Canadian Operating Room Nursing Journal

Volume 8, Number 1, February, 1990

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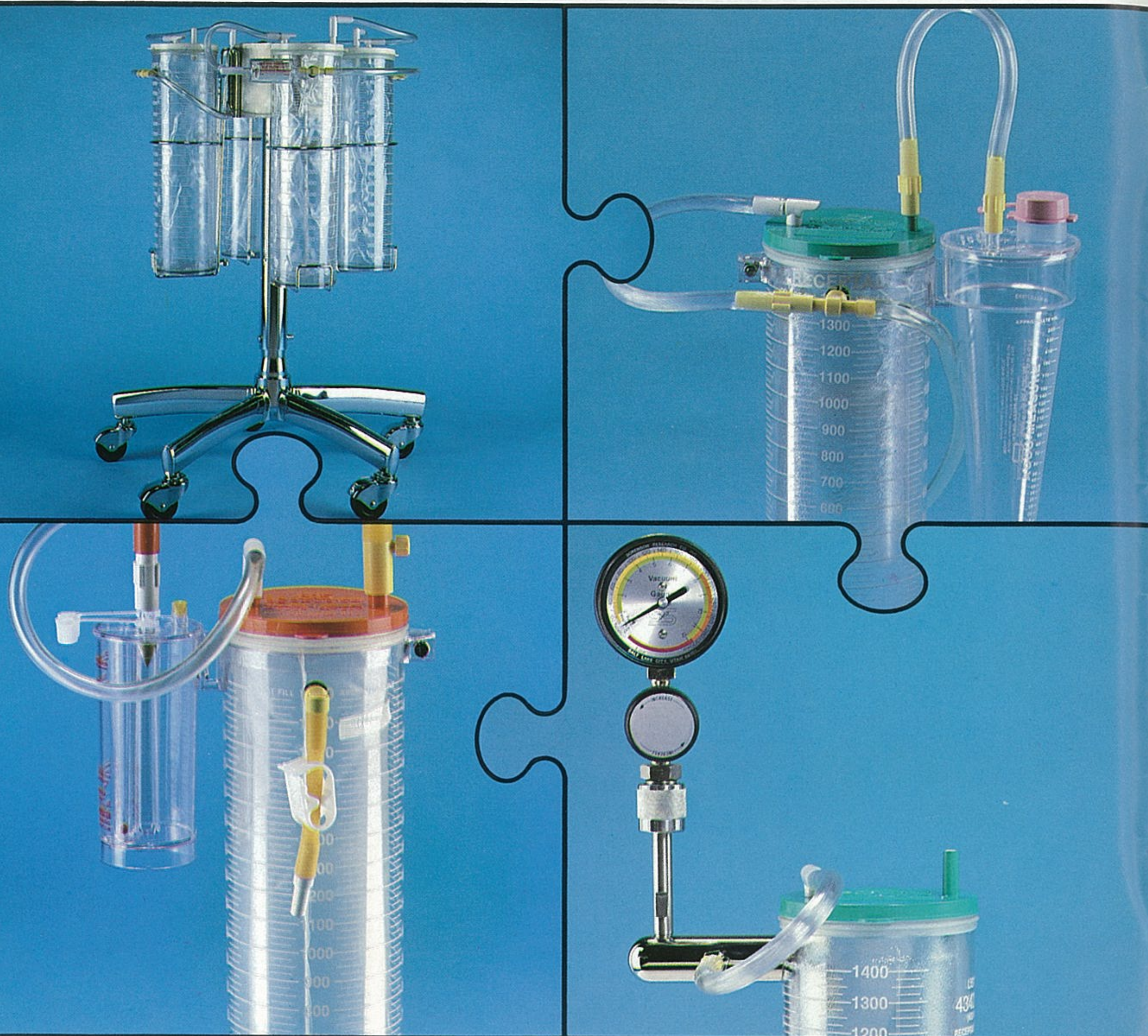

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Fortunately, to date, the educational base of operating room nursing has been able to cope with the technological and pharmacological changes. However, the demands of the future will require that there be standardized O.R. nursing education. Why this standardization is so desperately needed and how it can be accomplished is the subject of this discussion.
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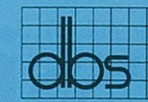

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Professionalism and the O.R. nurse

By Geraldine McEvoy, R.N.

Why is professionalism so important to the operating room nurse today, and what can be done to foster an image that reflects what the operating room nurse truly stands for?

These questions, and the issues implied, were addressed in a presentation at the 23rd Annual Provincial Conference of the Operating Room Nurses Association of Quebec held in Montreal last Fall.

Understanding professionalism

The first step in presenting oneself as a professional is having a firm understanding of what professionalism is.

Professionalism requires that a discipline possess its own body of knowledge, that it control its own level of entry and qualifications, and that it set its own standards and quality of work.

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

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

Enriching our image

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

Operating room nurses have been challenged by change. As O.R. nurses, we have been called upon to keep abreast of the latest developments in technology and healthcare. These changes have occurred in a number of areas including:

1. Education
2. The multi-disciplinary approach
3. Research
4. Quality assurance
5. The nurse consultant
6. Continuing education
7. Primary nursing
8. Standard care plans
9. Staff development
10. Nursing calendars
11. Evaluation
12. Central orientation
13. Parallel professionals
14. Nursing grand rounds
15. Problem identification

We must look carefully at the above list and identify those areas where we have to reinforce ourselves collectively and individually on an ongoing and regular basis.

Some of the rewards O.R. nurses share with other professionals include:

1. Respect by and for colleagues
2. A fair salary
3. A healthy balance in work and personal life
4. Recognition of achievement and opportunities for growth
5. Supporting our peers and colleagues involved in regional, provincial and national organizations whose efforts are beneficial to the profession
6. On-going education
7. Participation in research
8. Never being satisfied with the status quo

Role perceptions

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

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

We must be very clear (in the professional perception of our role), otherwise frustration, conflict of interest and disintegration will occur. We must know not only our own roles, but those of others in order to have a reliable frame of reference. We must experiment, keep searching and attempt to direct ourselves towards a positive professional potential... and we must be committed to the nursing process in order to be more effective in our role.

In order to do this efficiently and effectively, the nurse must do all the right things, as we are doing all things right, using the nursing process:

- Assess well
- Plan with thought and care
- Implement and/or intervene as required
- Review often and have on-going evaluation.

Professional development

Karen Zander in her article *"The nurse as a professional gaining the respect we deserve,"* (January/February, 1985, Nursing Life), states that the nurse must first overcome three unprofessional characteristics:

1. Passivity
2. Low self-esteem, and
3. Poor unit organization

She goes on to say that:

Learning = Education

Take a closer look at the connection between learning and being professional, she said. We should never assume that we will learn something if we happen to be at the right place at the right time. We must make learning and teaching our priorities. Furthermore, she states, sharing information is the basis of other professions.

Zander went on to mention two individual strategies which are easily implemented and which will spread knowledge and upgrade the profession:

1. Finding a mentor
2. Being a resource for other nurses

In other words, operating room nurses must share their knowledge, support their colleagues, and upgrade their profession.

To examine your contributions toward your profession and to find out if you share your expertise and support your colleagues, ask yourself these questions:

Do you:

- Accept individual responsibility and accountability for nursing interventions and their results?
- Share responsibility for patients by collaborating and consulting with team members?
- Initiate and/or participate in change when required to improve quality of care?
- Participate in activities for keeping yourself informed about new knowledge and nursing roles?
- Initiate and/or participate in activities, discussions, and projects which will extend the knowledge needed to improve the quality of care?

Our nursing environment is one of tradition and history. We have so much to give and so very much to gain. This giving and gaining, I would say, literally promotes a professional bonding, thereby creating a oneness or wholeness in giving professional nursing care.

Role modelling

How do we role model this professional identity in the O.R.? The best way we can role model is:

- act competently
- adhere to professional standards
- be assertive
- develop the ability to set priorities
- be responsible and accountable
- show enthusiasm
- develop writing skills
- be active in committees, i.e., QA, research, etc.
- develop a business-like, professional attitude,

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We must fully realize as professional nurses that the basis of our practice is scientific knowledge. Thus, we must exercise the right of professional judgement in decision making at any and every opportunity.

A changing system

In the operating room, problems will always be encountered. Nurses will become more apprehensive as health care and the role of nursing in the health care system keeps changing.

Nor is nursing projected as a powerful and self-governing body. This is partly due to our on-going internal struggle for recognition. We are insecure, guarded, overly polite, watchful and mistrusting. We hesitate too often to transmit the wealth of O.R. experience and expertise we have. We are thus abdicating our right to active participation in the surgical intervention of the patient. We are too passive in the operating theatres. Remember, you are the patient's best advocate, speak up and act as a check and balance to ensure quality nursing care.

We must be aware that we are being misused if we are restricted to the carrying out of medical orders rather than the professional nursing role that prepared us initially.

We must use our power by gaining access to the information, resources and people who have influence on our health care system.

According to the McGill Model of Nursing (Gottlieb/Rowat):

Nursing is not 'setting-specific'. It occurs wherever there is a client.

In other words, the McGill Model emphasizes family and environment as a single context and the nurse as a collaborator. It emphasizes health behavior as a learned behavior.

Collaboration

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

Collaboration is the most significant indicator of the evolution of professionalism in nursing. It is absolutely essential in the O.R., as we move toward perioperative nursing and that of primary nursing practice on our wards.

The sharing of responsibility (through collaboration) by means of negotiation with nursing colleagues is an absolute must if we are to say that we provide quality nursing care in our hospitals.

Pursuit of excellence

All professionals who are top performers and in the upper echelon of their chosen careers, have, without exception, begun with a clear, conscious decision to be the best. This commitment to excellence quickly becomes the central focus in their personal as well as professional lives.

Excellence, or continued outstanding performance, doesn't just happen over a period of time. Excellence comes about only as a result of constant, vigilant striving to improve in all areas, economically, socially, politically.

Deterents

The greatest deterents to excellence are complacency and self-satisfaction. The path is wide-open and down hill. We start by not thinking or caring, by being content with poor or mediocre performances. We make excuses and rationalize about 'hit and miss' performances.

But, there is another path to choose from. This path implies that you are a winner, a champion.

As you grasp the attitude of being a winner, a change will appear in your character in a positive, constructive and enthusiastic way. You become in charge of your future and, with a feeling of excitement and pleasure, you grow, develop, and accomplish many new tasks and skills. Suddenly you realize that you possess the key to self-motivation. You now accomplish goals which were, until now, completely out of your grasp.

Stages of development

Achieving success as a professional nurse must be well planned. How well you implement the intent of any plan will determine if the outcome will be a success or failure.

Consider the following as a guide to a better understanding of the stages of development one must go through or experience:

1. Immediacy:

Do I love my work, or am I just putting in time? Maybe I can wait until something better comes along. Better still, when that nurse leaves, I'll take her place and be just as professional.

2. Reading skills:

Begin a do-it-yourself project of personal development. Try reading about your profession at least 30 minutes a day - every day. Seek out the best books on nursing available and begin by learning everything expected in the O.R. field. Try to apply, on a daily basis, one new skill, one new way of doing and planning professional care.

3. Listening skills

Try listening to audio cassettes while you drive to work. There are numerous subjects available, and if not accessible, find out where the last O.R. conference was. Most conference agendas are taped.

4. Invest in yourself

Invest approximately five percent of your annual income into your most valuable asset - yourself. Don't waste your professional life learning by trial and error. Pay for a seminar, workshop or a conference. They are well listed in the various nursing journals, especially the *Canadian Operating Room Nursing Journal.*

5. Social

Watch the company you keep. Associate with winners: positive, optimistic, upbeat people with goals, purpose and direction to their lives. Observe top people in your professional group and seek them out. Ask their advise on books, tapes, and courses for on-going professional development. Watch people in the upper echelons. Note how they dress and how they adhere to dress code policy.

Observe the way they utilize their time and the way they treat their nursing colleagues.

Pattern yourself after the people you admire most. You will become like them, especially their positive, success-oriented and professional manner.

6. Health

Guard your health. Enthusiasm is one of the vital ingredients if one is to be in top form. This important and observable attribute is possible only when you are well rested and in good physical shape.

Get enough sleep. You can't nurse properly if you are not well rested. Start your day with a nutritious breakfast. Avoid poor eating habits. Remember, you are a professional role model. Ideally, exercise at least three times a week. Exercise develops the stamina for your long working hours.

7. Communication skills:

Start by investing in a good nursing/medical dictionary. Continually improve your vocabulary. It is an inexpensive and easily acquired skill, and it will be appreciated universally. It will develop your confidence, your self-esteem and it will be well utilized when writing and speaking in public.

Conclusion

Collegiality is a critical factor in achieving the goals of respect and trust. As well, the ability to share and defer judgments are contingent on collgiality. This is essential if we are to reach the highest level of professional behaviour in the operating room. ■

About the author

Geraldine McEvoy, R.N., is Clinical Instructor Operating Room, Montreal Children's Hospital. She received her diploma from the Sudbury General Hospital and is presently studying for her B.A. at Concordia University. She is co-president of the Operating Room Nurses Association of Quebec.

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Promoting OR education

The need is now!

By Joan Donald, R.N., B.Sc.N., M.A.

Probably no field of nursing has been as bombarded by the technologic and pharmacologic explosion as that of operating room nursing. In order to cope, our educational base has had to encompass many subjects. As never before, in order to meet the challenges of the future, we must be prepared. Education, an essential, on-going pursuit for all of us, prevents us from clinging to the past. At the same time, it allows us to embrace the future.

Basic nursing education

During our basic nursing education programs we were taught various skills and gained a practical and clinical knowledge base. We were taught the importance of adequate patient assessment as applied to the nursing process, and we all know the value of patient teaching. **How** we communicate has become as important as **when** and **to whom** we communicate. As members of the operating room team, the techniques we have been taught enhance our participation and role, a role that is integral to the providing of the best patient care possible.

University education

Because of the pharmaco-technological revolution in medicine and health care, I am convinced that nursing is ready to move ahead and plan, organize and participate in the transition to university-based education. Toward this end, we desperately need standardization of nursing education.

Nursing graduates from all types of programs are required to write a standard registration exam. Should they not, then, be educated with a standard curriculum in a standard program?

As Baumgart and Larson noted in a published discussion about the future of nursing in Canada...

"As the only major health occupation which has not standardized entry qualifications and required a university degree for its basic preparation, nursing is in a disadvantaged position." (1)

Whether we like to admit it or not, we have to meet our colleagues on the same level. University credentials serve to enhance nursing power, particularly when negotiating with other power groups. We have a responsibility to be prepared for the future and ensure that we have input into what any nursing education program will contain. More importantly, now is the time to make our views known and to influence the contents of nursing education at the university level.

The O.R. experience

The Operating Room Nurses Association of Canada feels that the basic nursing education program must include operating room experience. No other area of the hospital provides the opportunity for learning aseptic technique, anatomy and physiology, pharmacology in action, and on and on the list goes. There is no better educational set-

ting than the operating room environment from which to learn an appreciation for what the patient goes through during the surgical experience.

As well, wouldn't it be wonderful to know that a nurse who graduates from a university-based nursing program has OR experience whether she studies in B.C., Alberta, Quebec or Newfoundland?

How do we achieve this goal - or any other goal in this high-tech world - with the increasing emphasis on academic credentials? If we are to fully demonstrate our value and influence others, we must equip ourselves with the tools to do so. We need to have a greater understanding of the following areas of expertise and learning:

- research methodology
- computers
- pharmaco-dynamics
- proposals/guidelines for submissions to administrators and government
- financing and budget management
- forecasting and future planning
- teaching methodology
- the assertiveness and confidence required to approach decision makers and influence them in a positive way in order to achieve our goals.

"Real" patient care

In discussing the image of the operating room nurse, Roller mentioned that...

"One perioperative nurse wrote that her nursing instructors could not understand how she could use her BSN degree in the OR because it (the OR) has a surgeon-oriented and technical atmosphere." [2]

We have to dispel the myth that perioperative nurses do not participate in "real patient care." We have a responsibility to change this perception of OR nursing. Strategies for changing the perceived image of OR nursing are suggested by Roller:

1. Portraying a positive image
2. Acting professionally
3. Interacting with patient/family
4. Networking
5. Presenting in-services
6. Educating the public
7. Informing the media
8. Becoming involved

The complexity of clinical judgement s required in nursing is not temporary or stagnant. The demands for the future can only increase. Thus, as operating room nurses, we must be dynamic, both in our practice and in our quest for knowledge.

This quest for learning is a lifelong process. As we race into the 21st century, the need for a greater knowledge base is increasingly evident. By augmenting our basic education, we increase our ability to interpret and predict. Staying on top of things is more difficult with each passing day. We have to grab every opportunity to learn, i.e., attend every workshop that we can, participate in every inservice program provided, etc. More and more we are being challenged to project what our needs will be over the next five to 15 years.

New techniques

I don't know the experiences of all perioperative nursing personnel, but my crystal ball gets cloudy from time to time, particularly when a totally new surgical technique looms on the horizon. Just think, for instance, of the impact that lasers have had on us over the past few years.

We have to learn to read the statistical charts and develop graphs for predicting trends. Other disciplines are just as pressured in this regard. We must utilize our networking system in the nursing, academic, administrative and government communities. We have to share insights with colleagues, and offer to teach and share expertise and enthusiasm for the nursing profession with others.

Professional responsibility

I believe O.R. nurses have the dedication and commitment to achieve their goals and ensure that educational needs are met. The Code of Ethics for Nursing published by the CNA in 1989 states...

"Nurses should engage in continuing education and in the upgrading of skills relevant to the practice setting." [3]

Can any nurse feel competent and comfortable to do otherwise? Even the Recommended Standards for Operating Room Nursing Practise compiled by ORNAC states...

"Operating room nursing practice requires a base of knowledge that is current and practical for meet ing the needs of the surgical patient." [4]

In standard #3.2.6, we further read...

"The nurse in the operating room actively seeks opportunities for professional development."

And in 3.3 of the Recommended Standards...

"Operating room nurses are required to comply with the Code of Ethics of their profession."

If we are to comply with this code, then we will engage in continuing education.

Number Five of the American Nurse's Association code for Nurses asserts that...

"The nurse maintains competency in nursing." [5]

This obligates the nurse to maintain competency. Most nurses obviously believe this to be essential, and this is evident by the number who regularly attend workshops, seminars, courses, national, provincial and regional meetings.

The O.R. role challenged

The role of the nurse in the OR has frequently been questioned and challenged. The attempt by the American Medical Association, for example, to see introduced the Registered Care Technologist jeopardizes our value and very existence in the OR. We must continually be on guard and equipped with the knowledge and skills to stay on top and thwart attempts to be subverted.

Linda Groah, a renowned writer and educator in the nursing field in both Canada and the United States has stated...

"In the future, research will be an important component of professional operating room nursing. Clinical research projects designed to identify patient outcomes and to test the body of knowledge used in implementing patient care are vital (in order) to validate the perioperative role." [6]

Conclusion

Operating room nurses must be viewed as professionals who are intelligent, creative, assertive, progressive and committed to quality nursing care. I am convinced that we are progressing toward that common goal. Our commitment to OR nursing will provide us with the cohesiveness and dedication to learning that will be required to meet the future head on. Though perioperative nursing continues to be a challenge, its rewards are many. ■

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Spinal narcotics

Implications for nursing

By Carol Markowsky, R.N., B.S.N.

Interest in pain control has resulted in considerable study of the various techniques for providing analgesia. One such technique that is growing in popularity is the use of spinal narcotics (injection of narcotics either into the subarachnoid or epidural space). Spinal narcotics are used in the treatment of chronic or acute pain whether it be due to surgery, trauma or disease process (Buckley, 1987).

The apparent advantage of spinal administration of narcotics over systemic administration is the generation of segmental analgesia by direct spinal action so side effects commonly associated with the systemic route are avoided. However, there is evidence that spinally administered narcotics undergo supraspinal redistribution activating brain stem centers responsible for side effects such as nausea, vomiting, pruritis, respiratory depression (Moulin, 1984). This article will review anatomy, technique of injection, contraindications, mechanism of action, side effects, and the resulting implications of spinal narcotics.

Anatomy

The spinal cord is covered and protected by the three meninges that perform the same protective function for the brain. The dura mater is the outer most membrane, a strong, expandable sheath of dense, fibrous connective tissue that ends in a blind sac at the end of the second or third segment of the sacrum. (See Figure 1) The epidural space is located between the outer surface of the dura and the bones of the vertebral canal. It contains a network of blood vessels, adipose, and loose connective tissue. The subdural space is that area between the inner surface of the dura and the underlying arachnoid membrane.

Injection technique

The middle meningeal layer is the arachnoid membrane. The inner-most layer of the meninges is the delicate pia mater and is very closely applied to the spinal cord. The subarachnoid space is a roomy area between the arachnoid and the pia mater. The subarachnoid space contains an abundant amount of cerebral spinal fluid (CSF) (Drain, 1987).

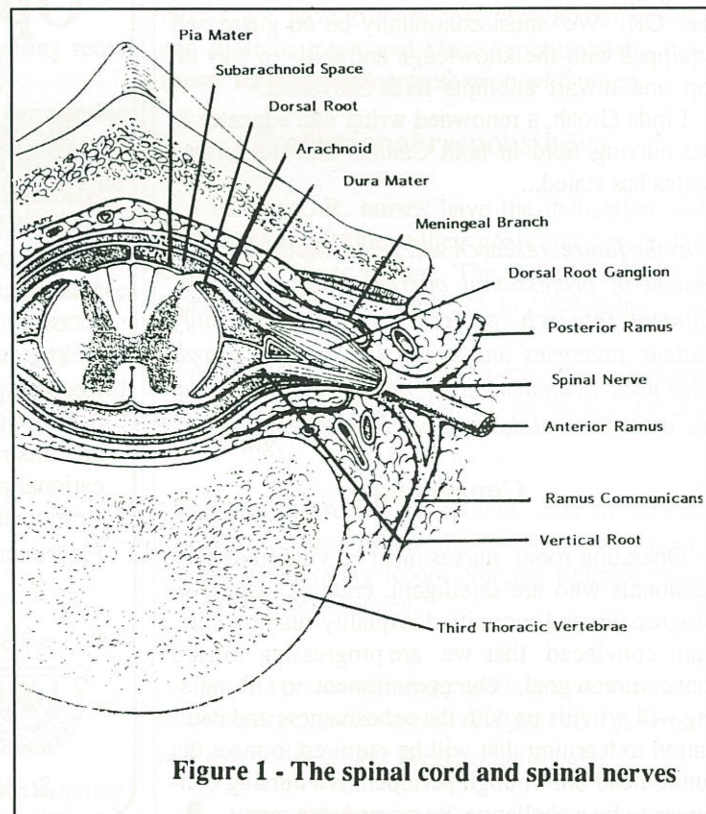

Figure 1 - The spinal cord and spinal nerves

Whatever the site of pain, injection of epidural or subarachnoid narcotics is usually done at the lumbar level for reasons of safety. In the adult, the spinal cord terminates at the level of the first or second lumbar vertebrae. The meninges, lumbar and sacral nerve roots extend into the sacral portion of the spinal canal (See Figure 2). Thus, a needle that enters the subarachnoid space below the termination of cord cannot possibly strike the cord with resulting trauma, but will simply move the nerve roots aside.

For subarachnoid or epidural injection the patient can be in the sitting or lateral position.The patient is asked to curl up in the fetal position which opens the spaces between the spinous processes. An imaginary connecting line is drawn between the two iliac crests. This line will pass through the tip of the spinous process of L4. Injection is usually made between L2 and L4. Passage through the meninges into the subarachnoid space is detected by a slight "pop". CSF will then flow freely from the needle after the stylet is removed.

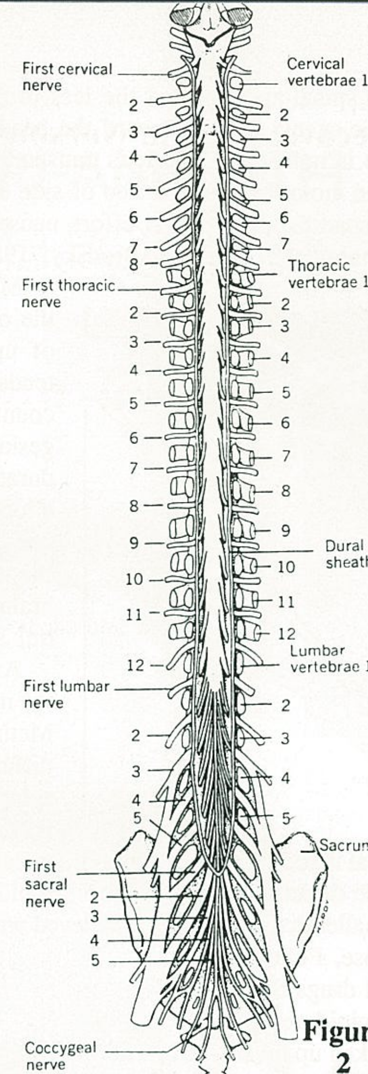

Figure 2

Infection and spinal headaches

For epidural injection, a larger, blunt-tipped needle is used. The needle is advanced until it is firmly in the interspinous ligament (a strong fibrous cord that connects the tips of the spinous processes). The stylet is removed and a 5 cc or 10 cc glass-barreled syringe is attached, filled with air or saline. The needle tip is then advanced into the ligamentum flavum (a thick band of yellow elastic fibers that connects adjacent laminae). There is considerable resistance to injection in the ligamentum flavum, with the plunger actually "bouncing" when compressed. Loss of resistance identifies the epidural space (Buckley & Brodsky, 1987).

It is common practice to insert an epidural catheter through the epidural needle, which is then left in place for subsequent injections. It is also possible to insert a subarachnoid catheter; however, this is much less common because of the risk of infection into the CSF, and because of the risk of spinal headache due to the leak of spinal fluid through the puncture site. The subarachnoid route is more suitable when a single-dose spinal anesthetic is used, and at the time of induction a narcotic is mixed with the local anesthetic (Bromage, 1982).

Contraindications

There are few contraindications to the use of spinal narcotics. Most are related to the technique of injection. A pre-existing coagulopathy is considered an absolute contraindication. There is a great risk for formation of hematomas and the resulting neurological deficit from compression of the nerve roots or spinal cord.

Systemic infection is considered a relative contraindication because of the risk of creating a focus for central nervous infection, especially if a bloody tap occurs. However, active infection at the insertion site is an absolute contraindication. Obviously, the infecting organism might be carried into the epidural or subarachnoid space.

Another absolute contraindication is patient refusal. The patient must be cooperative. There is little to gain from coercing patients into a procedure that they do not accept.

Spinal deformities, i.e., scoliosis, are relative contraindications in that they make the injection more difficult (Buckley and Brodsky, 1987).

Mechanism of action

Opioid receptors are concentrated in the substantia gelatinosa in the dorsal horn of the spinal cord. Whether administered by the epidural or subarachnoid route, opioid drugs must reach the spinal cord to activate the receptors and block pain trans-

mission is blocked. The block from spinal anaesthetics (injection of local anaesthetic agents into the epidural or subarachnoid space) is"non-selective" in that sympathetic, sensory and motor block can be accomplished. Using local anaesthetics, it is possible to achieve complete anaesthesia and muscle relaxation, but not with spinal narcotics.

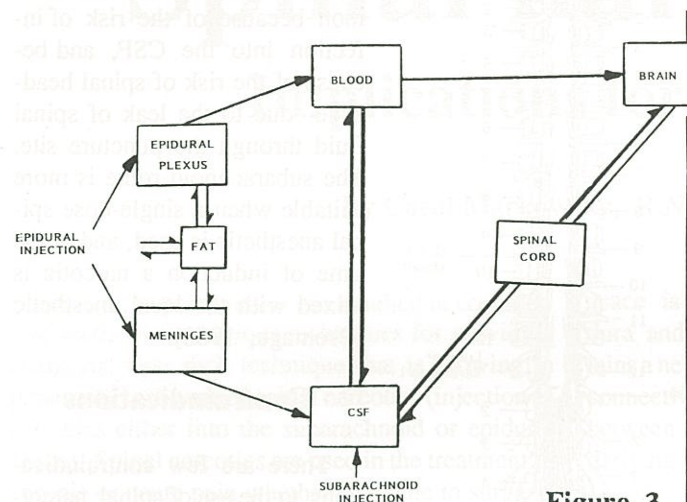

Figure 3

Subarachnoid injections are made directly into the CSF and thus require a much smaller dose, approximately 4% of the epidural dose. Following subarachnoid administration, opioid drugs diffuse into the spinal cord to occupy opioid receptor sites. Some of the narcotic is also taken up by surrounding vessels. (Fig 3) (Buckley & Brodsky).

Analysis of epidural uptake is more complex. Epidural fat is found throughout the epidural space and is one of the main competitors for narcotics injected into the epidural space. The other two being blood vessels and the spinal cord itself. Some of the drug is taken up by the rich epidural plexus which drains into the intracranial veins and then into the central circulation. The result being similar to that of intravascular absorption (as in I.V. injection) of the narcotics with its subsequent central effect. (Moulin, 1984). Epidural narcotics also diffuse across the meninges and into the CSF. From there the drug is taken up by the surface of the cord to opioid receptor sites (See Figure 3).

Drugs used

Narcotics have certain characteristics that determine their mode of action and speed of transport. Lipid solubility is one such characteristic. The more lipid soluable the drug, the more rapidly and completely it is taken up by the spinal cord and the less drug is left over to move cephalad (toward the head). The degree to which the narcotic is transported to the brain determines the incidence of side effects such as depressed respiratory effort, nausea, vomiting and puritis (Buckley and Brodsky, 1987).

Morphine, the least lipid soluble of the opiate analgesics has a slow rate of uptake into the spinal cord and tends to linger in the CSF. This accounts for the delay in onset of analgesia (30-60 min.) and the prolonged duration of action (12 to 24 hours). It allows for a greater fraction of the drug to ascend in the CSF to reach the 4th ventricle and surrounding brain stem centre responsible for central side effects (Moulin, 1984).

Available evidence suggests that the more fat soluble narcotics, such as Methadone, Fentanyl and Demerol, diffuse out of the CSF and into the spinal cord fast enough to escape the rostral spread seen with poorly lipid-soluble drugs such as Morphine. Analgesic effect is of more rapid onset and shorter duration than that achieved with Morphine. (Bromage, 1982).

Side effects

The major side effects of spinal narcotics, be they administered via the epidural or subarachnoid route, are primarily four in number:

- Respiratory depression
- Pruritis
- Nausea and vomiting
- Urinary retention

Respiratory depression

The most serious, though least frequent, is respiratory depression. Respiratory depression associated with intraspinal narcotics is biphasic in nature. Early respiratory depression (first 30 - 60 minutes) is believed to be the result of intravascular absorption of the narcotic with its subsequent central effect. This is not generally of serious significance as the patient, at this time, is usually under close observation either in the O.R. or P.A.R.

In addition, vascular absorption of a fraction of a 5 or 10 mg dose of Morphine does not result in great risk since it is common practice to administer a similar or even greater intravenous dose to

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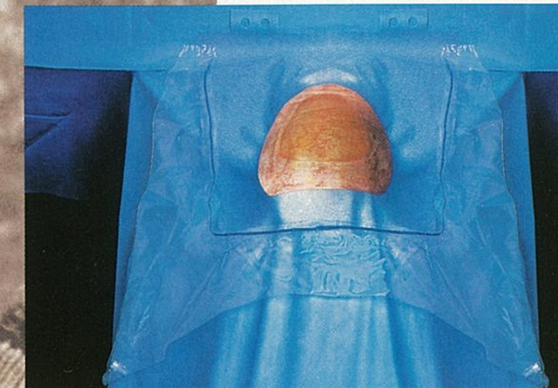

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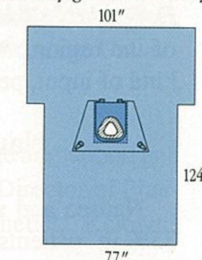

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the patient in the early post operative period.

The most dangerous is the late respiratory depression. It commonly occurs from 8 - 16 hours post injection, but may occur up to 24 hours post injection. As previously stated, late respiratory problems occur chiefly with the poorly lipid soluble agents such as Morphine. Due to its limited lipid solubility not all of the drug is taken up by the spinal cord. This allows more unbound drug to reach the fourth ventricle. Respiratory centers of the brain stem are bathed in concentrations of the drug infrequently achieved with oral or parenteral administration. The delay in respiratory depression is due to the time required for the narcotic to spread rostrally (toward the head) in the cerebral spinal fluid.

Fortunately, respiratory depression, as well as other side effects of spinal narcotics may be treated with Naloxone Hydrochloride. The side effects can be reversed while not compromising the analgesia because of a greater blood flow to the brain than the substantia gelatinosa (gray matter surrounding spinal canal). (Bochenek, 1988). Naloxone is usually given in small doses (0.1 mg to 0.2 mg) via intravenous bolus. The duration of Naloxone is 15 to 20 minutes, so repetitive doses may be required (Moulin, 1984).

Pruritis

Another common side effect of intraspinal narcotics is pruritis, occurring in 10 - 30% of patients. The itching may be generalized but is usually restricted to the nose and perioral region. In most cases this pruritis is not histamine-induced; however, if the patient is allowed to scratch before treatment with Naloxone, a histamine component may be initiated and treatment with antihistamines may be beneficial.

The most recent theory with regard to the etiology of pruritis is that the ascending narcotic results in an imbalance in the sensory perception of the region, resulting in a predominance in one kind of input, perceived as itching (Bochenek).

Nausea and vomiting

Nausea and vomiting occur at a rate of 15 to 35% in patients who have received spinal narcotics. Nausea and vomiting is likely a result of direct stimulation of the chemoreceptor trigger zone in the floor of the fourth ventricle. (Bochenek, 1988). Tolerance to this side effect apparently develops rapidly as the incidence of vomiting is reduced with repetitive dosing in the patient with chronic cancer pain. Again, the most successful treatment is Naloxone Hydrochloride. (Moulin).

Urinary retention

Urinary retention is probably the only side effect of spinal narcotics due to direct action on the spinal cord. Inhibition of parasympathetic outflow from the sacral spinal cord may be the mechanism. There is a 10 - 30% incidence in males. Urinary retention, however, is the least clinically noted side effect, as most patients requiring spinal narcotics also require indwelling urinary catheters for at least 24 hours. (Bochenek, 1988).

The potential development of serious side effects generally limits the use of spinal narcotics to individuals with pain below the mid-thoracic level. The higher the level of drug administration (dependent on dose, injection site, drug used, and rate of injection), the greater the degree of rostral redistribution via the CSF and the greater the likelihood of central side effects. (Moulin, 1984).

Complications associated with the technique of spinal injection itself include spinal headache, epidural hematoma, epidural abscess and direct trauma to nerve roots or the spinal cord. If the dura is accidentally punctured with an epidural needle (larger needle of 17 or 18 gauge), there is a 50 - 70% incidence of headache. (Bochenek).

Headache is thought to be due to persistent CSF leak. Usually, conservative treatment such as fluid and analgesia is sufficient, and the headache resolves itself within 24 to 48 hours. If conservative treatment is not sufficient, epidural blood patch is the most effective and reliable treatment available. (Buckley and Brodsky, 1987).

Rare complications

A hematoma may form in the epidural space after administration of an epidural narcotic. This is a rare complication and is almost always seen in association with clotting deficiencies. The patient may complain of back pain and/or neurological deficit (i.e. leg weakness). Symptoms may appear within hours to several days after insertion. The symptoms are related to spinal cord compression. Surgical decompression of the cord must be performed as soon as possible otherwise, permanent loss of motor function is likely.

Epidural abscess is also a rare complication. Infection may be related to faulty technique or it may occur in association with general systemic infection. Signs and symptoms include marked back pain, leg weakness, paresthesia and fever. Treatment includes immediate drainage of the abscess and aggressive antibiotic therapy. (Bochenek).

"It is imperative that nurses be well informed about spinal narcotics. Appropriate assessment skills and interventions can then be implemented when caring for the patient who has received spinal narcotics."

As mentioned previously, spinal narcotics should be used in patients with coagulation disorders or local and/or systemic infection. Other complications such as direct trauma to nerve roots or spinal cord are very rare. Nonetheless, neurological symptoms following epidural or subarachnoid injection warrant careful assessment and prompt intervention. (Buckley and Brodsky, 1987).

Nursing implications

Management of the patient who has received spinal narcotics lies with effective monitoring, especially ventilation. It should be noted that respiratory rate alone is poor measurement of ventilatory adequacy and apneic episodes may occur with very little warning. Apneic monitors, pulse oximetry and end tidal capnography can be used to assist the nurse. The most dangerous time for respiratory depression is between the 6th and 12th hour after intraspinal administration. This is often the time when visitors may have left and the patient is thought to be safe left on his own resources with occasional nursing visits.

Nurses must also understand the importance of not administering parental narcotics or other sedatives in conjunction with spinal narcotics. This is because most life-threatening respiratory complications that have occurred involved combinations of spinal and parental narcotics. Standing Orders can be written to assist nursing staff in dealing with problems related to inadequate analgesic, pruritis, nausea, vomiting, and respiratory depression. (Buckley and Brodsky, 1987).

Because of concerns related to delayed respiratory depression, the majority of patients receiving spinal narcotics are cared for in the I.C.U. setting (i.e. thoracotomy, total cystectomy, bowel resection, etc). However, this superior form of analgesia is being utilized with increasing frequency in other areas outside of I.C.U. such as medical wards for terminally ill patients, or obstetrics for caesarian-section patients who have also received epidural anesthesia. It is imperative that nurses be well informed about spinal narcotics. Appropriate assessment skills and interventions can then be implemented when caring for the patient who has received spinal narcotics. ■

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About the author

Carol Markowsky, R.N., B.S.N., is head nurse, Post Anaesthetic Recovery, and Director of Central Supply, Kelowna General Hospital, Kelowna, B.C. She received her R.N. and B.S.N. from the University of Victoria, Victoria, B.C.

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Calendar of Events

March 18 - 23, 1990, Houston, Texas: 37th Annual AORN Congress, the George R. Brown Convention Centre. (Contact AORN Meeting Services, 10170 East Mississippi Ave., Denver, Colorado 80231; (303) 755-6300).

April 9 - 11, Hamilton, Ontario: 13th Annual National Conference, Orthopaedic and Arthritic Nurses Association. "Nursing Strength Through Knowledge. (Contact: David Morland, R.N., 15 Allan Ave., Guelph, Ont. N1H 3G1).

May 3 - 5, Vancouver, B.C.: 12th Biennial Institute of the B.C. Operating Room Nurses Group, Hotel Vancouver. (Contact Susan Wynne, 1371 Mathers Ave., West Vancouver, B.C. V7T 2G5).

May 5, 1990, Windsor, Ontario: 11th Annual Symposium, Malignant Hyperthermia Association, Hotel Dieu Hospital. (Contact Juliette Beaudet, R. N., Hotel Dieu Hospital, 1030 Ouellette Ave., Windsor, Ont. N9A 1E1. (519) 973-4421).

May 19 - 21, Rexdale, (Toronto), Ont.: 14th Annual Convention, the Canadian Society of Orthopaedic Technologists, The Carlton Place Hotel, Rexdale, Ontario. (Contact Pam Smith, 4433 Sheppard Avenue East, Suite 200, Agincourt, Ontario M1S 1V3 (416) 292-0687.

June 27 - 29, Banff, Alberta: 21st Annual Scientific Sessions, Canadian Association of Neuroscience Nurses. (Contact Maureen Robertson, Box 676, Bragg Creek, Alberta T0L 0K0)

September 28 - 30, Regina, Sask.: 6th Annual Conference, Saskatchewan Operating Room Nurses Group. (Contact Ginny Mielke, 106 Lockwood Rd., Regina, Sask. S4S 3G2. (306) 359-2325).

October 18 - 20, Gander, Nfld: 11th Annual Conference, Newfoundland & Labrador O.R. Nurses Association, Hotel Gander. (Exhibitors contact Henry Norris, James Paton Memorial Hospital, 125 Trans Canada Highway, Gander, Nfld. A1V 1P7).

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Agenda

11th National O.R Nurses Conference

Harbour Castle - Westin Hotel

Toronto, Ontario, April 2 to April 6, 1990

Sunday, April 1, 1990

1600 - 1700 Pre-registration
2000 - 2230 **Get-together Cocktail Party**

Monday, April 2, 1990

0700 - 0815 Registration
0830 - 0915 **Opening Ceremonies**
0915 - 1000 Keynote Speaker (Josephine Flaherty) "Power and Influence in Nursing... Is it a Desired Goal Today?"
1000 - 1030 Coffee/break
1030 - 1130 O.R.N.A.C. Information Meeting
1130 - 1135 **Opening of Exhibits**
1135 - 1430 Viewing of Exhibits/Lunch
1500 - 1630
1. Are You Future Tense? (Karen Fraser)
2. The New Theoretical View of the O.R. (Gerte Torres)
3. Use of the Ilizarov in Children and Adults (Drs. D. and R. Bell)

1830 - 2100 **Ethicon Night**

Tuesday, April 3, 1990

0700 - 0815 Registration
0830 - 1000
1. How Nursing Can Influence the Health Care System (I. Milton)
2. Personal Financial Planning for the Nineties (Alf Schmocker)
3. Heart Transplants (Margo Fretz, Dr. A. Menkis, Dr. H. Rosenberg)

1000 - 1030 Coffee/Break
1030 - 1130
1. The Recruitment-Retention Dilemma (Audrey Macdonald)
2. Ethical Decision Making and the Nursing Shortage (M. Burgess)
3. Nurse/Physician Communications (Jane Finan, Dr. B. Taylor)

1130 - 1430 Viewing of Exhibits/Lunch
1500 - 1630
1. Hypothermia in the O.R. (Dr. D. Chung)
2. The Legal Implications of the Nursing Shortage (Fay Rozovsky)
3. Dealing with Stress (Marian Pitters)

2000 - 2230 **California Tacky Beach Party**

Wednesday, April 4, 1990

0700 - 0830 Registration
0830 - 1000
1. O.R. Nurse Personalities (Dr. Brian Little)
2. Introduction to Nursing Research (Marg Fitch)
3. Management of Pediatric Cranio-Facial Problems (Dr.J. Posnick)

1000 - 1030 Coffee/Break
1030 - 1130
1. Arthroscopic Assisted Cruciate Ligament Repair (Anna Hales)
2. O.R. Research Paper (Touchette, Wood, Lightburn, and Calpito)
3. Multiple Birth Experience (Dr. Paul Bernstein)

1130 - 1430 Viewing of Exhibits/Lunch
1500 - 1630
1. Protecting Women's Rights (June Callwood)
2. The Future of O.R. Nursing (Muriel Shewchuk)
3. Orbis-Mobile Eye Surgery Unit (Dr. Jeff Hurwitz)

1900 - 2000 **Exhibitors' Cocktail Party**
2000 - 0100 Dinner/Dance (Black Tie) **"An Affair to Remember"**

Thursday, April 5, 1990

0700 - 0830 Registration
0830 - 1000
1. Pro-Nurse (M. Chenervet)
2. Safe Practices in the O.R. (G. Stephens, C. Goldman)
3. Repair and Growth in the CNS -

Surgical Implications (Dr. M. Rathbone)

1000 - 1030	Coffee/Break
1030 - 1130	1. Pro-Nurse (Cont'd)
	2. Nursing Power (M. Campbell)
	3. Stone Wars - 1990 (Dr. K. Psihramis)
1130 - 1430	Viewing of Exhibits/Lunch
1500 - 1630	1. The 21st Century Nurse (I. Capanolla)
	2. Florence Nightingale (Dr. P. Cruse)
	3. Current Concepts in Facial and Neck Cancer Extirpation and Reconstruction (Dr. J. Freeman, J. Blatherwick)
2000 - 0100	Evening Event (TBA)

Friday, April 6, 1990

0730 - 0845	Registration
0900 - 1030	Closing Session Women's Equity in the Health Care System (Stephen Lewis)
1030 - 1100	Coffee/Break
1100 - 1200	Closing Ceremonies

Registration Information

Five-day Rate - $200.00
(Does not include Dinner/Dance)
Daily Rate - $50.00
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Pre-registration deadline - March 10, 1990
Registration enquiries directed to...

Audrey Macdonald
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Exhibitor enquiries...

Valerie Shirreff
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Exhibitors to date - 11th National O.R. Nurses Conference (Jan. 20)

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Exhibit booths

There are 150 exhibit booths reserved for the National O.R. Conference. The exhibitor's committee say there are several booths not yet contracted. Interested companies are asked to contact: Val Shirreff, Mississauga Hospital, 100 Queensway West, Mississauga, Ont. (416) 848-7628.

1990 ORNAC Executive Nominations

Nominations have been received by the Nominating Committee of the Operating Room Nurses Association of Canada (ORNAC) for election to four executive positions:

- President-elect
- Vice-president
- Secretary
- Treasurer

Noted is that the incumbent president-elect, Gloria Stephens (St. Paul's Hospital, Vancouver), will automatically assume the position of President. Thus, there is no nominee for this position. Also, the outgoing president, Joan Donald (Sackville Memorial Hospital), will be past-president.

Elections for the remaining four executive positions will be held Sunday, April 1, in conjunction with a meeting of the National Board. The Harbour Castle Hilton Hotel in Toronto is the site of the meeting, which will be held prior to the start of the 11th National Conference of the Operating Room Nurses Association of Canada. Individuals nominated for the positions are:

• President Elect
- Carol Lenox-McDougall (Ontario)
- Anne Hughes (Newfoundland)

• Vice-president
- Jackie Waisman (Alberta)
- Anne Hughes (Newfoundland)

• Secretary
- Muriel Shewchuk (Alberta)

• Treasurer
- Carole Starr (Ontario)

Nominee Profiles

President Elect
(two nominees)

(1) Anne Hughes

Currently Nurse Manager, Operating Room, General Hospital of Newfoundland, St. John's, Anne Hughes has been in the nursing profession since graduating from St. Bartholomew's Hospital in London, England. She has served on the ORNAC board representing Newfoundland as well as on the Standards and Education Committees.

Besides a Midwifery Diploma from Cambridge Maternity Hospital, Cambridge, England, she completed the Post-basic Course in Operating Room Technique and Management at the University of Alberta Hospitals, Edmonton, and the Departmental Management Course from the Canadian Hospital Association. Her work background includes staff graduate experience, Ophthalmology and Cardiovascular Thoracic Operating Rooms, St. Bartholomew's Hospital, London, England; staff graduate experience, Operating Room, Montreal General Hospital; satff graduate experience, Operating Room, Fisherman's Memorial Hospital, Lunenburg, N.S.

From 1976 to 1985 she was an instructor in Post Basic O.R. Nursing, Staff Education Department, The General Hospital, St. John's, Newfoundland. Currently, she is studying for her B.Sc. in Biology at the Memorial University of Newfoundland.

Her professional affiliations and offices include: President (1987 - 1989), Newfoundland and Labrador Operating Room Nurses Association. She currently serves as Past-president of this association.

Ms. Hughes has outlined her goals and objectives for ORNAC:

- The promotion of operating room nursing education programs at both the basic (R.N., B.N.) and post-basic levels;
- To update operating room nursing standards, and develop recommendations for O.R. nursing;
- Work towards making ORNAC a more truly national entity by using the resources of the national body to build up and strengthen existing provincial operating room nursing associations.

(2) **Carol Lenox-McDougall**

Nurse Clinician, the Operating Room, P.A.R., Day Surgery and Endoscopy, Mississauga Hospital, Ms. Lenox-McDougall is President of the Operating Room Nurses Association of Ontario, a past-president of the Operating Room Nurses Association of Hamilton and District, and has served on the ORNAC executive and board for the past four years, the last two as Vice-president.

She received her R.N. from the Miami Valley Hospital School of Nursing in Dayton, Ohio and attended Wright State University there as well as McMaster University in Hamilton, where she received her B.Sc.N. She is a member of the Rules and Regulations, Standards, and Editorial Advisory Committees of ORNAC.

Ms. Lenox-McDougall wants to see ORNAC develop a strategy plan with both short and long term objectives. She also wants to see ORNAC become more actively involved in continuing education programs for operating room nurses in Canada.

She envisions the exploring of various mechanisms for financial assistance to operating room nurses who wish to expand their educational horizons. As well, she advocates lobbying the appropriate government and health care agencies in order to allow ORNAC the opportunity to provide input into educational programs for O.R. nurses.

Vice-president

(Two nominated)

(1) **Jackie Waisman**

Presently, she is a general duty nurse, operating room, Red Deer Regional Hospital Centre in Red Deer, Alberta. Her experience includes specialty nursing in general and thoracic surgery, and gynecology and obstetrics.

Ms. Waisman, an ORNAC board member for the past two years, has been an active participant in O.R. nursing at all levels. Currently, her involvement includes: provincial president, O.R. Nurses of Alberta; ORNAC board member representing Alberta; member of the ORNAC Finance Committee; Protocol chairman for the 1991 National Conference Committee (Banff, Alberta); and vice-president of the Central Operating Room Nurses of Alberta.

Ms. Waisman sees four areas within ORNAC where she would like to see greater emphasis:

1. The promotion of continuous communication between the ORNAC executive and board members;
2. Effort expended that will see ORNAC continue to be recognized as dynamic and professional;
3. The support and promotion of the established goals and plans of ORNAC, i.e., standards, certification, strategic planning, encouraging new ideas and goals for the association, and emphasis on continued growth and the promotion and maintenance of professionalism within the association.
4. Encourage the involvement and support at the regional, provincial and national levels.

(2) **Anne Hughes** (See profile previous page)

Secretary

Muriel Shewchuk

Director of Nursing, OR, PAR, Foothills Hospital, Calgary, AB, she received her R.N. and B.Sc.N. from the University of Alberta in Edmonton. Besides post-graduate studies in O.R. Technique and Management, she studied and received her Diploma in Teaching and Supervision from the University of Alberta, and prior to her present position, was an instructor in Post-Graduate O.R. Technique and Management.

She has held a number of executive positions with the O.R. Nurses of Alberta, and has served as an ORNAC board member, executive member and has chaired several committees for ORNAC.

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Unit Supervisor, O.R., Civic Hospital, Peterborough, Ontario, Ms. Starr is currently on the executive of ORNAC and is Past-president of the Operating Room Nurses Association of Ontario.

She has a certificate in Nursing Unit Administration, Departmental Management Certification, as well as an O.R. Post-graduate Certificate. She currently attends the University of Ottawa part time where she is completing her B.Sc.N.

Her goals and objectives for ORNAC include:

- Promoting its work and objectives so that all nurses in Canada have a greater awareness of ORNAC;
- Enhancing ORNAC's professional image so that nurses are aware of membership benefits.

Legal woes of incomplete intraoperative charting

By L.E. and F.A. Rozovsky

Legal defense to litigation based on a surgical or anaesthetic accident can be made or lost on the basis of intraoperative charting. Plaintiffs' lawyers thrive on weaknesses or glaring contraindications in the surgical and anaesthetic record. They cringe, however, when faced with well documented records that demonstrate clear, concise charting that provides plausible or reasonable explanations for intraoperative problems.

For operating room supervisors and staff nurses it is important to understand the legal pitfalls of incomplete charting. In doing so, steps can then be taken to avoid some of the more common, yet serious legal problems.

The issue in context

The fact that a patient emerges from the operating room in a vegetative state is not by itself a sufficient basis for establishing a claim of negligence. By the same token, the fact that the patient leaves the operating room suite with a "retained" surgical needle is not automatically considered a cause for a negligence suit.

The plaintiff must demonstrate that it was more likely than not that the "injury" occurred as the result of the failure to abide by reasonable, prudent standards, resulting in reasonably foreseeable harm or injury; and, in the circumstances, there was no reasonable excuse for failing to live up to the recognized standard of care.

In particularly grey areas, the record might supply the "reasonable excuse" for failing to meet the recognized norm.

In other instances, the record may demonstrate that the injury experienced by the patient was not attributable to negligence, but a recognized and accepted risk of the procedure. In other instances, the record may show glaring deficiencies in treatment to warrant making a prompt offer of settlement to the plaintiff.

Whatever the decision, the record plays a pivotal role in how the defence and the plaintiff handle potential litigation.

How plaintiffs use poor records

Plaintiffs' lawyers can use the poor intraoperative record in a number of ways, including:

1. Demonstrating departures from the standard

Plaintiffs' lawyers can introduce into evidence policies and procedures governing intraoperative charting to establish the average, reasonable, prudent practice. They can then compare the record against the standard practice to show deficiencies in charting required information.

If the deficiencies focus on the injury, the record can be used to show a departure from recognized practices resulting in reasonably foreseeable harm.

2. Attacking credibility of the record

Lawyers can also use poor intraoperative documentation to destroy the credibility of key aspects of the record. Once the court is aware of how the record is supposed to appear and what it actually contains, plaintiffs' lawyers can use record keeping deficiencies to question the reliability or credibility of the entire record. This could be terribly damaging, particularly if great reliance is placed on the record by the defense.

3. Attacking credibility of witnesses

Poor intraoperative recordkeeping can also be used to destroy the credibility or weight of evidence given by defendants. An operating room nurse, anaesthetist, or surgeon may "claim" that they followed procedure, but a heavy shadow may be cast on their testimony by intraoperative records that do not support or even contradict their evidence.

Other spin-offs of poor charting

Aside from litigation, poor recordkeeping in the operating room may be the basis for professional disciplinary or staff privileges proceedings. The failure of anaesthetists to record concurrent observations in the operating room may be sufficient grounds for taking privileges action. Similarly, the failure of nurses to properly complete and record instrument counts in the operating room suite may be the basis for professional disciplinary proceedings.

Preventing legal problems

Several steps can be taken to avoid the legal pitfalls in intraoperative charting. These are largely quality assurance and risk management measures designed to establish and maintain a reasonable level of patient care and liability exposure. The steps which should be considered include:

1. Documentation analysis

Is there too much charting taking place on inconsequential matters? Are more important considerations being overlooked? Can the charting requirements be streamlined? In many instances, a rationalization of intraoperative charting may reduce problems with doctors and nurses failing to comply with recording requirements.

2. Education

Is it assumed that anaesthetists, surgeons, and nurses are well trained in handling documentation? It may be that charting difficulties stem from little time and energy being devoted to practical, hands-on training in managing intraoperative recording requirements.

3. Monitoring

Is the system geared to accurately monitor intraoperative charting? If the answer is "no," there is little incentive for recalcitrant individuals to become more compliant. Furthermore, hospitals need effective lines of communication to facilitate reporting and investigation of non-compliant intraoperative charting.

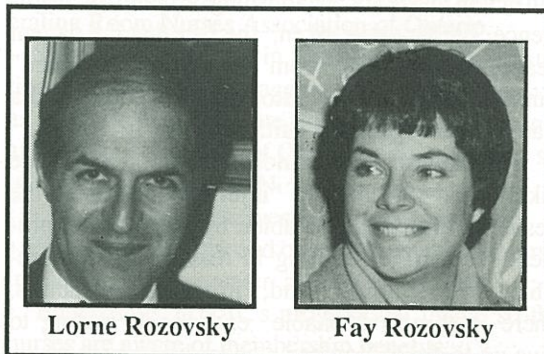
4. Discipline

Are offenders let off with a slap on the wrist? Are they let off without any discipline at all? Documented reports of substandard charting, warnings, and education may not be enough to turn around the most stubborn professionals. If so, consideration should be given to disciplinary action. This is a last resort, but an important tool employed to assure compliance with accepted practice. ■

About the authors

Lorne Rozovsky is a Halifax lawyer with the firm of Patterson Kitz, and adjunct associate professor of law and medicine, Dalhousie University, Halifax, Nova Scotia.

Fay Rozovsky, MPH, president of LEFAR Health Associates, is a visiting lecturer in Health Law, Harvard School of Public Health.



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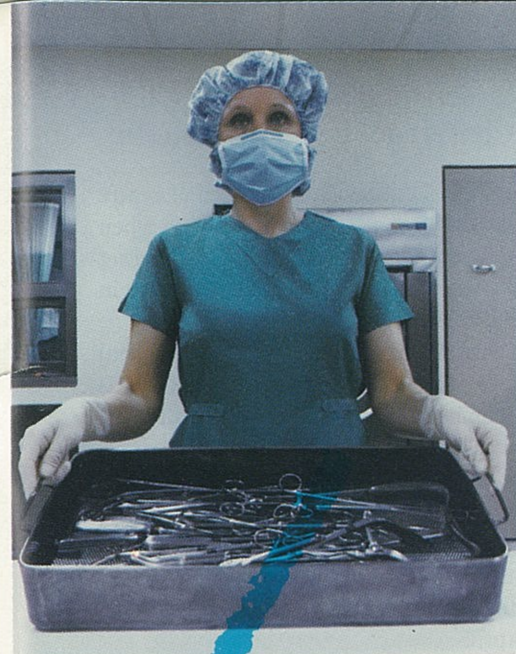
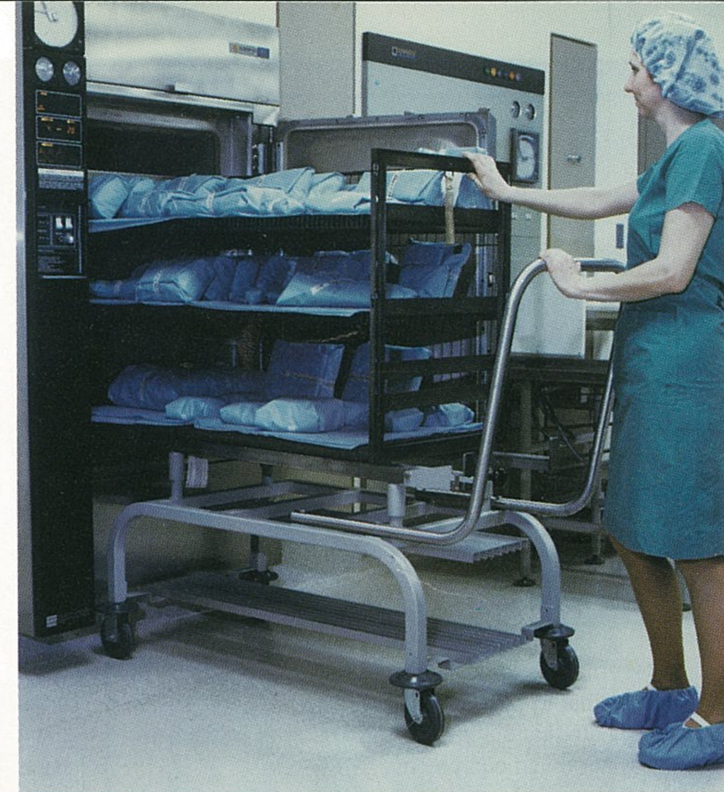
Editor's Note

The ORNAC Executive and Board will have a number of changes following the National ORNAC Conference in Toronto in April. Provncial OR groups are asked to keep the Journal informed of changes in their executives.

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Organizers starting preparations for '91 O.R. Conference in Banff, Alberta

The mountain theme will be front and centre again for operating room nurses in Canada when the 12th National Conference of the Operating Room Nurses Association of Canada takes place in Banff, Alberta, May 12 to 17, 1991.

It was six years ago (1984) that the 8th National O.R. Nurses Conference was held in Jasper, Alberta. The theme for that memorable event was "Mountains to Climb."

Two years later, in Montreal, the theme became "Over the Mountain," and in Vancouver, in 1988, the theme was "Caring and Commitment."

"Progress through Power: Personal, Professional, Political is the theme for this year's gathering in Toronto in April.

For Banff next year, the imagery of the mountains returns. "Moving Mountains" will be the theme, as conference organizers gear up for back-to-back national gatherings.

In the past, the National O.R. Nurses Conference was held every two years, that year always being an even year.

For a number of reasons, the ORNAC executive and board, in consultation with the provinces and regions, chose to move future national conferences to odd-numbered years. Instead of waiting over three years for another national gathering in 1993, the national body decided to hold back-to-back conferences; thus the scheduling of Banff in 1991.

Details of the Banff National O.R. Conference in '91 will begin appearing in the next issue in order to accommodate the 1990 conference scheduled for Toronto in April.

O.R. nurses in B.C. "Eying the Future" in planning their 12th Institute' in May

The 12th Bienniel Institute of the British Columbia Operating Room Nurses Group will be held May 3 to 5 at the Hotel Vancouver, Vancouver, B.C.

Theme for the "Institute," one of the largest nurses' conferences in Western Canada, is "Eyes to the Future."

Registration information for both delegates and exhibitors can be obtained from:

Miss Susan Wynne
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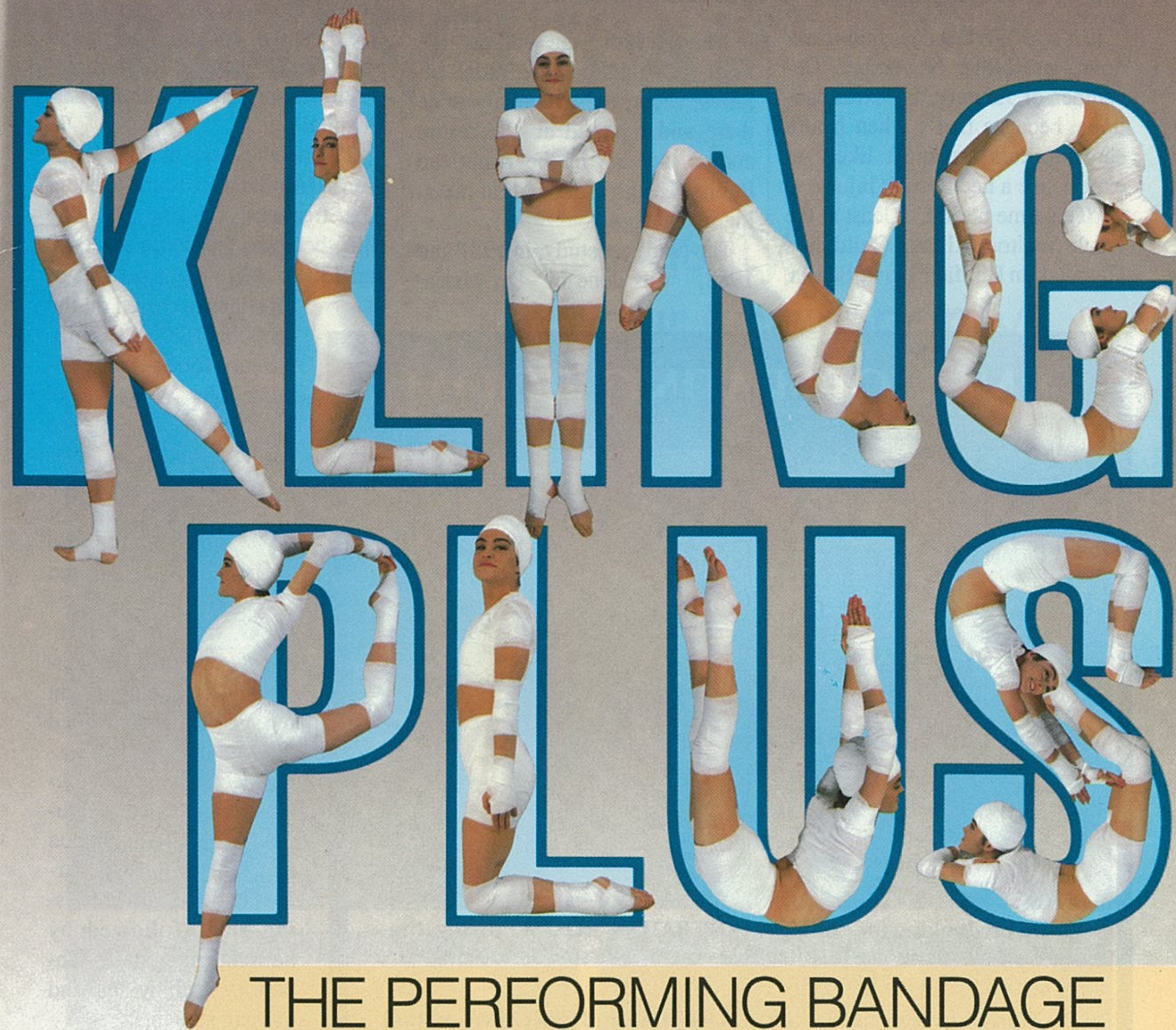

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Study finds a pattern to needlestick accidents

If it's a Wednesday, mid-afternoon, and either November, December or January, be extra cautious, because that's when health care workers are most likely to experience a needlestick injury.

This time period, at least at the Izaak Walton Killam Children's Hospital in Halifax, Nova Scotia, is when health care workers are most vulnerable to needlestick injuries, according to a study done there and reported at the recent annual meeting of the American Public Health Association meeting in Chicago.

The two-year study, in 1987 and 1988, was done by Dr. Maria-Angels Pasarell, Dr. Lynn McIntyre, hospital epidemiologist, and Marjorie Mackenzie, R.N., director of occupational health at IWK Hospital.

The needlesticks at IWK Children's Hospital were found to occur most frequently during the day shift, between the hours of 10:00 and 13:00. Fifty-eight percent of all sticks occurred on the 08:00 to 16:00 day shift. Twenty-four percent occurred on Wednesdays and 35% during the three winter months, November to January inclusive.

The first three days of the week (Monday to Wednesday) accounted for 63% of the needlesticks, which may be related to the fact that major elective surgery at the hospital is scheduled for Mondays and Tuesdays. The two-year cumulative incidence of injuries was 10.2 percent and almost two-thirds occurred among regular nursing staff, followed by housekeeping staff, laboratory technicians and nursing students.

Needlestick injuries occurred at a relativly even frequency in the medical, surgical and intensive care wards and the emergency department. ■

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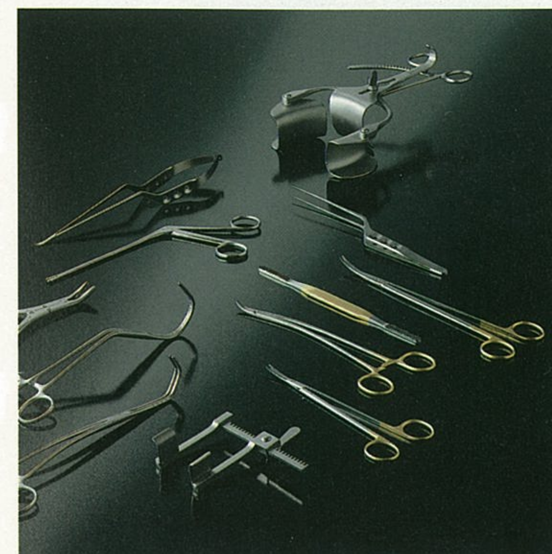

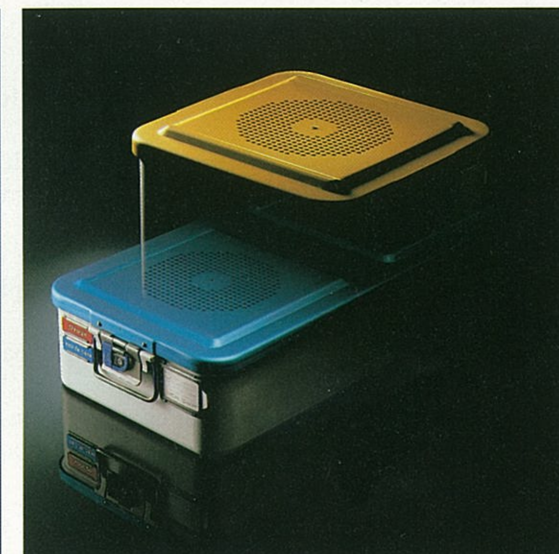

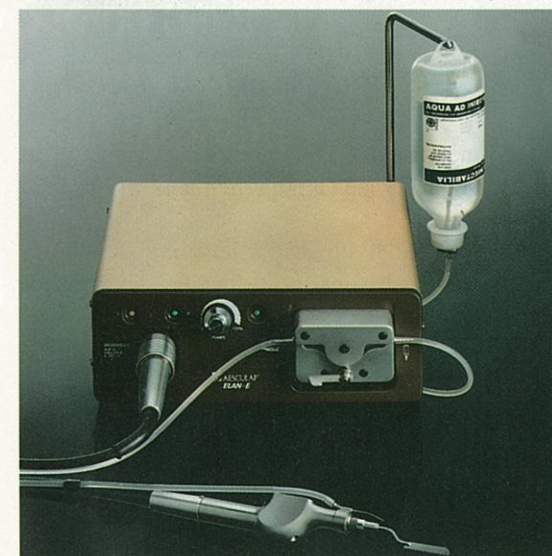

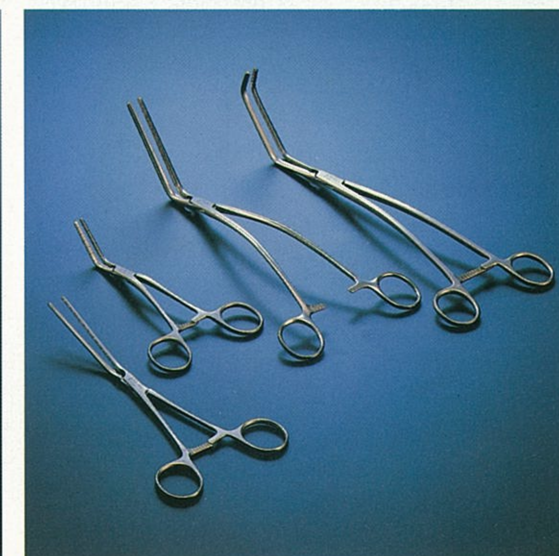

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Special educational teleconferences scheduled for operating room nurses

The Operating Room Nurses Association of Canada is planning a series of "teleconferences" on a number of operating room nursing topics. The first conference will take place in late February. Interested participnats/groups are asked to register early, as each teleconference is limited to 80 lines. Details on how to participate in the conference will be provided below. The topics to be presented, the speakers, the specific time and dates, and how to connect into the teleconference are as follows:

Code	Date	Topic	Speaker
0259	February 21	"Legal responsibilities with documentation for the O.R. nurse."	Muriel Shewchuk
0339	March 28	"Computer automated O.R. systems: The gap from technology to implementation."	Donna Prokopczaak
0447	April 18	"Care of the elderly patient in the O.R."	Carol Lenox-McDougall
0527	May 9	Confrontation, negotiation and mediation for the operating room nurse."	Audrey Macdonald
0583	May 30	"Using problem solving in perioperative nursing."	Mary Knight Kubasiewicz
0655	June 20	"Competency skill levels in the operating room."	Glora Stevens

Speaker's profiles

- Muriel Shewchuk, DON, Operating Rooms, Foothills Hospital, Calgary, Alberta.
- Donna Prokopczak, Clinical Nurse Specialist, Surgical Suite, University of Alberta Hospitals, Edmonton, Alberta.
- Carol Lenox-McDougall, Nurse Clinician, Operating Room, The Mississauga Hospital, Mississuga, Ontario.
- Audrey Macdonald, Nursing Unit Administrator, Mount Sinai Hospital, Toronto.
- Mary Knight Kubasiewicz, Perioperative Nurse, Orleans, Ontario. (Formerly, Director of Nursing Practice - Surgical Suite, Seven Oaks General Hospital, Winnipeg, Manitoba).
- Gloria Stevens, Instructor, Inservice Co-ordinator, Operating Rooms, St. Paul's Hospital, Vancouver, Brritish Columbia

How to participate

The time for all teleconferenes has been set at **1:10 Eastern Time.** Thus, participants must adjust to their time zones.

Groups or individuals participating should appoint or delegate a **leader** to handle the arrangements for the teleconference connection. This involves calling **(416) 599-1234.** The operator will ask for information: name, telephone number calling from, etc. and the code (shown above) that identifies the date and topic to be heard. Ideally, those delegated should organize and register early.

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