

# Canadian Operating Room Nursing Journal

Volume 11, Number 1, March/April, 1993



## Happy Birthday

ORNAC - 1983 - 1993

&

The Canadian Operating Room Nursing Journal  
1983 - 1993 Volumes 1 to 10

### In this issue:

- The Advocacy Role of Perioperative Nursing
- Laparoscopic Surgery in a Rural Hospital
- History of Endoscopic Surgery
- Special Care for Neonates in the OR
- Nominations for ORNAC's Board

First of Four  
Special  
Birthday Issues

# STANDARD ALERT



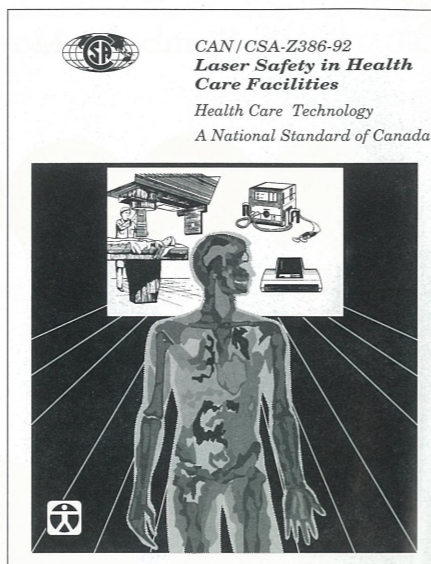
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**Canadian Operating Room  
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White Rock, B.C.  
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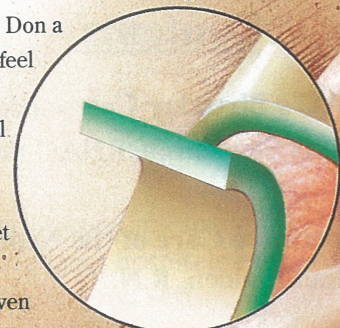
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## ORNAC'S Birthday Celebration

By Gloria Stephens

ORNAC is still a young organization as compared to some of the provincial operating room nurses organizations which have been active since the late fifties and early sixties, such as Quebec, Ontario, and British Columbia. The national beginnings stemmed from a meeting in Toronto in 1965 with an attempt to help all provinces in Canada form an OR organization. In attendance at this meeting were representatives from BC, Alberta, Manitoba, New Brunswick, Quebec, and Ontario. The members of this meeting endorsed the need for a national group; and provided funds for a National Committee. Isabelle Adams was voted as the first Chairman of the interim national planning committee.

From '65 to '70 many attempts were made to get the national organization "off the ground". The difficulty was lack of funds, communication systems, and several provinces were yet to be organized.

The first official meeting/conference was organized by the Toronto OR Group and the Quebec group in 1970. Quebec was the hosting province assuming the financial responsibility. The first official meeting to investigate the creation of a national committee is considered to be 1970.

The British Columbia Operating Room Nurses Group (BCORNG) in April 1972 held what is considered the 2nd official meeting related to attempts to form a National Committee. BCORNG had been working with OR nurses across Canada on this project as early as 1967. The committee met at National Conferences every two years on the Sunday before the conference and in the off years in Toronto. This National Committee functioned until 1983 when ORNAC became the official operating room nurses organization. The first President was Valerie Shirreff of Toronto, to be followed by Ann Robinson of

Quebec, Joan Donald of New Brunswick, and Gloria Stephens of British Columbia.

ORNAC's accomplishments in ten short years are staggering and too numerous to list here. These successes are not due to a few members, but to many from coast to coast, who have volunteered their time and sometimes money to the betterment and advancement of the organization. Any organization's progress stems from a solid foundation. The Operating Room Nurses Association of Canada (ORNAC) is fortunate to have such a foundation. What makes a solid foundation are well defined guidelines, careful documentation, clean and open communication lines, valid resources, and a sincere commitment of the people involved. This ORNAC has.

To participate in the 10th anniversary celebrations come to Quebec City, June 6 - 11, '93.

Happy Birthday ORNAC and may your future be long, proud and successful.

### Announcements:

The World Operating Room Nurses Conference will be held in Adelaide, Australia, Sept. 6 - 11, 1993.

1. Travel Arrangements: Contact your Provincial President for detailed information.

2. World Attire: For Fellowship Night, Tue. Sept. 7 '93, Canadian shirt and red mountie hat which can be purchased at the National conference in Quebec City. Shirt \$15.00 and the hat \$5.00.

Don't forget to bring items for 'give-a-ways/traders' for this fun filled and interesting evening.

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.

# Perioperative Care of the Neonate

By Lilian Budden, R.N.

The neonatal period is the first 28 days of life and presents the greatest risk to the newborn. It is a period full of physiological transitions and adaptations, and to the surgical neonate are added the pathophysiological changes which accompany the surgical condition.

The two major adjustments from intrauterine to extrauterine life are with the respiratory and the cardiovascular systems.

## The Respiratory System:

There are several stimuli that promote spontaneous respirations:

1. Rebound of the thoracic cage following vaginal birth. Descent through the vaginal canal also squeezes fluid from the lungs.
2. Chemical changes: With the clamping of the umbilical cord there follows a low blood  $PO_2$ , a high  $PCO_2$ , and a low pH which excites the respiratory center in the medulla.
3. Thermal changes: As the neonate leaves the warm aquatic environment for the cooler air, sensory impulses in the skin are excited and these

are also transmitted to the respiratory center.

4. Tactile stimulation: This is now questionable with only gentle, if any, tactile stimulation used.<sup>1</sup>

When respirations are established the normal neonatal rate is between 30/40 breaths per minute.

## Cardiovascular System:

As the lungs expand, the pulmonary blood flow increases; the pressure in the right atrium, right ventricle and pulmonary vessels decrease, the pressure in the left side of the heart increases and as blood flows from a higher to lower pressure the circulation through the fetal shunts are reversed. The high  $PO_2$  level of the blood causes the duct walls to constrict and the foramen ovale and ductus arteriosus functionally close soon after birth.<sup>2</sup> This transition may take from minutes, hours, to weeks and during this time the neonate's circulation can be thought of as an unstable, transitional system.<sup>3</sup>

All systems undergo change and most are immature at birth, however, neonates can see, smell, hear, taste and feel pain.

Some other changes will be incorporated as we follow the neonate through surgery.

## Abstract

The neonate is a unique individual with his/her own needs. This article deals with the adjustments the neonate has to make to extrauterine life; some of the differences between neonates and older children and adults, and the special needs of the neonate who needs surgery.

## Author

Lilian Budden, R.N., is a staff nurse at the Dr. Charles A. Janeway Child Health Centre, St. John's, Newfoundland, and is currently president elect of the Newfoundland and Labrador Operating Room Nurses Association.

## Some Neonatal Conditions

### Requiring Surgery

Omphalocele  
Gastroschisis  
Diaphragmatic hernia  
Tracheoesophageal Fistula  
Meconium Ileus  
Imperforate Anus  
Total Anomalous Pulmonary Venous Return  
Hypoplastic Left Heart  
Laryngotracheoesophageal Cleft  
Tracheomalacia  
Myelomeningocele  
Hydrocephalus

When a neonate is booked for surgery, one of the major concerns is for thermoregulation. In preparation for this surgery: the heat in the operating room should be increased, a well-padded warming blanket placed on the OR bed and drapes and prep solutions placed in a warmer.

Neonates have a proportionately larger surface area in relation to body weight which provides more exposure to the environment and greater heat loss per unit of body weight.<sup>4</sup> They also have a very thin insulation or subcutaneous fat layer.

Heat is lost in four ways:

1. **Evaporation** - heat lost through moisture. Wet newborns lose five times as much heat as dry babies.
2. **Radiation** - heat lost to cooler solid objects in the environment that are not in contact with the neonate.
3. **Conduction** - heat lost from the body through direct contact of the skin with a cooler solid object.
4. **Convection** - heat lost due to warm air rising and being replaced by cooler air.<sup>5</sup> This is accentuated by doors opening, and anything that creates a draft.

Man is homeothermic; that is heat production increases when exposed to a cold environment to maintain body temperature.<sup>6</sup> The central nervous system receives multiple sensory inputs concerning thermal balance within the body, it interprets the data and activates the mechanisms to adjust the balance of heat loss/heat gain. In other words, man shivers! Neonates do not shiver. He/she can only maintain a constant body temperature within a narrow range of environmental conditions and if the neonate is cold stressed then non shivering thermogenesis occurs. The oxygen consumption and metabolic activity increases which breaks down brown fat located between the scapulae, neck, behind the sternum and around the kidneys and adrenals. The heat generated by the breakdown of the

brown fat is distributed around the body by blood which is warmed as it flows through the fat. In this non-shivering thermogenesis as much as 20% of the cardiac output may be diverted through the fat and this causes pulmonary and peripheral vasoconstriction. This gives the neonate its mottled appearance. The consequences of this can be hypoxia, metabolic acidosis and hypoglycemia.<sup>7</sup>

For the neonate we have to try and provide a neutral thermal environment, that is one that permits the neonate to maintain a normal body temperature with minimal oxygen consumption and caloric expenditure. A skin temperature of  $36.5^\circ C$  will indicate a neutral thermal environment for most neonates.<sup>8</sup> With a neonate  $> 2.5Kg$  a room temperature of  $26^\circ$  is fine,  $< 2.5Kg$  the room should be  $29^\circ$ , but if the neonate is uncovered the room heat may need to be increased to  $32.5^\circ C$ .<sup>9</sup> If the neonate becomes too hot the same reaction will occur as during cold stress.

If the axilla is being used to measure the temperature it should be the axilla without the IV as IV fluids can produce a false temperature reading.<sup>10</sup>

Most neonates who need surgery will be nursed in a neonatal intensive care unit and a pre-operative visit should be done. The neonate should be assessed for needs in transporting to the operating room and for needs in the operating room. Some considerations are: premature or full term, weight, co-existing anomalies, etc. Check that a type and cross-match have been done and when the blood will be available. The blood reports are also checked keeping in mind that in a neonate the haemoglobin, haematocrit and white blood counts are higher than an adult's.

Hgb- 16-18 g/100 ml blood

Hct - 45-50%/100 ml blood

WBC - 20,000  $mm^3$ <sup>11</sup> for the first 24 hours decreasing to 12,000  $mm^3$  by the end of the first week.<sup>12</sup>

It should also be verified that Vitamin K was given post delivery. Vit K catalyzes the synthesis of prothrombin in the liver. It is produced by intestinal bacteria but as a neonate's gastrointestinal tract is sterile there is no vit K available for prothrombin formation for about four days.<sup>13</sup>

The consent for surgery is also checked. At our hospital we accept a telephone consent witnessed by two people. The mother may still be a patient in another hospital and the father may not be able to be with the baby. If the parents are present when the baby is taken to the operating room they will be emotionally upset, so allowing them to touch, kiss or say goodbye to their baby may help.

When everything is ready in the operating room and with the neonate, he/she is transported to the OR. This is usually accomplished as a joint effort with the anaesthetist, maybe a respiratory technologist and the OR nurses. The baby is transported in either an isolette or an Ohio bed with the radiant heaters. Even if the baby is not intubated O<sub>2</sub> and a pulse oximeter are used for transport and a warm blanket is placed over the baby. If the baby is not being nursed in the NICU then he/she will be transported to the OR by the nursery nurses and the chart is checked in the OR admission area.

In the operating room the baby is carefully transferred from the isolette/Ohio bed to the warm operating room bed and preparation for induction begins. The isolette should be plugged into an outlet in another area to keep it warm for when surgery is finished.

EKG leads have to be placed for good surgical access but also so they won't cause any pressure on the skin when the baby is positioned. This is not a problem if you use the flat preattached wire electrodes. The two layers of a neonate's skin, the dermis and epidermis, are loosely bound to each other and are very thin. Slight friction can cause separation of these layers and blister formation.<sup>14</sup> Care should be taken when repositioning leads and removing tape.

The precordial stethoscope, the temperature probe, B/P cuff and pulse oximeter probe are applied.

If possible, at the first opportunity a hat should be placed on the neonate's head for "heat loss from an uncovered head may represent 60% of the total heat loss in the OR".<sup>15</sup>

If there is an existing IV and it is functioning even though it may be a butterfly, the anaesthetist may opt to use this to induce the baby. Getting an IV can be a time consuming process (sick baby, every vein used prior to coming to the OR etc.)

The intubation of a neonate is an extremely stressful time for everyone. The differences in a neonate's airway and why they can be more difficult to intubate than an adult are:

1. The tongue is relatively larger and more easily obstructs the airway.
2. The larynx is higher in the neck.
3. The epiglottis is narrower, shorter and angled away from the trachea and more difficult to lift with the blade.
4. Tip of the endotracheal tube catches in the vocal folds.
5. The larynx is funnel-shaped so the ET tube may pass through the vocal folds but not the subglottis.<sup>16</sup>

Neonates also desaturate very rapidly. They consume O<sub>2</sub> twice as fast (premies 3 times)<sup>17</sup> as an adult and they have very little lung reserve so until the ET tube is securely taped in place, tension is high. (34% of infants under one year (1) of age experienced critical incidents under anaesthesia and 22% of these occurred during induction.)<sup>18</sup>

After the intubation, better IVs, arterial lines, central venous lines, etc. are obtained. The baby's eyes are protected with lubricating drops, eye pads and tape. Urinary catheters may be needed and for this very small Foleys or even feeding tubes may be used. During this phase, team work is very essential as the baby is only so big and many people try to have a piece of the action. Prevention of heat loss must be remembered.

After the anaesthetist gives the O.K. the neonate can be positioned for surgery. We make donuts from combine pads and cling to support the head. We also use combine pads and/or foam to make rolls and bolsters to support the baby in the lateral and prone position and to protect the pressure areas. The smaller size electrosurgical dispersive pad is placed under the baby - the back and buttocks for supine and flank for the lateral position.

The prep should be done with warm solution and the sponges not too wet. There should be no pooling of solution under the baby to prevent chemical burns and heat loss from evaporation and conduction. Ideally the prep should be done when the surgeon is in the room and ready to drape for, as I said earlier, a wet baby loses heat five times faster than a dry one<sup>19</sup> and there is usually a lot of the body exposed. (in one instance the preprep temperature was 36.8°C but decreased to 34.9°C by the time the surgeon came in the room.

Sponges are weighed as soon as they are discarded from the setup so an accurate blood loss can be determined. A neonate has a blood volume of 80-90 ml/Kg<sup>20</sup>, so a 10% loss in a 3Kg baby is only 24-27 ml of blood. A small suction receptacle which gives a more accurate measurement of blood loss can be used. Irrigating solutions must be warm and, as they cool quickly and have to be replaced, accurate records of volume must be maintained. We use a marking board visible to the anaesthetist to keep a running tally of blood loss and volume of fluid on the setup.

Instruments used for neonatal surgery can be small and more delicate than those used for larger children and adults and must be handled and processed with care. Surgical team members must take care not to rest on, or put pressure on, the neonate's body or limbs.

Record keeping and care of any specimens is the same as for any surgery - accurate and complete.

Following closure the incision is dressed or not dressed as per the surgeon's instructions. If drainage is expected it would be good perioperative nursing care to use Montgomery straps to keep the neonate's dressing in place. The electrosurgical dispersive pad is gently removed and the site checked for burns. Warm, dry blankets should be placed over and under the baby.

A nurse should stay with the neonate ready to assist the anaesthetist with extubation if it is planned, or to help with the transfer of the intubated baby to the ICU and PARR. There are probably more lines and tubes postoperatively, and it is important that they do not get dislodged.

Some studies suggest that too much environmental stimulation, e.g., loud noises, jarring of the isolette, too much handling etc., are stressful for the sick neonate and can cause decreased PO<sub>2</sub> and increased heart rate, respiration and intracranial pressure<sup>21</sup>, so neonates should be handled gently, especially in transport. The baby is then handed over to the ICU or PARR nurses and a report is given.

The neonate is a unique individual with unique needs, and we have to be aware of these to give the optimum care for his/her stay with us in the O.R.

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**A 95th reunion of the School of Nursing of the Toronto Western Hospital is planned for September 18, 1993.**  
For details contact:  
Jean Mitchell-Bain  
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# The Advocacy Role of the Perioperative Nurse

By Loretta Thomas-Aasen, R.N., B.S.N.

## The Advocacy Role: An Overview

In 1903 Leila Woodbury made it known to her peers that the "good nurse" was one who informed her patient about the surgical ordeal and supported the patient as an individual. These functions are widely recognized in the contemporary view of the patient advocate.<sup>1</sup>

The advocacy role evolved from a critical examination of the ideological base, values, and concepts of perioperative nursing. The role has changed from the concept of skilled manipulation of equipment and supplies to that of preventing illness and maintaining the patient's health status.<sup>2</sup>

In 1978 in the United States the advocacy role was examined and the five models of nurse patient advocacy were identified:

1. The nurse acts as a counsellor helping the patient by reducing the patient's fears and establishes the patient's feelings of self-control,
2. The nurse assists the patients with health care decisions congruent with personal beliefs,
3. The nurse acts as a watch dog over patient rights,
4. The nurse ensures that quality health care is delivered to the patient such as: family contacting, double checking blood types and medications, and
5. The nurse acts as a representative or spokesperson when patients cannot speak for themselves.<sup>3</sup>

Perioperative nursing practice is often judged according to how quickly the operating room can be turned over, how efficiently the surgical staff needs are met, and how instantaneously patients can be prepared and moved through their surgical experience.

Perioperative nurses are valued for their efficiency,

time-management skills and of course their technical expertise.<sup>4</sup>

The perioperative nurse has numerous responsibilities besides patient care. These responsibilities include: checking all the equipment, supplies and instruments which are being utilized in the intraoperative environment.

Perioperative nurses have a duty to make sure that all products which are utilized in the operating room environment are safe and promote optimal patient care.

## The Patient

The consumer has also become better educated in health care related to health promotion and maintenance. Today many patients exercise their right to be informed of their health status, their right to participate in decisions related to their health care and their right to high quality care. Nurses must be able to intelligently assume the role of patient educator. If the nurse doesn't keep pace with the development of new knowledge the nurse will lose credibility, (Conway 1983).

## Author

Loretta Thomas-Aasen, R.N., B.S.N., is the Nursing Unit Manager, Operating Room, ER, CSR and PACU, St. Joseph's Hospital of Estevan, Estevan, Saskatchewan, and currently President of the Saskatchewan Operating Room Nurses' Group. She is working towards her Masters of Science in Administration through Central Michigan University. This article was presented to the October '92 conference of the Operating Room Nurses of Alberta Association.

## Ask Yourself These Questions

- Do perioperative nurses need to justify their existence?
- How are perioperative nurses judged?
- How are we advocates for our surgical patients?
- How can perioperative nurses enhance their advocacy role? (For example - how can we better represent the best interests of our patients and speak on their behalf?)
- How can we improve the image of perioperative nurses?
- How are we keeping pace with advances in technology with regard to patient advocacy?

Perioperative nursing care involves giving your patient prioritized attention during the preoperative, intraoperative and immediately following the surgery in the post-operative phase. Patient advocacy involves protecting the patient and of course the aseptic environment. The perioperative nurse is responsible for assessing the operative environment and ensuring that the surgical team functions according to the policies of the hospital. The nurses' priority is ensuring that the patient receives quality care throughout their perioperative experience.

Preoperatively, the perioperative nurse interacts with his/her patients and their families outside the operating room setting. Consequently, the nurse establishes a positive rapport with the patient and family members.

The perioperative nurse collects and analyzes data pertaining to the patient's health status, makes nursing diagnoses, plans nursing care utilizing the nursing process, and prescribes specific nursing actions according to the chosen conceptual model and finally implements and evaluates the care which is given. The perioperative nurse has the opportunity during the pre-op visit to teach, answer questions and provide support and reassurance to the patient and family members. By performing preoperative visits this signifies to the surgical patient that you care about the person. People are really terrified due to the fear of the unknown. We have an obligation to inform our patients about the surgical environment.

It is hard to do everything in one day. Consequently, we have to commit ourselves beyond our usual work day in order to perform perioperative visits. We must accept the challenge to try and find extra time each day to complete preoperative/post-op visits. By taking the necessary time to complete patient visits we can add to and improve the image of perioperative nurses. Not to mention that preoperative

visits assist in preparing the patient for their operating room experience.

## Characteristics of Advocacy

There are two characteristics of advocacy:

1. **Passive mode** - the visiting nurse provides support to the surgical patient as long as the patient's needs are in line with the norms and rules of the institution.

2. **Active mode (autonomous)** - the perioperative nurses' actions are based on his/her personal and professional beliefs and standards that reflect what is morally and ethically right on behalf of the patient - not the institution.

The passive (non-autonomous) perioperative nurse will stray away from making independent judgments and hide behind the institutional policies.

The active (autonomous) perioperative nurse will become involved by making decisions, and providing support and strength towards his/her patient.

In order for the perioperative nurse to effectively perform the advocacy role the nurse must retain the following characteristics - the nurse must have:

- The ability to advocate for others,
- The knowledge of what it means to be an advocate,
- The autonomy to carry out the commitment of caring, and,
- An understanding of nursing as a caring relationship.

There may be conflict related to the perioperative nurses' role as a patient advocate. Stress due to lack of time available, other commitments, and insufficient support from colleagues and physicians may cause conflict. There may be confusion related to who should perform this function. Consequently, all these stresses may only encourage the perioperative nurse to not perform preoperative patient interviews.

For review thus far, the perioperative nursing activities include: knowledge and validation of the plan of care which will include a plan which is patient-focused, and goal oriented. This will include a review of assessment data, nursing diagnoses, intended patient outcomes, and planned nursing actions. The plan will need to be validated with the patient and the members of the health care team.

## Preoperative, Intraoperative and Postoperative Routines

The perioperative nurse will prepare the patient for the surgical experience by completing the pre-op visit. This will include:

1. Verifying identification of the patient,

2. Completing the physical assessment,
3. Establishing a rapport with the patient and family members,
4. Explaining all procedures and actions,
5. Being supportive towards the patients need for psychological support,
6. Giving complete instructions regarding postoperative exercises and health maintenance procedures, and lastly,
7. Describing activities and routines to be anticipated in the surgical experience.

Preparation of the operating room is the second last step in the preoperative nursing activities. The perioperative nurse is responsible for assuring the availability of resources to assist with the continuation of planned nursing activities. This will allow for safe, high quality delivery of protected patient care.

Finally, the perioperative nurse must have the knowledge and skills to perform the necessary care for his/her patient. If the nurse is unable to perform specific nursing skills, the appropriate health care personnel must be informed.

Intraoperatively, the perioperative nurse will assess the patient on an ongoing basis. Potential problems are then discussed with the surgical team. Implementation of the plan of care during the intraoperative phase of the surgical experience must be performed. Nursing actions should be client focused and consistent with expected patient outcomes.

Intraoperatively patient safety is extremely important. In order to provide patient safety adequate health-care resources (both in terms of personnel and equipment) will be readily available; aseptic technique must be observed; the physical environment should be inspected and approved; and the principles of physiological and psychological functioning must be observed.<sup>5</sup>

High tech equipment does not calm the uninformed patient, it only adds stress to the situation. It is the perioperative nurse's duty to keep informed of the changing technology especially with regard to the equipment being used in the operating room theatre.

The perioperative nurse is responsible for promoting the patient's right to individualized care and must also demonstrate appropriate, safe and judicious use of equipment and supplies.<sup>6</sup>

Intraoperatively, the plan of care must be executed skilfully and efficiently by the perioperative nurse. The nursing care plan should be modified according to the patient's health status. The nurse is responsible for the coordination and direction of the patient's care.

Therefore, the perioperative nurse must assure continuity of care throughout the preoperative, intraoperative and postoperative periods by utilizing the patient care plan. In the O.R. the perioperative nurse has a primary role, that of patient advocacy.

Documentation of nursing care during the implementation period reflects what has been done for the patient and also includes the patient's response to the actions.<sup>7</sup>

Postoperative nursing activities include: patient teaching, assessment of the patient's compliance with the plan of care and documentation of goal attainment. The perioperative nurse is able to continue to implement the plan of care through helping to prepare the patient for discharge.

As a patient advocate the perioperative nurse provides quality care and will acknowledge that his/her professional and ethical responsibility for patient advocacy, dealing with conflict, and maintaining competence, all of which will make a significant difference in the lives of patients.

It is very important that nurses continue to be patient advocates. In doing so they are allowing the patient to plan their care and both the nurse and the patient can learn from their experiences. Advocacy allows for a positive surgical experience for the patient. However, we must remember that a nurses warm touch and verbalized concern will also assist the patient through their preoperative, intraoperative and postoperative experiences.

### The Perioperative Nurse's Role in Promoting O.R. Nursing

In order to discuss the promotion of O.R. nursing we must consider the development of professional nursing in Canada.

Several forces have affected the development of professional nursing. These include: the British military's influence on Florence Nightingale, Christian religious tradition, medicine's dominance of health care, the rapid increase of knowledge in the social and biological sciences, and the escalation of health care costs. We are all aware that Florence Nightingale is recognized as the 'Founder Of Modern Nursing'. Florence was called up into the British army in 1854 so that she could provide women nurses to care for the sick and wounded soldiers in the Crimean war. Consequently, through this service, the British military affected the development of nursing in the areas of nursing functions, responsibilities and authority.

The rapid increase of knowledge in the social and

biological sciences has had a positive impact on the image of professional nursing. Nurses are now seen as intelligent and caring professionals. We have progressed by moving away from our subservient role. As Dr. Josephine Flaherty, Principle Nursing Officer with Health and Welfare Canada stated, "We are no longer handmaidens who do only what other people tell us to do except in an emergency. In emergencies we become articulate decision making, intelligent, autonomous professionals!"

In the October, 1988 issue of *R.N.* Bernice Keutzer wrote, "Nurses who feel their primary duty is to the patient are professionals; nurses who exist to help the doctor will always be technical nurses regardless of their education".

Health promotion and maintenance and the alleviation of illness and suffering is an important feature of nursing. The women's movement has enabled nurses to become increasingly assertive with regard to their professional independence. (Besner, 1983).

However, in the 90's we must consider four factors that have put nurses into a better position than ever before to gain autonomy. The improved status of women, a critical shortage of nurses in some locations, increased consumer input in health-care decisions, and research confirming the profound impact of emotional and social stress on physical well-being.<sup>8</sup>

How can we promote O.R. nursing among perioperative nurses? Think about this question? How can we sell our specialty? In order for perioperative nurses to promote their profession they need to affirm to the public as well as the health care community that perioperative nurses are required to give quality nursing care.

However, how many people ask us what we do? Unfortunately, O.R. training has been removed from basic nursing education, so the majority of general duty nurses are unaware of what perioperative nurses actually do. The Operating Room Nurses Association of Canada (ORNAC) has been trying to encourage Schools of Nursing and Universities to increase the perioperative nursing experience for student nurses. Our outlook towards perioperative nursing makes or breaks us and our profession!

Perioperative nurses should be recognized for their contributions to our health care system. Let me explain the three (A's) which are: perioperative nurses are adaptable, assertive, and aggressive. Perioperative nurses often intimidate other members of the health care team because of our assertive skills.

We are there for our patients, just like our col-

leagues, 24 hours a day - 365 days a year, and that is often a struggle with trying to juggle work and family commitments plus our professional responsibilities.

We can't sell our specialty unless we can think of something good about our career! It is really hard to promote our nursing specialty unless we all come together and take pride in our commitment to the practice of perioperative nursing. Vince Lombardi a professional football coach stated:

*"The quality of a person's life is in direct proportion to their commitment to excellence, regardless of their chosen field of endeavour"*.

### Professional Collaboration

(1) We need to stop our back biting and face situations head on! Everyone can learn something from each other. We shouldn't compare challenge and change. Practice change alone because change is inevitable and there are costs as well as benefits to accepting changes.<sup>9</sup>

(2) Let's get rid of that old saying - "I suffered so you shall suffer". Nurses need to care for nurses. We must stick together, stand up and be counted. By showing we care signifies that we're committed to perioperative nursing.

Let us all take a more positive, supportive, encouraging role and help each other through challenging times!

The image of perioperative nursing is not likely to change until nurses see their role in patient care as being just as important as that of physicians.<sup>10</sup>

Perioperative nurses must realize that how we visualize our role affects the overall image of perioperative nursing.

An issue that affects the future of perioperative nursing is the low visibility that perioperative nurses have. Patients have limited contact with OR nurses, thereby have no opportunity to visualize our nursing skills. The lack of public visibility makes it difficult for perioperative nurses to define their unique role and services to the consumer. Therefore, it makes it difficult for the consumer to appreciate the nurses' role as essential to the O. R. experience.<sup>11</sup>

How do we deal with improving our image? We all need to improve the image of perioperative nursing and guess where that begins - it begins with you!

Being aware of your own personal image can improve the view of perioperative nursing. Be an optimist - an optimist focuses on the positive aspects of any situation or problem. A pessimist has a helpless and hopeless outlook. One way to portray a positive

view is to complete preoperative visits. Introduce yourself to the family members and of course the staff nurses on the ward. This presents a positive image! How we interact with our patients will reflect in how they treat us! We must be cheerleaders for our profession!

If we continue to view perioperative nursing as burdened with problems we then see every situation as a complication. In nursing we spend too much time complaining about and focusing on our problems. What profession, what individual is without problems? <sup>12</sup>

One way we can improve our image is to quit calling each other girls! We'll never get the respect we deserve. Lynda Miles a Practice Management Lecturer stated, "we must sell our unique strengths and not our weakness".

We must get enthusiastic about our perioperative career. We must have an upbeat attitude. An upbeat attitude is a confident person who is proud of the service being offered. <sup>13</sup> Try not to think of your career as a job! We must feel confident that we can deal with most problems. We need to create a positive mental image which will enable us to become more enthusiastic about our perioperative nursing career. Perioperative nurses need to become involved with their professional organizations to let their voice be heard! We must network with other professional organizations in order to become more powerful and improve our image. Networking is an important tool in professional development, thereby allowing you to become informed of the changes in perioperative nursing.

Let's all get involved and promote our National O. R. Nurses Day November 14. We can promote perioperative nursing by encouraging ward nurses to view the operating room, participating in high school career days and offering public tours of the intraoperative setting. We need to present O. R. inservices, educate the public, inform the media and get actively involved with our professional operating room nursing organizations.

### Power Enhances Advocacy

Self-esteem is a power resource, it enhances our potential for success. Indicators of impaired self-esteem include - such behaviours as devotion to routine, awe of authority, retreat from initiative, negative self-talk, resistance to change and an oppressed attitude all of which have characterized nurses. <sup>14</sup> Those nurses with secure self-esteem can withstand major obstacles. One is more powerful with a secure self-

esteem. The major source of power in a professional field is knowledge. We will acquire power by sticking together which will assist us in improving our image among other health professional and with the health care consumer.

Think of this statement by Kalisch & Kalisch, "Every social act is an exercise of power, every social relationship is a power question, and every social system is an organization of power."

What is your reaction to this statement? How you respond will depend on how you view the concept of power. What is power? Power is the ability to do or act, a rather neutral concept. Bertrand Russell offered a more complex definition of power which is: "power is the capacity to alter behaviour or to produce intended effects".

In order for perioperative nurses to have a positive image we need to be aware of the sources and kinds of power available. Therefore, symmetrical power (power which is equal) defines the interaction among peers. Consequently, we choose to interact with people whose behaviour we can affect and who have the power to affect us. This means that we want to do things with them and they want to do things with us. Asymmetrical power (power which is unequal), exists throughout our societal interactions. The seven key elements of power are:

(1) - Base of power - which includes: resources or assets such as knowledge of human functions and needs.

(2) - The means of power - refers to how we use our resources to influence others such as: how we educate the consumer regarding the nature of Perioperative Nursing.

(3) - The scope of power - the specific set of actions we can have individuals perform so that we can increase the image of O.R. Nursing.

(4) - The amount of power - this is when someone will perform a specific action as the result of utilization of the means of power by one person against another. Therefore, there is the probability of being able to effect changes.

(5) - The extension of power - the number of subjects the power holder exercises control over such as: networking - how we can effect change on other professional groups, the public and our patients.

(6) - The cost of power - what are the costs going to be for using our power. What do OR nurses have to give up to utilize their power to change their image?

(7) - The strength of power - what will it cost in terms of resistance by persons with whom you are exhibiting the power on. Therefore, how much will the

group such as other health care providers and individuals give up in order for us to increase our image as knowledgeable health care providers?

Nursing in general has a very strong power base in western society. Nurses have a negative perception of themselves as being only a nurse. However, we are autonomous health professional accountable for our actions. We all need to work together to increase our power base. Maybe our power will increase once the sex-role stereotyping has decreased.

In order to promote our image we need to first think more of each other. I cite the *Commitment To My Co-Workers* from the May, 1990 *AORN Journal*.

"As your co-worker with a shared goal of providing excellent nursing care to our patients, I commit to the following:

- I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every other member of this staff. I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need the advice or help in deciding how to communicate to you appropriately.

- I will establish and maintain a relationship of functional trust with you and every other member of this staff. My relationships with each of you will be equally respectful, regardless of job titles or levels of educational preparation.

- I will not engage in the three B's (bickering, backbiting and bitching) and will ask the same of you.

- I will not complain about another team member; and ask you not to as well. If I hear you doing so I will ask you to talk to that person.

- I will accept you as you are today, forgiving past problems and ask you to do the same with me.

- I will be committed to finding solutions to problems, rather than complaining about them or blaming someone for them and ask you to do the same.

- I will affirm your contribution to quality patient care.

- I will remember that neither of us is perfect, and that human errors are opportunities, not for shame or guilt but for forgiveness and growth."

### Conclusion

The advocacy role of the perioperative nurse involves:

1. Performance of the patient advocate role,
2. Providing continuity of care,
3. Coordination of activities, and
4. Focusing on nursing activities.

In addition to the advocacy role, perioperative nurses must promote their specialty by advocating to the health care consumer and his/her professional colleagues, that the perioperative nursing role within the system is required. Perioperative nurses must continue to support their role within the delivery of health care services.

As Norman Vicent Peale said:

"Think enthusiastically about everything; but especially about your job. If you do so, you'll put a touch of glory in your life. If you love your job with enthusiasm, you'll shake it to pieces".

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



**1993 Nominations for Office**

The following list indicates the candidates that have agreed to let their name stand for consideration for the positions indicated on the executive and board of the Operating Room Nurses Association of Canada (ORNAC). Nominations have been received by the nominating committee for the four ORNAC executive positions: President-Elect, Vice-President, Secretary and Treasurer. President-elect Jackie Waisman of Alberta officially becomes president when the chain of office and gavel are passed from Gloria Stephens at the closing ceremonies of the '93 ORNAC Conference in Quebec City. The newly elected executive is known following the June 6th Board meeting.

The following biographical information and photography has been assembled by the chairperson of the nominations committee Joan Donald, and presented herewith in an abbreviated form for the information of the membership at large.

The candidates that have agreed to let their name stand for ORNAC executive positions are:

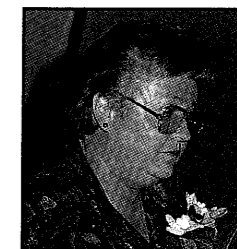
**President-Elect**  
Gatchell, Hilda  
Hughes, Anne  
Thomas-Aasen, Loretta

**Vice-President**  
Hay, Vija  
Hill, Marlene  
Hughes, Anne  
Lessing, EvaMarie  
McEvoy, Geraldine  
Simon, Marnie  
Stuttard, Darlene  
Thomas-Aasen, Loretta

**Secretary**  
No names standing

**Treasurer**  
Gatchell, Hilda  
Hill, Marlene  
McEvoy, Geraldine

**Hilda Gatchell**  
Nursing Unit Director  
Surgical Suite  
Oshawa General Hospital  
Oshawa, Ontario



Hilda Gatchell is a Founding member and Past President of the Operating Room Nurses Association of South Central Ontario. She is the Immediate Past President of the Operating Room Nurses Association of Ontario, and a member of the Board of the ORNAC from 1988 to 1992.

**Nominated Position:**  
President-Elect, Treasurer

**Goals and Objectives for ORNAC:**  
To maintain a high profile for O.R. Nursing Practice, to represent OR nurses from ALL Provinces and from ALL sizes of hospitals.

**Anne Hughes**  
Nurse Manager, OR,  
PORR and Day Surgery  
The General Hospital  
St. John's, Newfoundland



Anne Hughes was President (1987 - 1989) of the Newfoundland and Labrador Operating Room Nurses Association (N&LORNA). She has served as a Board Member (1988 - 1990) of ORNAC, and as Secretary (1990 - 1993) of ORNAC.

**Nominated Position:**  
President-Elect, Vice-President

Anne Hughes (continued)

**Goals and Objectives for ORNAC:**

-To continue the strategic planning process identifying both short and long term goals for ORNAC.

-To actively lobby for the inclusion of Operating Room nursing in basic nursing education programs, and to promote O.R. Post-Basic Education for nurses.

-To define the role and scope of practice of the O.R. nurse taking into consideration trends in health care, expanded roles in nursing, fiscal restraints and the needs of our consumers.

-To promote an environmental awareness amongst OR nurses and to work with industry and Provincial OR Associations towards reducing waste and increasing recycling of products used in the O.R.

-To foster communication and exchange of ideas between ORNAC and its members across the country, and internationally.

**Loretta Thomas-Aasen**  
Nursing Unit Manager  
Operating Room, ER,  
CSR, PACU  
St. Joseph's Hospital  
of Estevan  
Estevan, Saskatchewan



Loretta Thomas-Aasen has been a member of the Saskatchewan Operating Room Nurses' Group since 1986 and has served on numerous committees including currently as Chairperson, Provincial President. She has been a Board Member of ORNAC since 1989.

**Nominated Position:**

President-Elect, Vice-President

**Goals and Objectives for ORNAC:**

-Development of a firm base through the internal and external communication process.

-Enhancement of our image and unification through the development of an ORNAC video with related pamphlets. ORNAC advancement and visibility through the Canadian Operating Room Nursing Journal and The Canadian Nurse. Recognition of our specialty through the CNA certification process. National membership focus by means of a National (ORNAC) membership card.

-National lobbying campaign to have perioperative nursing reintroduced into the basic nursing curricula. On a National basis - research "Perioperative Nursing: Inclusion within the Basic Nursing Curricula".

-RN First Assistant and RN as Assistant to the Anaesthetist are also very important, as is waste management and how we can assist in this area.

**Eva Marie Lessing**  
Staff Nurse  
Operating Room  
St. Boniface General  
Hospital  
Winnipeg, Manitoba



Eva-Marie Lessing has been a member of the Manitoba Operating Room Nurses' Association since 1981. She served as MORNA's President from 1989-1991 and in 1989 as Conference Chairperson MORNA's Third Biennial Conference. She has been an ORNAC Board Member from 1987 to 1991.

**Nominated Position:**

Vice - President

**Goals and Objectives for ORNAC:**

-To promote the continuing education and research for all Operating Room Nurses throughout Canada.

-To ensure that ORNAC continues in developing it's role in facilitation effective communication and exchange of ideas between all Operating Room Nurses across Canada.

-To ensure that ORNAC continues to address the needs and concerns of all Operating Room Nurses in the development of policies and standards.

**Marlene Hill**  
Staff Nurse, O.R.  
Queen Elizabeth Hospital  
Charlottetown,  
Prince Edward Island



Marlene is currently President of the Operating Room Nurses of Prince Edward Island, and has been an ORNAC Board Member for past three years serving on several ORNAC committees.

**Nominated Position:**

Vice-President, Treasurer

**Goals and Objectives for ORNAC:**

-Promoting a good working relationship between all board members and executive.

-Creating a greater awareness of ORNAC at provincial and national levels.

-Help towards revising the strategic plan using realistic short and long term objectives.

**Vija Hay**  
Nurse Manager,  
OR/RR/DS  
Queensway Carleton  
Hospital  
Nepean, Ontario



Vija Hay has served as President of ORORNA and is currently President of Operating Room Nurses Association of Ontario. She is a long standing member of the Board of ORNAC and Chairman of 1994 ORNAO Conference Planning Committee.

**Nominated Position:**

Vice-President

**Goals and Objectives for ORNAC:**

-Advance Standards of patient care and facilitate O.R. Nurses to expand their knowledge.

-Collaborate with other professional organizations to maintain a position of strength.

-Be in the forefront of changes that affect O.R. Nursing/Nursing to enhance our participation in health care reform.

**Geraldine McEvoy**  
Operating Room  
Montreal General Hospital  
Montreal, Quebec

Geraldine McEvoy was previously a Clinical Instructor and Laser Safety Officer at Montreal Childrens Hospital. She has served as Co-President of the Operating Room Nurses of Quebec, and Board Member, Operating Room Nurses Association of Canada.

**Nominated Position:**

Vice-President, Treasurer

**Goals and Objectives for ORNAC:**

-Qualitative Research

-Marketing Perioperative Practice

-Education

**Darlene Stuttard**  
Manager,  
O.R. Nursing  
Saskatoon City Hospital  
Saskatoon, Saskatchewan



Darlene Stuttard was the Sole Founder of the Saskatchewan OR Nurses Group(SORNG) in 1982.

She was Provincial President of SORNG1982-91. She has been a Board Member of ORNAC (1982-1989), Chairperson of the Nominations Committee and Chairperson of the Ad Hoc Committee on Criteria for Elections and Nominations.

**Nominated Position:**

Vice-President

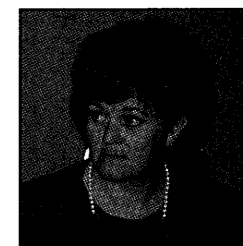
**Goals and Objectives for ORNAC:**

-In light of the economic times and financial restraints being placed on the health care system, the Executive and Board Members of ORNAC must be ready to support and lobby with all perioperative nurses to maintain our standards of nursing care. We may need to re-define our definition of perioperative nursing as it relates to other health care professionals and be prepared if necessary to act as a coordinator of patient activities, rather than a care giver.

-ORNAC must re-focus their attention on pertinent national issues and set realistic and attainable goals and objectives.

-We must continue to strive towards putting OR nursing back into the nursing curriculum and we must devise strategies toward recruitment and retention of our Canadian OR Nurses.

**Marnie Simon**  
Program Head  
OR Nursing  
British Columbia  
Institute of Technology  
Vancouver, B.C.



Marnie Simon has been a BCORNG member since 1970 and served as President from 1990-1992.

She has been an ORNAC Board Member from 1988 to 1992.

**Nominated Position:**

Vice-President

**Goals and Objectives for ORNAC:**

-Promote and expand the role of perioperative nursing in Canada.

-Conduct and promote research in perioperative nursing with the goal of improving nursing care and conditions of practice

-Collaborate with CNA to develop Perioperative Nursing Certification.

# Endoscopic Surgery Scope vs Scapel

By L. Beeston, R.N.

"Endoscopic surgical principles and techniques are established methods of therapy in medical specialties, including gynecology, urology and gastroenterology." (White, 1991) Technological advances in fiberoptics, camera lenses, lasers, insufflation equipment, coagulation devices, and accessory instruments have extended the usefulness of endoscopic surgery. Endoscopic surgery has not been utilized to its fullest potential but with the rapid progression of medical and surgical technology, the era of endoscopic surgery is nearing. The prediction is that 90% of all cholecystectomies, prostate cancer stagings, and select lung procedures; 80% of kidney removals; 70% of hysterectomies, appendectomies, and hernia repairs; plus a potentially significant number of vagotomies and bowel resections will be done endoscopically within the next five years. (Burke, 1992)

In this article it is my intention to trace the history of the endoscope and to examine where endoscopic surgery is heading. I will explain some of the present surgical procedures highlighting the advantages and disadvantages for this new minimal access surgery.

## History of Endoscopy

The remarkable advancement of endoscopic surgical technology began with man's innate curiosity of viewing the inside of body cavities and canals. This dates back to the time of Hippocrates II (460 - 375 B.C.) (White, 1991). This crude beginning involved the examination of the rectum using a rectal speculum. The vaginal speculum was first used in 65 B.C. to distinguish between vaginal and uterine bleeding and it was the first incidence of gynecological endoscopy. In 1012 - 1013 A.D. an Arab named Abulkasim used a glass mirror to reflect light into the vaginal cavity "he

was thus the first to use reflected light for the purpose of illumination and observation of the interior of a body orifice." (White, 1991). Tulio Caesare Aranzi is credited with using the first endoscopic light in 1585. His method involved using light rays entering through a hole in a window shutter then brought into focus by using a water filled round glass flask and being projected into the nasal cavity, (White, 1991). In 1805, a man named Bozzani is credited to be the first to visualize the interior of the urethra using candlelight and a tube as an endoscope. Segalis, in 1826, developed an obturator to aid in urethroscopy. 1935 saw the development of a simple cystoscope by Desormeaux and in 1869 Cornial Pantaleoni modified this cystoscope and was able to cauterize a hemorrhaging uterus with silver nitrate, thus hysteroscopy. In 1877 Nitze added a lens system. It is this lens system that is the forerunner to today's endoscopes. 1880 saw the invention, by Edison, of the incandescent lamp. In 1883 Newman utilized this lamp as a light source. 1889 saw the development of different parts on the endoscope.

Manipulation could be done via a sheath. Using this sheath, Poirex was able to successfully catheterize ureters.

By the end of the 19th century, medical practitioners were well established in the use of body orifice scopes, such as, cystoscopy, laryngoscopy, hysteroscopy and esophagoscopy.

It wasn't until 1902 that the first incisional endoscopy was performed. (The term for incisional

## Author

L. Beeston, R.N., is a staff nurse in the Operating Room at Ladysmith & District General Hospital, Ladysmith, B.C.

endoscopy being laparoscopy.) In 1910 cases of visceral exploration were being performed abdominally and thoracically using a separate needle to produce a pneumoperitoneum with filtered air. By 1912 Jacobeus had described the liver changes in cirrhosis, metastatic cancer, and tuberculosis peritonitis and predicted "a great future for laparoscopy." (White, 1991) The credit of utilizing reverse trendelenburg position goes to Nordentoft in 1912.

Up to this time period, endoscopic development was based in Europe. 1920 saw North America gain interest and become involved. Orndoff of Chicago introduced the sharp pyramid point on trocars. In 1924, Carbon dioxide was deemed the gas of choice, instead of air, because it is absorbed quickly and easily by the body and there is less chance for air emboli to occur. In 1929 a German man named Kalk devised a lense system that produced 135 degrees of viewing. He can be referred to as "the Father of Modern Laparoscopy" (White, 1991) and it was he who first utilized a second puncture.

By 1933, simple operative procedures were being combined with endoscopy. 1952 saw the development of an intense light attached to the distal end of the telescope. History slowly continued until 1968 when fiberoptics was developed. With the emergence of fiberoptic light, North America saw extensive and expanding horizons for endoscopy. The early 80's brought about the use of Carbon dioxide and Argon lasers being used in conjunction with endoscopic procedures. In 1983 the first appendectomy was performed through a laparoscope as was the cholecystectomy in 1989. Today, laparoscopic cholecystectomies are performed more routinely than the previous open method.

Current procedures being done as endoscopic (key-hole) surgery include: appendectomy, herniorrhaphy, bowel resection, hysterectomy, and hiatus hernia repair.

The advancement of endoscopic surgery started at a very crude and nonglamorous beginning a long time ago and has progressed steadily. What was once considered to be an invasive procedure is now routinely being done via the endoscope.

With all the technological advances new endoscopic

surgeries are on the horizon. In the near future, procedures done will also include kidney removal, adrenalectomies, splenectomy, and lung procedures. It is important for us as O.R. nurses to be familiar with these new instruments and their accessories. The development of surgical endoscopic instruments is still in its infancy. The cost and shortage of instruments has resulted in the use of various devices for functions for which they were not originally intended.

## Endoscopic Appendectomy

The laparoscopic appendectomy procedure is basically the same as the laparoscopic cholecystectomy. The patient is given a general anesthetic and is also injected with local anesthetic. The patient is in trendelenburg position. This procedure involves three trocar puncture sites. (See Figure 1) When inserting a trocar the surgeon feels for three separate pops and then injects some saline into the trocar to ensure placement is in the abdominal cavity and not the peritoneum. The appendix is freed from the surrounding mesentery in the usual laparoscopic manner utilizing the ESU unit. Ligation of blood vessels and nerves is usually accomplished with a surgical clip applier. Titanium clips are placed distal and proximal on such structures before they are cut. The appendix pedicle is purse string tied or cauterized and the appendix specimen is delivered from the abdomen via one of the trocar ports. Endoscopic Allis, Babcocks, and Poole suction are utilized. Before closing, the abdomen is irrigated with copious amounts of saline to detect any missed bleeders. The small trocar sites are closed in two layers and opsite is used as the dressing of choice. This method of appendectomy takes just as long as the open version but causes less trauma, and a greatly decreased risk of infection for the patient. (White, 1991)

## Endoscopic Herniorrhaphy

Approximately 500,000 hernia repairs are performed each year. (Corbitt, 1991) By the year 1995, it is estimated that 70% will be done endoscopically. All types of hernias can be done with this method. The

patient is given a general anesthetic and is injected with local anesthetic, such as Marcaine or Xylocaine. The patient is placed in trendelenburg position. This laparoscopic hernia repair involves three puncture sites. A 12 mm trocar is used with a 30 degree telescope and camera. Through complete dissection of the inguinal space, the deficit wall is brought into view. Groin anatomy is difficult so it is very important to identify landmarks, such as Coopers ligament, Iliac vessels and the Internal ring. The surgeon must be careful of the spermatic cord. Prolene and Marlex mesh may be used as a reinforcement strip. It comes in different sizes depending on the size of the deficit. It is passed into the abdomen via the 12 mm port. The mesh is fixated over the deficit area with sutures or clips. It is attached to Coopers ligament to prevent it from drifting. The area is irrigated with antibiotic because of the implant. The trocar sites are closed in two layers. Unlike the standard hernia repair, laparoscopic hernia patients can resume their usual activity level the next day and have no lifting restrictions. The adverse part of this surgery is that the patient must have a general anesthetic. In an otherwise healthy individual however, this does not pose as a problem and the benefits are outweighed. (White, 1991)

### Endoscopic Assisted Bowel Resection

Previously, the most limiting aspect of endoscopic intestinal surgery was the lack of appropriate instrumentation. Prior to 1989, manufacturers of laparoscopic equipment showed little interest in developing any instruments that were different from the existing devices. However, nowadays, there is such competition involved in this area of the market that they cannot come out with the equipment fast enough. I found the manufacturers very pleased and willing to help by providing information for this project.

Once endoscopic surgeons became experienced with the endoscopic appendectomy, they realized that the next step would be endoscopic bowel resection. It should really be termed endoscopic assisted bowel resection. The patient is under general anesthetic and also receives a local anesthetic injection for control of post-op pain. This injection is good for 12 - 16 hours. The abdomen is then distended with Carbon dioxide and a 10 mm trocar with sheath is inserted just above or below the umbilicus. The abdominal cavity is then observed via the telescope and camera. The patient is then put into trendelenburg position which moves the small bowel out of the way. Three or four more trocars

are inserted. (See Figure 1) The position of these trocars is the surgeons preference. The colon is freed using dissecting scissors and atraumatic babcock forceps. Once free, the colon is mobilized to the midline. Now, either a 40 mm trocar or a small incision is utilized and the segment of bowel is delivered out of the abdomen. The bowel is then stapled and cut using a disposable GIA staple unit. The lesion has now been excised and the bowel is end-to-end anastomosed together. It is placed back in the abdominal cavity and the area is irrigated with copious amounts of saline. The wounds are closed in the usual manner.

This method of laparoscopically assisted bowel resection cannot be performed on the small bowel. Like any other laparoscopic surgery it cannot be performed on patients with ascites or previous abdominal surgeries (as they would have adhesions and scarring). A major problem with this surgery is that it is hard to accurately identify the exact site of the lesion and as a result, there have been cases of incorrect bowel resections. On the positive side however, 70% of patients are discharged within 96 hours on a regular diet and having regular bowel movements. Average length of hospital stay for an open bowel resection is 12 days and is only six days with laparoscopic surgery.

### Endoscopic Hysterectomy

It is important to distinguish between laparoscopic assisted vaginal hysterectomy and laparoscopic hysterectomy. Presently, laparoscopic assisted vaginal hysterectomy is the most common approach. It involves the freeing of the higher abdominal structures by operating through the scope and then the procedure is finished through the vagina. The other method involves the procedure being carried out entirely via the scope. The patient receives a general anesthetic and is placed in a low lithotomy position. Four trocar ports are utilized, according to surgeons preference (See Fig.1). Surrounding the basic reproductive structures are many ligaments, arteries, and the ureters that make hysterectomy a complicated procedure. The ligaments function to suspend the uterus in the pelvis. These ligaments must be preserved in order to support the bladder once the uterus has been removed. As well, the bladder sits on top of the uterus and must be dissected down away from the uterus during the procedure. Scissors, ESU unit, dissecting forceps and irrigation is utilized. A 10 mm trocar is placed at the umbilicus. The ureters must be identified and preserved. The ligaments are identified and the tedious

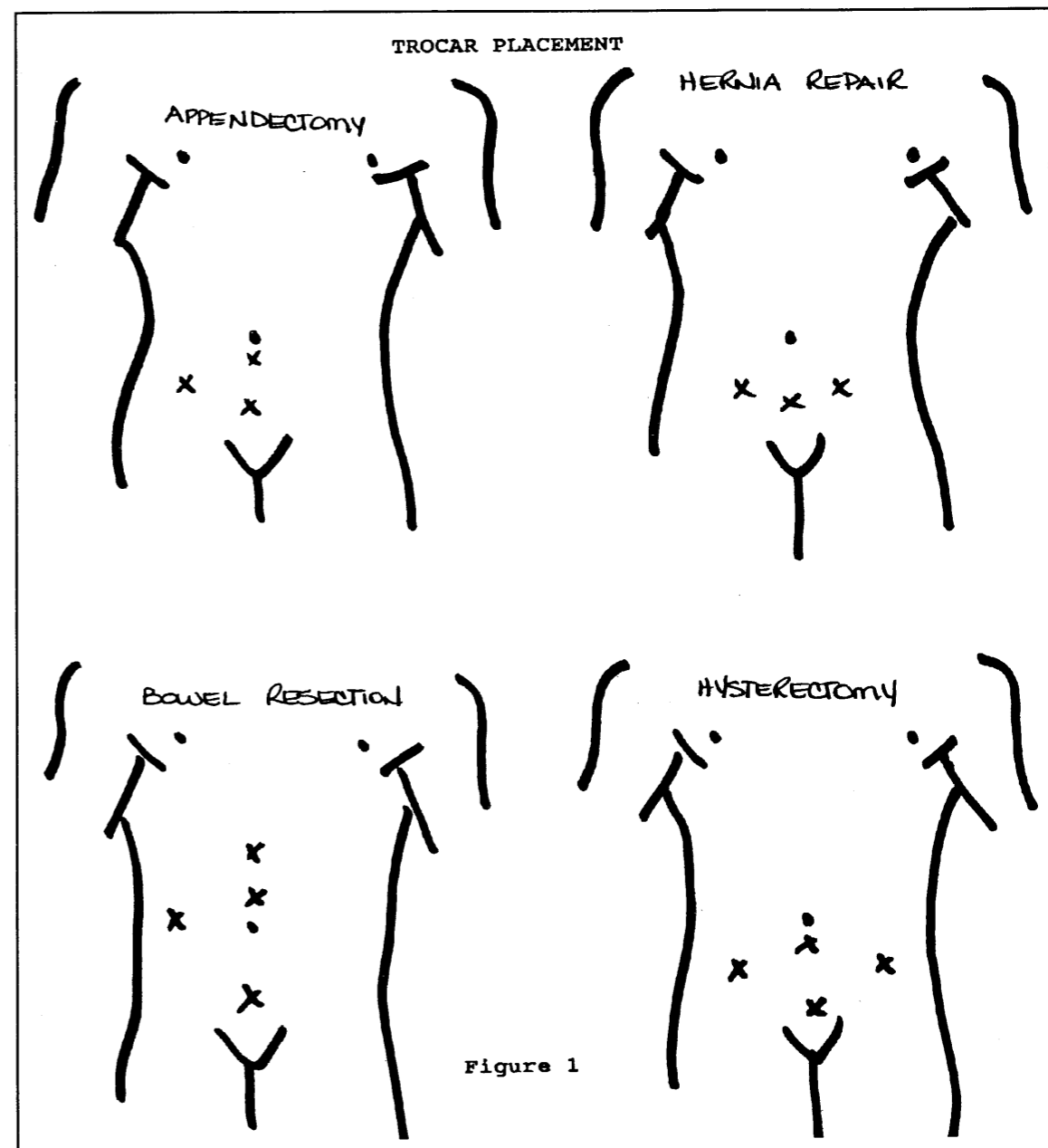


Figure 1

procedure of ligating vessels begins. Some of the ligaments are dissected and ligated (round and cardinal). Once the uterus is freed, it is removed through a vaginal incisions. The surgeon must suture the uterosacral and cardinal ligaments to the vaginal membrane to ensure good vaginal support for the bladder and other pelvic structures. The vaginal incisions is closed. The abdomen is reinsufflated and checked for bleeding.

Trocar incisions are closed and steristrips or opsite applied. There is a minimal blood loss. The laser can be utilized in this procedure. I could find very little

information on this procedure.

### The Pros and Cons

There are some general complications to endoscopic, minimal access, surgery. From an anesthetic viewpoint the patient will experience discomfort with a distended abdomen and may not breathe deeply if under a regional block. Because of this, general anesthetic is required for all endoscopic surgery.

Insertion of the verres needle has the potential of

causing some serious problems because it carries with it the 'risks of inserting a sharp object into the patients abdomen without the margin of relative safety provided by established pneumoperitoneum.' (White, 1991) The instruments are potentially dangerous and the surgeon must have a feel for the two dimensional video monitor. In laparoscopic surgery there is no depth perception.

Laparoscopic instruments are, by necessity, extremely long and thin and, therefore, can easily penetrate most abdominal organs. As long as the tip of an instrument can be seen by the surgeon, it's position can be easily adjusted. Loss of depth perception is a part of the difficulty the surgeon must overcome when learning the skill of laparoscopic surgery. The difficulties of working without the benefit of depth perception become apparent even when performing such simple tasks as dividing vessels. Endoscopic surgery is contraindicated in those patients with ascites, who are obese, or who have abdominal scarring.

The advantages of endoscopic surgery are many. The patient experiences a rapid disappearance of pain, less chance of wound infections, no wound dehiscence, no incisional hernias, and a quicker return to their daily activity level. There is less overall cost to the health care system as hospital stays are shortened. In an evermore budget conscious system, this new technology will pave the way for future surgeries. Endoscopic surgical instruments are expensive. Hospitals increase that expense by using disposable instruments (Trocars). By using reusable instruments, the cost is approximately 50% less per procedure.

## Conclusion

There are many up-to-date articles regarding new endoscopic surgical techniques. In this paper, I have explored the baseline techniques and there are, I am sure, many variances. Endoscopic surgery is obviously where medical and surgical technology is heading. The treatment mode of the future is outpatient care as much as possible. Because these procedures are new, not every surgeon may be willing to try them, or, not all who try may be skilled in the procedures. When successfully performed endoscopic surgery provides the surgical team with the means to eliminate the discomfort and the disability patients encounter while shortening surgical, anesthetic, and recovery time, and reducing overall patient costs.

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**ORNAC**

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# The Joys of Initiating Laparoscopic Surgery in a Small Rural Hospital

By Dianna Havin & Patricia Frayne

It all started with a phone call from our surgical supply representative regarding an upcoming seminar on laparoscopic cholecystectomy.

Our hospital is a 71-bed acute care facility in Peace River, a town of 7,000 with a catchment area of 16,000, situated 500 km north of Edmonton, Alberta. There are two operating theatres in our hospital and we operate each morning, doing three to five cases per day. There are three nursing positions, one full-time, one three-quarter time, and one half-time, and we rotate between circulating, scrub and recovery room duties. There are four other nurses working in the hospital who share on call duty and do relief work in the O.R. when necessary.

We had discussed doing laparoscopic surgery for several months, and after the phone call regarding the seminar, we consulted with our two surgeons and our Director of Patient Care. It was decided that the four of us, the two G.P. surgeons and ourselves, would attend the upcoming course in Vancouver in February, 1992.

The seminar included lectures for the surgeons and nurses, some together and others separately, and several presentations by our surgical supply representatives. There were also workshops on camera techniques, instruments, capital equipment, setting up the nurses tables, etc. We also attended a one day workshop in the animal lab for the nurses and doctors. The doctors rotated positions - surgeon, assistant and camera man - to gain experience with the equipment. We nurses were able to examine the instruments and handle them as well.

When we returned to Peace River, the real work began. Our physicians arranged their preceptor program with colleagues in Edmonton who were already performing laparoscopic cholecystectomies. They each

spent two weeks in Edmonton learning and doing laparoscopic surgery.

A cost comparison of six companies dealing in laparoscopic cholecystectomy systems was undertaken and three different companies were invited to attend our preceptorship weekends to demonstrate their equipment and services. The physicians were able to use two different systems while on their in-service in Edmonton, thus providing them with a wide choice of systems from which, ultimately, to choose.

We organized two preceptorship weekends. The doctors, in order to obtain privileges to perform laparoscopic cholecystectomy as approved by the College of Physicians and Surgeons, were required to perform at least six laparoscopic cholecystectomies as primary surgeon in their own hospital, supervised by a preceptor, meaning a surgeon from a teaching hospital with vast experience in performing laparoscopic cholecystectomy. This involved a lot of planning and preparation on our part and also involved most of the hospital departments.

A pre-admission program was set up, so that part of the admission process could be done ahead of time. The admitting department started the documentation and the charts the day before surgery, but the patients would sleep at home and return the following day, thus

## Authors

Dianna Havin, R.N., is the Nurse Manager of the Emergency Department and Operating Room of the Peace River Health Care Complex. Patricia Frayne, R.N., is Charge Nurse, Operating Room, Peace River Health Care Complex in Peace River, Alberta.

saving a night's stay in hospital. Consultations were conducted with the ward managers, then a preoperative instruction sheet was drawn-up to be given to the patients when they were preadmitted.

The Lab was required to do a liver profile, as well as the routine preoperative work-up. This was also done on a pre-admission basis, the day before surgery.

Central Supply had to be staffed for each weekend, and their staff had to be instructed in the special care and cleaning of the equipment. Trays were prepared for the trocars, tubings and instruments. We had to set up a whole new "Lap Incision Tray." We had a suggested set up from the surgical supply reps which was adapted to suit our doctors' preferences and our available equipment and space. (We have made a couple of minor changes since first organizing it, but that's been part of the fun.)

### The First Patient

Our very first patient was one of our full time ladies from CSR (there are two full time and two casual staff in CSR). She had her surgery on Friday and was back to work on Monday!

The Maintenance Department supplied tanks of CO<sub>2</sub> to use with the insufflator. They also helped us set up a temporary stand for the capital equipment using a video stand and an inverted laundry tub. We also had to remember to have them leave the steam on for CSR to use during the weekend (it's usually turned off at 3:00 each day and left off over each weekend).

The hospital seamstress made new laparotomy sheets for us with a larger opening to accommodate the four ports necessary for the surgery.

The laundry department had to be staffed for the weekend, too. They also made-up seven special gown packs with an extra gown for the preceptor, and four laparoscopic cholecystectomy linen bundles.

The Dietary Department was also involved. We operated all day and into the evening on Friday, and then on Saturday into the afternoon. They supplied lunches and snacks for the doctors between cases, and the nurses whenever we could grab a bite.

Both the surgical and medical wings had extra nursing personnel on duty and rooms set aside for our laparoscopic cholecystectomy patients. The pre-admission program helped a bit, as these staffs were able to do their nursing histories the day before surgery.

A schedule was drawn up for the weekend with spaces for the doctors to sign up for assistant or anaesthetist for each case, and nurses to sign up for

scrub, circulating or recovery duties. The nurse manager had done laparoscopic surgery while working in Australia before moving to the Peace River Country, and so was able to instruct the rest of the staff on the use and set-up of the equipment.

The equipment all comes apart for cleaning and the nurse has to assemble it before each case. The doctors call it our "clock maker's shop" because there are so many springs, washers, and bits to put together.

### First Preceptorship Weekend

For our first preceptorship weekend, we booked eight laparoscopic cholecystectomies - five on Friday and three on Saturday. We started at 0730 a.m. doing two dental surgeries before the Preceptor's plane arrived from Edmonton, then started the laparoscopic cholecystectomies at 1000 and finished at 2300 on Friday. We worked from 0700 to 1600 on Saturday.

There was also one emergency case, an appendectomy which turned out to be a mass in the colon. We ended up doing a bowel resection! These are not done on a routine basis in our theatre, so we were very glad of the visiting surgeon's expertise. During this weekend, sales representatives from companies selling reusable and disposable instruments were invited to show us their equipment. We alternated reusable and disposable systems, which gave us all a chance to try both and gave CSR the time to clean and sterilize the reusable equipment. This worked very well.

During our second weekend, eight cases were lined up, but two patient's were unable to make it. This still gave our physician the mandatory six cases needed for his preceptorship. This was another long two day weekend and again we alternated reusable and disposable set-ups.

Based on our surgeons' preference, a final decision was made on which system to go with. They chose the completely reusable system, but disposable instruments are kept on hand as well, for infected cases, patients with metal allergies, or if extra instruments are needed.

Our equipment arrived in August, 1992. At that time, we also purchased a new electrocautery machine, and since then, another telescope has been purchased so that we can perform two laparoscopic surgeries per day.

There is a high incidence of TB in our area, which means the telescopes have to be soaked for ninety minutes instead of just the routine twenty minutes. The telescopes are soaked for ninety minutes after use

for the tuberculocidal effect, and then only need to be soaked for twenty minutes before using them again the next day. We have also purchased the necessary equipment to perform Laparoscopic Bilateral Tubal Ligations. Again, a cost comparison was done before we chose to buy reusable instruments.

Since starting up, we have done 52 Laparoscopic Cholecystectomies, 56 Laparoscopic Bilateral Tubal Ligations, and five Diagnostic Laparoscopies between April of 1992 and February, 1993.

This has been a worthwhile learning experience and we are still discovering ways of improving our technique. One thing we had problems with was the telescope frequently fogging. Although the telescope was warmed ahead of time, after attaching the light source and camera it was kept ready by the surgeon. Now, we bring up a tray with a K-basin with hot water and keep the end of the telescope in the bath until it is inserted into the port. There has been no further problems with fogging.

This has been a most exciting time for all of us and we are proud to have been part of it. We hope the describing of our experiences will be helpful to our nursing colleagues, especially those in other small, rural hospitals. ■

## New surgical technique for breast implant surgery

"Now there is good news for women seeking breast enlargement," says plastic surgeon, Dr. Hugh McLean of the McLean Clinic, Toronto and Mississauga. He is the first Canadian to employ a "belly-button surgery" technique developed in the U.S. for scar-free breast augmentation which uses a safe, saline implant.

Through an incision in the navel, McLean manipulates an access tube under the skin to the breast area. An endoscopic fitted with a telescopic camera allows the doctor to check his progress on a television monitor. McLean manoeuvres the empty implant into place and then fills it with sterile salt water.

"I call this breast enlargement by remote access," explains McLean. "It is the leading edge in breast augmentation technology. It has a high margin for safety and leaves no visible scars - essentially 'seamless surgery'."

Tens of thousands of women have breast enlargement implants each year, says McLean. He believes this new technique will provide a much safer operation for women wanting this procedure in the '90s.

## Hearing loss may signify a brain tumor

Irreversible nerve damage can result from the delayed diagnosis of a possible cause of one-sided hearing loss, ear noise, loss of balance and other unexplained problems.

These symptoms may be early warning signals of acoustic neuroma, a slow growing tumor which attaches itself to a nerve of the inner ear. If allowed to grow it can have severe consequences, however, if diagnosed early the effects usually are minimal.

Dr. Charles Tator, one of Canada's leading surgeons, states in a recent article, "All too often patients are referred to the neurosurgeon only when their tumor has become large and has already involved the delicate surrounding nerve fibres. As a neurosurgeon with special interest in this condition I cannot stress too strongly the importance of early diagnosis."

Such marvellous advances have been made in modern surgery that this tumor, if diagnosed in an early stage, can be removed with little or no damage to surrounding nerves. The facial nerve can be monitored during surgery, sparing the dreaded loss of facial animation. Even the ear nerve can be monitored and hearing saved in some cases.

For medium to large tumors, recovery from the necessary surgery can be longterm. Complications can be almost insurmountable-severe balance problems, dry eye requiring constant eye care, difficulty talking and swallowing, headaches, total loss of hearing on the affected side and worst of all a paralysed face with resulting emotional and psychological trauma.

The Acoustic Neuroma Association of Canada is most interested in the number of patients who, in many cases, have been ten or more years receiving an accurate diagnosis. Acoustic neuroma has, until recently, been considered rare and difficult to diagnose and symptoms are often attributed to other causes. Now, however, there is an extremely accurate non-invasive test known as brainstem auditory evoked responses (BAER) which, coupled with magnetic resonance imaging (MRI), can detect even the smallest obstruction. Persons having these symptoms should insist on having this test done.

Further information may be obtained by writing to: Acoustic Neuroma Association of Canada, Box 369, Edmonton, AB TSJ 2J6. Phone: (403) 428-3384.

## Alberta marks 15th Anniversary

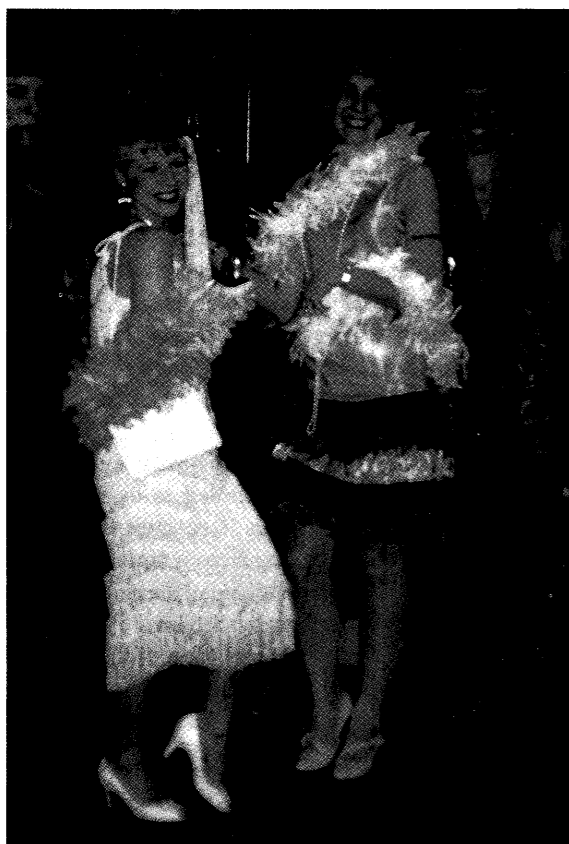
The Operating Room Nurses Association of Alberta (ORNAA) marks its 15th anniversary this year. They were organized in 1977 as an interest group of the Alberta Association of Registered Nurses (AARN). The small band of enthusiastic members has grown to an active gang of 343 in 1993. The founding president Dorothy Orr of Brooks, Alberta, is also ORNAC's National Historian.

In the March, 1993 issue of "Snips & Snaps" the association's newsletter, President Jane McClain lists the impressive accomplishments of ORNAA in the past 15 years. They include:

- Sponsored 14 annual provincial conferences,
- Produced a quarterly newsletter for its members,
- Set-up educational & bursaries for its members,
- Contributed in a major way to the development of ORNAC, including a strong role in establishing the national OR practice and technical standards, and,
- Brilliantly hosted two national OR conferences, Jasper '84 and Banff '91.

The list of ORNAA accomplishments is long and impressive. Congratulations!

Another very important notice was published in the ORNAA newsletter. It was a notice to all Alberta OR nurses to attend the April 28, '93 general meeting



of the AARN at the Edmonton Convention Centre to vote on two important resolutions. It will be interesting to hear the outcome of this vote. The resolution calls for... "AARN take the necessary pro-active steps to define advanced nursing practice in the operating room, to explore the requirements for preparation and legislation related to advanced nursing practice, and the licensing for advanced nursing practice in the operating room."

The second resolution calls for AARN to... "be pro-active in the setting of curriculum for the education of student nurses to include the operating room specialty."

In an explanatory note, ORNAA past president Sharon Balkan states: "During one of the most critical times of a client's hospitalization, his surgical intervention, a continuity of nursing services must be provided. If our students are not given this opportunity, the dilemma of recruitment is very real. We, as a profession and a core group of dedicated operating room nurses, must ensure our clients always receive this essential nursing service."

Congratulations are also in order for Muriel Shewchuk of Foothills Hospital, Calgary, who was officially honored by her peers and colleagues of ORNAA for many years of service to the profession.

Muriel's contributions provincially and nationally are extensive and she has again been chosen to represent Alberta and Canada as a speaker at the World OR Conference this September in Australia.

*Razzmatazz & all that Jazz. The 20s theme and the good sports dressed -up in sparkling flapper outfits for ORNAA's annual dinner dance. Betty LaFrenz of Calgary General and Brian Smith of J&J were well dressed as were the four flappers from Foothills Hospital shown photo left. (LtoR) Cory Coughlin, Teresa Blackwell, Karen McComb and Liz Taylor. Liz won the prize for most "authentic dress".*



**ORNAA Executive - 1992-1993.** Front row (L to R) Linda Smith, Dahlia Robinson, Jane McClain (President), Sharon Balkan, and Gloria Nemeck. Back row (L to R) Jackie Waisman, Donna Orton, Marilyn Starling, Sharon Guy, Lenore Lemire and Joan Foster.

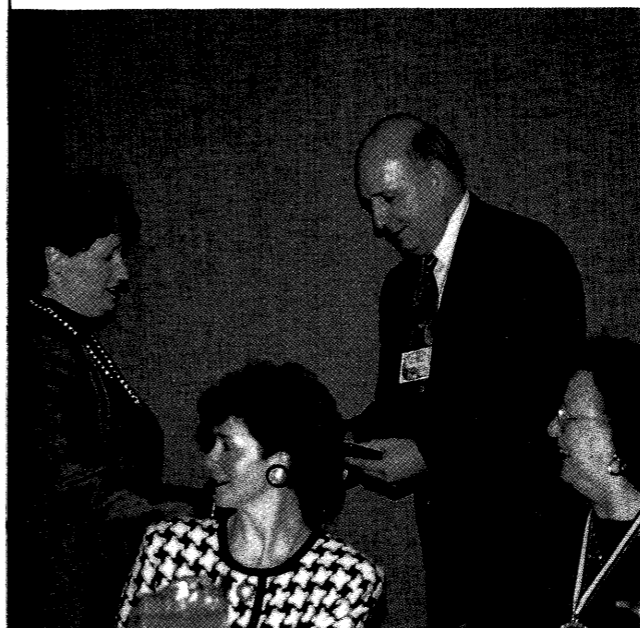
**1992 Conference Planning Committee** Photo below in their Octoberfest outfits. Front row (L to R) Carol Rolfe, Dorothy Cocks, Barb Watson. Back Row (L to R) Dorothy Gillrie, Marilee Saunders, Rosemary Strand, Sharon Guy, Isabella Nestransky and Jackie Waisman. (Photo Credit: Marg Ensminger)



Sharon Balkan, (left) hands over the gavel to ORNAA President Jane McClain

Mary Knight-Kubasiewicz (photo left) is formally awarded the Johnson & Johnson Medical Products Drake-Thompson Editorial Award at the 14th ORNAA Conference. Her winning article "Problem Solving in Perioperative Nursing" was published in the May/June, 1991 issue of the Journal.

Mary is OR Manager, Royal Alexandra Hospital, Edmonton and also won the 1988 award. The award is valued at \$3000 and is presented by Bill Morin, Vice President of Johnson & Johnson Medical Products. Looking on is Linda Price, Alberta Exhibitors Advisory Committee and ORNAC President Gloria Stephens.



## Congratulations Saskatchewan ! 10th anniversary - 1982-1992

The Saskatchewan Operating Room Nurses' Group (SORNG) celebrated its 10th anniversary last Fall during their annual conference in Saskatoon.

In 1984, Saskatchewan was the only province in Canada without an OR interest group. Dorothy Orr, national liaison officer for the National OR Interest Group, approached Darlene Stuttard of Saskatoon in March, 1982 to form a provincial Special Interest Group, the beginning of today's official organization.

Because of the vast provincial demographics, Darlene Stuttard, in consultation with Margaret Farley of Regina, divided the province into North and South Chapters and a provincial executive was formed to assist both chapters and guide the development of the group. SORNG was approved as a special interest group by the Saskatchewan Registered Nurses Association in 1984.

SORNG has encouraged continuing nursing education for all perioperative nurses in the province. Through chapter meetings and conferences, the dedicated executives have provided educational opportunities at the chapter level, the provincial level, and have sent representatives to the national board meet-

**Top Photo:** (LtoR) Judy Dilts and Marge Unterschute at the 7th annual conference. **Middle Photo:** Saskatoon City Hospital OR nurses at the conference. **Lower photo:** (LtoR) Carol Coomber, Elly Mertins and Jim Turton of Auto Suture. Lower Photo: (LtoR) Marie Brigidear, SORNG President-Elect, with Shannon Richardt of Davis & Geck, sponsors of the Anniversary publication.



**Atlantic Conference** - Last Fall Gloria Stephens, President of ORNAC, was one of the guest speakers of the Atlantic Operating Room Nurses Conference in Charlottetown, P.E.I. The conference theme was "Caring in the Age of Technology". Shown (left to right) **Carolyn Hughes**, Conference Co-Chairperson, **Gloria Stephens**, and **Marlene Hill**, conference co-chairperson and President of the Operating Room Nurses of P.E.I.

ings as well as national and international conferences.

Membership has grown from 22 members in 1982 to 122 in 1992. Although small, the group is mighty with hard working executive and an enthusiastic membership. SORNG produced a logo as well as a newsletter, *The Circulator*, in the early years of its development and continue today to meet the ever changing needs of its members. SORNG also established an educational bursary for its members.

**Darlene Stuttard**, SORNG founder, served as President from 1982 to 1990. **Loretta Thomas-Assen**, is serving the 1991-1993 term. The Group published a history of SORNG in booklet form for presentation at their September, 1992 conference.

Keynote speaker for the Anniversary Conference was **Dr. Josephine Flaherty**, Chief Nursing Officer, Department of National Health and Welfare, Ottawa. Dr. Flaherty spoke on the changes, challenges and choices facing the the OR nurse in today's complex health care services system.

Major speakers at the Conference included: **Skyla Lundgren**, Clinical Coordinator, Foothills Hospital,

Calgary, speaking on Initiating Laser Programs in the OR and in a second session the Movement to Outpatient Treatment Modalities; **Elsie Thoma**, Transplant Coordinator, Royal University Hospital, Saskatoon, on Multi-Organ Retrieval and the OR nurse; **Dr. John Conly**, Department of Medicine and Microbiology, Royal University Hospital, Saskatoon on HIV & Hepatitis; and, **Dr. Demetrius Litwin**, Department of General Surgery, Saskatoon City Hospital, speaking on Laparoscopic Surgery - Present and Future. **Pat Bailey**, St. Paul's Hospital - Basic Recovery Room Care and two other speakers from Royal University Hospital, **Sharon Griffin** on Cardiac Arrest in the OR; and **Marian Morrissey** on Pre-Operative Information Visits.

With a little encouragement from OR nurses in the hospitals mentioned, the Journal may well receive some of the conference presentations in prepared manuscript for future publication. In this way, SORNG will have two permanent records of their anniversary.

Congratulations to all the committed OR nurses in Saskatchewan who made SORNG such a success !



## The RACORSE Network

Are you concerned about waste in your OR, or interested in service to developing nations?

Are you interested with the idea of short term overseas missions, e.g. Romania, Georgia?

Involvement in RACORSE is an opportunity to act on your values, contribute your ideas, learn about hospital recycling programs and assume a key role in network development.

The RACORSE Network is a non-profit support group established to share expertise on reduction of waste in hospitals. In addition to providing supplies for non-profit use overseas, they promote ideas that encourage conservation.

The RACORSE Network is about sharing resources, people, things and ideas. The volunteers:

- (i) Gather and disseminates ideas for utilization of unneeded health care supplies and equipment.
- (ii) Share expertise on the reduction of waste.
- (iii) Encourages good stewardship of health care materials and resources.
- (iv) Support non-profit medical outreach projects to the poor of the Third World.

For further information, please contact:

**Janet Dysart, R.N. Operating Room  
Lionsgate Hospital 988-3131 Local 253**

**Fax: (604) 988-3184 Home Fax: (604) 983-3092**

When requesting a reply, please include a business size, self addressed, stamped envelope.

RACORSE was founded as a support group for people who are concerned about waste in North American hospitals, interested in protecting the environment through conservation and/or interested in service through medical outreach to developing nations.

The founder of the group is an American OR nurse, Liisa Nenonen, BSN, CNOR, from Oakland, California. Janet Dysart met Liisa at the 1992 World Conference of OR Nurses in Vancouver and was encouraged to establish a Canadian Network.

If you wish to start a project site at your hospital, please contact Janet Dysart and she will send you the necessary information and materials.

RACORSE Canada achievements to date are:

- Received a donation from B.C.O.R.N.G. of \$300 for start-up funding as well as support for the venture.
- Received many donations from manufacturers such as uniforms, sutures, and medical samples.



### Nurse Manager Surgical Suite & PARR

The Alberta Children's Hospital Child Health Centre is the principal teaching and referral facility for paediatrics in Southern Alberta. The Centre offers a diverse and comprehensive range of services including inpatient care, ambulatory care, educational research and outreach programs.

Your outstanding leadership skills and innovative approach will help you meet the challenges of assuming 24-hr authority and responsibility for the nursing unit. Your excellent interpersonal skills will allow you to work collaboratively with colleagues in surgery and anaesthesia.

You will demonstrate fiscal responsibility by adhering to the budget you set, and you will ensure the provision of quality nursing care in accordance with the philosophy, objectives and policies of the Department of Nursing. Experience in the planning of new programs, as well as evaluating and reviewing present programs will be highly valued. Management experience and proven decision-making skills are essential. You must be focused yet flexible, and be able to articulate a vision for nursing in this area.

A Master's Degree in Nursing or Health Services Administration is preferred. A Bachelor of Nursing and a minimum of five years' Operating Room experience, during which time management skills were demonstrated, are required. Paediatric experience is highly valued.

An excellent remuneration and benefits package is available.

Please forward your resume to:

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Human Resources Department, 1820 Richmond Road S.W., Calgary, Alberta T2T 5C7

*The Hospital is a smoke-free environment.*

• Sent out several small shipments. Marcy McKay of St. Vincents, Vancouver, sent a package with one of the religious sisters from her hospital who was going to Bolivia, and Janet Dysart sent two shipments to International Teams currently working in Albania.

Liisa Nenonen's definition of The RACORSE Network is as follows:

**R** - Recycling refers to appropriate medical use of opened, unused supplies and equipment currently being discarded or under utilized. It includes how to do it, determination of highest use, and in some cases, how to reprocess.

**A** - Allocation refers to the storage and handling of resources until an appropriate end-user is found.

**C** - Conservation will be promoted through increased awareness of what types of supplies are being opened and not used. Once people start developing a conservation mindset, they will approach many health care situations with new "eyes", and new habits will take root in their department.

**OR** in RACORSE means "operating room", but all these principles can be applied hospital wide. ■



### OPERATING ROOM & O.R. BOOKING NURSES

#### Required for Operating Room Expansion

R.N. candidates must have recent operating room experience and be eligible for R.N. registration in B.C. O.R. Booking Nurse relief position also available for experienced candidate.

Please apply to:

**Betty Graham  
Human Resources Officer  
M.S.A. GENERAL HOSPITAL  
2179 McCallum Road  
Abbotsford, B.C.  
V2S 3P1**

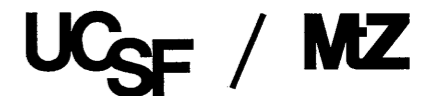
## OR Nurses



Join the OR Nurses at the University of California, San Francisco or UCSF/ Mount Zion and you'll enjoy:

- being a part of the University of California statewide hospital system.
- state-of-the-art technology in your area of expertise.
- expanding services and number of suites.
- a variety of educational programs and paid educational leave.
- an on-staff OR Nurse Educator.
- outstanding benefits for nurse and dependents beginning at date-of-hire.
- an active clinical ladder.
- an excellent retirement plan.

Scrubbing and circulating experience is required. To find out more about opportunities at UCSF, contact Lynda Purves, Nurse Recruiter, UCSF Medical Center, Department of Nursing, Room L-171, San Francisco, CA 94143; or call COLLECT (415) 476-2252. For opportunities on the Mount Zion site, contact Elly Krause, Nurse Recruiter, UCSF/ Mount Zion, 1600 Divisadero, San Francisco, CA 94115, or call COLLECT (415) 885-7877. As an Affirmative Action/Equal Opportunity Employer, the University of California is committed to a diverse workforce.



**R I C H I N D I V E R S I T Y**

## Conference Calendar

### Quebec City - Quebec 13th National O.R. Nurses Conference.

June 6th -11th, 1993

"Comprehensive approach to care:  
A beacon in a world of automation "

Contact: Forum Quebec  
30 Grande Allee Ouest  
Quebec, PQ GIR 2G6  
Tel: (418) 5248093

Attn: Steve Marchessault

### The 5th Windsor & District O.R. Nurses Association Conference

"Challenged by Change"

The Cleary Auditorium,  
April 23 & 24, 1993

Contact: Henrietta Thurston (519) 735-1928  
Pat Busted (519) 979-3973  
Judy Doherty (519) 737-6740

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

at the Ramada Renaissance Hotel,  
1919 Saskatchewan Drive Regina, SK

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 brings (20) years of practice, teaching and research in the field of operating room nursing and author of *Operating Room Nursing the Perioperative Role*.

For further information please contact:

Ms. Marie Brigidear  
#308 - 193 Rink Avenue  
Regina, Saskatchewan, S4R 7V3  
Phone: (306) 949 - 7493 (Home)  
(306) 359 - 4252 (Regina General)

### World Conference of Operating Room Nurses - VIII Sponsored by AORN September 6-10, 1993 Adelaide, Australia

Canadians attending this conference and who wish to join in the celebration of Fellowship night and comply with the request to be dressed in a manner to signify your country - the Canadian Mountie shirt and hat can be purchased at a cost of \$20.00 through ORNAC President Gloria Stephens. See page 16.

### Operating Room Nurses of Alberta 15th Annual Conference October 20 - 23, 1993.

Convention Centre, Calgary, Alberta.

Keynote Speakers: Barb Higgins & Pat Pitzel  
Feature Topics include: Imposter Syndrome, Humour in the Workplace, Environmental & Biohazard Issues, Canadian Nurses Protective Society, Trauma Care in Southern Alberta, Research, TURP Syndrome and Pain Control. Contact:

Joan Foster, Chairperson  
(403) 670-1377 or (403) 259-2193

### Operating Room Nurses' Association of Hamilton and District

Regional conference - October 22 & 23, 1993.  
White Oaks Racquet Club, St. Catharines.  
Theme: Champions of change uniting for a better future.

Registration Contact: Charlene Smith  
Milton District Hospital  
Phone: (416) 878-2383

## 1994

**Operating Room Nurses of Ontario**  
3rd Provincial Conference - April 25 - 27, 1994,  
Ottawa Congress Centre, Ottawa, Ontario.

**B.C.O.R.N.G. 14th Biennial Conference**  
June 2 - 4, 1994, VERNON, B.C.  
Contact: Trish Allen, 4108 - 14th St., Vernon, B.C.  
VIT 8B9 Phone: (604) 542-2418

**ORNAC -14th National Conference**  
Vancouver, May 8-12, 1995  
**ORNAC -15th National Conference**  
Ontario, 1997.

**FAST AND EFFECTIVE  
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**PLEASANT SCENT**

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- MetriZyme, a unique, fast acting liquid enzymatic detergent, dissolves organic solids on instruments and equipment prior to disinfection/sterilization.
  - ColdSpur kills all vegetative organisms, including TB in just 12 minutes at room temperature (1:20 dilution), sterilizes in 10 hours (1:5 dilution), and makes quick work of HIV-1 in a mere 30 seconds.\*
- When every minute counts, count on MetriZyme and ColdSpur, a sign of the times!

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\* See HIV Bulletin #7. MSDS, Testing and Efficacy Data on file.

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## 13<sup>e</sup> Conference Nationale des Infirmières et Infirmiers de Salles d'Operation, du 6 au 11 juin, 1993

*"Vision Globale Des Soins: Phare au milieu De L'Automatisme"*

### Dimanche, 6 Juin

Visite de Centres Hospitaliers et brunch a l'île d'Orleans; Ateliers scientifiques; Inscription - Foyer du Centre des Congres  
Soiree: Elixirs et Frivolites.

### Lundi, 7 Juin

Inscription - Ceremonie d'ouverture  
1- Silence... maintenant on se parle: **Agathe Riverin**  
2- Lithotriptic par ondes de choc extra-corporelles: **Dr. Bruno Laroche**  
3- Du ronflement au syndrome des apnees du sommeil: **Dr. Frederic Series**

#### Ouverture des kiosques

1- Ethique: Le savoir-faire avec art et dexterite: **David Roy**  
2- Silence... maintenant on se parle: **Agathe Riverin**  
3- Responsabilite et imputabilite de maintenir sa competence: **Gloria Stephens**

Soiree Johnson & Johnson -  
Salle de bal Quebec Hilton.

### Mardi, 8 Juin

Inscription  
1- La chirurgie etincelante: **Denis Chabot**  
2- Diagnostic des soins infirmiers; j'ai pas le temps!: **Lina Rahal, Danielle Schmouth-Valois**  
3- Glisser, rouler sans forcer: **Raynald Larouche**  
1- Le laser et la securite: **Nicole Fortin**  
2- Tu dors, je veille: **Yves Arcand**

3- Les points de pression: J'y vois: **Lise Boillard**  
1- Action neurone vers l'an 2000,  
2- Demystifier l'antre operatoire,  
3- Au travail que faites-vous avec vos emotions et vos sentiments profonds: **Yvon Bureau**

Soiree: **La Magie Du Romantisme a Travers Les Epoques** - Salle de bal, Chateau Frontenac.

### Mercredi, 9 Juin

Inscription  
1- Nouveau paradigme: Les precautions universelles: **Louise Monette**  
2- Au nom de la loi: **Fay Rozovsky**  
3- La selection des dechets - pas seulement pour les villes  
1- Assistance operatoire: Un nouveau role attrayant pour l'infirmiere en perioperatoire: **Jane C. Rothrock**  
2- L'informatisation des dossiers au bloc operatoire: **Kathryn Hannah**  
3- Centre de jour: **Raymonde Auclair**

Apres-midi (libre) Mieux-etre et qualite de vie.  
Soiree Amsco - Casino et danse sur le fleuve St-Laurent.

### Jeudi, 10 Juin

Inscription  
1- L'endoscopie abdominale: **Eric Poulin, Denise Hamel**  
2- L'approche alternative, est-ce

possible en pre et per-op?: **Sylvie Auger**  
3- La reutilisation de l'uniservice- Qui en prend la responsabilite?  
1- Au nom de la loi: **Fay Rozovsky**  
2- Controle statistique de la qualite des soins, un modele operationnel applique au bloc operatoire: **Rita Martel, Francoise Latouche**  
3- Robotiser ou humaniser l'accueil: **Marie-Therese Caron**  
1- L'infirmiere a-t-elle toujours sa place en anesthesie?: **Yan White, Gloria Stephens, Jack Kriss**  
2- L'infirmiere riche ou pauvre: **Marcel Roberge**  
3- Abus verbal: **Jean-Claude Blondeau**

#### "Soiree Champetre"

### Vendredi, 11 Juin

Conference de fermeture "Au-dela de la technique, il y a l'equipe". Ceremonie de cloture. Brunch de l'au revoir. Un service de traduction simultanee sera offert pour toutes les conferences.  
L'inscription au congres et la reservation d'hotel doivent s'effectuer par l'intermediaire de:

**Forum Quebec**  
30 Grande Allee Ouest  
Quebec, PQ, G1R 2G6  
Tel.: (418) 524-8093  
Att.: **Steve Marchessault**

Annulation: Les demandes d'annulation d'inscription seront recues jusqu'au 22 mai 1993. Un cout administratif de \$20.00 sera retenu.

## 13th National Operating Room Nurses Conference Quebec City, June 6th to 11th, 1993

*"Comprehensive Approach to Care: A Beacon in a World of Automation"*

### Sunday, June 6

Hospital visits; Brunch at Ile d'Orleans; Workshops; Registration at the Convention Center.  
Evening: Elixirs and Frivolities

### Monday, June 7

Registration - Opening ceremony  
1- Silence... Let's talk,  
Speaker: **Agathe Riverin**  
2- Lithotripsy by extra-body shock waves: **Dr. Bruno Laroche**  
3- From snoring to sleep apnea syndrome: **Dr. Frederic Series**

#### Opening of exhibits

Afternoon Sessions:  
1- Ethics: Savoir-faire with art and dexterity: Speaker: **David Roy**  
2- Silence... Let's talk. Speaker: **Agathe Riverin**  
3- Competency and life long learning. Speaker: **Gloria Stephens**

**Ethicon Evening**  
presented by **Johnson & Johnson, Medical Products.**

### Tuesday, June 8

Morning Registration  
1- Glittering surgery: Speaker: **Denis Chobot**  
2- Diagnostic nursing; no time: **Lina Rahal, D. Schmouth Valois**  
3- Slide and roll without lifting: **Raynald Larouche**  
1- Laser and security: **Nicole Fortin**  
2- You sleep, I watch: **Ives Arcand**  
3- Pressure points: I see to it: Speaker: **Lise Boillard**

1- Neuron action towards the year 2000  
2- Enlightening the world of surgery  
3- At work, how do you manage your feelings: **Yvon Bureau**

#### Evening

**The Magic romance Throughout the Centuries** - Ballroom, Chateau Frontenac.

### Wednesday, June 9

Registration  
1- New paradigm: Universal precautions, **Louise Monette**  
2- Legal aspects, **Fay Rozovsky**  
3- Garbage selection - not only for cities.  
1- First assistant: An exciting new role of the perioperative nurse: **Jane C. Rothrock**  
2- Computerization of records in O.R.: **Kathryn Hannah**  
3- Day Centre: **Raymonde Auclair**

#### Free afternoon

**Amsco Evening** - Casino and dance on the St. Lawrence River.

### Thursday, June 10

Registration  
1- Abdominal endoscopy: **Eric Poulin, Denise Hamel**  
2- Alternative approach: Is it possible in pre and post-op? Speaker: **Sylvie Auger**  
3- Reusing disposables: Whose responsibility is it?

1- Legal aspects: **Fay Rozovsky**  
2- Statistical quality control an operational model applied in the O.R.: **Rita Martel, Francoise Latouche**  
3- Robotizing or humanizing the reception: **Marie-Therese Caron**  
1- Is the nurse still needed in anaesthesia? **Yan White, Gloria Stephens, Jack Kriss**  
2- Rich or poor nurse: **Marcel Roberge**  
3- Verbal abuse: **Jean-Claude Blondeau**

#### "Country Evening"

### Friday, June 11

Closing conference "Beyond technology, the team", Closing ceremony/Farewell brunch  
Three (3) sessions will be held simultaneously. All conferences are translated.

Registration to the Conference and hotel reservations must be made through:

**Forum Quebec**  
30 Grande Allee Ouest  
Quebec, PQ, G1R 2G6  
Tel.: (418) 524-8093  
Att.: **Steve Marchessault**

Registration cancellation requests will be accepted up to May 22, 1993. A \$20.00 administrative fee will be charged.

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