

Canadian **Operating** **Room** Nursing Journal

Volume 11, Number 2, May/June, 1993



13th National OR Conference
Québec City - June 6-11



Ten Year
Editorial Index
Vol. 1 - Vol. 10



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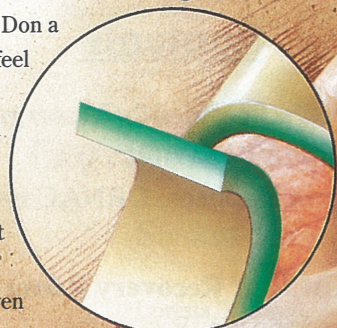
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Motivation/Behaviour

By Gloria Stephens

Motivation comes from a Greek word "to move", which refers to a whole process whereby a person is energized to behave. Behaviour is seen as purposeful, goal directed and based on conscious intentions which can be negative or positive. Motivation can be looked at as an energy flow of an individual, directed at or through a given behaviour. If one makes a wrong assumption, then one's behaviour will be wrong. Assumptions should always be checked out before reaching conclusions. A person with leadership responsibility might ask ... what impact do I have on others ?

There are five basic concepts that may influence behaviour. This means that one should develop a habit of looking for numerous causes (motives), not the single motive of any given behaviour. The same motive can cause different behaviour at different times. Conversely, the same behaviour can result from different motives, e.g. absenteeism, or conflict with co-workers, supervisors or illness. Motives do have limits because they cannot immediately bring about a behaviour for which one does not have the skill or competence, but motives may encourage one to learn a difficult new behaviour.

Once a person feels a "need" there will be a response of some inner state of disequilibrium and therefore one perceives an incentive as a means of restoring equilibrium and so directs the behaviour towards the goal. Therefore a "need" is the mainspring of behaviour.

All goals are not that easily attained as there may be various barriers to overcome. Many people never reach their goals for one reason or another, which may be due to simple procrastination, or lack of self-discipline, and they will always be in a mode of disequilibrium. A person who accomplishes, gets things done, will always find a way around any barrier and reach their goal. This type of person will not be satisfied for long because there will always be another challenge around the corner to conquer.

If we want to understand and work effectively with others, we should give attention to the individual, to the situation and to the relation between an individual and the situation. Situations tend to activate people in certain ways, e.g. bored, irresponsible, whereas other situations will bring about very different responses e.g. enthusiasm, responsibility, and these responses can come from the same person or same group.

Behaviour can be influenced by five basic concepts which are:

1. Behaviour depends on both the person and the environment - so behaviour can be changed by modifying or changing the environment.
2. One behaves in ways which "make sense to us". We have to understand the meaning of a situation.
3. Perception influences experience and behaviour. Each of us have unique experiences which we integrated into our own highly individualistic point of view. Reality looks different to us all - its all in the "eye of the beholder".
4. An individual's view of himself influences behaviour. Our own self concept influences our actions and is reflected in our relations with others.
5. Behaviour depends on varying needs. Needs drive or motivate people. In certain environments "needs" may be translated as "wants". Both needs and wants are a driving force behind any behaviour. "Needs" are usually personal and internal whereas "wants" may be external to a person.

Motivations and behaviours are a very complicated mixture of emotions, actions and outcomes. Most certainly to have any understanding of ones own behaviour, as well as others, motivation and behaviour become a life-long study and challenge.

Gloria Stephens is President of the Operating Room Nurses Association of Canada and a Nurse Clinician, Operating Room, St. Paul's Hospital, Vancouver, B.C.

The ABC's of Recovery Room Nursing

By Bev Johnson

The goal of providing safe, knowledgeable, compassionate and individualized nursing care to patients and their families, in the immediate post-anaesthetic period, is universal. The method of meeting that goal remains unique to the individual professional nurse and to her unit.

AORN (1983) identified the following outcomes as specific to patients requiring post anaesthesia care:

1. Respiratory status is maintained or improved.
2. Cardiovascular status is maintained or improved.
3. Fluid and electrolyte balance is maintained or improved.
4. Privacy and dignity are maintained.
5. The patient is protected from infection.
6. The patient has no adverse effects from lack of, or improper use of, safety measures.
7. The patient is as comfortable as possible.

There is a growing awareness in the health care community of the role of the post anaesthesia nurse. Major and complicated surgical procedures are becoming more prevalent with each passing year and therefore, the patient is more prone to crisis in the post-operative period than at any other time throughout the surgical experience. Because of this, the recovery

room nurse must have the skills to recognize and treat post-operative complications.

Recovery room nursing is a continuous process of assessment of needs, planning, implementation and evaluation of nursing interventions.

The Recovery Room Nurse

The R.R. nurse must be a "jack of all trades". She or he must have a sound background in physiology, pathophysiology and surgical procedures. An understanding of medicine, pediatrics and geriatrics is also essential. In addition, R.R. nurses must be thoroughly versed in the pharmacodynamics of anesthesia and analgesia, (Drain and Shipley, 1979).

The R.R. nurse must be:

1. **Independent**
 - the majority of problems arise in the absence of the anesthetist.
 - gets only brief moments of direct supervision.
2. **Logical and possess good judgement**
 - possesses diagnostic abilities.
 - is able to anticipate problems and complications.
 - knows when to get help.
3. **Phlegmatic**
 - uncomplicated recovery is the norm.
 - the occasional life threatening emergency must be attended to in a calm, rapid fashion.
4. **Conscientious**
 - it is an extremely responsible job.

Author

Bev Johnson is a Recovery Room Staff Nurse, Red Deer Regional Hospital, Red Deer, Alberta. This article was originally a presentation at the October, 1992 conference of the Operating Room Nurses Association of Alberta.

Roles of Recovery Room Nursing Staff

The recovery room must be staffed with specially trained staff in sufficient numbers to be able to provide consistently safe care.

More specifically the recovery room nursing staff is responsible for the following.

- providing a safe, comfortable and therapeutic environment for post-operative/post anaesthetic patients.

- providing readily available, specialized equipment in good running order and in sufficient supply.

- using the nursing process to provide individualized nursing care based on each patient's individual needs.

- providing constant observation of recovering patients to facilitate early detection of post-anaesthetic/post surgical complications.

- maintaining the level of theoretical knowledge and clinical practice required for efficient and safe recovery nursing.

- collaborating with other members of the health care team and other hospital departments to provide optimal physiological and psychological care.

- providing decisive specialized care to recovery patients who are in immediate life threatening situations, (i.e. respiratory failure, haemorrhage, cardiac arrest, shock).

- implement prescribed orders and procedures according to policy.

- remain abreast of changes in techniques and equipment and contribute to change through participation in research whenever possible.

- providing clear, concise and accurate documentation on each patient during their stay in recovery.

- being committed to and participating in quality assurance programs to ensure that optimal quality of patient care is achieved and maintained.

Admission to Recovery Room

It is imperative that a nurse fully assess the total physical condition of each patient on admission and at frequent intervals throughout the recovery room period. Physical assessment must begin immediately upon admission to recovery room. The Report is given by the anaesthetist and the O.R. nurse. Since all anaesthetics are depressants, post-operative assessment and care will generally be the same, regardless of the specific agent used.

The emphasis in recovery room nursing is on anticipation and prevention of post-operative and

post-anaesthetic complication.

On admission to the recovery room the nurse should do a quick assessment:

A - Airway - open, patency, start O₂

B - Breathing - assess respirations, color

C - Circulation - B/P - pulse, ECG monitor, dressings and drains.

We start this assessment while we are receiving the report from the OR nurse and the anaesthetist.

Once the initial observations are made it is essential to assess systematically the patient's total condition. The assessment may be made from head to toe, or by systems, whichever the individual nurse prefers, the observations are identical.

One approach to post-operative patient assessment is the A-B-C's systems approach.

A - Airway: Must be assessed first

- Note the presence of an artificial airway.

Airways are used primarily to maintain patient air passage so respiratory exchange is not hampered. Even with an artificial airway, respiration may be hampered.

- Patient may require chin held or jaw thrust.

- The airway must be kept clear of secretions to serve its purpose and may need to be suctioned.

- The airway should not be removed until the patient's laryngeal and pharyngeal reflexes, which enable him to control his tongue, to cough and to swallow return.

- Do not pull on airway. Watch for caps or loose teeth.

- Remove airway if patient is coughing or yawning.

- Endotracheal tubes can be removed as soon as the patient is able to maintain his airway without it or when the danger of aspiration is over. Many of our anaesthetists tell us to wait until the patient can extubate themselves.

- If intubated, check the cuff and have a syringe at the bedside.

Oxygen. Follow anaesthetist order if you don't have routine orders. Most of our patients have an oxygen catheter down their airway. When awake it is continued per nares. When ordered to be continued on the nursing unit, we change to what is ordered, e.g. nasal prong, cold neb, etc.

Use pulse oximetry if available. In our hospital, if the patients O₂ saturation is less than 90% on room air in recovery room, O₂ per nasal prongs at 2-3 L is

started for 24 hours and then reviewed. This is a standing order for recovery room. We write the order on the order sheet for the nursing units to follow.

Position. When possible, patients in R.R. should be maintained in a semi-prone, side lying position. This position promotes maintenance of a patent airway, prevents aspiration of vomitus into the trachea, and permits optimal ventilation of the lower lobes.

B. Breathing

The post-operative patient has experienced some interference with his respiratory system, therefore attention must be directed towards maintaining an adequate gas exchange.

- Respiratory function is assessed by observing the rate and character of the respirations and the patient's color. Check the mucus membranes.

- The resting rate of respirations in the normal adult is approximately 16-20 cycles per minute, regular in rate and rhythm.

- Respirations should be quiet, free and easy. The most important respiratory problems encountered in the immediate post operative period are hypoventilation, airway obstruction and atelectasis from obstruction of the bronchus.

- Chest should be move freely as a unit and expansion should be equal bilaterally. Alteration in symmetry may be due to many factors; including pain that may cause splinting at the incisional site; consolidation or pneumothorax.

- Note the character of respiration. An example is nasal flaring.

- Depth of respiration is as important as the rate. Shallow respirations are the cardinal sign of continuing depression from anesthesia or preoperative medication but may be due to other factors, such as pain, or obesity.

- Assess patients with shallow breathing and check frequently for signs of complications.

- Chest movements in themselves are not adequate evidence that air exchange is occurring. You should place a hand over the patient's airway and feel the amount of exhaled air.

- Check the patient's color. This is sometimes a difficult evaluation. Cyanosis when present, is a late sign indicative of severe tissue hypoxia. Restlessness, confusion, anxiety or apprehension are early signs of hypoxemia and carbon dioxide retention and also should receive immediate attention to differentiate the cause. This is where a pulse oximeter is very useful.

- Listen to the patient's respirations. Normal

respirations should be quiet. Noisy breathing indicates problems. Extraneous sounds always indicate some kind of obstruction, however quiet breathing does not indicate freedom from problems. Some sounds you might hear here:

1) Gurgling sounds usually indicate the accumulation of mucus or other secretions in the respiratory passage.

2) Crowing may indicate laryngospasm, a sudden violent contraction of the vocal cords, that may result in complete or partial closure of the trachea. Note that total blockage of the airway due to laryngospasm has no sound because of the absence of moving air. With complete obstruction, there is sternal retraction.

If the patient goes into laryngospasm:

- establish airway
- suction carefully to remove secretions making sure you don't go near the vocal cords

- give patient O₂
- may have to bag patient with O₂ 100% via ambubag, giving a sustained push of O₂ and hold a few times to open vocal cords and break the spasm.

- If unable to break the spasm the patient will require a muscle relaxant and be reintubated.

3) Wheezing may indicate bronchospasm caused by reflex from some irritating mechanism such as secretions (blood, mucus, vomit) or it may be from an allergic reaction from blood, drugs such as antibiotics.

- It may also be from pulmonary congestion due to fluid overload.

- Bronchospasm occurs most often in patients with pre-existing pulmonary disease.

- The patient may need ventolin, either through aerosol or nebulizer.

- Encourage patient to cough and mobilize secretions.

4) Laryngeal Edema following endotracheal intubation is not uncommon and contribute significantly to airway obstruction.

- These patient may have:

- A croup like cough

- Inspiratory stridor

- Apprehension

- Use excessory muscles for ventilation

Patients may be treated with: a cold humidifier, steroid therapy, or may need reintubation.

C - Circulation

Most assessment is aimed at evaluating cardiac output. Blood pressure and pulse should be taken frequently. Cardiac monitoring if available.

Blood pressure readings in the post-operative period should be compared to baseline pressures taken before surgery to compare their significance. A low post-operative blood pressure may be due to a number of factors including muscle relaxants, pre-op medication, blood loss and changes in the patient's condition. The administration of oxygen to help eliminate anaesthetic gases will cause an increase in blood pressure. Deep breathing may help to raise the blood pressure.

An increase in blood pressure post-operatively is not uncommon, due to the effects of the anaesthesia, decreased respiratory rate, or pain.

The pulse should be checked for rate and character. A tachycardia may be present due to fever, pain or anxiety. Evaluate cause of tachycardia before treatment, remembering increasing tachycardia is an early sign of shock. A bradycardia may be due to prostigmine.

Patient temperature.

Peripheral vasodilation and skeletal muscle relaxation contribute to heat loss. If patients are hypothermic, they have slower circulation which could cause them to be drowsier and have shallow respirations. These patients will shiver. Shivering may increase O₂ consumption by up to 400%. In such cases, give patients warm blankets. We are using a Bair Hugger which is a patient warming system.

D - Depth of Consciousness

Patients arrive in the recovery room at all levels of consciousness from fully awake to completely anesthetized. Emergence from anesthesia is generally quiet and uneventful, occasionally a patient will become agitated and thrash about, this seems to occur in teenagers and young adults more often than any other age group.

The patient should be told where he/she is and that his/her surgery is over as part of the stir up routine. It is important to remember that although the patient's consciousness may be impaired, their hearing usually is not.

E - Examination of Surgical Site

Check operative site, dressing, drains, sumps or if a cast, check fingers or toes for circulation.

Also this is where we include and examination of IV's, Foley Catheter, CVP's, arterial lines etc. Care must be taken to ensure that all drainage tubes and intravenous catheters remain in place, remain patent and that no tension on any of these lines is created.

F - Freedom From Risk of Injury and From Pain

Safety measure include side rails up, warm blankets, optimum position of semi-prone side lying.

Before giving any medications check for allergies.

Pain Assessment

Pain is a very individualized experience, therefore the control of pain must be individualized and treatment must take into account not only the physical status but also the wide variety of sociologic and psychologic influences incorporated into the patient's perception of pain.

The patient's responses to pain will vary in accordance with the extent to which his level of consciousness is altered. As the patient emerges through the second stage of anesthesia there may be a period of excitement and overaction to all stimuli including pain. As he emerges through the first stage of anesthesia there may be enough pain relieving effect from the anesthetic that he awakens then falls asleep again.

In our recovery room the administration of post operative analgesia is usually intravenously and occasionally intramuscular. Before analgesia is given, assess the patient and perhaps try other pain relieving measures. Examples include:

- Positioning to avoid stress on the incision

- Reassurance to an anxious patient. Fear and anxiety may significantly contribute to post-operative pain by causing rigid muscle contractions in an attempt to splint the operative site.

Before we give an analgesia, we check what was given in the O.R., i.e., Narcon, and what was given as a premed (if one given). Check for allergies.

We follow the anaesthetist's orders which are written on the recovery room record. Use your nursing judgement and common sense in deciding your narcotic dose. Inadequate analgesia can be as harmful as too much. It can make breathing more painful producing inadequate ventilation or it may produce restlessness and hyperventilation.

The drug and dose vary with each anaesthetist. All drugs given in the recovery room are underlined in red. Any IV drugs are checked by two R.N.'s and double signed according to hospital policy.

If the patient has an epidural line, these are topped up by the anaesthetist. If there is to be a continual infusion into the epidural line, such as fentanyl, the nurse in recovery room initiates this according to the anaesthetist orders. Adjust the rate according to the

patient's condition.

The assessment of pain in children and infants is more complex than that of adults. When assessing a crying, restless child, you must ask yourself if the child is experiencing:

- A) Hypoxia
- B) Emergence Delirium (occurs approx 2% G.A.)
- C) Hunger
- D) Physical Pain
- E) Separation Anxiety

G) Gather Data and Chart

Document as per hospital policy and procedure. Charting is the only source of patient information. It must be accurate, clear and not ambiguous. It must also be free from distortion of time and recall.

Charting should include:

- initial assessment
- ongoing assessments
- treatments
- actions, occurrences or complications which are significant.
- evaluation of treatments
- report attempt or successful communication with doctor. (Including whether or not orders were received)

Remember, in a court of law, the chart is what they use. The chart must indicate what was done or the court will conclude that the nursing action was not performed.

The checklist charting is recognized; however, some nursing observations and nursing actions cannot be recorded by the checklist. Therefore, make sure to document accurately and at the time, or nearest to the time of occurrence. Essentially, if it isn't written, it wasn't done.

Patients stay in recovery room different lengths of time according to the hospital's policy. In our recovery room the minimum length of stay is 30 minutes.

If the patient is given an analgesic, they stay 20 minutes, and some stay longer as the case warrants.

We use a scoring system which is on the back of our record. A patient should meet a score of eight before discharge, or a written order for discharge from recovery room is obtained from the anaesthetist or attending physician.

Before discharge: check dressings, pads, drains. Change or reinforce dressings. Empty any drainage receptacles (Chart these). Label the IV's. Chart the patient's condition and time of discharge.

Contact the nursing unit before leaving R.R., and

ensure the unit is informed that special equipment is needed, e.g., oxygen, suction, a lifting board.

A registered nurse always accompanies the patient back to their unit. We have a porter on days who goes with us. Sometimes on evenings or nights due to understaffing, we have to call the nursing unit and request they pick-up their patients.

Once in the patient's room, transfer the patient from the stretcher to his/her own bed. (Some patient's come to O.R. in their own bed, eg. hips, discectomies, or anyone who weighs over 200 pounds). Ensure that the patient's call bell is properly positioned, siderails are up and the bed is lowered.

The nurse from recovery should give a complete report to the receiving nurse including pertinent facts about the following:

1. The operative procedure performed.
2. The anesthesia used.
3. Length of anaesthesia time.
4. Patient's general condition including vital signs.
5. The incision, drains, catheter etc
6. The intravenous.
7. Any medications given in the R.R.
8. Doctor's orders.

For spinal or epidural anaesthesia, the following nursing care is provided in the recovery room.

1. Good body alignment
 - Don't hyperextend joints
2. Careful turning
 - Rapid turning can cause a decrease in BP. The circulation system cannot compensate.
3. Check for bladder distention
 - May cause bradycardia
4. Return of sensation and motor control
 - Anaesthetic works its way back from extremities
 - Keep in R.R. if the block is high.
5. Watch for Hypotension
 - Due to vasodilation and loss of sympathetic tone
 - May need expansion of circulation volume and/or a vasoconstrictor such as Ephedrine.
6. - May cause nausea and vomiting with continuous epidural line
 - Anchor line securely to avoid accidental removal.

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Frost, Elizabeth A.M., (Ed) (1985) *Recovery Room Practice*, Blackwell Scientific Publications.

Sources

Standards of Care for Post-Anaesthetic Nursing:

1. ASPAN - American Society of Post Anesthesia Nurses, 11508 Allecingie Parkway, Suite C., Richmond, VA USA 23235
2. OPANA Ontario Post-Anaesthetic Nursing Association, 486 Evans Avenue, Box 173, Toronto, Ontario, M8N 2I7

Hyaluronic acid could be the "wonder oil" of the future

Several world-wide companies hope to be first to put hyaluronic acid to greater use in medicine. They are working on applications in which the body's natural lubricant would be used to ease pain and facilitate the movement of arthritic knees, to prevent complications from surgery, to moisten dry eyes and even to smooth out facial wrinkles.

Hyaluronic acid is a slippery substance that lubricates the joints, protects delicate tissues in the eyes and helps the skin stretch and bend.

"The ideas there have been around for a long time," said Bryan Toole, chairman of anatomy and cellular biology at Tufts University Medical School and an expert on hyaluronic acid. "Some people really think it's going places. Others are not so sure."

Hyaluronic acid, according to a New York Times News Service report, is also called hyaluronan or simply HA, which is actually a complex sugar that is present in all animals, usually in the spaces between adjacent cells.

But what makes hyaluronic acid special is its mechanical properties. "It is the most viscoelastic substance known to mankind," said Dr. Endre Balazs, of Columbia University Medical School and a pioneer in the purification of hyaluronic acid.

Hyaluronic acid is biocompatible and has already found widespread use in skin moisturizers and other cosmetics, like Estee Lauder's Night Repair.

Since 1980, it has been used to help the eye retain its shape and to protect sensitive tissues during ophthalmic surgery, particularly in removing cataracts and implanting intraocular lenses.

Kabi Pharmacia, the Swedish company that is the leader in this market, had United States sales \$72.5 million for its product, known as Healon, in 1991. For all vendors combined, worldwide sales are estimated to be about \$200 million.

Hyaluronic acid is difficult to manufacture and is expensive. The material used in eye surgery sells for millions of dollars a pound, said James Bracke, founder and chief executive of Lifecore Biomedical. Fortunately, he said, only about \$100 to \$200 worth is needed for an eye operation.

Kabi obtains its hyaluronic acid from the combs of roosters, which, for reasons not yet fully understood, have a high concentration of the stuff. But several companies now make hyaluronic acid through fermentation of certain types of bacteria.

Another factor that could result in broader use is that companies have also succeeded in modifying natural hyaluronic acid to improve its properties. They can make forms that last longer in the body and thus would be more effective as medical treatments, and have produced solids, gels, membranes and other forms for specific functions.

Purchase the 'New'



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"Recommended Professional and Clinical Standards"

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This document is a combination of the 1986 and 1988 publications and includes a new section on competencies of an O.R. nurse.

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International File: The Finer Points of Working in England's ORs

By Lucy Wright

Introduction

Operating room nursing practices may be perceived as universal amongst Commonwealth countries; after all, a hernia repair is a hernia repair, irrespective of the country in which it is performed, isn't it? International diverse experiences contribute to the wealth of an individual's knowledge and competence, and as they say - travel broadens the mind. After being initiated to the Canadian OR from ward nursing, my encounters with British theatre nursing practices required deeper thought about the rationale supporting my own, as I was periodically challenged during my adaptation to the British system. As expected, the principles of OR nursing are fundamentally similar in both countries. However, it is the finer points which demand open-mindedness, assertiveness, diplomacy, flexibility and most importantly, a sense of humour.

The description of my international experience and the interesting differences encountered will commence at the beginning of my story. After emigrating from Britain to Canada with my family as a child and spending twenty-two years of my life there, I wanted to familiarize myself with the country of my roots, which I had so long admired from a distance. I resisted the current trend and travelled to England two years

ago, but I frequently get asked why I came to this country with its dreary gray weather from the sunny land of opportunity. So began the frequent explanations of my origins and motivations. When asked what part of the States I am from, I feel the responsibility as the local Canadian ambassador to patiently respond, "I am actually from Canada. Halifax, Nova Scotia - do you know it?" Surprisingly, I usually have to give a geography lesson to distinguish between Nova Scotia and Newfoundland, and I thought British education was the best!

Professional Variations

So England is not much different to Canada, right? Wrong! There are many cultural and professional differences to experience by changing countries of residence. To begin with, theoretically both countries speak English. However, despite our words being the same, we do NOT speak the same language. Even after living here for two years, I still find this a frustrating hindrance. I hear the words but do not understand the message, and laughingly have to say: "Would you rephrase that, please? We are having a communication problem here." This language problem extends from every day life to professional life in the theatre. What? Are we going to a show? No, the operating theatre, which Canadians know simply as the OR. A phrase, which is much easier and quicker to say, but not linked to any historical origins. Despite my attempts, the British will not be converted, since tradition is very important over here, and understandably so, for a

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Abstract

The fundamental philosophy behind quality patient care is international; the specialised area of OR nursing should be less susceptible to international differences. Yet, the experience of moving to a different country reveals the extent of the actual cultural and professional variations available. The subtle, yet real, practical differences observed by a Canadian OR nurse, after working in England for two years, are examined.

country so steeped in history.

The global geographical position of England, in relation to the European and African continents, makes it accessible for other foreigners to temporarily practice in the NHS. Thus strong accents contribute to the language difficulties encountered in English ORs. Remembering that conversations occur behind the muffling of a mask, translation time can be further delayed. Consequently, what do you do when an Egyptian surgeon asks for a mop during a seemingly routine hernia repair? How much experience does a scrub nurse really need to anticipate such a request? What could he possibly want with one, and should I ask if he wants a bucket as well? How was I to know all he wanted was another sponge?

So the Canadian scrub nurse dramatically enters, prepared to assist the surgical staffman or resident, with a cart of instruments, sponges, haemostats and the bovie to control any bleeding, to save the life of a patient with multiple injuries, admitted directly to the OR from the ER after an MVA (motor vehicle accident). Only I had to transform in to the British *theatre* nurse on the scrub side, prepared to assist the surgical *consultant* or *senior registrar*, with a *trolley* of instruments, *swabs*, *clips* and the *diathermy* to control any bleeding, to save the life of a patient with multiple injuries, admitted directly to the *operating theatre* from the *Accident and Emergency Department* after an RTA - road traffic accident).

Patient contact is limited in the British theatre nursing system, depending on where you work as a scrub nurse. There are separate rooms for the induction of anaesthesia directly connected to each OR and have been a constant feature of the British operating suite design. If there is enough staff, its advantage is reducing turn-around time between operations; the succeeding patient can be induced in a quiet, peaceful environment, while the current one is still in the OR. Additionally, some ORs have separate but connected "lay-up" rooms, where the scrub nurse can prepare for the next operation.

Specialist anaesthetic nurses, or ODAs (operating department assistants), run these anaesthetic rooms and have the responsibility of greeting and checking in the patient at the reception area. They provide the patient with emotional support and assist the anaesthetist. If you are on the other side of the doors inside the OR, you rarely experience any patient contact. Again tradition's influence exists and the nurses can be divided enough to carry on the war between surgery and anaesthesia, undermining the existence of a team

spirit. Fortunately, there is a prevailing trend to remove these barriers, by having skilled nurses functioning in both areas. This versatility will contribute to greater job satisfaction for the British OR nurse and would reduce some of the present threat facing them, concerning the validity of their role and the perceived invasion by the ODAs.

Generally, there seems to be a vague legal awareness in Britain's health care system by all groups of practitioners, yet there is change afoot. In most English ORs, untrained staff are utilized for circulating duties, which shifts the entire focus of responsibility and accountability upon the scrub nurse. She has to control the OR nursing staff from the operating table, as well as assisting in the operation. The instrument and suture counts are performed solely by the scrub nurse, however, she does count sponges with the circulator, who keeps a temporary record on a board on the wall. Consequently, only the scrub nurse signs the legal document called the theatre register, which remains outside the associated OR.

Documentation is minimal, usually consisting of a sheet with statistical information like names, times and the operation for entry on the computer. There is no separate detailed count sheet or comprehensive record of nursing care in the OR suite, but there are initial attempts to introduce perioperative nursing care plans as a permanent record. The medical records of the surgeon and the anaesthetist are the only documents which become part of the patient's chart. As much as I complained about paperwork in Canada, I became conditioned to filling in the forms, which legally described my contribution to patient care. Simply by moving country all of it is taken away, which generates a frighteningly, uncomfortable feeling and a compromise of one important aspect of OR nursing. However, a recent increase in available workshops and publications about legal aspects of health care practice reflects the professional's demand for information on this topic, and rising awareness of its implications.

Other differences involve the care of the tools of our trade, the instruments, which demonstrates how different systems can work well for various places.. In Oxford, we use prepacked sets of instruments and patient drapes sterilised in a central unit, which includes a drape to cover the cart as part of its outer wrapping. In Southampton, I witnessed two different systems. One which was similar to the Oxford style and another, which was like nothing I had ever experienced before. In the old hospital of the city of

Activities of ORNAC 1991-1993 "Moving Into the Mid-Nineties"

Southampton, there is no distinct sterilization unit. The twin OR suite uses a dirty utility area shared between the two ORs for hand washing of the used instruments by auxiliaries. The autoclaves adjoin this room, where the unwrapped instruments are counted in their trays by the qualified staff. Any necessary extras specific for the operation, are added from the cupboard shelves, and are placed along with the set of instruments into the autoclave for steam sterilisation. Surprisingly, their low infection rate is comparable to the larger modern hospital. Contrastingly, in Weymouth's small district general hospital, there is a staff employed specifically to clean, pack and sterilize the instruments between 8 am and 9 pm, Monday to Friday. If any operations were performed after hours, the qualified nurses were responsible for performing these non-nursing duties.

Even in the most progressive teaching hospitals, other non-nursing tasks are regularly undertaken by qualified nurses, because the British tend to cling to traditions. They spend their time routinely cleaning the ORs between cases and the OR furniture at the end of the day. "Weekend cleaning" is a weekly ritual, which includes damp dusting the supply shelves, and in my opinion is a waste of professional nursing time. This is a demonstration of how the importance placed on nurses' worth by nurses themselves, is indirectly proportional to the amount of non-nursing work they perform. Visionary British nursing leaders have analysed this aspect of nursing and are slowly adjusting the nursing staffing levels and attitudes, so qualified nurses are spending their time doing what they were educated to do - provide patient care.

On my arrival in the English O.R. the surgeon's title was a source of great confusion and amusement. Like Canadian doctors, the British spend several years studying to be awarded the revered title of "doctor". So how was I to know that it is an insult to call a British surgeon, doctor? In Britain, surgeons spend time and energy to enter the Royal College of Surgeons, but on completion of the series of fellowship examinations revert back to the title of "mister". So, you may ask what do you formally call Jane Smith, the female surgeon? Mr. Jane Smith has a strange ring to it, and no one really seems to be able to answer this question.

To further deliberately confuse me, the medical hierarchy uses a completely different set of titles, which in ascending order are: -house officer, senior house officer, registrar, senior registrar and consultant. It is difficult to draw comparisons with the Canadian system, except the consultant is equivalent to a

staffman, and the house officer to an intern.

Similarly, the nursing profession follows suit in its hierarchy. The charge nurse or coordinator of a particular operating room or ward is called a sister. It is a bit disconcerting to say or hear a term professionally, when it is normally used to refer to a member of a family or a nun. To generalise, British nurses have a tendency to be more subordinate to the surgeon and obstructive as a means of power play, instead of using their complementary role and being a collaborative team member. However, the younger generation of forward thinking surgeons respect the nurses for their skills and knowledge, and do value them as contributing members of the surgical team.

Cultural Variations

England is a small country, and despite its weather has a lot to offer. Its short distances between its ancient towns and villages allows you to visit many places, and enjoy the beauty and variety of the English countryside. Yet, it does take a while to get used to spending pounds and pence instead of dollars and cents; to driving on the left-hand side of the road; and to driving on motorways with a speed limit of seventy miles an hour, (which no one but me seems to adhere to). Furthermore, it can provide you with the opportunity of refining your driving skills on the narrow roads and squeezing into smaller parking spaces.

Conclusion

After being raised and educated in Canada, working and living in England has made me appreciate Canada's good and bad points, as well as opening my mind to think and try different methods. After my initial scorn of these different and seemingly inferior ways, I discovered that different does not necessarily mean wrong. However, it is human nature to cling to the familiar, and to think that our way is best.

The British National Health Service is undergoing long overdue changes at the moment, modelling itself on some aspects of the North American systems. It is an exciting time to be involved, and I am able to contribute suggestions to these ongoing changes from my Canadian experiences. Once I adjusted to this different way of life as well as to different methods of working without compromising my beliefs, I have discovered that the underlying principles of providing quality patient care is the universal link between nursing practice in the Commonwealth countries of Canada and England.

The accomplishments of the Operating Room Nurses Association of Canada (ORNAC) over the last three years are enormous, considering all the work is done by volunteer time, effort, and commitment.

The membership of ORNAC, as of March '93 totals 3114. Due to a special relationship with the Canadian Nurses' Association (CNA), ORNAC has full status as an Advisory Committee (CNA) member for '93. A "first" will occur at the ORNAC Board meeting in June, as the Executive Director CNA, Judith Oulton, will attend. ORNAC has an opportunity to submit agenda items to CNA and the following were suggested: Non-professionals into professional positions; waste management and environment protection; image of the nurse and nursing; how to cope with the changes in the health care system; how to keep competent in this age of technology; maintaining the "human touch" in health care; cost analysis & cost effective practices and yet maintain standards.

ORNAC plans to work closely with CNA on these items.

Two committees have been re-established:

Public Awareness - the mandate is to develop a statement "Scope of O.R. Nursing". Many future projects will need this statement as a foundation.

Certification for O.R. nurses - encouraging strides are being made with CNA toward this goal. If we are to maintain our status in the health care system, it is important that the opportunities for certification be made available to operating room nurses of Canada.

A Waste Management committee was formed and will be working closely with the National Exhibitors Association of Canada (NEAC), the Industry.

For the purpose of having all ORNAC statements and documents translated a **French Translation committee** was developed.

Many efforts have been made across Canada to increase subscriptions to the **Canadian O.R. Nursing Journal**. We must also encourage O.R. nurses to write high quality articles if the journal is to remain viable. The annual \$3000 Editorial Award makes the substantial effort worthwhile.

Twelve Teleconference programs per year have been conducted across Canada, and have been main-

tained over the past three years. The programs have been well supported and will continue.

ORNAC has become a very active member of the **International Planning Committee (IPC)** to assist with World O.R. Conferences. The representative from ORNAC is the Past President.

ORNAC's **philosophy and mission statements** have been developed, as well as goals and objectives for the near future. These statements may be obtained through Provincial Presidents.

The **Research Committee** along with assistance from the Research Marketing Department of 3M Canada, organized a National Questionnaire which was randomly distributed across Canada in October '92. The survey was to determine:

- current operating room nursing practices.
- opinion as to "expanded role" of the circulating and scrub nurse.

The full report of this survey will be available at the National Conference in Quebec City. The committee will be conducting a second survey during the Conference. The response ratio on the first survey was 44% and the data was substantial enough to give ORNAC a strong mandate to pursue many issues. The positions of R.N. 1st Assistant and R.N. Assistant to the Anaesthetist will be the major areas to consider and will be the future challenge of ORNAC.

ORNAC will be represented at a booth during the Canadian Anaesthetist Society (CAS) meeting in Halifax, in June.

"**O.R. Nurse Day**" is becoming a stronger celebration each year. This is an excellent method of promoting our role/image to the public, peers, and medical profession. In the future, "O.R. Nurse Day" will be any day during the 3rd week of November. Hopefully, for '93 there will be a National Proclamation, which should get everyone's attention.

New pamphlets developed during the past three years were: 1. "What is ORNAC?" - tells the history and organization of ORNAC; 2. "O.R. Nurse Day" - describes the roles and functions and image of O.R. nurses; 3. "Welcome to the Board" - to orientate new members to the Board.

Revisions were made to previously published

ORNAC President's Report continued...

pamphlet and position statements: e.g., "Waste Management"; "Primary Health Care and the Role of the O.R. Nurse"; and "O.R. Experience in the Basic Nursing Programs".

The Standards documents of 1986 and 1988 have been revised and combined into one document, including a section on competencies of an O.R. nurse. The document has been highly praised by many Nursing Provincial Associations and CNA. The Standards may be purchased for \$35.00.

The song "Because You Care" has been adopted as the ORNAC National song. Guidelines for using the song are set in the Rules and Regulations manual.

These are just the highlights of ORNAC's activities as there are many more "irons in the fire" and you will hear more at another time. This is my last report as President and I thank everyone for the years of support and guidance. I have learned a great deal and working with the Executive and Board has been a great honour.

The challenge of these past years has been rewarding in many ways and definitely a highlight of my nursing career. The people that I've met, the projects accomplished and the places visited will remain with me forever. My focus was always to promote ORNAC and professional operating room nursing. Thank you all again for helping me, as ORNAC's spokesperson, to move our organization forward into this uncertain but challenging future.

Gloria Stephens
President-ORNAC

Saskatchewan Operating Room Nurses' Group 8th Annual Conference
September 24-26, 1993

The Ramada Renaissance Hotel,
1919 Saskatchewan Drive Regina, Sask.

Keynote speaker will be: Linda K. Groah, Nursing Director of Operating and Recovery Rooms at the University of California Hospitals and Clinics, San Francisco. She is also a clinical faculty member of the University of California School of Nursing, and Director of its Post-Graduate course in Operating Room Nursing. Ms. Groah is the author of *Operating Room Nursing the Perioperative Role*.

For further information please contact:

Ms. Marie Brigidear

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**World Conference
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**Operating Room Nurses Association of
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Joan Foster, Chairperson
(403) 670-1589 or (403) 259-2192

**Operating Room Nurses' Association of
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The Contoured Anterior Spinal Plate

A Nursing Perspective

By Ellen Atwill, R.N. & Cathy Bustard, R.N.

The Contoured Anterior Spinal Plate (CASP) system was developed by Dr. G. Armstrong (Chief of Orthopaedic Surgery, Ottawa Civic Hospital) with the help of the National Research Council of Canada for anterior stabilization of the thoracolumbar spine. The plates are designed with a contoured fit to accommodate the curvature of the vertebral bodies. Multiple screw holes allow at least three screws per vertebra.

Existing bone plates were inadequate due to the fact that they were too narrow and did not allow for multiple screw fixation⁽⁴⁾. Previous attempts had a high failure rate in respect to improving symptoms. Vascular complications were also a problem due to the bulky devices being in close proximity of major blood vessels. After anterior decompression previous spinal stabilizations required a second posterior instrumentation procedure.

The CASP plates have been designed with tapered ends to accommodate the common iliac vessels when working at the lumbar five level. The recently developed thoracic plates have a contoured profile to accommodate the thoracic kyphosis. The plates are made of 316 LVM stainless steel. Plate sizes range from lumbar 9-24 hole and thoracic 11-28 hole.

A drill guide was developed to avoid complications such as vascular injury, canal penetration, angulation of screws, and perforation of the surgical glove⁽²⁾. The tip of the drill sleeve is designed to fit into the holes of the CASP plate while a C contour with a recessed tip fits around the vertebral body and stops the drill from advancing further. A depth gauge has also been designed for use with the guide to allow screw length measurement with the guide in place.

Originally AO cancellous screws were used, eventually fully threaded AO screws were implemented. Since then CASP screws were developed which have an inner core of 4 mm and an outer diameter of 6.7 mm

thereby increasing the amount of metal by 50%. Rather than having a sharp tip the screws have been designed with a blunt nose. This eliminates any damage that might be caused by a screw that is too long and penetrates past the vertebral body. The screws range in size from 27.5 mm to 70 mm in 2.5 increments.

The CASP instrumentation set is completed with a drill guide, tap guide, tap, screwdriver, 3.5 and 4.5 mm drill bit. (See Fig 1).

Indications and Contraindications

The system is suitable for stabilizing the following conditions:

- 1 - Anterior decompression and bone grafting of burst fractures. (Fig 2 A & B)
- 2 - Vertebrectomy and cement replacement of vertebra, to increase comfort and mobility of tumour patients. (Fig 3 A,B,C,D,E)
- 3 - Pseudarthrosis.
- 4 - Multiple posterior spine procedures with non union where an anterior interbody fusion might be indicated.
- 5 - Severe disc degeneration.

The plate is contraindicated where there is poor bone quality as in: (i) overt infection, (ii) severe osteoporosis, and (iii) widely disseminated metastatic tumours to multiple adjacent vertebral bodies.

Authors:

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Cathy Bustard is Charge Nurse, Orthopaedic Operating Room, Ottawa Civic Hospital. She received her diploma in nursing from Halifax Infirmary School of Nursing, Halifax, Nova Scotia.

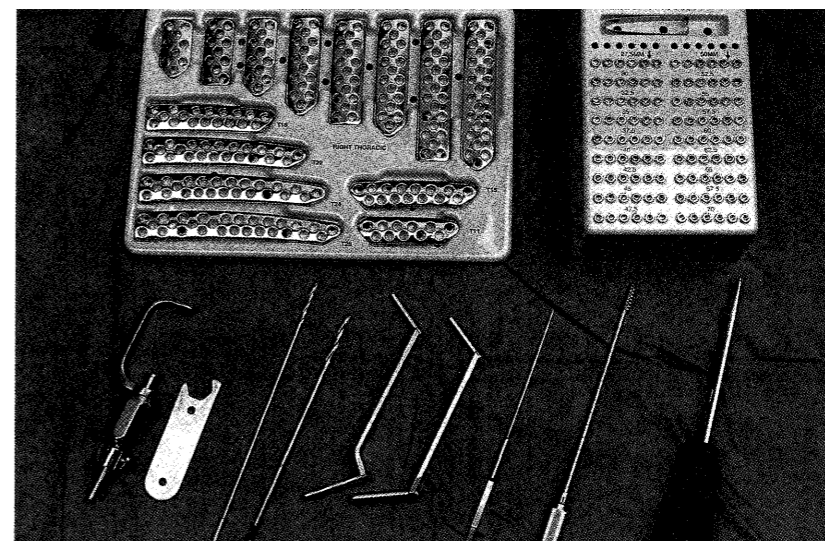


Fig. 1 - CASP plates, screws and instruments

Fig. 2A - Pre-op lateral view burst fracture (T12 - L2) Fig. 2B - Post-op AP view of burst fracture treated with a CASP plate and fibular strut graft

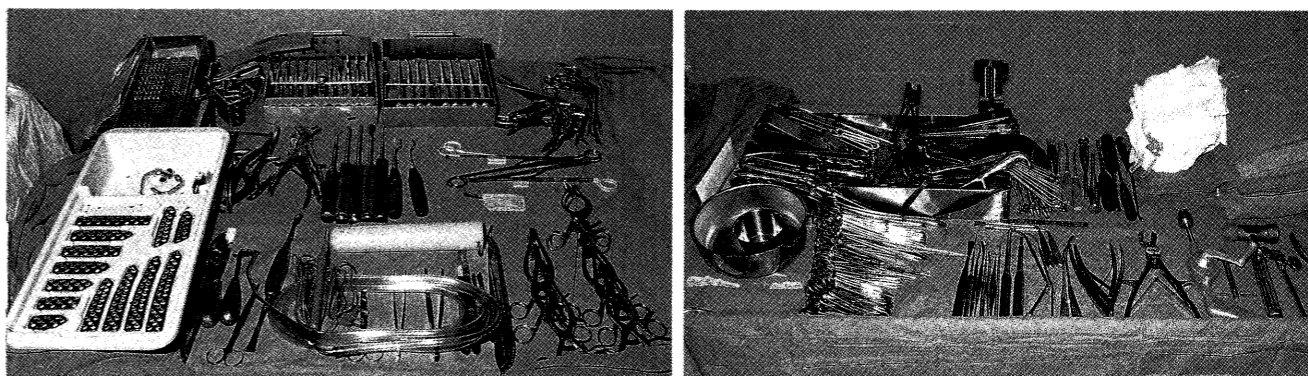
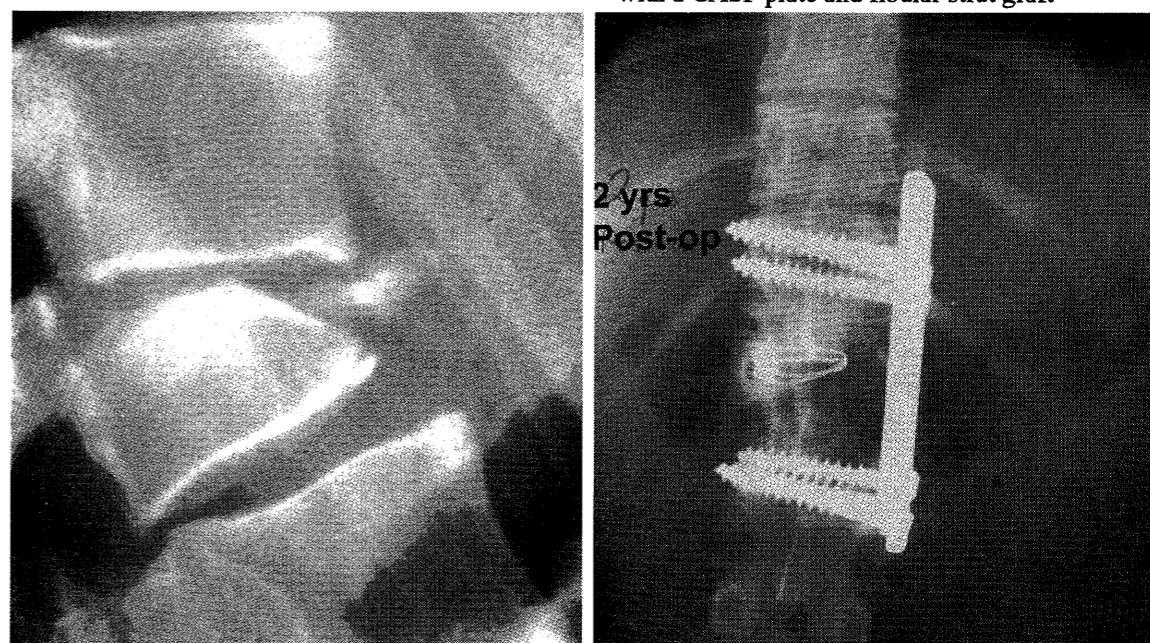


Fig. 4A - Basic spinal Mayfield table with CASP plates

Fig. 4B - Back table of basic spinal instruments



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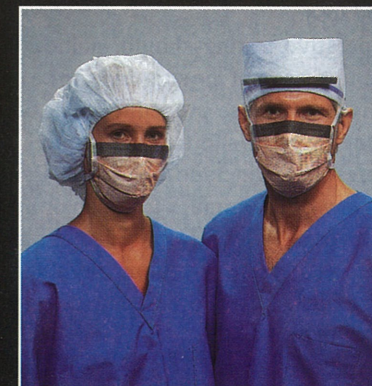


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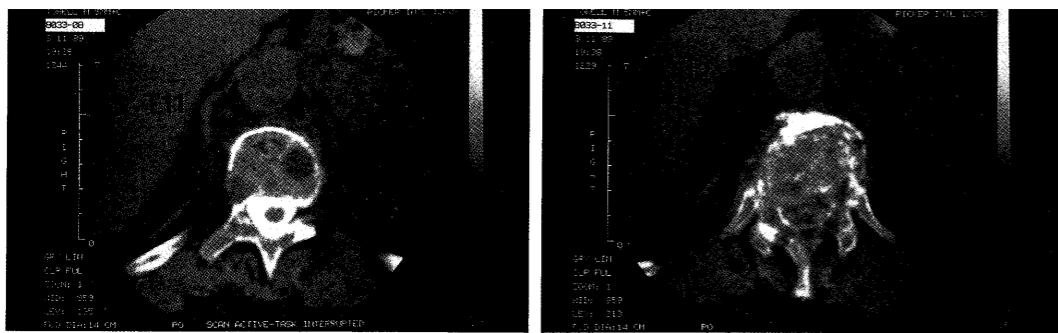


Fig. 3A & B - CT scan - metastatic breast cancer with secondary at T11 - T12



Fig. 3C - Complete block of T11-T12 as demonstrated on myelogram

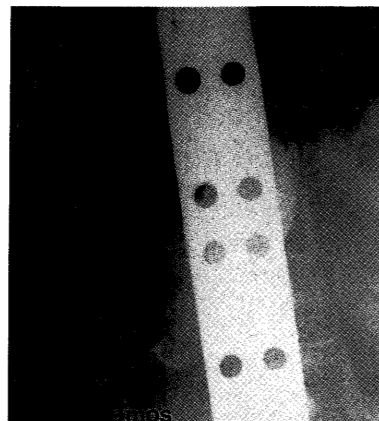


Fig. 3D - Post-op lateral treated with CASP plate, T10-L2 fusion with a bone/cement spacer

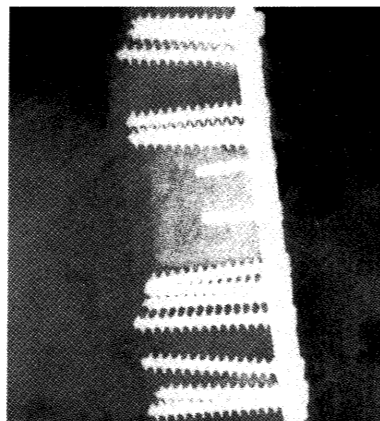


Fig. 3E - Post-op AP view of same patient

Preoperative Plan

The possible complications of this surgery means that patients should undergo a well defined and documented preoperative preparation. Patient's concerns must be addressed and answered. Blood loss during surgery can be 2-4 units due to muscle stripping and spine decortication, as more levels are explored the blood loss will be greater. The awareness of transmission by blood of infectious diseases has increased the demand for the collection of autologous blood. The intraoperative use of cell savers can help reduce surgical blood loss.

Preoperative testing should include blood work, E.C.G. and X-rays. If the surgery is to be performed as an elective case these procedures can be done as an outpatient thereby shortening hospital stay. X-ray procedures should include flat plate A-P and lateral for an overview of the spine, a CT scan or myelogram to detect stenosis. A M.R.I. may detect other levels of disc disease. If there is tumour involvement a bone scan and M.R.I. may be ordered to identify other areas of involvement.

Chest physio is carried out to familiarize the patient with postoperative procedures that will take place after surgery.

While doing a preoperative assessment the patients lifestyle should be explored. Proper nutrition should

be established to promote tissue healing. An obese patient should be encouraged to diet. Their weight loss will reduce the mechanical stress on the spine.

Patients that smoke are at risk for cardio-pulmonary problems and have a high risk of pseudoarthrosis. It is also felt that smoking leads to a slowed tissue healing process. These patients should be encouraged to stop smoking.

A complete neurologic assessment should be done and precisely documented to provide a preoperative-postoperative comparison. This assessment should include motor, sensory and bowel/bladder function. At this time the patient can be warned of the postoperative temperature and color difference of the lower extremities that will be present due to the sacrificing of the sympathetic chain.

A postoperative home care program should be explored to alleviate the patient and family concerns. This should be done early to allow time if any changes need to be instituted in the home environment.

Elective patients may be fitted for either a TLSO (lumbar) or Jewitt (thoracic) brace. Unfortunately many patients suitable for CASP plates have tumours or fractures and suddenly display neurological complications thereby shortening the preoperative period. In such cases, only the urgent preoperative items are implemented.

The CASP operation

In the operating room the patient is anaesthetized. The anaesthetist establishes a large bore intravenous catheter for the administration of fluids and blood products. An arterial line is placed in the arm and a foley catheter is inserted into the bladder. Eight units of packed red blood cells, which optimally includes four units of autologous blood, and a cell saver are available (the cell saver is not used in cases with tumours). All sponges, needles and instruments are counted and recorded at the beginning and end of the procedure. The sponges are weighed during the procedure to assist the anaesthetist in determining the total blood loss.

The patient is placed on the operating table in a lateral decubitus position. An overhead arm support is used to permit the dependent arm to be fixed above the head. The lower arm is brought out from the patient and placed on an arm support. A rolled flannel is placed at the apex of the scapula in the axillary space and sandbags are placed at the patients chest and back. Two pillows are placed between the legs. The lower leg is flexed. Adhesive tape is used to secure the patient to the operating table at the scapula and thighs. The legs and arms are covered with warm flannels and a safety strap is placed over the upper leg. Proper positioning is essential to ensure all bony prominence are padded and anatomical alignment of the extremities is maintained.

After a routine orthopaedic skin prep is performed the patient is draped in a thoracic fashion using a plastic drape to secure the draping. Available instrumentation includes a long handled spinal set-up with osteotomes, curettes, Cobb elevators, Kerrisons and pituitaries. Additional retractors, vascular clamps, dissectors, and hemoclips are also added. (Fig. 4 A & B)

The choice of side to approach the anterior spine is generally left retroperitoneal for T12 to L5 and right transpleural for T3 to T12. This is dictated by location of the pathology as the liver on the right is large and difficult to retract. The vena cava is also on the right and may be easily injured.

With a retroperitoneal approach to the anterior spine, the landmarks are the twelfth rib, the umbilicus and the anterior superior spine. Adrenalin (1:500,000) is injected into the subcutaneous and fascia layers to decrease the blood loss. The three layers of the abdominal wall are divided and the dissection of the peritoneum and renal fascia posterior to the kidney is carried out. The peritoneum is not entered. A self-retaining retractor opens the wound longitudinally. A

padded malleable retractor adds further exposure by retracting the kidney and peritoneal contents. The lumbar segmental arteries and veins are isolated, ligated or clipped and cut at the desired vertebral level. The periosteum over the lateral aspect of the spine is divided and elevated on both sides to provide better exposure and protect the iliac vessels. This also allows the CASP plate to lie flat at the time of insertion. The psoas muscle is retracted to avoid nerve root compression. The anterior longitudinal ligament is elevated using sharp dissection. Dissection includes the opposite side of the vertebrae so that the drill guide contour can be placed on the opposite cortex. An osteotome or rongeur is used to remove any osteophytes.

A discectomy is performed for degenerative disc disease; corpectomy for tumours; or decompression for fractures. Bone graft or cement is placed in the defect. Bone graft is harvested from the iliac crest or from the fibula. The graft is measured to fit the disc space or corpectomy defect. At least two grafts are inserted. If a corpectomy has been performed for tumour, bone cement will be used to fill the defect. Gelfoam is placed over the dura following decompression. A strip of polyethylene (PE) film is used as a mould for the formation of the bone cement strut. The cement is shaped and placed in the defect. The PE strip is wrapped around the cement to form a smooth cylinder. When the cement has hardened the PE strip and gelfoam are removed.

The plate is centred over the defect and temporarily held in place with short cortical screws. With the aid of the drill guide the screw holes are drilled, measured and the appropriate screws inserted. At least three screws should be inserted into each vertebral body. (See Figure 5.)

If a transthoracic approach was used, a chest tube is inserted; however, if a retroperitoneal approach there is no need for a drainage tube due to the bodies own ability to reabsorb retroperitoneal fluids.

One gram of Ancef IV is usually given during the latter stages of surgery to augment the dose that was given preoperatively. An x-ray is done in the O.R. to verify the position of the CASP screws.

Postoperative Plan

If there has been a large blood loss or if there are other serious medical problems the patient will be transferred to ICU. Routine cases are sent to recovery room where they are ventilated until awake. Complete intake and output monitoring is performed as well as continual monitoring of vital signs. A third gram of

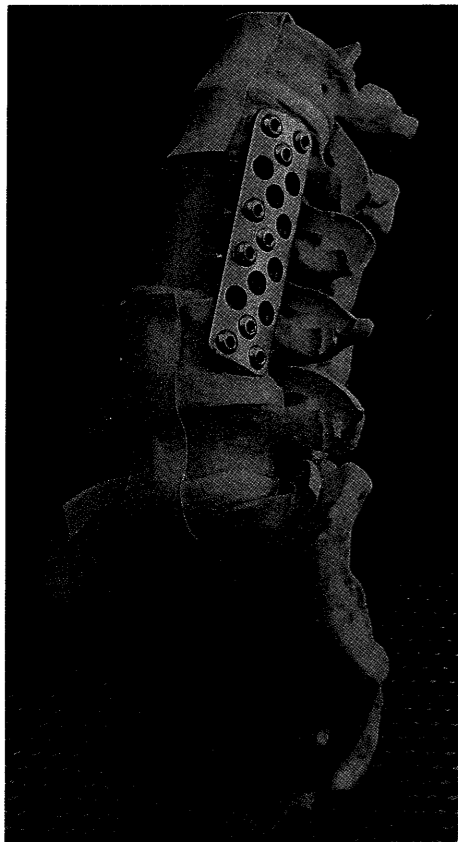


Fig. 5 - Spine model with CASP plate and screw

Ancef is given in recovery room and two more doses are administered over a 24 hour period. A neurologic sensory assessment is done and documented, then compared with the preoperative assessment.

Once the patient is alert and stable they are returned to the ward where deep breathing chest physio is maintained. Passive and active range of motion exercises of the limbs is established. A more complete motor and sensory neurologic assessment is performed and monitored daily.

On the second postoperative day the patient wearing a spinal brace is placed on a spinal chair and raised from a supine position by a pushing mechanism to a sitting position. If patients are neurologically intact, on the third day they will be ambulated with assistance. The spinal brace is to be worn continuously for three months. The brace is removed only to shower.

Abdominal strengthening exercises are initiated at the end of three months for fracture patients, and at the end of six months for tumour patients. X-ray follow up is done after the patient's first time in the spinal chair, six weeks postoperatively and then every three months.

Conclusion

The CASP system has successfully reduced operating room time in anterior displaced fractures and tumour dissections. This system allows for decompression and stabilization through the use of one, rather than two operative procedures which would include a posterior incision. The multiple screw sites contribute to plate stability.

The simplicity and safety factors of the drill guide have allowed surgeons to feel comfortable when drilling through the vertebrae. The system has also proven itself to be user friendly to both surgeons and to nurses assisting in the surgical preparation.

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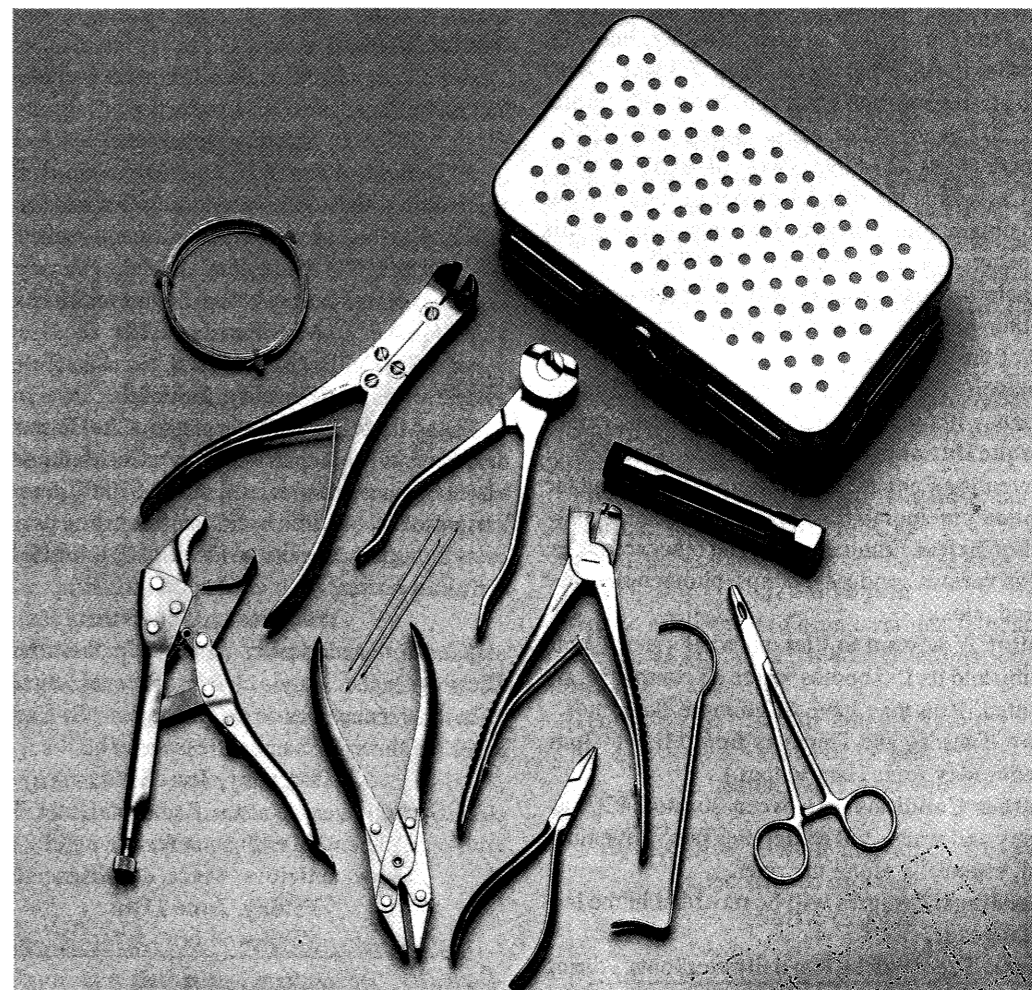
Acknowledgements

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13th National OR Conference

General Information

The advent of warmer weather signals the time for the 13th National Convention which will bring OR Nurses from across Canada together in the picturesque city of Quebec. While the organizing committee is wrapping up the work that precedes the unveiling of the program, here are some tips and reminders to help you plan a pleasant conference.

Registration: Saturday, June 5th: 3pm to 6pm; Sunday, June 6th: 8:30am to 6pm; Monday, June 7th: from 6:45am; All other days: from 7:30am. Don't forget to pre-register and book your hotel with Forum Quebec: 30 Grande-Allée ouest, Quebec, G1R 2G6.

Phone#: (418) 524-8093 Fax#: (418) 529-1172

Air Canada is the official carrier of the Convention. To obtain your discount, you must mention this reference number upon booking: CV930054.

Translation: All lectures will be translated. You can obtain headsets upon registering, returnable at the end of the week.

Tourism: Travel information available Sunday and Monday in the lobby of the Convention Center.

Kiosque Du Sourire: Booth located in the lobby of the Convention Center. This is where you will find the Convention's memorabilia -pins, posters, t-shirts; tickets for the Chateau Frontenac Ball and other activities; as well as various services -stamps, photocopies, lost and found, etc. . .

Exhibit: You want to find out what's new? Visit the exhibit and its 155 booths where 83 companies are represented. You may have to go more than once. . (Monday, Tuesday and Thursday from 11am to 3pm, and Wednesday from 11am to 1pm.)

Weather Conditions: Between 20 and 24C, usually sunny and warm, but sometimes rainy. Evenings are cool, especially along the river.

Recordings: Lectures will be recorded in the lecturer's language.

Fitness: There will be two daily workouts. . .bring your runners!

Scientific Workshops: Sunday, June 6th

In the morning you can choose one of two workshop: "Electrosurgical Procedures in the Endoscopy department"(English) and "Cleaning and Maintenance Procedures of Micro-surgery Instruments"(English or

French). In the afternoon "Electrosurgical Procedures in the Endoscopy Department" (French); "Demonstration of new techniques used to transfer patients safely" (English or French) and "Cleaning and maintenance of endoscopy instruments" (English - French). To participate, you must reserve in advance. There is a fee of \$25.00 per workshop.

Social Events

A well organized convention must include informal gatherings. Here is an overview:

Sunday, June 6th:

"Delightful Fancies" Opening evening at the Hilton's Ballroom, hors-d'oeuvres and wine. . . Come and meet your colleagues and make new friends, it is the beginning of the journey. (Semi-formal attire, tie not required)

Monday, June 7th:

Special Evening at the Concorde Hotel

Tuesday, June 8th:

"The Magic Romance throughout the Centuries" at the Chateau Frontenac Ballroom. Cocktail party followed by dinner, dance, and more! \$70.00 per person. Formal attire, inspired by romanticism and its expressions throughout the centuries. (Space is limited; book early and present your card upon arrival)

Wednesday, June 9th:

"Comfort and quality of life". In the afternoon, discover Québec City's charms. (Casual attire)

In the evening, cruise on the majestic St-Lawrence River. . .Dinner&Casino. Dress casual.

Thursday, June 10th:

Special evening at the Radisson Hotel. The Convention ends on a festive note! Show, activities, dance. surprises. . .!

Friday, June 11th:

"Farewell brunch"

Contact:
Steve Marchessault
Forum Québec
(418) 524-8093

Québec, Québec - 6 - 11 juin

Informations Générales

Le retour des beaux jours nous rapproche de la 13e Conférence nationale qui nous réunira, début juin, dans la pittoresque ville de Québec. Tandis que le comité organisateur s'affaire à mettre au point les derniers détails, sans lever le voile sur toute la programmation, voici quelques informations et rappels pour rendre votre séjour des plus agréables:

Inscription: samedi 5 juin de 15h00 à 18h00, dimanche 6 juin de 8h30 à 18h00; lundi 7 juin à compter de 6h45; les autres jours à compter de 7h30. N'oubliez pas de faire votre pré-inscription et votre réservation d'hôtel auprès de Forum Québec, 30 Grande-Allée ouest, Québec, G1R 2G6; Tél.: (418) 524-8093 - Fax.: (418) 529-1172

Air Canada (1-800-361-7585) est le transporteur officiel de notre congrès. Pour vous prévaloir d'une réduction, mentionnez la référence CV930054.

Traduction: toutes les conférences seront traduites. Procurez-vous un écouteur lors de l'inscription et n'oubliez pas de le remettre à la fin de la semaine.

Tourisme: informations touristiques offertes dimanche et lundi, au foyer du Centre des congrès.

Kiosque du Sourire: Situé dans le foyer du Centre des congrès, vous y trouverez des articles souvenirs du Congrès (épinglettes, affiches, T-shirts), les cartes pour le Bal au Château Frontenac et divers services (timbres, photocopie, carton d'invitation pour les différentes activités, objets trouvés).

Salon des Exposants: De nombreuses nouveautés vous attendent aux 155 kiosques regroupant 83 compagnies. Prévoyez d'y faire plusieurs visites (lundi, mardi, jeudi de 11h à 15h et mercredi de 11h à 13h).

Température: varie de 20° à 24° Celsius, généralement chaud et ensoleillé, mais quelquefois pluvieux. Les soirées peuvent être plus fraîches, surtout sur le fleuve.

Ateliers Scientifiques (dimanche 6 juin)

"L'entretien des petits instruments" (français-anglais). En après-midi "L'électro-chirurgie et l'endoscopie" (français), "Démonstration et techniques de déplacement sécuritaire des bénéficiaires" (français - anglais) et "L'entretien des instruments d'endoscopie" (français-anglais). N'oubliez pas de réserver votre place pour participer à ces ateliers (25.00\$ par atelier).

Activités Sociales

Un bon congrès comporte aussi une partie d'activités sociales. Chaque soirée sera l'occasion de fraterniser. En voici un aperçu:

Dimanche 6 juin

"Elixir et Frivolités", à la salle de Bal du Hilton sera notre soirée retrouvailles avec bouchées, vin... Venez nous rencontrer, c'est le départ!

Tenue de ville (cravatte non obligatoire)

Lundi 7 juin

Soirée à l'hôtel Concorde!

Mardi 8 juin

La salle de bal du Château Frontenac brillera de "La magie du romantisme à travers les époques". Cocktail, dîner gala, danse et surprise! le tout pour 70.00\$. Tenue de soirée inspirée par votre romantisme d'hier à aujourd'hui, laissez courir votre imagination vers la romance. Nombre de places limité, carte reguise à l'entrée)

Mercredi 9 juin

"Mieux être et qualité de vie" en après-midi, venez découvrir les multiples charmes de notre belle ville de Québec. tenue décontractée

En soirée: une croisière sur le majestueux fleuve St-Laurent, dîner, casino et plus...!

Tenue décontractée, prévoir un vêtement chaud.

Jeudi 10 juin

Soirée à l'hôtel Radisson, terminez le congrès en beauté sur un air de fête! Spectacle, animation, danse, surprise...!

Tenue de ville (cravatte non obligatoire)

Vendredi 11 juin

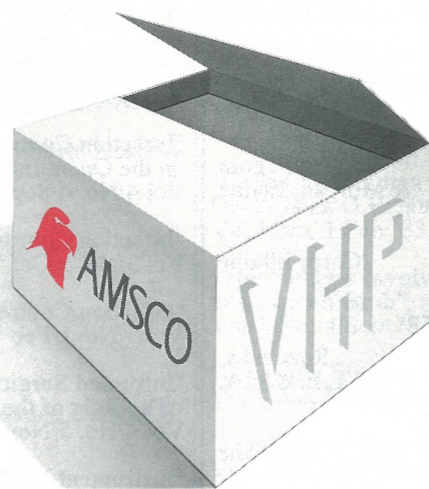
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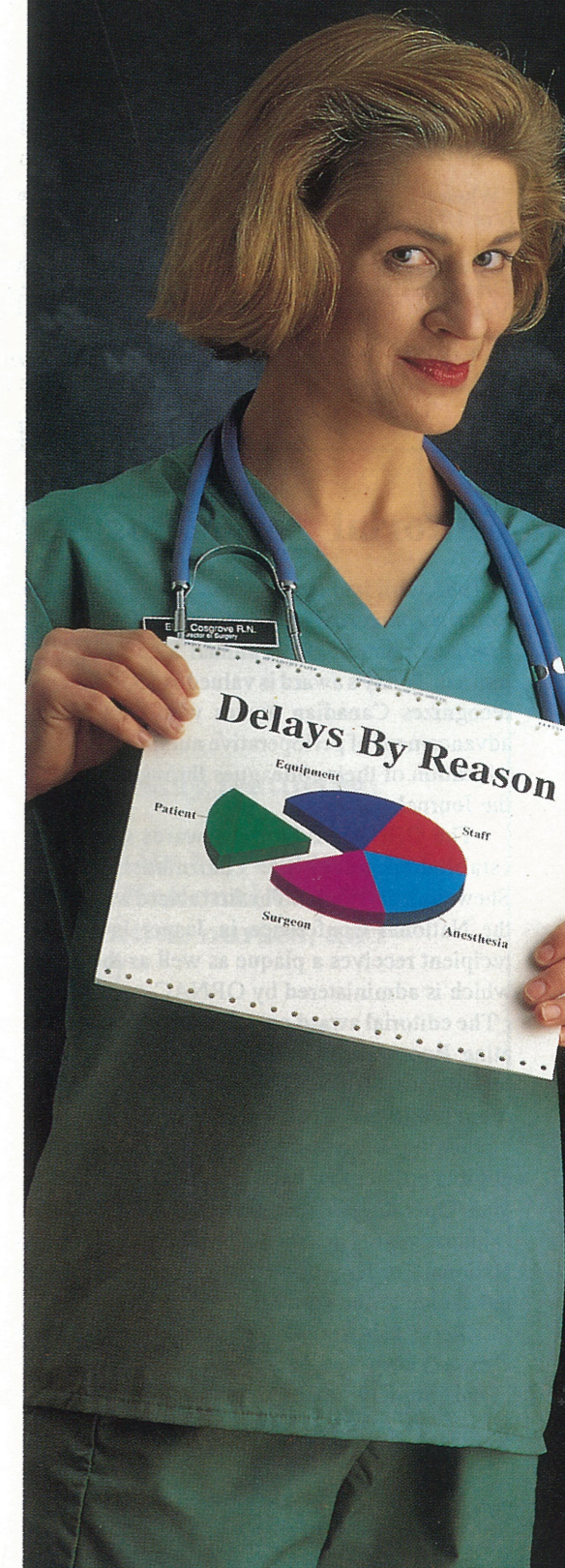
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Editorial Award for Authors Valued at \$3000

In 1983 with launching of the "Canadian Operating Room Nursing Journal", Johnson & Johnson Medical Products committed an annual \$2,500 award to the journal. Today's award is valued at \$3,000. The award recognizes Canadian nurses who contribute to the advancement of perioperative nursing knowledge and education of their colleagues through the medium of the Journal.

The ORNAC Editorial Awards Committee was established under the chairmanship of Muriel Shewchuk of Alberta. The first award was presented at the National Conference in Jasper in 1984. The recipient receives a plaque as well as the cash award which is administered by ORNAC.

The editorial award competition is open to all Operating Room staff nurses, managers, instructors and technicians. Students engaged in post basic operating room programs are also eligible.

Judging is done by the Awards Committee - on eligible articles that have been published in the Canadian Operating Room Nursing Journal during the calendar year. The awards presentation is done at the National Conference or at a provincial conference, on the choice of the winner.

The "Johnson & Johnson Medical Products Drake-Thompson Memorial Award" is in memory of the untimely deaths of two well known Johnson &

Johnson management personnel, Christopher (Chris) Drake and Gregory (Greg) Thompson. Both lost their lives during an emergency landing of a jet liner in Cincinnati, Ohio, in 1983.

Award Winners

The following is a list of the editorial award winners along with the title of their award-winning article.

1984 - Joanne Teskey - "O.R. Preceptors Promote Competence".

1985 - Jean Savickis - "The Separation of the Conjoined Twins".

1986 - Jerry Rudney - "Ultrasonic Percutaneous Lithotripsy".

1987 - Sharon Ball - "Laser Safety: Using the CO₂ Argon and Nd:YAG Lasers".

1988 - Mary Knight Kubasiewicz - "Controlling Anaesthetic Gas Exposure in PACU".

1989 - Donna Prokopczak - "Computers in the Operating Room".

1990 - Theresa Markowski - "Sanctioned Medical Acts in the OR".

1991 - Mary Knight Kubasiewicz - "Problem Solving in Perioperative Nursing".

The 1992 editorial award winner will be announced at the ORNAC National Conference in Québec City June 6-11th, 1993.



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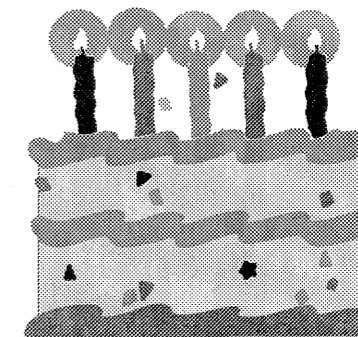
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