Canadian Operating Room Nursing Journal

Volume 9, No. 3, September/October, 1991

Special Issue

CARDIAC SURGERY

Disposable barrier products offer effective barrier properties . . .
But at a cost . . .

Now . . . effective barrier properties are available in reusable products and at a much lower cost.

GORE-TEX™ barrier Surgical Gowns and Drapes . . . an environmentally conscious alternative to traditional barrier products.

Lac-Mac Limited, 425 Rectory Street, London, Canada N5W 3W5
(519) 432-2616 or (313) 982-3730

Distributed in the U.S. by:
Haag Inc., P.O. Box 750, Arlington Heights, Illinois 60006-0750
1-800-323-7886

GORE-TEX barrier is a trademark of W.L. Gore & Associates, Inc.

Canadian Operating Room Nursing Journal

Published by Health Media Incorporated

Volume 9, Number 3, September/October, 1991

Editorial Staff

Editor: Agnes Forster

Legal Writers: Lorne Rozovsky
Fay Rozovsky

Editorial Board
Hilda Gatchell, R.N.
Head Nurse
Oshawa General Hospital, Oshawa, Ont.

Judith Wheeler, R.N.
O.R. Supervisor
Hotel Dieu Hospital, Perth, New Brunswick

Advertising Staff
Ron Forster
Publisher & Advertising Manager

Canadian Operating Room Nursing Journal,
14453 29A Avenue
White Rock, B.C.
V4A 9K8
Phone: (604) 535-7933
FAX: (604-535-9000

Subscription Rates:	1 Year	2 years
Canada	$ 16.00	$26.00
United States	$ 22.00	
Other Countries	$ 26.00	
Single Copy orders	$ 5.00	

Add GST @ 7% to all orders.

I.S.S.N. 0712-6778
Second Class Mail Reg. No. 5934

Contents

Projecting Ourselves As Professionals 4
ORNAC's president, a clinical instructor at St. Paul's Hospital in Vancouver, encourages nurses to start marketing themselves as professionals and to take a business approach to their careers.
By Gloria Stephens, ORNAC President

Angioscopy 6
The angioscope has emerged as a powerful diagnostic tool in this last decade. The implications and complications of this expanding technology are discussed along with the post operative nursing care of vascular surgery patients.
By Marge B. Lovell and Kenneth A. Harris

Atrial Myoxoma - A Dramatic Tale! 11
A warm and fascinating story about a young working mother who suffered an atrial myoxoma. This case history traces the patient prior to diagnosis through to emergency surgery.
By Elizabeth Harris

A Cardiac Arrest Policy 14
The description of the process in the development and implementation of a Cardiac Arrest Policy for the Operating Room, including a copy of the policy, the nursing record and a sample of the cardiac arrest data form.
By Judi Tyndall

The Surgeon and the Nurse Share the Blame:
A case of a retained sponge 20
The courts found the nurses negligent for failing to keep a proper count and the surgeon negligent for failing to order a formal count before closing in the case of Frandle vs MacKenzie.
By Lorne E. & Fay A. Rozovsky

Conference Calendar........ 13
ORNAC Standards 13
OR Nurses Day................ 13
Author's Information 22
News 19
Banff '91 Conference .23-30

Projecting Ourselves As Professionals

By Gloria Stephens

We are entering a new era in which nursing must assume its rightful place as a leader and a change agent in the health care field. We must be watchful of our professional role in the operating room, and not abdicate any of the patient care responsibilities. As nurses we can either accept the challenge to fight for our rightful place in the health care system or continue to perpetuate the current system. When accepting the challenge of change we must be prepared to accept and use new responses and put aside old strategies.

In the words of Doctor Earle Scarlett, "... any profession worthy of the name must forever be strengthening, and recreating its traditions. A profession is a sensitive, organic, growing thing, not a static order...". We therefore, must be prepared to advance into new and different roles as professional operating room nurses. The strategic plan of the Operating Room Nurses Association of Canada indicates many issues for the operating room nurse. To mention a few: waste management/environment; certification; expanded role of the O.R. nurse as Assistant to the Anaesthetist; and R.N. First Assistant, and, research activities. Another issue is to increase the professional status through education.

Scientific research is an essential element in a professional's education says Barbara K. Miller in "Model for Professionalism in Nursing". She further states, "educators have proclaimed this for decades but its difficult to convince the masses".

Characteristics essential to a professional include:

- Practising under the CNA Code for Nurses
- Giving service to the Community
- Participating in Professional Organization
- Autonomy
- Sharing knowledge thru speaking and writing (Publication/Communication)
- Participating in Research
- Continuing one's Education and promoting Competencies and certification

It is vital that each operating room nurse does more than just the daily work routines; we must broaden our perspectives; keep "on top" of the changes, and proposed changes within nursing as well as the role of the OR nurse in the operating room. We must be proactive rather than reactive. It is time for all nurses to critically examine their acceptance of certain "tenets" of professionalism.

Start marketing yourself as a professional:

1. Take a business approach to your career.
2. Develop writing skills - (publish in journals, present papers).
3. Learn to dress for power and success (your clothes make a statement about you).
4. Define what we do in a creative manner.
5. Market the "package" to the patient and other healthcare workers, e.g. O.R. Nurse day - Nov. 14th.
6. Enhance the professional image (portray OR nursing as a career for persons desiring power, status, respect, opportunities and job satisfaction).
7. Keep abreast of trends (take courses, certification exams).
8. Serve as a mentor/preceptor in the clinical areas.
9. Professional development - (serve on committees, make your name known-positively).
10. Keep an up-to-date resume. Use self-development inventory.
11. Portray a professional image whether on duty or off. (Appearance is a major part of wellness, but many health care professionals look more like illness models. Guard your health. We are so busy caring for others that we neglect ourselves).
12. Be able to "sell yourself". Always present your ideas and yourself positively and *take risks.* Living creatively eliminates failure. Invest in yourself.
13. Keep trying to visualize your goals. Set goals and then make plans to achieve them. Instead of waiting take charge and make things happen. Don't be a victim of life, be an initiator. Make dreams come true.

Ask yourself these questions:

- Where are we in the profession of nursing.
- How and where do I want to go in nursing? How do I want the profession of nursing to develop?
- What are my priorities; for my nursing career; for my profession of nursing?

"What's in a name?"

Since 1919, the name "Johnson & Johnson" has meant many things to health care professionals. Quality. Value. Service. And above all, a firm dedication to serving your needs.

Continuing this tradition, the Johnson & Johnson medical and surgical specialty franchises have joined forces as a new company to provide the benefits of dealing with a single supplier. In addition to bringing you the quality products you have come to expect, Johnson & Johnson Medical Products offers the convenience of one number to call, one monthly statement, and one payment to process.

In days to come, we will continue to anticipate and respond to your needs, working in partnership with you to build a healthier future for us all.

What's in our name?

Nine well-known franchises dedicated to serving the needs of Canadian health care institutions.

Codman*
CRITIKON*
ETHICON*
iolab*
Johnson & Johnson HOSPITAL SERVICES
Johnson & Johnson INTERVENTIONAL SYSTEMS
Johnson & Johnson MEDICAL CANADA
ORTHOPAEDIC DIVISION
PATIENT CARE DIVISION
SURGIKOS*

Johnson & Johnson
MEDICAL PRODUCTS

1421 LANSDOWNE WEST, PETERBOROUGH, ONTARIO K9J 7B9

*Trademarks

IN TUNE WITH TOMORROW

Angioscopy

By Marge B. Lovell, and Kenneth A. Harris

History

Angioscopy or Cardioscopy,as it was first called, is a technique for direct visualization of the inside of blood vessels and heart.The first recorded endoscopic cardiovascular procedure was in 1913 by Rhea and Walker[1] when they attempted cardioscopy in dogs.Intra cardiac surgery and the development of the cardioscope paved the way for the development of the angioscope.The first clinical studies of arterial endoscopy were done by Pinet et a1,[2] who tried to look inside blood filled unclamped vessels by perfusing them with saline. Early attempts at peripheral vascular endoscopy in dogs were done by Greenstone et al in 1966[3];using a flexible choledochoscope in live dogs and in human cadaver aortas; blood flow was temporarily obstructed with a clamp and saline was used to clear the field for better viewing. No further studies are documented until 1974; when Jorge Vollnar, by using a variety of instruments was able to define the basic principles of vascular endoscopy.[4] A pressure infusion of saline was used to clear the field after a clamp or balloon catheter had arrested inflow. Carotid endoscopy in cadavers was studied by Olinger in 1977.[5] He found that vessels that appeared normal by arteriography frequently contained plaques and thrombi;this proved to be a significant advance in the diagnosis and management of carotid artery disease and strokes.

Abstract

Over the past three to four decades vascular surgery has experienced increasing interest and rapid growth.This surgical speciality continues to show an annual increase in the number of procedures performed,and demonstrates increasing use of innovative technology. The author explains how the angioscope has emerged as a potentially powerful diagnostic tool for today's vascular surgeon. Its implications, complications and the post operative nursing care for the patient undergoing angioscopy will be discussed.

Current Use

Today the angioscope is widely used by the vascular surgeon in a variety of clinical settings.It is used: intraoperatively to identify technical errors, particularly of anastomoses and endarterectomy sites; following laser angioplasty for native artery visualization- areas not well seen by angiography. It is very useful in insitu vein bypass assessment intraoperatively and allows immediate correction of technical errors and elimination of missed valves during surgery. It allows the vascular surgeon direct inspection of vessels post embolectomy and thrombectomy.

The angioscope permits the surgeon to identify intraluminal pathology and gives further insight to areas of restenosis and late graft failure. Angioscopy promises to provide an efficient and practical alternative to arteriography as demonstrated in Table 1. Perhaps the most important disadvantage of angioscopy compared to arteriography is that it does not provide full visualization of the runoff vessels - for example after femoral tibial reconstruction or embolectomy.

Authors

Marge B. Lovell R.N. and Kenneth A. Harris M.D., FRCS(C), F.A.C.S., are with the Division of Vascular Surgery, University of Western Ontario, Victoria Hospital in London, Ontario.

Table 1
Advantages

Angioscopy	Arteriography
- 3 Dimensional	2 Dimensional
- Colour	Black and White
- No contrast used	Contrast used
- No radiation exposure	Radiation exposure
- Direct visualization of anatomic detail and clots	Not seen by angio
- Defects can be corrected under direct visualization	Cannot be done by angiography

Current State of Art Technology

The basic components of an angioscopic system consist of a flexible fiberoptic scope, a light source and an irrigation system. Together these create the image that allows the vascular surgeon direct visualization of arteries and veins. Television cameras, monitors and video recorders expand the utility of the angioscopic system by providing permanent recording for display and educational purposes.

The flexible angioscope is used today. They range in size from 0.55 to 0.95 mm. in external diameter to access vessels from 0.7 to 1.8 mm. in internal diameter. Each angioscope is composed of a central viewing bundle containing 4000 to 8000 fibers and a concentric ring of illuminating fibers.

Heparinized saline(1000 units/1000 mls) is used as an irrigating solution delivered by a pressurized system with a catheter placed into the lumen. The angioscope is inserted through proximal or distal arteriotomy sites, synthetic graft material, distal anastomoses or venous graft side branches before release of proximal vascular control. By gentle rotation the scope is guided, advanced, withdrawn and the vessel is externally manipulated . This procedure is currently done in the operating room, during peripheral vascular surgery and with further technological advances, it could potentially reduce graft failure and improve limb salvage rates.This is used in some centres to replace on table or completion angiography.

Complications and Postop Nursing Care

Vascular Endoscopy is associated with few complications when performed by experienced investigators. Also with the advent of smaller scopes there has been less damage to vessels studied. Complications of endoscopy can be divided into three categories: systemic, traumatic and ischemic. Systemic include infections and sepsis from the use of the device, as well as fluid overload because of the need for irrigation fluid to clear blood so the vessel can be visualized. Following revision of the procedure and the introduction of a closed perfusion system, this has ceased to be a problem[6].

The development of miniature cameras which allows the image to be projected onto a television monitor is an advance, the surgeon no longer has to worry about contamination between his periorbital tissue and the scope as it is manipulated in the artery,and everyone in the operating room can view the study simultaneously. Also the fact that most vascular surgeons use prophylactic antibiotics probably contributes to the low incidence of infection.

Fluid overload is probably the greatest problem encountered in vascular endoscopy, because of the need for obtaining a bloodless field that allows clear visualization. Even the smallest amount of blood obscures the vision and prevent precise evaluation of the luminal surface. Several techniques have been designed to prevent this problem; the easiest and most straightforward is to perform endoscopy on an isolated vascular segment. The type of procedure that I speak about would be the carotid endarterectomy and distal bypass to the lower extremity; the amount of irrigating fluid used is minimal because the residual blood in the vessel can easily be irrigated away,and none of the irrigation fluid reaches the patients intravascular space. Another technique to avoid fluid overload is a fluid filled balloon, which when inflated prevents antegrade flow. Generally the infusion is limited to 500 mls. of normal saline and the procedure is performed in less than five minutes.

Vessel injury or traumatic complications

It is easy to see how passing a foreign body into vessels can cause trauma such as perforation endothelial damage, spasm, embolization, thrombi or hemorrhage.Vessel complications of vascular endoscopy are obviously related to the size of the scope in relation to that of the vessel. From reviewing literature reports of studies there have actually been

THREE OLYMPUS SCOPES THAT FULFILL THE PROMISE OF PRACTICAL ANGIOSCOPY

Through the use of advanced 8-micron fibers, and optical technology derived from microscope and camera research, Olympus has developed three ultrathin fiberscopes *designed specifically for angioscopy*.

Ultrathin Angioscopes

PF-22 Steerable – 2.2mm Diameter

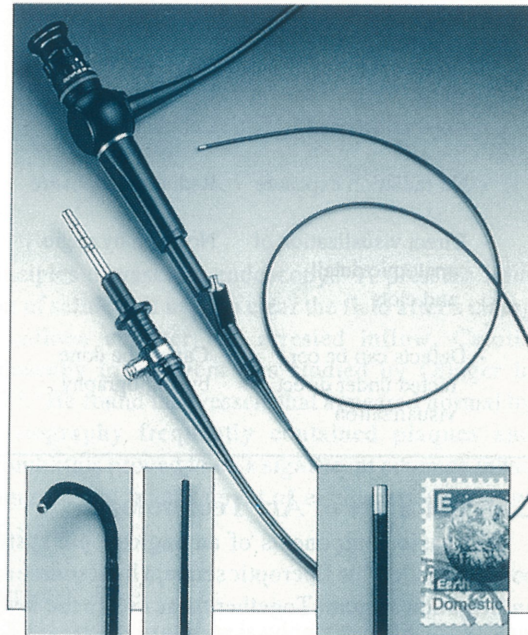
The PF-22 is the first angioscope offering a steerable distal tip with 240° angulation. The tip is precision-controlled from the handle, enabling the surgeon to easily negotiate vessel branches and bends. PF-22 is particularly useful for accessing vessels in the trifurcation below the knee.

PF-14 – 1.4mm Diameter

The PF-14 is the thinnest Olympus angioscope. It is designed to access the smaller vessels while maintaining the best possible image.

PF-28 – 2.8mm Diameter

The PF-28 contains a built-in 1.0mm channel, for irrigation. This self-contained irrigation channel avoids the need for introducing a catheter, reducing the number of separate parts and improving ease of handling.



OLYMPUS Angiopump™

Olympus meets the challenge of maintaining a blood-free visual field with the Angiopump™. This foot-controlled instrument has an adjustable flow feature to begin with a high flow rate, then maintain clarity of vision using the lowest flow possible. Thus, you are in direct control over the amount of irrigation fluid used for optimal results.

OTV-S2 CCD video camera

For use with all three Olympus angioscopes, the new OTV-S2 is *four* times brighter and provides a working distance *double* that of previous models. The OTV-S2 combines the qualities of "light" and "bright" to deliver ease of use and maneuverability. It is also fully immersible and can undergo ETO sterilization.

A complete system for all your angioscopy needs

In addition to angioscopes, Olympus supplies all components needed for the procedure. Only Olympus brings angioscopy to full fruition—there is no need to remember any other name.

CARSEN GROUP INC. MEDICAL INSTRUMENT DIVISION

151 TELSON ROAD, MARKHAM, ONTARIO, CANADA L3R 1E7 TEL: (416) 479-4100 • FAX: (416) 479-1610

very few vascular injuries. In a series of five hundred operations, Vollmar reported no vessel complications[7]. White et al reported transient vessel spasm in three patients (12.5% of their series) when the angioscope was introduced into tibial vessels[8]. From our experience endothelial damage is the most frequent complication, and this may lead to early or late postoperative graft thrombosis.

Ischemic complications consist of those related to the effects of partial or total occlusion of the vessel being evaluated. The areas primarily affected are the central nervous system, the renal arteries and the heart.Ischemia is not usually a factor in the leg, which can tolerate ischemia for several hours.

Post operative nursing care of these patients include: assessing the incision, extremity evaluation for pulses, warmth etc, vital signs, wound care and special emphasis on the above mentioned complications. Careful attention must be emphasized to fluid overload, which may not occur for several hours post op.The need for continued education and follow up is very important for these patients as for all peripheral vascular patients.

Care of Equipment

Angioscopy equipment is expensive and delicate,therefore it is mandatory that nursing personnel are aware of the care of the angioscope. One should always handle the angioscope carefully. Squeezing, kinking, or stretching should be avoided,as the glass fibers break easily. Do not allow the scope or the light cable to hit any hard surfaces.The light cable should be grasped by the strain relief handle only. When not in use, the angioscope and the transport channels should be rinsed to prevent drying of foreign matter. The light source should never be left on when not in use, since it may come in contact with surgical drapes that could be flammable.The equipment should be cleaned with a mild detergent and rinsed and dried well.Protective caps or vents on the scopes must be used when immersing them in solution or sterilizing them in gas. Instruments should be placed in containers for sterilization.The camera lens must be kept clean and dry. Although no medical devices are indestructible the life expectancy of the angioscope will be increased significantly by careful handling.Some hospitals appoint special nursing teams to care for delicate endoscopy equipment.

Conclusion

In summary,vascular endoscopy is in a phase of rapid development with refinements occurring in both techniques and equipment. Angioscopy now allows for further diagnostic and therapeutic intervention in vascular surgery. This field is only beginning to unfold and holds great hope for the future for the vascular surgeon and all vascular surgery patients.

References

(1) Rhea L. and Walker I.G., The surgical treatment of mitral stenosis: Experimental and clinical studies. *Arch. Surg*. 9:689,1924

(2) Pinet F., Archimbaud J.P., Problems posed by cardiovascular endoscopy. *Presse Med*. 74:351,1966

(3) Greenstone S.M., Shore J.M., Heringman E.C., Massell T.B.: Arterial endoscopy (Arterioscopy). *Arch. Surg*. 93:811-812,1966

(4) Vollmar J.F., Storz L.W. Vascular endoscopy: Possibilities and limits of its clinical application. *Surg. Clin. North America*. 54: 111,1974

(5) Olinger C.P.: Carotid artery endoscopy (Autopsy). *Surg. Neurol*. 7:7-13,1977

(6) Vollmar J.F., LoePrecht H., Hutschenreiters: Advances in vascular endoscopy. *Thorac Cardiovasc. Surg*. 35:334-341,1987

(7) Vollmar J.F., Storz L.W. Vascular endoscopy: Possibilities and limits of its clinical application. *Surg. Clin. North America*.54 111,1974

(8) White G.H., White R.A., Kopchak G.E., et al: Intraoperative video angioscopy compared with arteriography during peripheral vascular operations. J. *Vasc. Surg*. 6:488-495,1987

OPERATING ROOM.

Ontario's northern communities have room.

Room for a better quality of life. Room for you to discover a richer quality of practice as well.

Discover a community with modern health clinics, hospitals and other facilities, set against a backdrop of clear lakes and lush forests.

There are rewarding opportunities for a wide range of health and social service professionals. Student bursaries and tax-free practice incentives of up to $40,000 may be available to you, depending on your profession.

Make room in your schedule to meet representatives from northern communities at one of these receptions:

October 7: Ottawa (4:00 p.m.–9:00 p.m.) Chateau Laurier, 1 Rideau Street
October 8: Kingston (4:00 p.m.–9:00 p.m.) Holiday Inn, 1 Princess Street
October 9: Hamilton (4:00 p.m.–9:00 p.m) Sheraton Hamilton, 116 King Street West
October 10: Toronto (4:00 p.m.–9:00 p.m.) Sheraton Centre Hotel, Dominion Room, 123 Queen Street West
October 11: London (2:00 p.m.–7:00 p.m.) Centennial Hall, 550 Wellington Street

If you would like to know more, but are unable to attend, call collect (416) 327-8295.

Ministry of Health
Ontario

Ministry of Northern Development and Mines
Ontario

Ministry of Community and Social Services
Ontario

This advertisement is directed to Canadian citizens and permanent residents of Canada.

Atrial Myxoma - A Dramatic Tale !

By Elizabeth Harris, R.N., CNOR.

Having a spare moment on Wednesday, her day off, Mrs. B. dropped in for her echocardiogram. She had no idea of the sharp curve the course of her life was about to take.

Mrs. B. is a 36 year old Caucasian female, the mother of a nine year old boy and a seven year old girl. She has worked for eighteen years in a local nursing home as a personal care attendant. She is a very health conscious individual who follows an excellent program of diet and exercise with no alcohol or tobacco use. She is active as a Brownie leader, in her church, with craft sales and family projects - never a dull moment.

It all began in September 1989, while on duty at a local nursing home. While moving a patient, she felt "something" in her chest, was slightly dyspneic, and thought she'd pulled a muscle. It was 6 AM, the end of her three 12 hour nights, that she, upon the insistence of her supervisor, reluctantly went to a nearby hospital. It was determined that she probably had "pulled a muscle". After two weeks of rest she returned to a lighter work schedule without discomfort.

Four months later, in January she began to experience some shortness of breath upon climbing stairs, however, she dismissed this as not being a problem. She had a physical exam and no problems were detected.

In March, while at the doctor's office for her children's visit, she again mentioned her occasional shortness of breath, the doctor was not concerned. She was back, now, hard at work rarely ill.

The registered nurse, with whom she worked, noted her dyspnea after climbing stairs, and suggested that she have a stress test. Her physician didn't feel this was necessary, however, he suggested that she see a cardiologist, which she finally did because her nurse friend was so insistent.

She went to visit the cardiologist, was given a very thorough, unusual exam. He spent almost an hour listening to her heart sounds as she sat, stood, knelt, and turned one way, then the other. He wanted her to have an echocardiogram ASAP.

Two days following, she had her echocardiogram. Later that same day she received a call from her doctor to tell her that she had a tumor inside her heart and must go to the hospital immediately. Calmly she packed a small bag and went to the hospital, somewhat amazed as she was feeling fine.

She was scheduled to have a cardiac catheterization on Thursday, however, it was cancelled, as the tumor was shown on the echocardiogram to be very large.

Her family history indicated that a maternal grandmother had had a "leaky valve", otherwise there was nothing pertinent. Her personal history showed increasing fatigue over a four month period with detection of a heart murmur. Also of note was detection of systolic and diastolic murmurs with a thrill. The chest x-rays showed upper lobe vessels slightly prominent, suggestive of possible raised venous pressure with the

Author

Elizabeth Harris, R.N., CNOR, is currently Head Nurse, Cardiovascular Surgery, Health Sciences Centre, St. John's, Newfoundland. She is a graduate of Grace General Hospital School of Nursing, St. John's, and The University of Western Ontario in London. She has worked at several Medical Centers in the United States. Thanks are extended to Mrs. B., Dr. Kevin Melvin, the Audiovisual Department, Colleen Manuel, RN, and Bernice Ludlow.

LA enlarged in both PA and lateral views. Her Hct. was 0.341, Hbg was 113 with a normal ESR. Other lab values were normal. EKG showed a regular sinus rhythm with some anteroseptal ST-T wave changed. The echocardiogram showed a large atrial myxoma.

Textbook and article information re: atrial myxoma was somewhat scarce, however, I did find the following textbook description:

> "Tumors within cardiac cavities are usually myxomas, fibromas, or sarcomas and are most commonly found in the atria. Right atrial tumors produce symptoms and signs of inflow tract obstruction; left atrial tumors are characterized by evidence of lesser circulation obstruction. Because of the similarity of the clinical presentation of left atrial tumors and mitral stenosis and the importance of differentiation, left atrial tumors (particularly atrial myxoma) are here discussed as a prototype of tumors. Atrial myxoma must also be differentiated from infective endocarditis.
>
> **Data Base: Atrial Myxoma** The history may include syncope, seizure activity, weight loss, bizarre behaviour, fatigue, angina pectoris, dyspnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, and haemoptysis. There is a wide array of physical findings, which frequently change with the position of the patient. Findings include cyanosis, gangrene of extremities, shock, coma, atrial fibrillation, fever, clubbing, and cardiac murmurs (related to obstruction of the atrioventricular valve). The most specific murmur is a low-pitched diastolic rumble at the apex, which may be intermittent and may vary with the position of the patient. A "tumor plop" may be heard in early diastole.
>
> This sound is caused by movement of the tumor near or across the mitral orifice during early diastole and is similar in timing and quality to the opening snap of mitral stenosis. Other physical findings may include variation of blood pressure with position, a petechial rash, and endocardial friction rubs due to physical contact of the tumor with the endocardium. Laboratory data may reflect haemolytic anemia and often an elevated sedimentation rate. Electrocardiographic abnormalities include arrhythmias, conduction distances, abnormal P waves, and ST-segment changes; changes of myocardial infarction have been reported. Chest x-ray may be normal except in the late stages of the disease, when pulmonary edema and cardiac enlargement are seen; at times the tumor may be calcified."[1]

On Friday morning I was Mrs.B's patient nurse, i.e. the one greeting her in the holding area, accompanying her while intravenous and arterial lines were started, then continuing on into the operating room. As we talked, I found Mrs. B's main concern was that someone be at home to greet her children when they returned from school. She had arranged for a relative to be there, and, as I tried to reassure her that this seemed to be acceptable, she was able to relax considerably.

Once in the operating room, the induction, preparation, chest opening, and cardiopulmonary bypass proceeded, as we had anticipated, without incident.

The heart was opened; with aplomb the surgeon inserted his left hand and, by blunt dissection, plucked the largest atrial myxoma that anyone in the room had ever seen, from her left atrium.

It was the size of a large black Friar plum - measuring 8 cm x 5 cm x 3 cm. Medical media came in to photograph the myxoma and the intraoperative course continued as expected, without complications. The heart and chest were closed in the usual fashion and the patient was transported to the intensive care unit in quite satisfactory condition.

I interviewed her on the eleventh post-operative day. She had experienced a somewhat difficult first three post-operative days, with nausea, vomiting and chest discomfort. On the eleventh post operative day she was actively moving around and looking forward to going home the next day.

A recent telephone conversation (one year later) confirmed that she is feeling very well and enjoying her normal life style.

References

1. Nanette K. Wenger, J. Willis Hurst, Mildred C. McIntyre, *Cardiology for Nurses* (McGraw-Hill Book Company 1980).

Conference Calendar

1991

November 1st and 2nd, 1991.
The Operating Room Nurses Association of South Central Ontario
presents their: Annual Fall Seminar
Haliburton Highlites
at the Pinestone Inn Haliburton, Ontario
Tentative Programs and Pre-Registration Forms to follow. Inquiries may be directed to:
Kathy Bruce, R.N.
c/o Whitby General Hospital
Gordon St., Whitby, ON
L1N 5T2
Phone: (416) 668-6831
Fax: (416) 430-3421

1992

The Operating Room Nurses of Ontario
are sponsoring a three day conference in Toronto
April 12th-15th, 1992
at the Western Harbour Castle Hotel.
The Topics are applicable to all operating room and day surgery nurses.

The Conference Committee Members are: **Hilda Gatchel**, (Conference Committee Chairperson), Oshawa General Hospital, Oshawa. **Vija Hay**, (Vice-chair and Protocol), Queensway Carelton Hospital, Ottawa. **Jocelyn Staynes**, (Treasurer), St. Catharines General Hospital, St. Catharines. **Carole Starr** (Exhibitors), Peterborough Civic Hospital, Peterborough. **Wanda Ward**, (Hospitality), Orthopaedic and Arthritic Hospital, Toronto. **Darlene Beaudet**, (Registration) Metropolitan Hospital, Windsor. **Judi Tyndall**, (Publicity), Henderson General Hosptial, Hamilton, and **Diana Jorgensen**, (Hostesses), North York General Hospital, Toronto.

1993

Québec City, Québec
13th National
Operating Room Nurses Conference
June 6th -11th, 1993 .
Theme:
"Global Vision of Care, Guide in the Midst of Automation"
Watch the Operating Room Nursing Journal for additional information in upcoming issues

Operating Room Nurses Day November 14th, 1991

Prepare now for November 14th, OR Nurses Day across Canada - the day recognized and promoted by the Operating Room Nurses Association of Canada,(ORNAC). This one day a year is set aside to give recognition to perioperative nurses in hospitals and day surgery clinics.

On this day the public as well as other care professionals are invited beyond the "sterile doors" to see perioperative nursing in action and view the highly complex technology used in today's surgery.

Gloria Stephens, President of ORNAC, stated: "There's a lot of versatility in the area of perioperative nursing and that is why there is such a low turnover rate in Canada's ORs. It is a very rewarding field and Operating Room Nurses Day, November 14th, provides an opportunity to demonstrate this versatility-both the nursing practice and the technical aspects of perioperative nursing

Plan your activities and demonstrations today. Contact your Provincial O.R. Association president for posters and buttons.

ORNAC

Recommended Standards

The Recommended Standards for Operating Rooms in Hospitals, as established by the Operating Room Nurses Association of Canada, are available for sale
Recommended Standards
@ $12 per copy
Recommended Technical Standards
@ $20 per copy
Cheques and money orders should be made payable to:
The Operating Room Nurses Association of Canada. Postage and GST @ 7% will be added.
Direct your orders with a return address to:
Shirley Hemerling, Operating Room
Kelowna General Hospital,
2268 Pandosy St.,
Kelowna, B.C. V1Y 1T2
Telephone Orders: (604) 861-5945
FAX Orders: (604) 862-4250
(Fax: Attention: Operating Room)

A Cardiac Arrest Policy

By Judi Tyndall

Imagine yourself as the circulating nurse in the following scenario. You have worked in the Operating Room for twelve years. Today is just another routine day, and your next case is a fifty-two year old lady who is scheduled for an abdominal hysterectomy. As you bring Mrs. Smith into the case room, she tells you she is "scared to death of being put to sleep". How many times have you heard that? You reassure Mrs. Smith that "everything will be okay".

Approximately thirty minutes into the procedure, the anaesthetist comments that the patient is "a little hypotensive". The intravenous rate is increased. A few moments later, he requests an arterial line set-up. Before you have had a chance to prime the line, the anaesthetist says, "I've given her 75 mgm. of Lidocaine; I want a Lidocaine drip infusing at 2 mgm./minute". Seconds later he shouts, "I want Dopamine infusing at 10 mcg/kg". Your eyes glance at the ECG monitor. "Oh my God, she's in ventricular fibrillation!"

The scene that follows is chaos. The anaesthetist calls a code. Within minutes the room is full. There are three anaesthetists, two surgeons, five residents, five O.R. nurses and a cardiac arrest cart. Each physician is screaming orders. Three O.R. nurses are running to obtain the same item. You're not certain who is documenting the resuscitation. Imagine the noise. No one medical person has taken control. Nursing is totally disorganized.

Forty-seven minutes after the cardiac arrest is initiated, the patient is pronounced dead. The crowd seems to dissipate, almost as quickly as it had arrived. The surgeon and anaesthetist are in the O.R. Nurse Managers office. Four O.R. nursing colleagues returned to their assignments. All who remains in the room are yourself, the scrub nurse, the O.R. nurse clinician and "your" patient. As you attempt to recall how to proceed with an O.R. death, your eyes fill with tears. You were the person who reassured the patient "everything would be okay".

Obviously, in the aftermath of such a scenario such as the one described there would be a number of medical and nursing issues to be resolved. Of prime significance, is the question, "Who should respond to a cardiac arrest in the O.R.?"

Abstract

The following article describes the process in the development and implementation of an Operating Room's Cardiac Arrest Policy. The actual guidelines and forms developed are presented.

Responding to an O.R. arrest

In our hospital, multidisciplinary meetings were held to consider alternatives in responding to an O.R. arrest. Present were representatives of every department that could possibly be involved in a patient's resuscitation. This included medical representatives from the Departments of Anaesthesia, Surgery, Cardiology, (chairperson of the CPR Protocol Committee) Intensive Care and the hospital's Senior Medical Resident,(S.M.R.) who is the designated captain of the hospital's cardiac arrest team. Nurse managers and clinicians from the O.R., Intensive Care Unit and Coronary Care Unit were present, as was the Chief Respiratory Therapist.

Three alternatives were considered for an O.R. arrest. These were:

1. The O.R. medical and nursing staff independently manage their own arrests;
2. Selective medical and/or nursing assistance could be summoned (ie. a stat call to ICU for Critical Care Nursing assistance); or,
3. The hospital's cardiac arrest team would respond to the O.R.

Author

Judi Tyndall is the O.R. Clinician, Department of Nursing, Henderson General Division, Hamilton Civic Hospitals, Hamilton, Ontario.

The group agreed that one consistent approach that was viable twenty-four hours a day was needed.

Initially, members of the group believed that the first option was the most appropriate. However, guaranteeing sufficient staff around the clock for both medicine and nursing was a problem, as was the unavailability of the Respiratory Therapist.

The second option was disregarded for two main reasons. First, anyone summoned to the O.R. would not, respond with the same urgency as when they were responding to a cardiac arrest elsewhere. Secondly, the nurses strongly believed this option was too vague and might leave a resuscitation decision up to the individual medical staff involved and would not guarantee nursing support.

Finally, in order to provide the highest quality of care, the group agreed on the appropriateness of summoning the cardiac arrest team. This decision forced us to carefully re-evaluate past cardiac arrest experience. The following problems were identified:

- There was no designated medical leader during an arrest;
- There were no guidelines regarding roles and equipment;
- There were no guidelines indicating when a cardiac arrest should be called in the O.R;
- Clarification regarding which members of the cardiac arrest team would respond to the O.R. was required, and
- There were potential infection control risks resulting from the cardiac arrest team's response.

Developing the Guidelines

Appendix A outlines the cardiac arrest guidelines for the Operating Room developed at our hospital. In developing the guidelines, it was our goal to provide a mechanism, to enable the nursing staff to have as much control as possible, and to organize themselves efficiently during a crisis situation where emotions are high. The O.R. nursing staff's input was continually sought during the development of the guidelines. This communication not only improved the quality of the guidelines, but it also conveyed to the staff that we were addressing problems that they had encountered during actual patient crises.

The entire multidisciplinary group, previously identified, were continuously involved in discussions and critiquing of the guidelines throughout their six month development period. Finally in January, 1989, the proposed guidelines were taken to the hospital's CPR Protocol Committee for final approval. The guidelines were accepted as presented to this committee.

Following this meeting, the physicians representing the Departments of Anaesthesia and Surgery were responsible for communicating with their colleagues regarding the specific guidelines and the necessity of consistency in the implementation of the guidelines.

Formal Access to Critical Care Staff

The O.R. nurses were informed of the approved guidelines. The O.R. nurses were reassured to know that the guidelines provided them with a means to obtain Critical Care Nursing assistance when necessary, for example during a malignat hyperthermia crisis on nights. In addition the O.R. and Critical Care Nurse Clinicians recognized that the O.R. nurses required additional education to competently manage either a pre-arrest crisis, or those first few minutes prior to the cardiac arrest team's arrival. In collaboration with the anaesthetists, the following skills were identified as being necessary for O.R. Nurses:

- the preparation and/or assembly of cardiac arrest medications;
- the set up and regulation of cardiac arrest infusions (Dopamine, Xylocaine);
- preparation for defibrillation and the patient for countershock and documentation of the events

Wherever possible preassembled and/or premixed medications were purchased, an easy reference system was compiled, to provide the nurses with step by step instructions to the location, assembly and regulation of the I.V. infusions. An example is provided in Appendix B. These reference sheets hang on a pole on top of the cardiac arrest cart.

A form was developed to provide the O.R. nurse with a method of charting activities during any crisis, not only for cardiac arrests. This chart form is available in every Operating Room. Appendix C is a copy of the O.R. Nurses Record.

An essential step in the implementation of the O.R. Cardiac Arrest Guidelines, was the O.R.'s duplication of the I.C.U.'s and C.C.U.'s cardiac arrest carts. The O.R. nurses felt very reassured to know the guidelines provided them with a means to obtain Critical Care Nursing assistance for a particularly critical patient, as for example during a malignant hyperthermia crisis. The I.C.U. and C.C.U. nurse would be of the greatest assistance if they were working with a cardiac arrest cart identical to the system they use on a daily basis.

The final stage in the implementation of the above guidelines has been the use of mock arrests. Prescheduled cardiac arrest drills are conducted by the

Appendix A

O.R. Policy & Procedure ManualRevised: January, 1989 Henderson General Hospital Dept of Nursing-Operating Room

Cardiac Arrest Policy

A. Cardiac Arrest PolicyDuring Surgery

1. A Code 55 will be called when:
(a)the Anaesthetist requests an arrest to be called
(b) the patient is to be defibrillated
(c) the Anaesthetist agrees to the OR nurses' request to call a "code 55" for Critical Care Nursing assistance

2.The circulating nurse:
(a) calls the code by Dialing 5555 and stating "Cardiac Arrest OR room #____"(Repeat three times)
(b) reports to the desk that a cardiac arrest has been called in Room #___
(c) assume responsibility for the nursing organization of the room. She must remain at the scene to:
i) organize the nursing staff
ii) delegate staff to obtain the cardiac arrest cart and additional equipment, etc.
iii) monitor and control traffic flow
iv) document the proceedings on the OR Crisis Record until the ICU/CC nurses assume the documentation
(d) On arrival of the ICU/CCU nurses, the circulating nurse:
i)identifies herself as the nurse in charge of the room
ii)identifies the Anaesthetist in charge of the arrest
iii)gives the ICU/CCU nurses a brief history
iv)ensures the O.R. cardiac arrest cart is taken out of the room.
v)continues to delegate requested items
vi)ensures ICU is notified ASAP if the patient is to be transferred to the ICU

3. The Charge Nurse will be responsible for:
(a) ensuring the Cardiac Arrest Team Members are only allowed in the room.

The Cardiac Arrest Team responding to the O.R. consists of the following staff:
A. The Senior Medical Resident
B. 1 - ICU Nurse
C. 1 - CCU Nurse
D. Respiratory Technologist
E. Critical Care Clinician

(b) reassigning necessary staffing
(c) monitoring traffic control

Anaesthesia Policies:

1.The Anaesthetist in charge of the case is responsible for determining who is the arrest captain. He/she may:
(a) assume responsibility himself/herself
(b) delegate responsibility to another anaesthetist;or
(c) delegate responsibility to the SMR.

2.If an anaesthetist leaves a room with a patient under anaesthesia to assist in an arrest:
(a) the patient must be stable
(b) a competent person shall be delegated to monitor the patient's vital signs in his absence

3.No new surgical cases shall proceed during the arrest period unless the patient has been stabilized and/or permission has been given by the "arrest room"

If The Patient Expires:

1. Investigate whether or not it is a Coroner's Case. In the event of a Coroner's Case do not remove any equipment (i.e. I.V.'s Foley Catheters, NG Tubes, Drains, E.T.T.'s) unless notified by the Coroner to do so.
2. If it is not a Coroner's Case proceed with the usual care after death - see O.R. Policy under "D"
3. Refer to the Hospital Information Manual regarding the Policy on completing the appropriate death forms

B. Cardiac Arrest Policy Other Than Surgery

This policy refers to the situation when surgery is not in progress(ie a patient awaiting surgery, hospital personnel,..)

1.The person discovering the arrest:
(a) initiates basic C.P.R.
(b) initiates a "Code 55" by yelling for help.
Note: Once you have established the Patient has arrested do not leave your patient-basic C.P.R.must be maintained.

2.The second person on the scene is responsible to:
(a) ensure a "Code 55" is called - Dial 5555, State: Cardiac Arrest O.R. and Room #.
(b) report to the desk that a cardiac arrest has been called.
(c) if the patient is on a stretcher quickly move the patient into the closest available case room.
(d) if the victim is unable to be transferred to a case room, the second person must ensure the portable oxygen, suction and arrest cart are obtained.
(e) proceed as the "Circulating Nurse" as outlined in the "Cardiac Arrest Policy During Surgery"

3.Refer to "Cardiac Arrest Policy During Surgery"

anaesthetist in conjunction with the SMR (Senior Medical Resident) and the O.R. and Critical Care Nurse Clinicians. The cardiac arrest team is unaware that the "code" is a drill. Following the exercise, the entire staff involved discuss the strengths and weaknesses of the resuscitation. Problems were identified and resolved as appropriate.

It has been over two year since the implementation of our O.R. Cardiac Arrest Policy. The Cardiac Arrest Data Form, (see Appendix D), provides an ongoing means to identify and pursue problems encountered.

This article has described both the actual O.R. Cardiac Arrest guidelines and the process by which the guidelines were developed and implemented in a University teaching hospital. Our goal throughout this project has been to improve the quality of patient care.

Appendix B

Xylocaine

Dosage mg/min.	mL/hr
.5	8
1	15
2	30
3	45
4	60

2 grams/500 ml

Approved:May 1986 K.A. Ockenden, B.Sc., M.D.
Chief, Department of Emergency Care
Hamilton Civic Hospital

Appendix C Hamilton Civic Hospitals - Henderson General Division

Operating Room Nursing Record

Nursing Assessment

Medications

Time	Name of Drug	Dosage	Site	Ordered By	Given By
	Atropine				
	Epinephrine				
	Sodium Bicarbonate				
	Xvlocaine				

I.V. Solutions

Time	Site	Solution	Medication	Ordered By	Given By	Initial Date	Time	New Time Rate	New Rate
		250 D5W	Dopamine(400mgm)						
		500 D5W	Xylocaine(2g)						

Procedures

Time	Procedure	Size	Site	Performed By
	Arterial Line			
	Central Line			
	Swan Ganz			
	Peripheral I.V.			
	Foley Catheter			
	N.G. Tube			

Code 55 called at ___ hours.

Signatures:____________________RN's ____Nurse's Notes____CPR Record_____OR Record

Appendix D

Cardiac Arrest Data Form

Place of Arrest:____________________
Date:__________Time:______________
Problems With: ☐ Equipment ☐ Personnel ☐ No Problems

Problem Description:____________________
Action Taken:____________________
Recorder:____________Team Captain:___________

(Not a Chart Form)

Central Sterile Processing Manager

Kelowna General Hospital has an opening for an innovative person to fill a vacancy within an expanding and creative team environment. This full time position reports to the Director, Materiel Services. The Department currently services six OR's in a 662-bed regional referral facility, expanding to ten OR's in the hospital's forthcoming building program.

The successful applicant for this out-or-scope position will ideally be a Baccalaureate RN and hold a diploma in Central Supply Management or OR technique. Short listed candidates will have a good track record and at least three years recent managerial experience in central processing. (Candidates with some combination of equivalent education, training and experience are encouraged to apply).

Wages and benefits are scaled in accordance with the hospital's administrative policy for non-contract staff and are competitive in the industry.

Please sent resume in confidence to:

Personnel Department
Kelowna General Hospital
2268 Pandosy Street
Kelowna, B.C. V1Y 1T2

Peri-Operative Instructor
Full Time Position

Lions Gate Hospital, a dynamic, multi-discipline 720-bed facility located in North Vancouver is accepting applications for the position of Peri-Operative Instructor in the Operating Rooms and P.A.R.

Reporting to the Director of Nursing, Peri-Operative, the Instructor is responsible for teaching in an environment which is developing competency-based and self-directed approaches. Our Nursing Department promotes unit-based decision making, collaborative practice, and shared governance.

Requirements for this position include:
- Current R.N.A.B.C. Registration
- B.S.N. Degree
- Three years' related experience in addition to clinical teaching experience with adult learners

Please reply **in confidence** to: **Randi Enweani, Director of Peri-Operative Nursing, c/o the Human Resources Department and/or telephone (604) 984-5768.**

LIONS GATE
HOSPITAL

231 East 15th St.
North Vancouver, B.C.
V7L 2L7

Stanton Yellowknife Hospital

A challenging opportunity awaits a highly motivated individual in the Nursing Services Department as the Operating Room Head Nurse at the Stanton Yellowknife Hospital, a 135 bed accredited acute care Regional Hospital in Yellowknife, N.W.T. This is a three theatre Operating Room with a six bay recovery room.

Head Nurse Applicants:

•Must be registered or eligible for registration with the N.W.T.R.N.A.
•Five years current Operating Room experience with experience in P.A.R.R., general, orthpaedic,ophthalmic and ENT surgery required.
•Previous supervisory, teaching and budget preparation experience and an OR Course preferred. Previous experience working in a decentralized nursing department an asset.
•BScN or Nursing Administrative Course desirable.

Salary:
• From $43,297 to $51,235 per annum (under review).
• Excellent Benefits Package.
• $5,400 per year Private Accommodation Allowance.
• Generous Relocation Policy.

The Stanton Yellowknife Hospital is a 135 bed facility located in Yellowknife, the capital and largest centre in the Northwest Territories. Yellowknife is a modern city of about 15,000 accessible via the Mackenzie Highway and daily air service from Edmonton, Alberta and Winnipeg, Manitoba.

Registered Nurses:

Due to program enhancements, opportunities are available in the Operating Room for Registered Nurses with special training or Operating Room experience. Applicants must be eligible for registration with the N.W.T.R.N.A.

Salary: From $40,935 to $48,209 per annum. Excellent Benefits Package.$5,400 per year Private Accommodation Allowance. Generous relocation policy.

Contact: **Stanton Yellowknife Hospital**
Personnel Department
P.O. Box 10
Yellowknife, N.W.T. X1A 2N1
Fax:(403) 873-4382
Tel:(403) 920-4111 ext 329 (collect)

Understanding cultural differences and customs is important in determining child abuse suspicions

Health care workers, especially physicians and nurses, need to be aware of the differences between their own cultural expectations and those of the patients they care for if they are to avoid misunderstandings, an expert in child abuse warned recently.

Certain medical practices of other cultures may appear to a "Canadian" nurse or doctor to be child abuse, said Dr. Allan Kornburg, the director of the Buffalo (New York) Children's Hospital's Emergency Department.

Unless the cultural practices cause damage or inflict injury, health care workers should accept it as normal, he told the First North American Conference on Child Abuse and Neglect held in Toronto this past summer.

"After all, some people from elsewhere might (and do) consider circumcision as a form of child abuse," he said.

Dr. Kornburg pointed out that many Chinese and Asian therapies could leave bruises and odd marks on the body. For example, the practice of "coining," where a coin is rubbed repeatedly over an area of the body, can leave red marks and a discernible rash.

Another practice, called "cupping" involves placing a warmed, inverted glass on the skin. As the air in the glass cools, the skin is pulled into the glass. This often leaves a rather suspicious-looking circular bruise.

Harmless customs

Dr. Kornburg pointed out that all these treatments might appear suspicious because of the marks left. But as a practice, they are accepted customs and do not seriously harm the child.

But where to draw the line. Some practices, such as "moxibustion" are definitely unacceptable. In this practice a burning tube resembling a cigarette is placed on the body and leaves a round burn.

Such practices, Dr. Kornburg believes, involving burns, have crossed the border into child abuse. In such cases, the parents should be advised to stop the therapy. They should be cautioned that they will be reported to the child protection services if they continue the practice.

Marriage counsellor/physician steals patient's wife

A lawsuit was won by a Michigan man recently when he took his marriage counsellor/family physician to court for stealing his wife's affection.

The court awarded the 28-year-old man over $67,000 because the jury decided that the counsellor/doctor did "steal" his wife.

The man and his wife went for counselling to the doctor for two months in 1988 with the hope that their marriage could be saved.

The attempt proved unsuccessful, and the doctor/counsellor later dated the wife and eventually married her.

They moved to another part of the state with the women's two children. They now have one of their own.

The ex-wife, under Michigan State child support laws, will be eligible to collect a significant part of the money that the jury awarded the spurned husband.

OR News

Baby powder use should be discouraged

Baby powder can cause severe respiratory symptoms in infants and its use should be discouraged.

That's according to a news item in the *British Medical Journal* which reported a study that investigated the hazards of talcum powder on infants.

The study by Dr. Peter Pairaudeau and colleagues at the Southampton General Hospital in the U.K., was prompted by a 12-week old baby who was admitted to hospital after having talcum powder inadvertently spilled on his face during a diaper change.

The baby had severe respiratory difficulty and required endotracheal intubation for three days before making a good recovery.

Dr. Pairaudeau noted that there was little dermatological evidence for using nonmedicated powders in the routine skin care of infants. He believes health workers should discourage the routine use of talcum powder, because infants can be adequately dried after bathing. Barrier creams, he pointed out, are more appropriate for the area that is covered by the diaper.

According to Dr. Pairaudeau, eight cases of babies dying from inhaling baby powder have been reported in the literature, and up to 1% of calls to poison centres concern children under age five who have had an incident with talcum powder.

Sweatshirts for Sale !

ORNAC **red** sweatshirts withthe white ORNAC logo. Small, medium, large @$20. Send order to: **Shirley Hemerling, 1773 Smithson Dr., Kelowna, B.C. V1Y 4E4**

The Surgeon and the Nurse Share the Blame:

A case of a retained sponge (1)

By Lorne E. & Fay A. Rozovsky

The Facts of the Case

On April 19, 1982, orthopaedic surgeon, Dr. MacKenzie, operated on the 61-year old plaintiff, Frandle. A sponge was left in the plaintiff's left hip while bone from the hip was being removed and grafted onto an ankle. The sponge was not discovered until December, 1983 and was removed on January 30, 1984.

The patient subsequently sued the doctor and the hospital. The matter was heard before Mr. Justice Mackoff of the British Columbia Supreme Court. His Lordship found that both the surgeon and the nurses were responsible for the retained sponge. He found that the nurses were negligent for failing to keep a proper count and the doctor was negligent in failing to order a formal count before closing the incision.

The justice also found however, that the doctor was negligent in failing to conduct a careful search of the incision for the presence of foreign objects. He was also found negligent in failing to order an X-ray which would have revealed the sponge, since there was a radioactive marker attached to it.

In conclusion however, the trial judge placed full responsibility on the surgeon since it was he who could have prevented the consequences of the nurses' negligence and his own initial negligence.

In fact, action could not have been brought against the nurses because of the fact that the plaintiff was receiving compensation under the Workers Compensation Act which prohibited such action. However, this did not prevent the court from determining whether or not the nurses were at fault, since this would affect the responsibility of the doctor. If the facts had not involved workers compensation, the question of actual liability on the part of the nurses would have been very different.

The Court of Appeal

Dr. MacKenzie appealed the verdict of the trial judge. The plaintiff also appealed on the amount of compensation awarded.

In reviewing the decision of the lower court, the British Columbia Court of Appeal stated that it was clearly a case where the damage had been caused by the fault of two or more persons. Mr. Justice MacFarlane speaking on behalf of the the three appeal judges who heard the case said that it is clearly a case of shared responsibility between the doctor and the nurses calling for apportionment or division of fault.

His Lordship noted that the hospital made available to the doctor three methods to ensure that surgical sponges were not left at the surgical site. The first was for the nurses to conduct an informal count. The second was for the nurses to conduct a formal count upon the surgeon's request. The third was the provision of sponges with radio-opaque markers and x-ray equipment to detect them.

In this particular case, the doctor chose to rely on the first method only, that is the informal count by the nurses. The trial judge said that it was the surgeon's responsibility to order a formal count. The appeal court agreed with the trial judge's conclusion. The court said however, that it was clear that the failure of the doctor to do that did not relieve the nurses of the responsibility to take reasonable care to keep track of the sponges.

Because the doctor failed to search for and find the sponge and to confirm the absence of foreign material by X-ray, both the trial judge and the appeal judges found that the doctor's negligence was greater than that of the nurses. Considering all these factors, the Court of Appeal overturned the decision of the trial judge, and divided responsibility as 80 percent to the doctor and 20 percent to the nurses. The award of $15,000 by the trial court was raised to $25,000.

Lessons to be Learned

From the point of view of operating nurses, what lessons can be learned from this decision?

1. The wrong-doing or negligence of a surgeon (or in fact an anaesthetist) does not excuse a nurse from responsibility for negligence or other wrongdoing.
2. The fact that the negligence or other wrongdoing of a nurse could have ben prevented, or the injury caused by the negligence could have been prevented by a surgeon and was not, does not remove the nurse from legal responsibility for any injury which may result.
3. Many risks of surgery such an the retention of surgical sponges or other foreign bodies are shared between surgeons and nurses.
4. The surgeon is not the captain of the ship nor does the surgeon take complete responsibility for everything that occurs in the operating room.
5. Nurses who suspect that something has gone wrong during surgery have a duty to the patient to bring it to the attention of the surgeon and to take whatever steps are necessary to correct it. If the surgeon attempts to prevent reasonable nursing steps to be taken, such as a sponge count, nurses should record the matter and appeal immediately to the operating room supervisor.
6. Since the problem of retained sponges, needles and other foreign bodies continues to be a problem, every hospital should have a written standard of practice established following the advice of both surgeons, operating nurses and the risk manager. The procedure should include a method by which outside assistance can be summoned if there is a medical-nursing disagreement.
7. The failure of any surgeon in following the procedure without a reasonable excuse should be reported to the appropriate medical staff committee and should be considered as a matter for privileges review.
8. The failure of any nurse in following the procedure without a reasonable excuse should be grounds for discipline and possibly dismissal.
9. Any suspicion that foreign material may have been left in a surgical patient should be immediately reported to the risk manager. No further comments are to be made on the subject to anyone without the instructions of the risk manager.
10. The risk of retained foreign material should be reviewed on a regular basis to ensure that the procedure to prevent this from occurring is being followed and is working, and that all necessary equipment to alleviate this risk is available and is effective.

(1) Frandle v. MacKenzie (1991), 5 C.C.L.T.(2d) 113 (B.C.C.A.) appld. from (1989), 47 C.C.L.T. 31 (B.C.S.C.)

Authors:

Lorne E. Rozovsky, Q.C. is a Halifax lawyer with the firm of Patterson Kitz and adjunct associate professor of law and medicine at Dalhousie University. Fay A. Rozovsky, J.D., M.P.H. is president of LEFAR Health Associates, Inc., a risk management consulting firm and a visiting lecturer in health law at the Harvard School of

OR Nurses

An RN doesn't have to look far to find a job these days. Yet our nurses have been known to move thousands of miles to join us. Because Community Hospitals of Central California (CHCC) offers more than a job. *A lot* more.

We currently have opportunities available for OR Nurses. These positions are 12-hour shifts. Of course, OR experience is preferred, but we will train the right individual with a med/surg background.

Our nurses have a workstyle that complements their lifestyle too. The attitude is open and friendly. The pace is exhilarating. And there's a flexibility that's truly unique. And when you live in Fresno, you're right in the middle of it all. Everything that makes the state so exciting, beaches to deserts, mountains to parks, is within easy driving distance. And, the hardest thing to believe is, for all Fresno has to offer, it has one of the lowest cost of living of any major metropolitan area in America.

If hired, we'll assist with your TC or H-1A status, as well as provide relocation assistance. Call us collect at (209) 442-3927 and ask for Sandy Haeberle or Kate Christmas. Or, send your resume to them at: Community Hospitals of Central California, P.O. Box 1232, Fresno, CA 93715, U.S.A.

Author's Information

The *Canadian Operating Room Nursing Journal* is intended to serve the information needs of perioperative nurses in hospitals and clinics throughout Canada. Readers include staff nurses, technicians, head nurses, nursing supervisors, coordinators, clinical instructors, directors of nursing and many other speciality nurses including post-anaesthetic recovery room nurses. The journal is peer-reviewed and published quarterly by Health Media Incorporated under the aegis of the Operating Room Nurses Association of Canada (ORNAC). Manuscripts are reviewed by the editorial board appointed by the ORNAC, and when necessary by outside experts. Submissions are invited on new surgical techniques, descriptions of new technologies or advising of new programs and educational material. Selection is based chiefly on the following criteria: originality, timeliness and relevance to the needs of the journal's readers

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

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

All **illustrations**, graphs, tables, etc. should be clearly labelled and, if necessary, reference should be made as to where they are to be inserted in the text. The author should submit the original manuscript and three(3) copies for reviewers. A copy of the edited text will be sent to the author for approval.

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

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

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

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

Address all correspondence to: The Editor, Canadian Operating Room Nursing Journal
c/o Health Media Inc.
14453 29A Avenue
White Rock, B.C., V4A 9K8

ARTHROSCOPY PROGRAM FOR O.R. NURSES

Orthopaedic and Arthritic Hospital
in conjunction with
Zimmer of Canada Limited
are pleased to offer a series of two-day arthroscopy courses for operating room nurses

Course Director:
Robert Jackson, M.D., M.S., F.R.C.S.(C)
Course Instructor:
Marlene Muir, R.N.

Program Highlights...

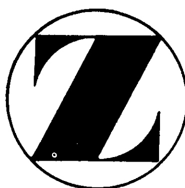
- Peri-operative management of patients undergoing arthroscopic surgery
- Anaesthetic techniques
- What to purchase
- Care, handling and sterilization of instrumentation and equipment
- Normal/abnormal knee pathology
- Skills laboratory - models and videos
- Trouble shooting the video system
- Observation of OR arthroscopy procedures

Location:
Orthopaedic and Arthritic Hospital
43 Wellesley St. East
Toronto, Ontario
M4Y 1H1

Course Dates:
October 7&8
November 18&19
December 9&10

Course Fee:
$175.00 per nurse - includes coffee breaks & lunches. Does **not** include accommodation.

Registration: To register, phone or write:
Bette Hales, Zimmer of Canada Limited,
2323 Argentia Road, Mississauga,
Ontario L5N 5N3
Phone (416) 858-8588 **FAX** (416)-858-8747



(See conference photo coverage page 26-30)

Because We Care

A Report on the 12th National Conference Operating Room Nurses Association of Canada

By Pat Petersen, Publicity Committee, Banff '91.

Banff, Alberta: Operating Room nurses believe that they are responsible and accountable in assuring the patient undergoing surgery receives the highest quality nursing care.The Operating Room Nurses Association of Canada recognizes its responsibility to the OR nurse and the health care field by setting standards of practice, contributing to nursing education and providing opportunities for continuous learning through a program of educational activities. This constantly changing practice of perioperative nursing drew 653 OR nurses from across Canada, to the heart of the Canadian Rockies in Banff, May 12 - 17, 1991. The challenge was to learn to move mountains, master skills and mature professionally.

The Isabelle Adams Award

At Opening Ceremonies, delegates heard how the professional association for OR nurses moved mountains. The ORNAC information meeting was a review of last year's accomplishments and this year's goals. The Isabelle Adams Award for Excellence in perioperative nursing was presented to Muriel Shewchuk, R.N., B.Sc.N. This award is considered the highest award accorded exclusively to Operating Room Nurses in Canada.

Muriel is a native Albertan and is currently the Director of the Surgical Suite, Foothills Hospital, Calgary. She has been an active member on both the Alberta and national OR associations and is a frequent and popular speaker. This year, serving as the Chairperson for the Conference Exhibits, as well as a speaker, Muriel had her capable hands full. The announcement of the award during the conference was met with great enthusiasm from her nursing colleagues. Previous winners of the award are Gloria Stephens, Vancouver, the first recipient in 1988, and the late Valerie Shirreff of Toronto, who received the award in 1990.

The Surgikos Drake-Thompson Memorial Editorial Award

The Surgikos Drake-Thompson Memorial Award, consisting of a plaque and $3,000, was presented to Joan Donald, Immediate Past President of ORNAC from Sackville NB. Joan Donald, R.N., B.Sc.N., M.A., is Director of Nursing, Sackville Memorial Hospital. Her article - "Promoting OR Education" was published in the February '90 issue of the *Canadian Operating Room Nursing Journal,* Vol. 8, No. 1. Joan is a frequent speaker at provincial and national OR conference and most recently served as Co-Chairperson for the World Conference of Operating Room Nurses held in September in Vancouver. Joan served as chairperson of the ORNAC Standards Committee established in 1983, which has since published two major Standards publications. The award was presented to Joan during the conference by Arnold McLean, President of Johnson & Johnson.

"Communique" - the History of ORNAC

"The Official History of the Operating Room Nurses Association of Canada,1965-1991" was presented to all delegates and exhibitors at the conference. This updated "Communique" was compiled by Dorothy Orr, ORNAC Historian, and Muriel Shewchuk, both from Alberta. The printing of this historical document was generously sponsored by Valleylabs Canada.

Johnson & Johnson Medical Products paid a major tribute to ORNAC and the National Conference delegates. Since the inaugural ORNAC Conference in Jasper in 1984, a local artist is commissioned to paint a water-color that provides each delegate with a memento of the area of each National Conference. This year, artist Peter Thompson of Calgary portrayed a

water-colour titled "Healing Waters", the hot sulphur pools of Banff in the deep of winter. The original painting was presented to ORNAC President Gloria Stephens by Bill Moran, Vice-President of Johnson & Johnson. Delegates were also provided with a limited edition print at Ethicon Night.

Ethicon has announced it has established a $5,000 bursary to be awarded every two years. ORNAC will administer the award and develop criteria for candidate selection.

Conference Speakers

Ginette Roger shared her ideas on how to move mountains as she delivered an inspiring address to officially open the Conference. She emphasized that the challenge to all nurses is to exercise our power if we are to move mountains, master skills and mature professionally.

The song "Because We Care" has been adopted as the National song for ORNAC. This tradition was established in 1988 at the 11th ORNAC Conference in Vancouver. This year, the song was dedicated to Valerie Shirreff, former ORNAC President, who died last year after a courageous battle with cancer. This theme song and video was presented during the presentation of the Isabelle Adams Award. Needless to say there was not a dry eye in the Banff Ballroom.

Val's dream was to one day have a National ORNAC Office and in her memory the Val Sheriff Headquarters Fund was established. The U.S. Association of Operating Room Nurses (AORN) President, Dr. Jean Reeder, announced that their Board of Directors has donated $1,000 towards this fund!

Topics during the Conference ranged from self-motivation to patient positioning and dealing with nurses' role in organ and tissue procurement. Issues such as health care funding and OR theatre planning were addressed. Timely presentations such as legal implications for the '90's, "greening" of the O.R., and the dynamic shift from inpatient to outpatient surgery, drew large numbers of delegates. And, we musn't forget the Fairy God-nurse, Melodie Chenevert's presentation, "I'm in Charge."

Exhibitors

Our very special friends in the medical surgical companies have closely monitored our progress and "generously provided more than moral support." They have gone on to become the National Exhibitors Advisory Committee (NEAC), with provincial affiliations such as Alberta Exhibitors Advisory Committee (AEAC) and continue to guide us in an advisory role. ORNAC and the Banff '91 Planning Committee thank them for their interest, support and encouragement for our continued growth.

At Opening Ceremonies, National Exhibitors Advisory Committee (NEAC) Chairman, Bob Bothwell, of MDT Canada informed delegates that this is the single, most important conference that the exhibitors attend. The confirmation of the statement was the 103 exhibiting companies occupying 151 booths.

Fantastic Social Events

Even with all the lectures, films and meetings and lectures going on, there was still time to relax and meet friends, old and new. On Sunday, Smith & Nephew sponsored the Shampaine & Strawberry Ski Tournament - in the rain! Monday night was Western night under the land of the big, blue sky where delegates received a taste of Western hospitality. Tuesday afternoon, for the first time, nurses were given a mental health break which fit into Alberta Nurses Week which ran May 12 - 18. Their theme was "Mental Health and Nursing." Delegates were encouraged to relax, enjoy the spectacular scenery and meet new friends. Wednesday evening saw the Great Canadian Buffet with the fabulous sculptures and delicacies from each and every province across the country. Discussion proved lively as to which province was known for which delicious dish. Thursday evening was the delightfully formal and elegant Ethicon Night. The social events were chaired by Sharon Balcan, Edmonton, president of the Operating Nurses Association of Alberta

At the ORNAC business meeting, the *Canadian Operating Room Nursing Journal* announced its plans to start the process of developing an OR Product Directory in 1992. Many hospitals will be interviewed for this OR Directory. Watch the Journal for details!

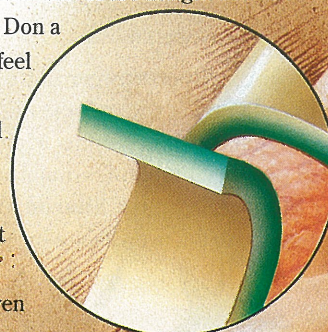
Far too soon, it was the last day. As we listened to Sharon Wood, the first North American woman to conquer Mount Everest, tell us of the need to establish smaller goals on the way to conquering the summit, and to keep those goals in mind despite frustrations, everyone of us related to what she was saying. Over the Farewell Brunch, we decided that we definitely were leaving this Conference with a sense of where we are going. We were also taking home many practical and innovative ideas to ponder and employ in our O.R! After all, we were there "because we care!'

"Quality Education is a journey, not a resting place. To stand still is to fall behind" - *Author Unknown.* With this in mind, plan now to attend the 13th ORNAC Conference, June 6 to 11, 1993 in Québec City, Québec.

Anatomy of the World's Finest Surgeons' Glove.

Today's surgical team needs more from a surgical glove. More protection, more precision, more confidence. Detail after detail, Biogel® Surgeons' Gloves are designed for the way you work today. Don a pair. You'll see and feel the difference.

A patented hydrogel lubricant makes absorbable dusting powder obsolete, yet the glove is exceedingly easy to don, even with damp hands.



Patented Biogel® coating (indicated in green) makes glove powders obsolete

The result? Glove starch-related, post-operative problems such as granulomatous adhesions and starch peritonitis are no longer a risk. The powder-free environment contributes to increased tactile sensitivity as well.

What's more, every single Biogel® glove is visually and inflation tested for pinholes and structural integrity. That means unsurpassed barrier protection, glove after glove. And Biogel® gloves are hypoallergenic to help prevent the chapping, chafing and discomfort often associated with surgeon's gloves.

Glove powder-related, postoperative problems are eliminated

Each Biogel® glove takes its shape from precision-sized glove molds for a more natural fit and feel. Surgeons who have tried the gloves are amazed at how comfortable and durable they are, even during lengthy procedures.

Each glove is 100% visually and inflation tested for structural integrity

For more information about the powder-free Biogel® Surgeons' Glove, call 1(800) 763-6364.

Biogel®

The world's finest surgeons'glove

Distributed by **REGENT HOSPITAL PRODUCTS, LTD**, Greenville, SC **1 (800) 843-8497.** Made in the UK by LRC Products Limited, London. Members of London International Group plc. REGENT and BIOGEL are registered trademarks. European Patent Nos 0113526 0105613 U.S. Patent Nos 4,499,154/4,548,844/4,575,476/4,482,577/3,813,695. ©1990 Regent Hospital Products Limited. All rights reserved.

Keynote Speaker **Ginette Roger** addressed the changes and challenges facing society, the nursing profession and the individual. (Photo Centre: **Melodie Chenevert** promoted personal and professional success. Closing Speaker Mountain climber **Sharon Wood,** renewed our confidence to suceed.(Photos by Marge Ensminger)

Joan Donald, Past-President of ORNAC, (left) is the 1991 recipient of the Surgikos Drake-Thompson Memorial Award for Editorial Excellence. Joan is Director of Nursing, Sackville Memorial,**Sackville, NB. Arnold McLean**, President , Johnson & Jonson Medical presented the commemorative plaque and the $3,000 annual award. Mrs. Donald's winning article "Promoting O.R. Education" appeared in this journal - Vol. 8,#1, February, 1990. Muriel Shewchuk,(r) is Chairperson, Awards Committee.

Photo Below: The winner of the 1991 Isabelle Adam's Award for Excellence in Perioperative Nursing is **Muriel Shewchuk**, Director, Surgical Suite, Foothills Hospital, Calgary. Gloria Stephens, ORNAC President and recipient of the same award in 1988, presented the medal and commemorative plaque.

Banff '91 Planning Committee. This great group masterminded one of the finest National OR conferences to date with record setting attendance and exhibitors. ORNAC's 12th National Conference was outstanding in its educational content and the social events were unsurpassed. Planning Committee members are shown in their official western attire: (seated left to right) Muriel Shewchuk, Calgary; Pat Petersen, Lethbridge; Jackie Waisman, (Conference Chairperson),Red Deer; Nadine Englehart, Calgary; and Gerry Diehl, Edmonton. Standing (left to right): Marge Ensminger, Medicine Hat; Sharon Balkan, Edmonton;Dorothy Orr, Brooks; Marjorie Phillips, Edmonton; Carol Rolfe, Red Deer; and Laurie Butler,

Photo Left: Mark Cooper, Vice President, Surgikos Canada, presents ORNAC President Gloria Stephens with a cheque for $5,000 with which to establish an ORNAC Educational Bursary on behalf of the Johnson & Johnson Family of Companies.

Photo Below: The National Exhibitors Advisory Committee (NEAC) met in Banff to advise and assist ORNAC in conference planning. The NEAC committee for 1991-92 are: (L.toR) Jim McCullough, Silver Stream Industries; Michel Arpin, Johnson & Johnson; Bob Bothwell, MDT Canada; Jim Lawrence, Bard Canada; and, Steve Carter, Davis & Geck.

Mark Schotlander of S&N in the black western hat, organized a ski day. Smith & Nephew's **"Shampaine & Strawberry Ski Tournament"** at Sunshine Ski Resort The day on the mountain was won by an Eastern Snow Bunny.
(Photo Credit) Marge Ensminger, ORNAC Photographer

12th National Conference

Operating Room Nurses Association of Canada - Banff, Alberta, May 12-17, 1991.

Donalda Fullerton (left) and Diane Cowan of Medicine Hat all dressed-up in Indian dress for the "Pemican Firewater Pow Wow" - a great welcoming night Alberta style - cocktails, steak & beans, followed by fireside dancing&singing.

Photo Left: Dancing & Dining at Ethicon Night. *Clockwise*: **Matt Henley**, Johnson & Johnson, **Sandra Grimwood,** St. Paul's Hospital, Vancouver, **Bill Reynolds**, Ethicon and **Mary Raikes-Tindle**, Head Nurse, Vancouver General.
(Photo Credit: Sue Kerr)

▲ Anna Kristoff,Regina, sang O'Canada in both languages to open Banff '91. She is seen dancing with Pat O'Dewyar, Howmedica. The big band followed the "Great Canadian Banquet" - a delicious specialty dish from each province.**(Photo Right)** Lynn Walters, OR nurse,VGH, Vancouver sings like the professional songster she is at the Baxter Fun Night with singer Cliff Erickson.Photo Credit:Vivian Knisley, Lloydminister

▼ ORNAC's full board met all day Saturday and Sunday prior to the Conference.

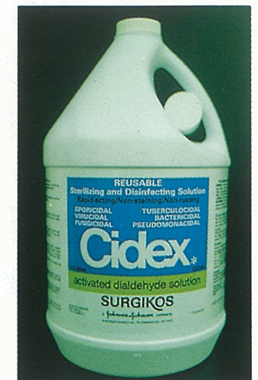
Bill Moran, Vice President, Johnson & Johnson Medical Group, presents a 5th conference commemorative to ORNAC, a specially commissioned water color of the Banff mountains and roses , Alberta's official flower. ORNAC president Gloria Stephens accepting.

Work, work, work! The ORNAC Board of Directors met in day-long sessions two days prior to the 12th national conferencein Banff. The business agenda was filled to overflowing with over 26 official members and several ex-officio members and visiting delegations. (Photo Credit: Marge Ensminger)

Twenty-one OR nurses from Vancouver, Victoria and the Lower Mainland travelled the nine-hours to Banff '91 singing, sight-seeing and eatingon the Happy Howmedica Chartered Blue Bus. Champaigne lunches and tasty treats were served on the road.

Before the five day educational conferences started each morning there were breakfasts sponsored by Baxter, Howmedica, Zimmer and Autosuture. At 06:00 each morning there was the MDT Fun Run for the fit . The gal in the pink shorts is **Helen Calverly**, Children's Hospital, a Vancouver marathon runner. In the blue tights - **Lynn Walters**, and OR nurse who is also an aerobics instructor and singer.

"We should have used Cidex*."



There's a saying that's as old as the ages—you get what you pay for. And when it comes to protecting expensive scopes and instruments, you can't buy better asepsis protection than CIDEX* Brand disinfectants. We have 25 years of documentation to prove it. Our highly trained professional representatives can show you how to select and implement the right disinfection system to meet the special needs of your department.

So don't let a few cents stand in the way of common sense. Get the CIDEX* system working for you before it is too late.

Johnson & Johnson
MEDICAL PRODUCTS
PETERBOROUGH, ONTARIO K9J 7B9

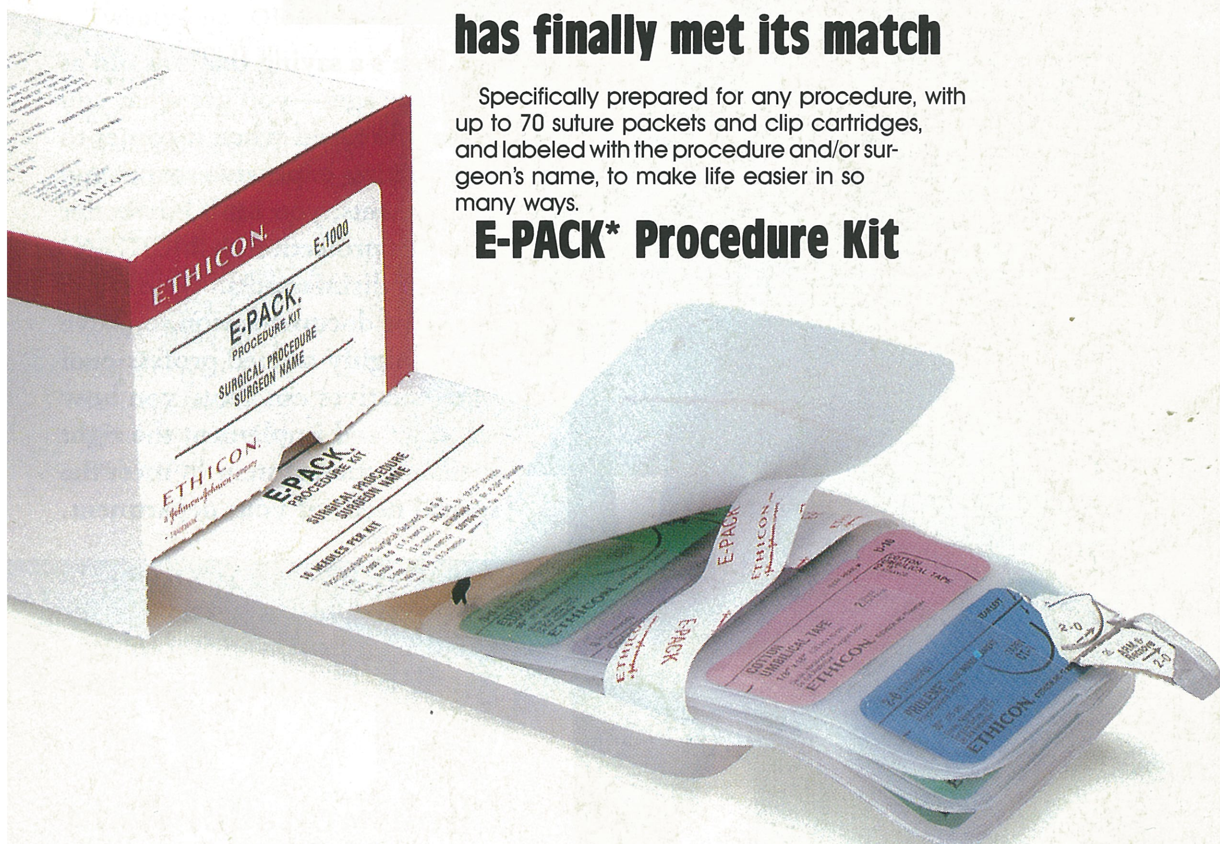
*Trademark

The task of pulling, preparing, setting-up, dispensing, counting, recording charges for, taking inventory of, reordering and receiving the thousands of sutures and ligating clips you handle every year...

has finally met its match

Specifically prepared for any procedure, with up to 70 suture packets and clip cartridges, and labeled with the procedure and/or surgeon's name, to make life easier in so many ways.

E-PACK* Procedure Kit



ETHICON LTD.
a Johnson & Johnson company
PETERBOROUGH, ONTARIO K9J 7B9

* Trademark
© ETHICON LTD., 1987