women. Despite good grades, honours, awards, advanced degrees, or promotions, these women persisted in believing that they were less qualified than their peers. They suffered from a terrible fear of being "found out" as imposters.

New situations that demand a certain level of performance from us can be quite anxiety provoking and can bring out feelings of being an imposter. Under these circumstances, the idea that someone might feel like a fraud or phony is not surprising. There is a sociological pressure to act as if you know exactly what you are doing in order to perform the functions and meet the expectations of the role. High achievers set high standards for themselves, so they feel the additional pressure of their own expectations. Inside, they may still wonder if they can "deliver the goods."

Unfortunately, IP victims tend to assume that they should know immediately how to play a role to perfection. But everyone must endure some frustration until they can learn a new role and come to "wear" it comfortably. Often, a person who is hired for a new job or suddenly gets a promotion may suddenly feel there is a great deal riding on the situation such as their income, reputation and career plans.

I believe temporary IP experiences are far more common than we now know. How may people are so certain of their abilities and intelligence that they do not ever wonder that perhaps they "put one over" on others?

The fact that these feelings are fragile and so short lived in some cases doesn't make them any less painful for the person experiencing them. If you have experienced temporary feeling of being a fraud, you know how troubling they can be. They still rob you of the pleasure and satisfaction in meeting a challenge.

The tendency to overwork and the need to be special are characteristics that are both tied to the pursuit of perfection. Not all perfectionists have the imposter phenomenon, of course, but many people with IP do strive to be perfect. Such individuals want all their work or ideas to be brilliant, creative and productive all the time. These people can't distinguish between which projects require the most intelligent, intellectual output and excellence, and those which require only minimal effort and quality. For them it is necessary to be perfect at everything they do; for them, it's necessary to become super human beings.

Author

Jean Rankin, BScN, MHSc, is Director of Nursing, Renal,Orthopaedic, Psychiatric, Foothills Hospital, Calgary. She was previously Assistant Professor, Faculty of Nursing, McMaster University, Hamilton, Ontario. This article was a presentation at the annual conference of the Operating Room Nurses Association of Alberta, held recently in Calgary, Alberta.

How Do You Throw Away The Mask? Day-to-Day Solutions For The Imposter Phenomenon

Here are four steps that you can follow to help you on a daily basis:

1. Make a list of the times that the imposter 'feelings' are likely to strike.

You probably know what situations intensify your own feelings of fraudulence. So take the step for primary prevention. Instead of trying to remedy the problem after it's already happened, anticipate and plan for it ahead of time. Write down the times and the feelings of being a phony when they flare up in full force. Is it when you take on a new assignment? Does it happen when you have to make an important presentation? Consult this list weekly or monthly. This way you will recognize what you are experiencing the next time a similar event rolls around. The feeling of faking it shouldn't take you by surprise and throw you off balance.

When you've identified the circumstances that have brought of IP feelings in the past, you can be ready for those feelings the next time. When you warn yourself to expect IP feelings, you're that much closer to keeping them from overwhelming you.

2. When the feeling of being a fake starts to take hold, you need to remind yourself that this is a symptom of the imposter phenomenon, and not an objective truth.

Once you can identify your feelings of phoniness, the symptoms of the IP, you can start to do something about them. If you have objective evidence of success in what you are doing, you can see that your feelings are probably part of the IP syndrome. Accept, once and for all, that your aren't a fraud, but simply someone who feels like a fraud.

If for example, you are about to make a presentation, mentally review what you have done to prepare. Do you know what points you want to get across? Have you looked up your facts? Write your thoughts down and rehearse them out loud. Once you acknowledge that you have indeed done what was reasonably required to prepare, you'll see that your feelings are based on unrealistic fears instead of on reality. Whenever possible, start with the easiest part of your task first. You know what aspects make you the least and most anxious. By starting out with the things you find easiest, you can see yourself accomplishing something, and you will feel more in control.

3. Try to relax.

This might sound like pretty basic advice, but it's very important. The feeling of being a fake can bring on intense anxiety. But you can't deal with that feeling when anxiety has you all wound up and frantic. You need to relax.

There are many relaxation techniques. Find one you like and use it whenever IP feelings strike. On a regular basis, you could do yoga or transcendental meditation. Some people find that sports help them ease their tension. Maybe you could get relief from a swim or a good game of tennis or squash. You might want to buy an audio tape program of exercises specifically designed to help you relax.

4. Being honest and open.

The fear of exposure brings with it a feeling of anxiety. One way to fight that anxiety is to be honest and open from the beginning about what you think, and about the things you don't know. Try to avoid falling into the trap of attempting to appear perfect, hiding any sign of nervousness, or concealing your lack of knowledge about something.

5. Practice being your own person.

If you have difficulty disagreeing with other people and expressing your own views, you have to pay attention to the times when you see this happening. Little by little, begin to practice saying what you think. If you risk being yourself, gradually, in small ways, step by step, you will find out that most people are capable of accepting expressions of individuality and disagreement.

6. Experiment with your work patterns.

If you have the habits of an IP workaholic, you should take a long hard look at how you approach new projects. Force yourself to arrange your priorities and to spend less time on those tasks that are the least important. Vary your behaviour. You will have to take

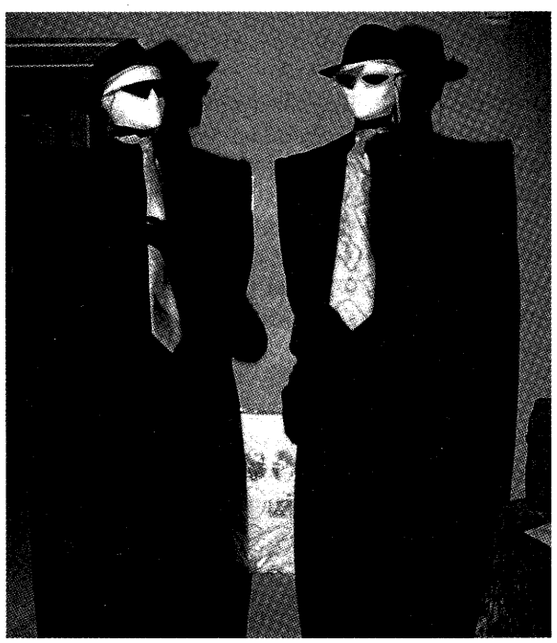
some small risks in order to find out that every task doesn't demand the same amount of your time and effort.

7. Break the worry ritual.

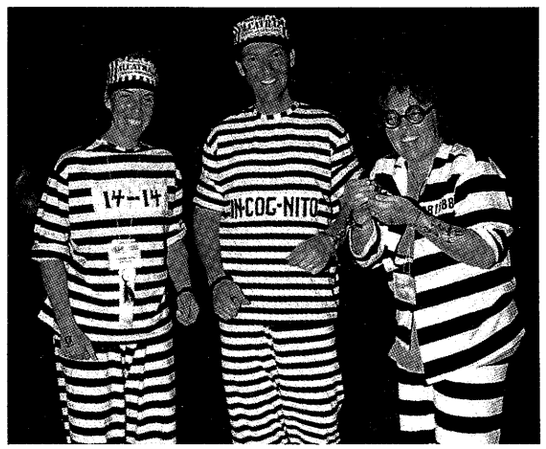
Do you have the IP magical thinker's habit of always envisioning failure? You must allow yourself to envision success instead. As you change the habit of superstitious thinking, you will learn that you can succeed without the same degree of advance worrying. Gradually you'll find that you can rely less and less on the worry ritual.

A mistake is a human error, not a fatal flaw that must be camouflaged forever. Sometimes, certain factors are just beyond our control. If you feel you must hide your mistakes out of shame, then you are trying to appear perfect - better than anyone else. Of course, you should try to do the best you're capable of in your career and in your personal life. You shouldn't stop striving to achieve, or settle for something less that you desire. But having to be number one and perfect all the time in everything is a very grandiose aim. You are setting yourself up for disappointment.

Ask yourself how you would respond if a friend told you that he or she had made the same mistake you made. Would you feel your friend was a failure? Would you even care very much about the mistake? How long would it take before you forgot about it? Chances are, it would have little effect on your overall opinion of your friend. You might even like him better for being vulnerable. Treat yourself as reasonably as you would your friend. ■



Black and White Night at the ORNAA Conference did not limit the imaginations of delegates. Some of the creative outfits photographed by Marg Ensminger.



Regina Leonard won the Johnson & Johnson Drake-Thompson Memorial Editorial Award for 1992. The $3000 cash prize was given for her article *"All the Right Moves-Positioning the Patient in the OR"*, published in 1992 (Vol.10,#4). Regina is Coordinator of the Licensed Practical Nurse-OR Technician Program, Royal Alexandra Hospitals, Edmonton. **John Dixon** of Johnson &Johnson Medical Products presented the Award at the '93 ORNAA Conference.

(Photo Right) **Dorothy Orr**, ORNAA founding president (right) was honored at the ORNAA Conference for her outstanding contribution to the provincial OR group. **Jane McClain**, immediate past-president (left) presented Mrs. Orr with an inscribed clock with both ORNAC & ORNAA gold pins. In response Dorothy acknowledged the accomplishments of ORNAA's charter executive members Sarah Doughty, Grace Thompson, Betty Armstrong and Marge Bushell. She recalled the first conference in 1978 in Edmonton, planned by the U of A charge nurses and financed by the exhibitors, whom she said had continued to support ORNAA efforts thru the years. Dorothy, recently retired from the Brooks Health Centre, offered thanks to all her colleagues, especially the OR members and leaders who came forth in the early days to form the districts. She wished her colleagues good luck in these challenging times. *Thank you Dorothy! Enjoy your well earned retirement.*

Operating Room Nurses Association of Alberta(ORNAA) Board - 1993-1994

(Left to right) Back row: Gloria Nemecek, Linda Smith, Donna Orton, Jackie Waisman,(ORNAC President) Dee Robinson, ORNAA President, and Marilyn Starling. Front Row: Sharon Guy, LenoreLemire, Jane McClain(ORNAA Past Pres.), Sharon Balkan and Carol Neil.

Operating Room Recycling

Jean Wessel, RN, the OR Clinical Coordinator, Mississauga Hospital, was honored for her waste minimization effort with the Peel Ontario Region's "Outstanding Individual Award of Merit". Present at the Awards were interests from around the world, including West Germany and U.S., and industrial giants such as Exon and Northern Telecom.

1) How can operating room staff be certain that biomedical waste does not mix with recyclables?

2) How does one talk medical staff into recycling?

The answer to the first question is based on good OR technique. It is the responsibility of the OR nurse to be knowledgable of universal precautions as it pertains to OR practice. Putting this knowledge into practice is our job. The answer to the second question was indeed far more difficult. Jean Wessel is the determining factor in staff commitment to the three R's..."Reduce, Reuse, Recycle".

Jean Wessel's quiet perseverance and belief in reducing expensive biomedical waste has unobtrusively influenced and inspired a large overlapping staff of 130 registered nurses, assistants, aids, anaesthetists, and surgeons to support her in a remarkable waste minimization initiative. The practical strategies she introduced have provided the Mississauga Hospital OR with three specific cost-saving waste reduction targets.

STRATEGY I

Intention: To reduce biomedical waste uncontaminated paper products.

Action: Outer wrappers on surgical supplies are bagged separately. Environmental Services Department has agreed to accept increasing amounts of this as shredible paper. The remainder becomes "Perfect Packing Paper" and is available to all hospital staff.

Result: Increasing amounts of shredible product have warranted the purchase of a shredder-bailer. Thirty-eight percent (38%) of waste stream at The Mississauga Hospital is shredible paper and has been earmarked for possible recycling programs hospital wide. An estimated twenty percent (20%) of operating room waste is being used by hospital staff as "PPP", translating into zero cost of disposal to the institution.

Luanne Robotham, Operating Room, submitted this report and acknowledges the help of John Lathan, Environmental Services, Mississauga Hospital, Mississauga, Ontario, in compiling this information.

STRATEGY II

Intention: To reduce plastic biomedical waste and reclaim it for useful purpose.

Action: Separate hard plastic sterile and saline water containers for reuse in Environmental Services Department - for decanting cleaning supplies. Separate and consolidate empty IV bags and outer wrappers for return to original supplier.

Result: Approximately 34,750 containers available at no cost to institution, for use in another hospital department. The Mississauga Hospital has been approached by Baxter Company to become a part of a pilot project to recycle IV plastic products. This translates into a "O" cost factor for disposal.

Other plastics separated include styrofoam peanuts, sealing rings from anaesthetic products, and plastic sterility indicators. The packing peanuts are at no cost, being taken by an outside company for packing. The coloured sealing rings and sterility indicators are being used by nursery schools for counting devices and stencils.

Cloth drapes are being studied as a future initiative to decrease use of disposable plastic drapes.

STRATEGY III

Intention: To decrease biomedical waste by converting it into marketable metal product.

Action: Separate uncontaminated copper cautery wire. Also, separate outer foil wrapper on surgical supplies.

Result: Copper is currently being stored. Future disposal as recyclable is being studied. The foil wrappers have been forwarded to an aluminum recycling company for analysis.

Financial Impact:

Biomedical Waste - $150/m ton x 2/week
Recyclable Waste - $25/m ton
Reused Waste - $0 /m ton

Operating Rooms have historically been the largest in-hospital producer of biomedical waste. Inspired by Jean Wessel, the 11 Operating Rooms are striving towards change, using "REUSE, REDUCE, RECYCLE" strategies. The impact on our institution has been instrumental in devising similar recycling initiatives in other departments.

"REDUCE, REUSE, RECYCLE. One person can make a difference. Jean Wessel has. ■

CALENDAR

1994

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 = Captial Gains"

Exhibitors Contact - Carole Starr
Peterborough, Ontario.
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

British Columbia Operating Room Nurses 14th Annual Conference

June 2nd - 4th, 1994

Silver Star Mountain Resort, Vernon, B.C.

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

Keynote speaker: **Herb Dixon,** BSc, MEd, noted speaker and educator who has 25 years of administrative 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 appeared 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 strategic 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 Perspectives 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 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; Disposables vs Reusables; Health care packaging issues; -Environmental Safety Guidelines; Laprascopic Surgery - 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
15th National Conference - Ontario

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

Newfoundland&Labrador OR Nurses elect new slate of executives

The Newfoundland and Labrador Operating Room Nurses Association held its 14th Annual Conference in Grand Falls-Winsor, Newfoudnland, September 30 and October 1 and 2, 1993. The meeting was attended by approximately 100 members and 26 exhibitors. The theme for this year's conference was "Our Patients Rely On Us". Keynote speaker was Marianne Lambe, R.N., B.Sc.N., M.N., Director of Nursing, Memorial University of Newfoundland.

Various social events such as wine & cheese and a bean party were enjoyed by all. The three day Conference concluded with the election of officers for the 1993-1995 term.

Next year's conference is scheduled for September 29, 30 and October l, 1994 in Gander, Newfoundland.
Photo and Copy : Submitted by Bernice Howell.

Newfoundland & Labrador OR Nurses Association Executive 1993 - 1995
Shown: (left to right) Hope Maloney, Gander,Nfld., Vice President Education; Sue Brocklehurst, St. John's, Secretary-Treasurer; Bernice Howell, Corner Brook, Nlfd., V.P. Public Relations; Angela LeMoine, Corner Brook, Past President; Sandra Giles, St. John's, President Elect; and Lillian Budden, St. John's, President.

CHICA-Canada
1994 National Conference
Chateau Halifax,
June 20-23, 1994
Site of Sesssions and Exhibits - St. Mary's University

Sponsored by the Infection Control Association of Nova Scotia, A Chapter of CHICA-Canada.

Contact Pauline Robins, Registration Chair
Ocean View Manor, PO Box 130,
Eastern Passage, N.S.,
B3M 1M4
(902) 465-6020

OR Bursary

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.

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
Chairman, Awards Committee
54 Foley Court
Fredericton, N.B.
B3B 2R8

World OR Conference

Australia (September 6-11, 1993)

By Gloria Stephens,
ORNAC International Planning Committee Member

The Theme of this year's World Conference was "Strategies for Strength". The Keynote address "Strategies for Strength - Towards Tomorrow's World" was given by Joan O'Hart of Australia. Navelle Hines, President of Australia, gave the closing address - "Strategies for Strength - Last Thoughts".

Approximately 2000 registrants from 32 countries attended, the second highest registration compared to the Vancouver World Conference in 1991.

ORNAC presented five speakers and all represented Canada with the highest integrity. Each speaker received a beautiful corsage from Jackie Waisman, President of ORNAC, and Gloria Stephens, Immediate Past-President of ORNAC, just before presenting their paper. No other country did this.

The World Conference Speakers were:

Joan Donald - "Fling Wide the Gates" for the session: Opening Doors to the OR - Marketing Perioperative Nursing.

Muriel Shewchuk - "Strategies for Strength in Resource Management" for the session: Bringing Strength to Resource Management.

Wendy McCulloch - "Limb Salvage Surgery: An Advancement in Surgical Technique" for the session: Innovations in Technology.

Darlene Stuttard - "The Future of Perioperative Nursing" for the session: Effects of Minimally Invasive Surgery on Nursing.

Mary Knight Kubasiewicz - "Effects of Criminal and Civil Law on Nursing Practice" for the session: Accountability in Nursing Practice.

Gloria Stephens - Moderator for the session: The Energizing Roles of Nurses and Assistive Personnel.

Speakers from other countries included:

Argentina 2	Germany 1
Ireland 1	Greece 2
Japan 2	United Kingdom....4
Italy 5	South Africa 1
United States ... 6	Australia 9

Next World Conference - September, 1995- Hamburg, Germany. Start planning to attend. It is an experience of a lifetime to attend the World OR!

Photo left:
Canadian speakers at the World OR Conference in Australia this past September included (left to right) Joan Donald, NB; Muriel Shewchuk, AB; Jackie Waisman, AB, President of ORNAC; Darlene Stuttard, SK; Mary Knight Kubasiewicz, AB; Wendy McCulloch, ON; and Gloria Stephens, ORNAC Past President.

Photo right: Opposite Page....
Sixty-three Canadians attended the Austrialia World Conference.

ORNAC promotes Advanced Role-Anaesthesia at the Canadian Anaesthetist Society Conference

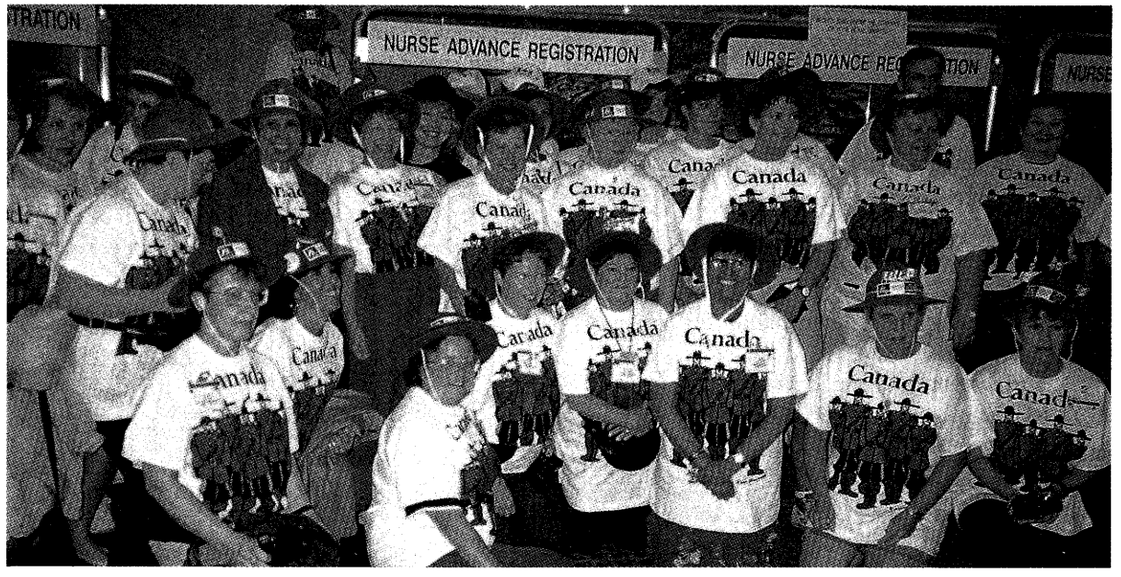
The ORNAC booth was exhibited in Halifax, Nova Scotia in June, 1993, under the direction of **Penny Gael**, (Photo:left) Director of Operating Rooms, Halifax Infirmary and Camp Hill Hospital, Halifax, Nova Scotia. The exhibit displayed and promoted the role of the OR Nurse - the circulating nurse in the "Advanced Role - Anaesthesia". **Pat (Corey) Plett** (Photo: Right) of Winnipeg, Manitoba, was of great assistance at the exhibit as she is a graduate of the Advanced OR Nurse Role - Anaesthesia program held at St. Boniface General Hospital, Winnipeg, Manitoba.

ORNAC will continue to promote the circulating nurse to Advanced Practice - Anaesthesia by participating with a booth at future conferences of the Canadian Anaesthetist Society.

The ORNAC Research Committee has identified a strategic plan for promoting the Advanced Practice-Anaesthesia and the Advanced Practice-Surgery.

Watch for reports in this Journal as the events unfold. **By Gloria Stephens.**

The Canadian contingent to the 1993 World OR Conference in Australia. Sixty-three Canadians were registered and actively participated in "International Night" - developing friendships with their OR nursing colleagues and exchanging mementos from the various countries represented from around the world.



The Importance of Research for the Continuation of the OR Nursing Profession

By Gloria Stephens

The future of registered operating room nurses and nursing as a profession depends on the determination of OR nurses to develop and use research.

The concepts of nursing research were first discussed by Florence Nightingale in her "notes on nursing" and to this day the promotion of research is still an "uphill grind".

Definition of Research

The Oxford dictionary's definition states: "endeavour to discover new or collate old facts by scientific study of a subject." Nursing research is a systematic critical investigation dealing in facts and relationships which covers clinical, educational and administrative practice.

Advantages of Research

Nursing research enables nurses to:

1. Validate decisions related to nursing practice because the decisions are based on scientific data.
2. Upgrade and/or create new techniques/procedures that will improve the administration of patient care.
3. Use health care resources more effectively and efficiently.

Successful research in an Operating Room depends a great deal on the person in charge of the unit. This individual should:

- be familiar with research methods and actively participate,
- identify and support opportunities for research,
- cooperate, encourage and make available time and resources to conduct research in nursing and/or other health care disciplines,
- utilize research findings,
- assist the staff in interpreting and implementing research findings,
- communicate research findings to appropriate disciplines,
- create a risk-free environment where staff nurses will question practices and/or try out new techniques.

The beginning of nursing research in North American may be the documentation in 1800 by James J. Walsh, in "History of Nursing", in which he stated the following:

> "...until Lister's revolutionary discovery of the value of antisepsis in surgery ... made it absolutely necessary that nurses should be of such intellectual calibre and development as would permit them to be trained in the prevention of infection through absolute cleanliness".[1]

At Johns Hopkins, Baltimore in 1889, operating room nursing was identified as an area of specialization and thus became nursing's first specialty.[2] So from this beginning it was evident that specific curriculum, policies, job performance and procedures had to be developed, hence the Schools of Nursing. Training schools developed and the established curriculum soon became acceptable traditional practices.

As knowledge and technology advances it becomes evident that traditional practices, as well as possible new techniques, should be questioned to make sure the patient care of today is based on sound scientific data.

Author

Gloria Stephens is a Clinical Instructor, Operating Room, St. Paul's Hospital, Vancouver. She is the Past President of ORNAC and Research Chairman. This is the first submission in a continuing series on research.

Clinical research designed to identify patient care outcomes and to test the knowledge used in the practice setting is vital if we are to validate the operating room nurses role in perioperative nursing. All practicing OR nurses have a responsibility for nursing research including: valuing research, understanding the research process, developing skills to interpret and to evaluate research findings.

The Canadian Nurse Association[3] and the Provincial Nurses Association[4] have position statements relating to Nursing Research which give important guidelines to nurses in Canada. The Canadian Nurse Foundation[5] is another organization where assistance may be obtained on any aspects of research including funding if the criteria is met.

The Operating Room Nurses Association of Canada (ORNAC) has supporting research statements in the philosophy and "Recommended Standards of Nursing Practice" document.[6] The research statements include staff nurses and administration indicating the roles, functions, responsibilities and accountability in relation to research.

The ORNAC Research Committee has developed a vision, philosophy and mission statement which wlll help guide the committee as they fulfil their mandate.

Vision

Research is a valued and integral component of professional perioperative nursing practice.

Philosophy

ORNAC believes that research should direct and support perioperative nursing practice with the goal of focusing on:

- patient care,
- collaborative and collegial relationships between members of the health care team,
- cost effectiveness

- **ORNAC** supports risk taking, creativity, curiosity and commitment to research which will enhance:
- the promotion of perioperative nursing,
- the Operating Room Nurses Association of Canada

- **RESEARCH** may be conducted individually or as a collaborative interdisciplinary project.

- **OPERATING** Room nurses involved in research will use a variety of methodologies to gather and analyze data in order to form a broad scientific base for decision making, delivery and evaluation of patient care.

- **ORNAC** research will be congruent with the organization's philosophy and strategic plan.

Mission

The ORNAC Research Committee is committed to:

1. investigate perioperative nursing practice by reviewing and evaluating nursing problems, traditional practice and current practices, in all levels including management, educators and staff,
2. develop methods to initiate and evaluate required change in practice,
3. promote and assist members to develop role model and mentoring skills for peers showing how to become involved in research and how research can influence nursing practice,
4. nurture and encourage others to become involved with work studies, projects and to question current practice.

Providing the assistance, creating and maintaining an environment that supports risk-taking, creativity and curiosity, requires commitment and focused attention from all levels of operating room nursing personnel.

Conducting researching studies is a tangible way to "live" the Recommended Standards of Nursing Practice in providing nursing care.

Operating room nurses will continue to be a vital link between technical advances and effective "caring" of the surgical patient.

Notes

1. James, J. Walsh, History of Nursing, New York: P.J. Kennedy, 1929) p. 236.
2. Bette Clemons, "Lister's Day in America", *AORN Journal* 24, #1, July '76:47.
3. Canadian Nurses Association Position Statement, *"Research in Nursing"*, Feb. '85.
4. Registered Nurses Association of British Columbia, *Position Statement: Nursing Research,* Jan. 1990.
5. Canadian Nurses Foundation
6. Operating Room Nurses Association of Canada *(ORNAC) "Recommended Standards Professional and Clinical Practice"*, 1993. ■

Canadian Operating Room Nurses Association of Canada

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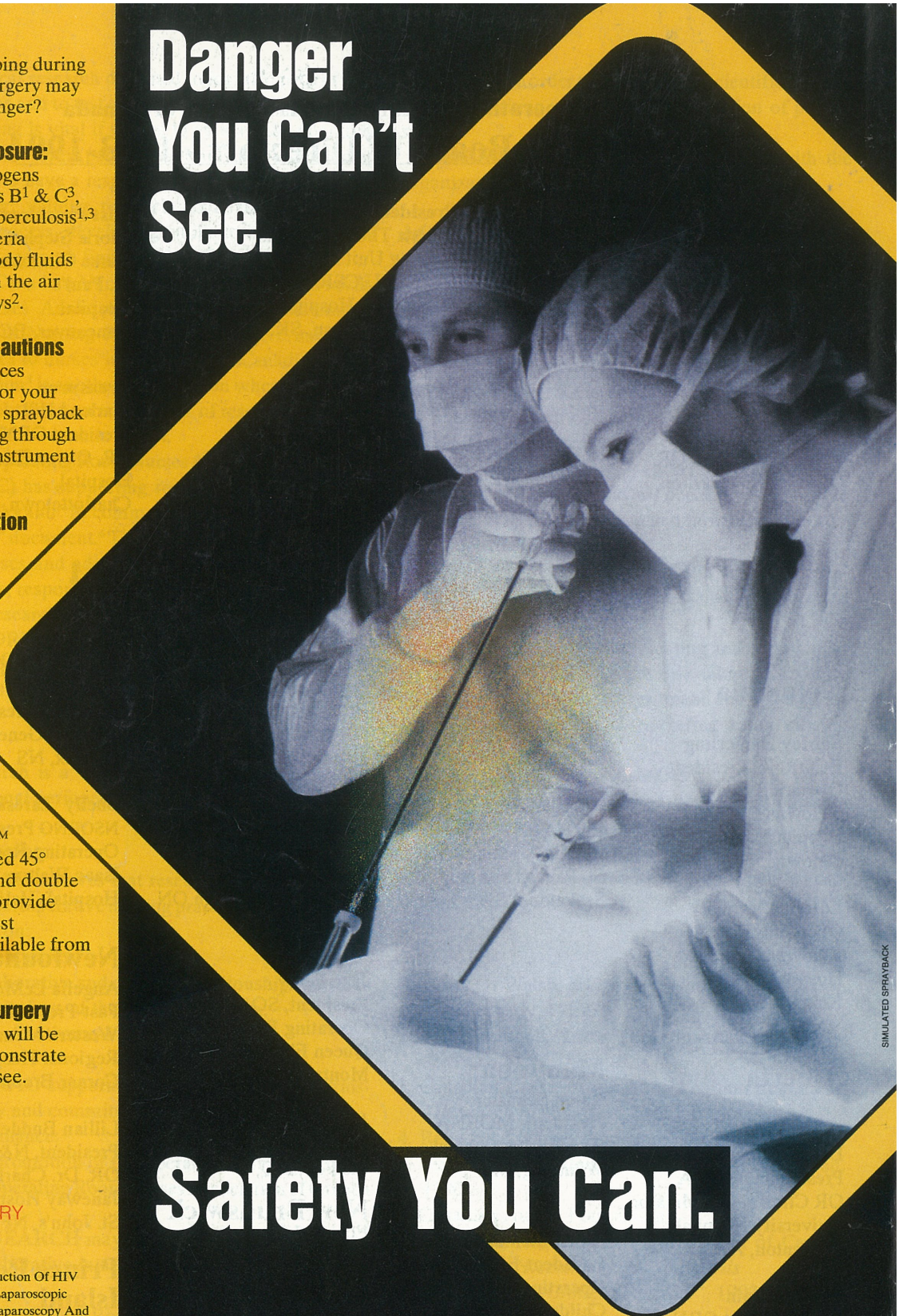
Danger You Can't See.

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

Danger of exposure:
infectious pathogens such as hepatitis B[1] & C[3], HIV DNA[2], tuberculosis[1,3] and other bacteria contained in body fluids can be active in the air for up to 14 days[2].

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

Get the protection you deserve!



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[1]Eubanks, S et al. Reduction Of HIV Transmission During Laparoscopic Procedures. Surgical Laparoscopy And Endoscopy Vol 3. No. 1, 1993.
[2] Baggish, M. S et al. Presence Of Human Immunodeficiency Virus DNA In Laser Smoke. Lasers In Surgery And Medicine 11:197-203, 1991.
[3]Fry, D. E.: Reduction Of HIV Transmission During Laparoscopic Procedures. Surgical Laparoscopy And Endoscopy Vol 3. No. 1, 1993.
[4]Data on File.

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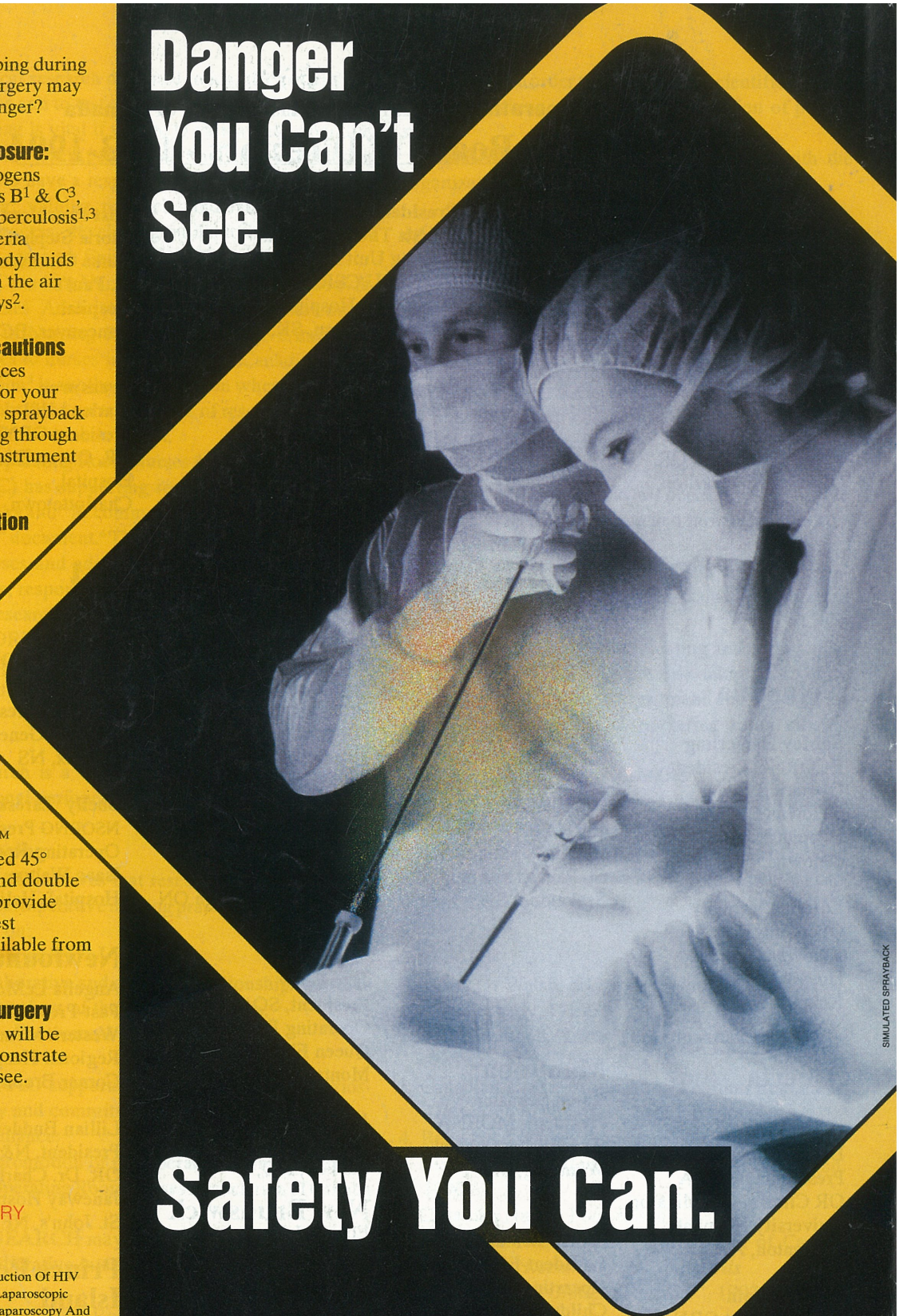

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