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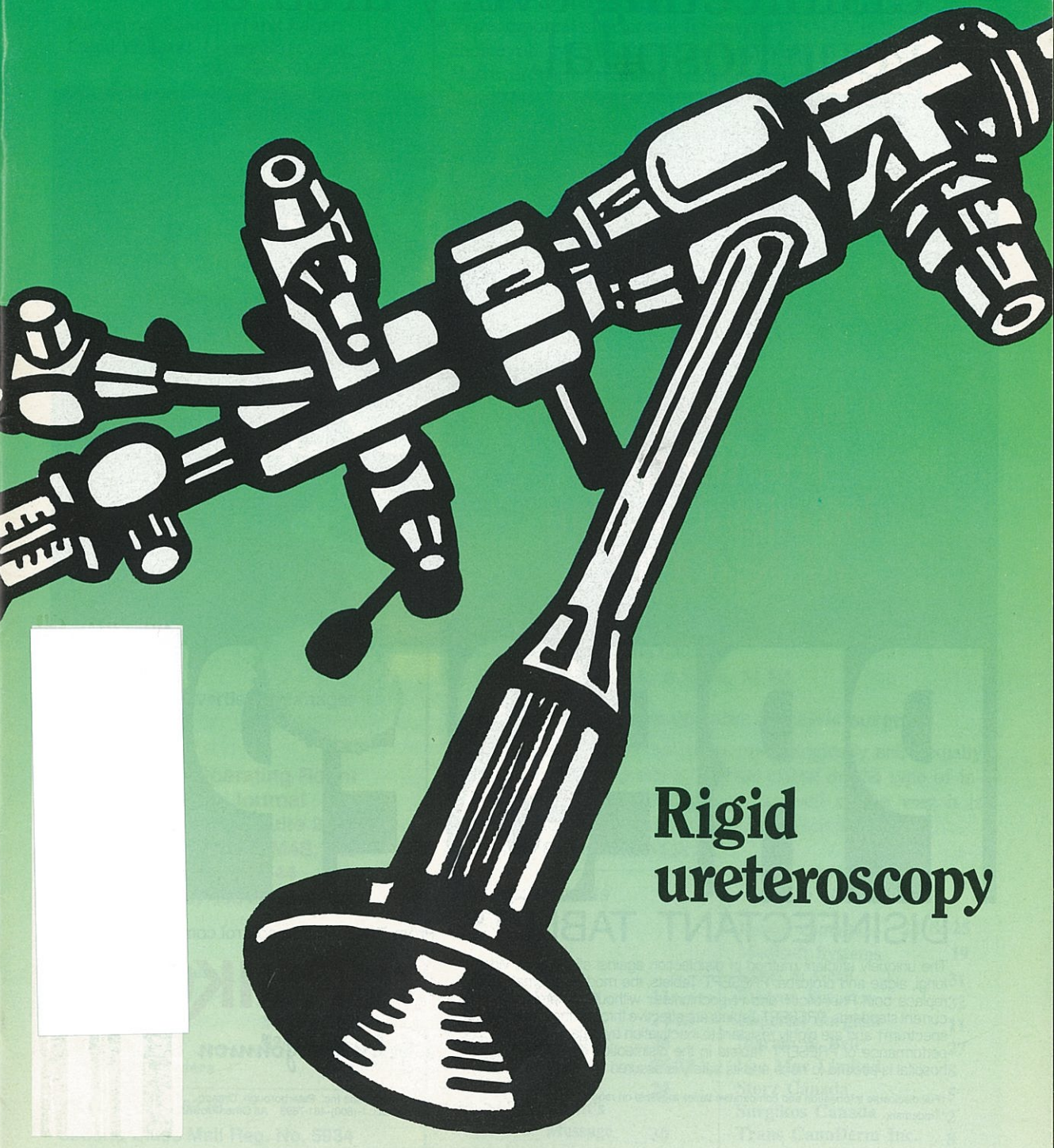

Rigid ureteroscopy

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Rigid ureteroscopy

By Jerry Rudney, O.R.T.

The introduction of extracorporeal shockwave lithotripsy (ESWL) in the treatment of ureteral calculi has proven to be safe and effective. Even though ESWL has gained acceptance as the primary choice of intervention, there are still many occasions when rigid and/or flexible ureteroscopy is necessary in the treatment of these calculi and other ureteral pathology situations.[1]

Indications

Following ESWL, fragmented stone particles occasionally progress distally down the ureter in partial unity into a narrow or sometimes strictured lower ureter where they become "jammed," thus causing obstruction and other complications. This natural phenomena is called "steinstrasse" (stone street), as the stone particles are held up in a row within the ureter.

The introduction of the rigid long ureteroscope and especially the new shorter "lower end" ureteroscope has proven, in our experience, to be very effective in treating the above-mentioned phenomena. We have found rigid ureteroscopy to be also effective and successful in extracting and/or disrupting those ureteral calculi that are non-opaque. Additionally, these rigid scopes have provided another alternative to open surgery in the treatment of some ureteral strictures, the biopsying of ureteral tumors and in the removal of foreign bodies such as migrating ureteral stents.

Since 1984, rigid ureteroscopy at the Health Sciences Centre in Winnipeg, Manitoba has been mainly performed in treating ureteral calculi. Usually a 11.5 FR. "lower end" or long ureteroscope is utilized. We prefer this size as it permits simultaneous use of a 3.5 FR. basket and an ultrasound probe. These scopes employ a 5° working telescope with a laterally mounted eyepiece **(See slide #6, page 10),** enabling calculi to be disrupted under direct vision.

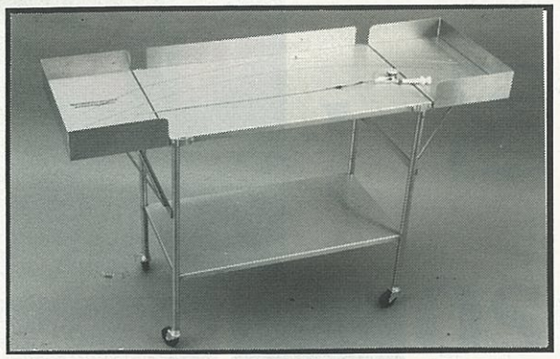
It must be stressed that all of our procedures were carried out in a cysto room that has fluoroscopic capabilities. To accommodate the usage of long 145 cm guide wires, catheters and ureteral ultrasound probes, we have found that the recently marketed Rudney/Hosking variable length endourological table is very practical. **(Slide #1a & 1b)**

As part of the pre-operative preparation, our patients must have a KUB (kidney, ureter, bladder) X-ray one hour before arriving in the O.R. Because this film will verify the most recent location of the stone, it is very important that the x-ray be in the operating room before the procedure begins.

Ureteric dilation

The patient is usually given a general anaesthetic and is placed in the lithotomy position with meticulous attention given to the padding of pressure points. To improve ureteral access, it is important that the leg opposite the involved ureter be abducted as far as possible. After the patient and fluoroscope are draped, cystoscopy is carried out and ureteric dilation is performed.

The dilation of the ureter begins with the insertion of a tip of a 7 FR. 4 cm long ureteral dilation balloon into the ureteric orifice. Contrast is then injected to confirm that the catheter is indeed in the ureter and that the stone is still present. **(See illustration #1)** This step eliminates the need to pass a ureteral catheter. A flexible 0.038 "J" 145 cm long guide wire is passed up the lumen of the ureteric dilating balloon and is advanced up the ureter under fluoroscopic control. **(Illustration #2)**



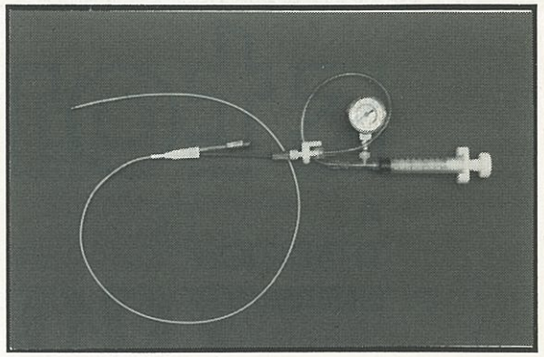
Slide #1a & 1b - The Rudney/Hosking endourological table. Slide 1a (top) shows the drop leaf shelves in place. Slide 1b, shelves are down in storage position.

The balloon catheter is then advanced over the wire and positioned in the intramural ureter using radiopaque rings at the balloon ends as helpful aids. Under fluoroscopic control, the balloon is inflated to 15 FR. at 90 lbs. per square inch pressure for a period of approximately two minutes.

A short-tipped balloon catheter is essential as it allows close approach to a ureteral calculus. Ureteral dilation to 15 FR. in our experience eases the passage of the ureteroscope and calculus through the intramural ureter. A high pressure inflation syringe and gauge will provide safe, smooth, accurate and sustained delivery of inflation pressure. **(Slide #2)**

We prefer to dilate the ureter with a balloon catheter as opposed to rigid or flexible dilators. This is because the balloon usually needs to be inserted only once and not several times as is the case with most other non-balloon dilators. The risk of ureteral injury is thus minimized.

Once dilation of the ureter is completed, the appropriate length of rigid ureteroscope is chosen and is passed transurethrally into the bladder. When the dilated orifice is identified, it is usually possible to advance the ureteroscope directly into the intramural ureter. Normal saline is used for an irrigating fluid at a height of 40 cm or more above the patient. If vision is still inadequate, the irrigating fluid may be raised higher. The ureteroscope is then advanced up the ureter under direct vision keeping the lumen in view at all times. **(Illustration #3)**



Slide #2 - Balloon dilator, high pressure syringe and gauge.

If a stricture is encountered, a much smaller 3 FR. ureteroscopy balloon catheter is inserted via the ureteroscope into the stricture and dilated at 150 lbs. per square inch pressure. Once the stone is encountered, water flow may be reduced to avoid displacing the stone. A 3 FR. or 3.5 FR. helical 4-wire stone basket is advanced past the stone and opened. We have found that this particular stone basket, with a blunt tip, is very successful in extracting the vast majority of stones.

Ureteral trauma

Under direct vision, an attempt is made to engage the stone in the basket, and if successful, the stone is manipulated down the ureter. If the stone is impacted or if there is a "hold up" on its way down, the stone is disrupted with a 1.5 mm ureteric ultrasound probe and the subsequent fragments manipulated. Manipulation of multiple fragments may require several passages of the rigid ureteroscope. Occasionally, in such situations, to minimize ureteral trauma, we have employed a Finlayson Ureteral Access Set. It is inserted in retrograde fashion to dilate the ureter and introduce a Peel-Away® radiopaque sheath that stays in place for the duration of the procedure. This sheath serves as a conduit for the ureteroscope, thus reducing the risk of perforation which is associated with multiple passages of the scope. At the end of the procedure , we usually leave a 6 FR whistle tip ureteral catheter in place for 24 to 72 hours to aid in drainage of the kidney. If there is concern about ureteric perforation, a retrograde ureterogram is performed before removing the catheter. In our experience, complications, exclusive of those associated with anaesthesia, include: migration of the stone higher up the ureter, perforation of the ureter with extravasation and inability to reach or remove the stone. Because of the risk of injury to the ureter with a rigid scope, meticulous attention must be paid to gentle technique avoiding any attempt to rush the procedure.

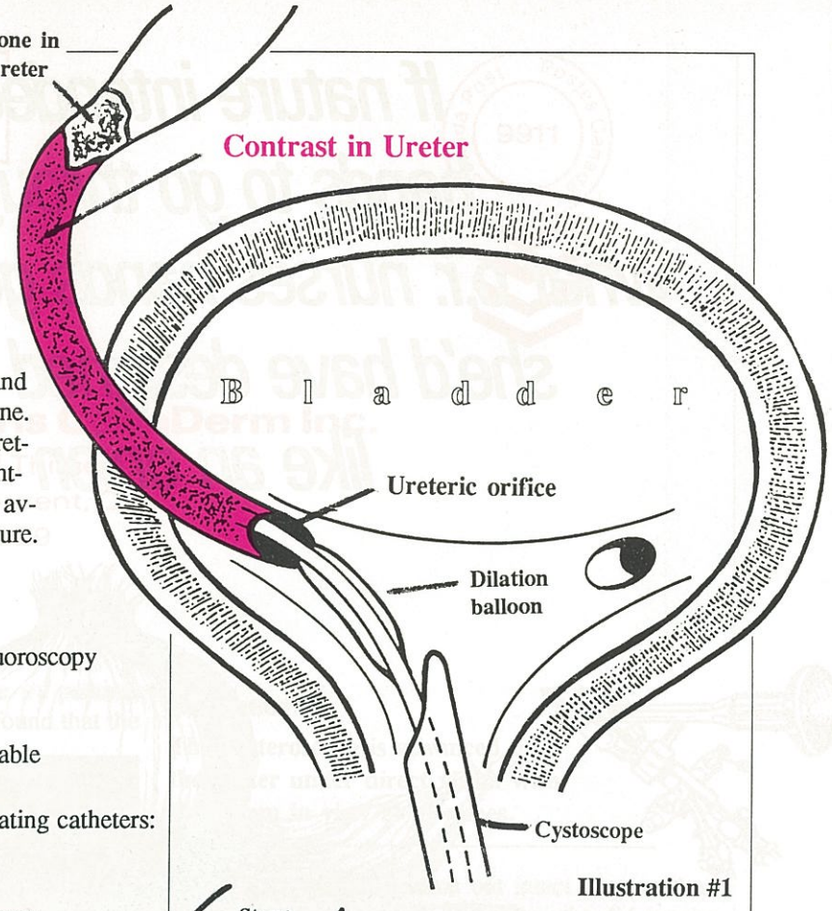


Illustration #1

Contrast being injected into the ureter via balloon dilating catheter

Equipment required

- Cystoscopy table that allows for fluoroscopy
- C-arm fluoroscope
- Sterile fluoroscopy cover
- Rudney/Hosking endourological table
- Cystoscopy set-up
- 7 FR. & 3 FR. ureteral balloon dilating catheters: 65-75 cm long
- 0.038 "J" x 145 cm guide wires
- High pressure 10 cc syringe and gauge
- 6 FR. whistle tip or open end ureteral catheters
- Long and short ureteroscopes
- Long and short ultrasound probes
- Ultrasound generator
- Flexible ureteroscope (if possible)
- Contrast media
- Finlayson Ureteral Access set

Review of cases

To date, at the Health Sciences Centre in Winnipeg, rigid ureteroscopy has been performed on over 200 patients. In a review of the first 139 patients performed by one of our urologists, 101 males and 38 females were treated. **(See slide #3)**

Stone removal was the indication for 116 of these patients while 23 required rigid ureteroscopy for other reasons, such as, evaluation of filling defects, ureteral obstruction, etc. **(See slide #4)**

Of the 116 above-mentioned patients, 91 of them had their stones removed successfully, 48 required disruption by ultrasound,

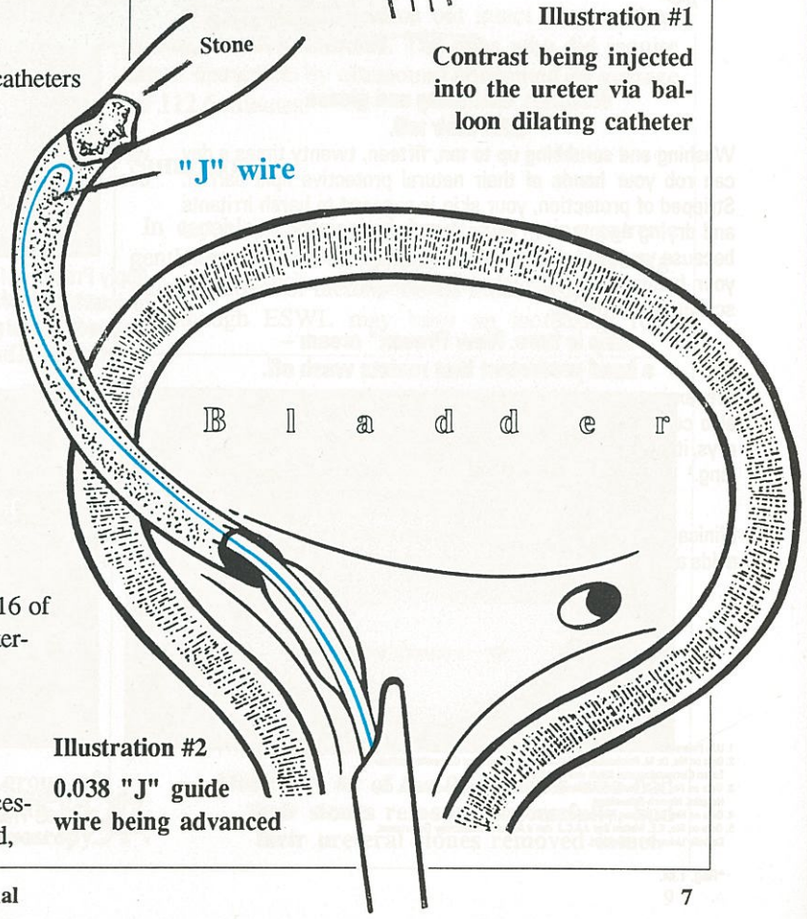


Illustration #2

0.038 "J" guide wire being advanced

If nature intended hands to go through what o.r. nurses hands go through she'd have designed them like an onion

Available now in all drugstores without prescription.

Washing, scrubbing and gloves take their toll.

Washing and scrubbing up to ten, fifteen, twenty times a day can rob your hands of their natural protective lipid barrier. Stripped of protection, your skin is exposed to harsh irritants and drying agents such as antiseptics, soaps and water. And because you can't peel off layers of ravaged skin like an onion, your hands may suffer chronic dryness, fissuring, redness, scaling and irritation.

Help is here. New Prevex* cream – a hand protectant that resists wash off.

Prevex is a revolutionary petrolatum protectant cream which also contains silicone to improve spreadability. When Prevex drys, it creates a unique, inert barrier that protects hands all day long.[1]

Prevex resists wash-off and protects against irritants.

Clinical research proves that Prevex protects against water, acids and alkalis.[1,2,3] Because it contains no emulsifiers, Prevex won't wash off.[4] Prevex is non-sensitizing, non-irritating, and does not contain any preservatives or perfume.

New Prevex protects and moisturizes rough, irritated hands.

Apply Prevex before and after work. Prevex forms an effective moisturizing barrier that works like an invisible glove. But unlike gloves, it allows your skin to breathe normally[5] and leaves your sense of touch unimpaired.

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Dry, rough, irritated hands don't need to be an occupational hazard. Let your hands enjoy the protection only Prevex can give. Fill out and mail in the coupon and receive free samples of Prevex from Trans CanaDerm.

Prevex*
Hand Protectant Cream
Invisible protection for your ravaged hands.

1. U.S. Patent No. 4,355,046.
2. Data on file, Dr. M. Reichenberger, Universitatsklinikum der Gesamthochschule Essen (Dermatologische Klinik und Poliklinik).
3. Data on file, H.-J. Bandmann (Dermatology and Allergology Department, City Hospital, Munich-Schwabing).
4. Data on file, Bj. Hausen (University Skin Clinic, Hamburg Eppendorf).
5. Data on file, K.E. Malten and J.A.C.J. den d Arend (Dermatology Department, Catholic University, Nijmegen).

*Reg. T.M.

T C D

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one by electrohydraulic lithotripsy and 42 of them had their stones removed intact. **(See slide #5)**

In 18 patients the stones were displaced into the renal pelvis to be later treated by ESWL or percutaneous lithotripsy. In the seven remaining patients, we were unable to reach the stone. When we reviewed the 49 patients who required disruption, 19 of them experienced ureteral perforation. In the group of 42 patients whose stones were removed intact, only 8 ureters were perforated. Obviously, risk of perforation increased with stone disruption. **(Slide #7)**

The patients who were perforated averaged 4.8 days of post-operative hospital stay. The ones who were not perforated averaged 2.7 days. When one considers operating room time, of the 91 patients who had their stones removed, it was found that the patients whose stones came out intact consumed an average of 68.4 minutes. The ones who did require stone disruption by ultrasound consumed an average of 112.6 minutes.

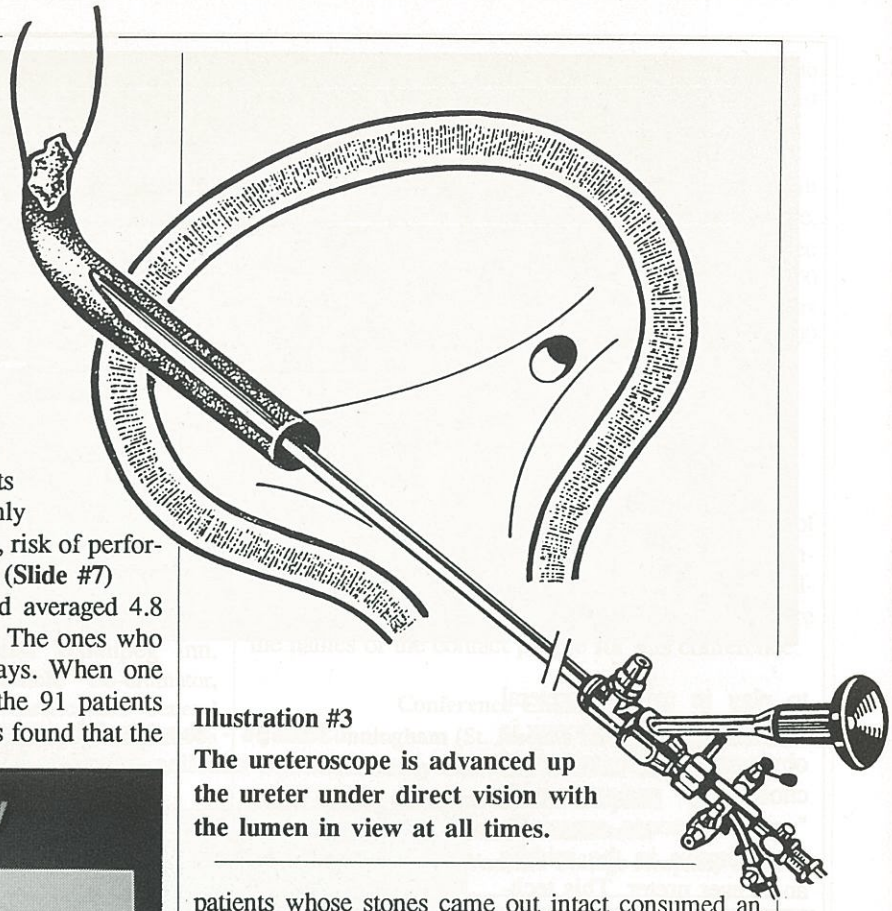
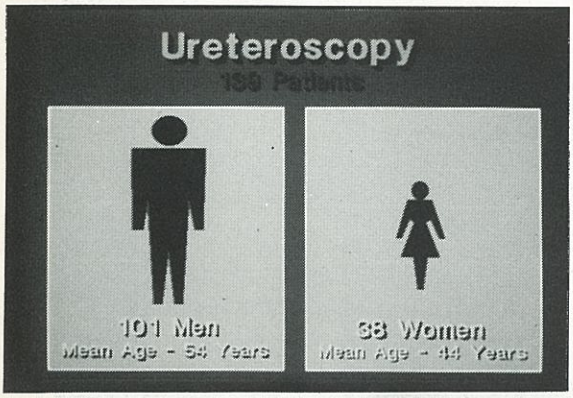


Illustration #3

The ureteroscope is advanced up the ureter under direct vision with the lumen in view at all times.

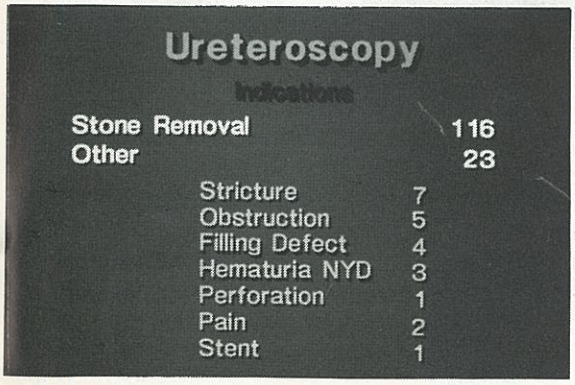


Slide #3 - Rigid Ureteroscopy has been performed on over 200 patients at the Winnipeg Health Sciences Centre.

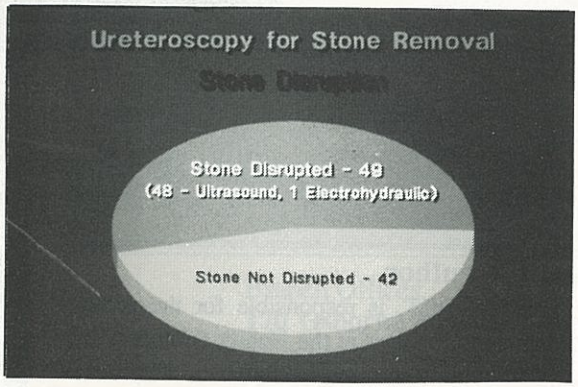
Summary

In capable, experienced hands and using extreme gentleness, rigid ureteroscopy has made the disintegration/removal of ureteral stones much easier.[2]

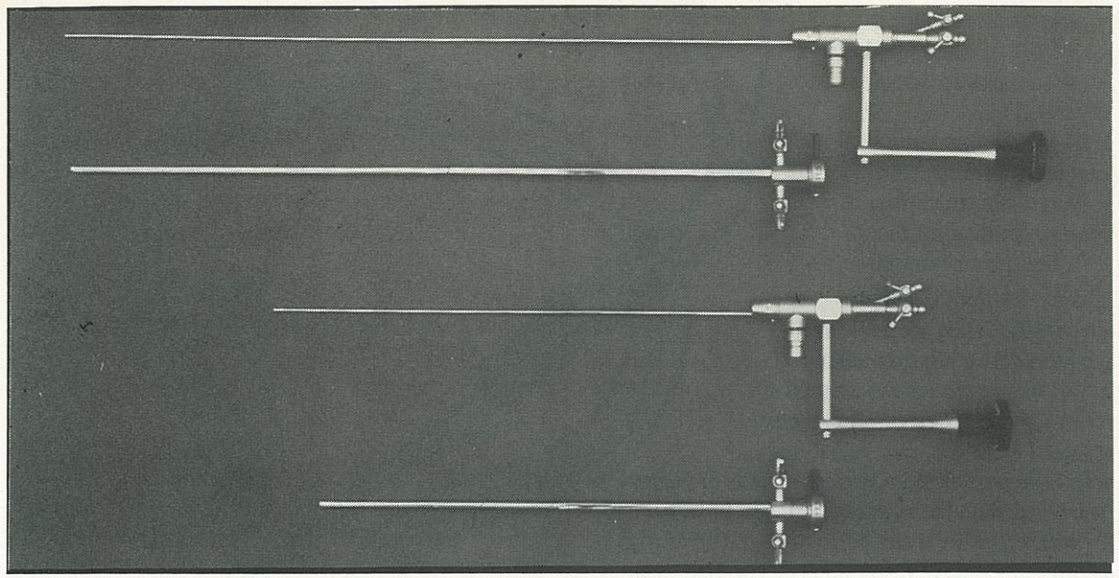
Although ESWL may have an increasing role



Slide #4 - Reasons why 23 of a group of 139 patients at the Winnipeg Health Sciences Centre required rigid ureteroscopy.

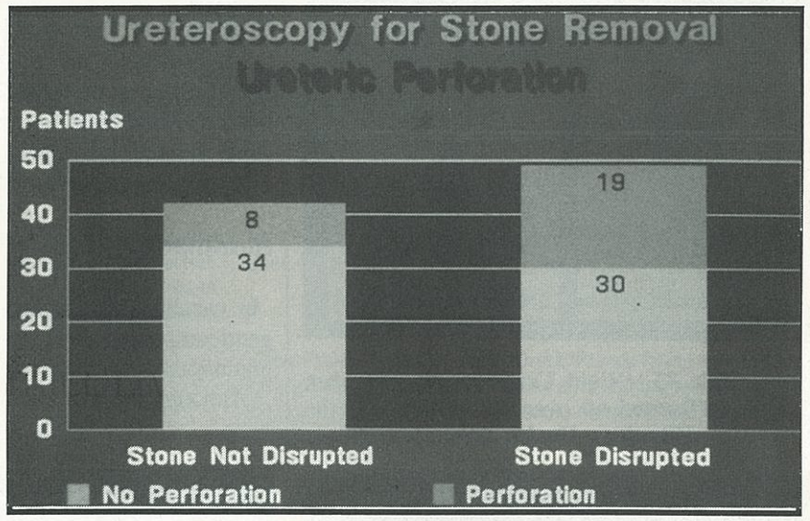


Slide #5 - 42 of the 91 patients who had their stones removed successfully, had their ureteral stones removed intact.



to play in treating ureteral stones, rigid ureteroscopy is obviously the treatment of choice in patients with "problem" stones, especially those stones in the middle and lower ureter. This technique has proven itself to be useful in establishing ureteral diagnosis where etiology is unknown and has been used to treat certain ureteral pathology. Therefore, rigid ureteroscopy obviously has a place in the effective treatment of selective urological patients. ■

Slide #6 - Short and long ureteroscopes employ a working telescope enabling calculi to be disrupted under direct vision.



Slide #7 - The figures on this slide suggest that the risk of ureteric perforation increases with stone disruption.

Acknowledgement

The author wishes to acknowledge the technical support of Faculty Graphics Winnipeg

References

1. & 2. Hosking, D.H. and Ramsey, E.W., "Rigid Transurethral Ureteroscopy," British Journal of Urology, Number 56, 602-603.

About the author

Jerry Rudney, ORT, is responsible for the urology operating room theatres at the Health Sciences Centre in Winnipeg, Manitoba. He has over 25 years of OR experience and has been at the forefront in the development of the ureteroscopy program, the ultrasonic percutaneous lithotrispy program and the retrograde nephrostomy program at the Winnipeg centre. Mr. Rudney was the winner of the' 85 Surgikos Editorial Award (Drake-Thompson Memorial Award) for his submission on percutaneous lithotripsy ("Ultrasonic percutaneous lithotripsy," *Canadian Operating Room Nursing Journal,* Volume 3, Number 1, 1985).

Calendar of Events

February 19 - 24, 1989, Anaheim, California: 36th Annual AORN Congress, Anaheim Convention Centre. (Contact Sylvia Rottman, Director of Meeting Services, AORN, 10170 East Mississippi Ave., Denver, Colorado 80231 USA).

April 23 - 26, 1989, Toronto, Ontario: First Provincial Conference, Operating Room Nurses Association of Ontario, Constellation Hotel, Dixon Road). (Details, Hilda Gatchell, Convenor, Publicity, 208 Oshawa Blvd. North, Oshawa, Ont. L1G 5S9).

June 11 - 13, 1989, Winnipeg, Manitoba: Third Biennial Conference of the Manitoba Operating Room Nurses Association, Delta Winnipeg Inn. (For details contact Bev Popowich, Co-ordinator, O.R. P.A.R. and Day Surgery, Misericordia General Hospital, 99 Cornish Ave., Winnipeg, Manitoba R3M 1E2 (204) 774-6581).

August 28 - September 1, 1989, Vienna, Austria: VI World Conference of Operating Room Nurses, Austria Centre, Vienna. (For more details, write to AORN Meeting Services Department, 10170 East Mississippi Ave., Denver, Colorado 80231).

April 2 - 6, 1990, Toronto, Ontario: 11th National Operating Room Nurses Conference, Harbour Castle (Westin) Hotel. (Delegates contact: Audrey MacDonald, OR, Mount Sinai Hospital, 600 University Ave., Toronto, Ont. M5G 1X5. Exhibitors contact Valerie Shirreff, OR, Mississauga Hospital, 100 Queensway West, Mississauga, Ontario L5B 1B8).

Preparations well underway for Ontario's provincial OR conference

The Operating Room Nurses Association of Ontario (ORNAO) will hold its first Provincial Conference from April 23 to 26, 1989 at the Constellation Hotel on Airport Road in Toronto. Below are the names of the contact people for this conference:

Conference Chairperson...
Jean Cunningham (St. Joseph's Health Centre) Toronto
Publicity Convenor... Hilda Gatchell
(Oshawa General Hospital)
Exhibitors Committee...
Donna Kaufmann (Women's College Hospital) Toronto

Dismissing an employee without the legal hassles

By L.E. and F.A. Rozovsky

It is bound to happen sometime in every hospital. Supervisory staff determine that a surgical nurse's performance is totally inadequate and, despite a series of warnings, the situation does not improve. The decision is made to dismiss the nurse and to replace him or her with another person considered more competent for the job.

In many instances there may not be any "fallout" from firing the nurse. Although disappointed, and perhaps embittered by the dismissal, the nurse decides to live with the decision and seek other employment. However, in a growing number of cases, nurses are not sitting back and "taking it." Rather, they seek the advice of their unions or they retain legal counsel to fight what is considered "wrongful dismissal" situations.

The trend toward increasing numbers of wrongful dismissal cases is not restricted to the health care industry. Indeed, it is a trend noted in a wide variety of sectors. As in other fields of work, there needs to be careful planning and well-delineated policies and procedures for the proper way of dismissing an employee. To do otherwise is an invitation to litigation.

The proper way to dismiss

It is not enough to say that someone is "not cutting the mustard" or that a nurse's conduct is substandard. There must be demonstrative proof to substantiate such a claim. Furthermore, there must be adherence to the principles of natural justice; that is, throughout the process leading to the dismissal decision, the rights of the nurse must be respected. This can be done in terms of giving her warnings and written notification regarding dissatisfaction with professional performance. Once the decision is made to dismiss the nurse, she has the right to know the reasons for her dismissal.

The successful dismissal of a nurse can be facilitated by the development and implementation of a comprehensive policy and procedure on the topic. Not only should the policy and procedure outline the process for dismissal, it should also specify the requirements for documenting the evidence and the reasons for the termination decision. To this end, policy and procedures should include:

1. Delineate employee job description

Spell out what is expected of the employee, including when it is permissible for the nurse to exceed the usual bounds of her job specifications.

2. Delineate means for assessing professional performance appraisals

Spell out how the performance of nurses will be evaluated, by whom and how frequently. It is important not to use a variety of performance appraisal methods since the results could obscure the true nature of a nurse's professional proficiency.

3. Specify "process" from warnings to dismissal

With the exception of severe departures from established norms, a nurse is not likely to be dismissed on the first encounter with management. Rather, the process is marked by a number of personal conferences, friendly and formal verbal warnings, written notices, and then a formal dismissal action. The appropriate mechanisms for processing a dismissal should be made known to all concerned.

4. Specify documentation requirements

Should a dismissal be challenged, the documentary evidence leading up to the firing could prove essential to both parties. Without sufficient documentation, a hospital is bound to find itself in a very difficult position in terms of ridding itself of the unwanted nurse. Therefore, it is important to follow the procedures set forth in the manual to ensure appropriate processing of the dismissal and the background information needed for a disputed firing.

5. Terms of reference vis-a-vis the collective bargaining agreement

If a collective agreement specifies the groundwork for employee dismissal, these conditions should be incorporated into a consistent approach to processing the dismissal of an employee.

6. Utilize legal advice in a proactive manner

Make certain that the hospital's solicitor is contacted if at any time in the process questions arise about certain aspects of the dismissal. It is far better to use legal counsel in this protective manner than to wait until a serious crisis occurs requiring complex legal manoeuvers.

7. Secure all evidence in the event of a lawsuit for wrongful dismissal

Once it is clear that a lawsuit will be filed based on wrongful dismissal, make certain that all evidence is secured in an appropriate manner. This item should be outlined in the policy and procedure manual governing disclosure of information to third-parties or release or reports to the plaintiff and his or her solicitor.

Dismissing from the inside

In some cases, hospitals find it more expedient to delegate the 'messy business" of employee firing to a so-called "termination firm." Termination firms are one of a number of busines management companies which have sprung up to handle the sometimes unsavory task of dismissing an employee. In each instance, the termination follows a specific format, including evidentiary requirements to justify the dismissal; adherence to health facility policies and procedures, and collective agreements.

It is questionable whether hospitals need to go through the added expense of hiring a termination firm. If the hospital follows its own requirements, there should be little difficulty in carrying out the dismissal. Moreover, there is no guarantee that that the involvement of the termination firm will preclude litigation based on wrongful dismissal. On balance it would seem therefore that there is little need for delegating the dismissal process to a professional termination firm.

Conclusion

Maintaining a qualified working staff with a high level of morale is very difficult in an atmosphere dominated by a wrongful dismissal lawsuit. The ripple effect is bound to have an impact on patient care. To avoid such problems it would be far better to take a proactive approach which establishes a practical but effective means of getting rid of the unwanted employee. ■

About the authors

Lorne Rozovsky, is a Halifax lawyer with the firm of Patterson Kitz, and adjunct associate professor of law and medicine at Dalhousie University and a principle in Lefar Health Associates, Inc. Fay Rozovsky is president of Lefar Associates, Inc. and a visiting lecturer in health law at the Harvard School of Public Health. She is a member of the Massachusetts and Florida Bars.

Lorne Rozovsky

Fay Rozovsky

"Maintaining a qualified working staff with a high level of morale is very difficult in an atmossphere dominated by a wrongful dismissal suit"

Computers in the O.R.

An assessment of trends, potentail and expectations

By Donna Prokopczak

Probably one of the most exciting technologies to enter the operating room in this century is the computer, with its vast potential for an infinite array of applications. How important is it for operating room nurses to become involved in this technology and participate by identifying their computer needs applications and share in the planning, selecting, developing and implementing phases? This presentation will focus on addressing this question and the myriad other considerations that must be dealt with if the operating room nurse is to be successful in his or her new role.

Computer literacy

In order to assume this role, however, operating room nurses need to prepare themselves by becoming computer literate and knowledgeable regarding the expectations and potential of the computer.

There are many factors that must be taken into consideration when computer automation is pursued. In addition to cost-benefit analysis, the purpose, expectations and alternatives must be carefully assessed. The concern for cost containment in any hospital's highest cost centre - the operating room - has motivated these O.R. departments to pursue ways of evaluating their own efficiency. Concern for rising hospital costs combined with pressure from hospital administrators to improve patient care while reducing costs, forces departments such as the O.R. to review utilization statistics.

A few examples of reports needed for resource utilization statistics and which require automation include O.R. utilization, supply and equipment usage, and staffing patterns. These become important management tools for problem solving, decision making, identifying trends, and designing surgical schedules.

In April, 1988, your author completed a *Master's Project Study*. The purpose of this study was to assess the potential for an O.R. computer-automated system for a major teaching hospital from a users perspective. The following questions were addressed in the study:

1. What are the trends in operating room computer automation?
2. What was currently happening in computer automation?
3. What was expected in the application of computer automation?
4. What options are available in computer automation?
5. What are the selection considerations for computer automation?

In order to answer these questions, the utilized data sources included:

- reviewing relevant literature for trends, computer applications, and system cost justification;
- interviewing both medical and operating room staff (30) to establish their perception as to what functions the computer system should be capable of performing and identifying their concerns;
- conducting a cross-Canada survey of 37 selected major hospitals to determine what was happening by way of operating room computer systems, applications, interest and system satisfaction;
- evaluating the suitability of the microcomputer and mainframe computer for intended applications.

The following is a synopsis of the findings predicated on this study assessment.

About the Author

Donna Prokopczak, R.N., B.Sc.N., M.Ed., Clinical Nurse Specialist, Surgical Suite, University of Alberta Hospitals, Edmonton. She is a graduate of the Royal Alexandra Hospital School of Nursing with a Post Basic B.Sc.N. from the University of Alberta. This study was conducted as a major project for the completion of a Masters of Educational Administration Degree, University of Alberta.

Literature review of OR computer automation trends

The literature pertaining to applications of O.R. computer technology as reported, became prevalent during the 1980s. Initial accounts in the literature describe the use of mainframe computers (large computers as distinguished from mini or microcomputers) for O.R. data analysis through batch reporting systems. These fixed format reports provided O.R. management with utilization statistics upon which to base administrative decisions, identify trends and long range plans, and to co-ordinate staffing and supplies.

Access to on-line (computer connected) systems led to a variety of innovative ways of using the computer for O.R. logging and statistical reporting. The ability of an operating room to study its utilization and efficiency provided opportunity for the development of more effective scheduling systems.

Some hospitals, mainly university affiliated, have developed totally integrated "on-line" mainframe programs that allow the documentation and retrieval of all patient information from the point of admission through to discharge.

Also, there appears to be a growing interest in the use of the microcomputer for a variety of O.R. applications. The flourishing of commercial operating room software packages appearing in the marketplace creates a selection dilemma for operating rooms considering the purchase of computer technology.

These packages are designed essentially for standalone systems or intra-departmental network systems. These software packages provide the department with control over their own data. With a hospital's mainframe computer system, any patient information would not be accessible unless multiple interface programs were to be written. Mainframe computers and microcomputers are generally not designed to be compatible or share logic and data without extensive programming.

Another alternative system that appears to be emerging is the minicomputer. These are capable of storing vast amounts of data and have a greater network capacity than a microcomputer. However, the development of suitable software programs appears to be lagging.

The full potential of O.R. computer applications is only now being realized. Hospitals involved in computer technology were moving from development of O.R. data bases, then redesigning their scheduling systems prior to implementing automated systems. Many other applications were identified such as communication by electronic mail, staff scheduling, manual and preference cards, inventory control and educational programs. Computer systems can penetrate the entire department by incorporating terminals in every operating theatre or by using portable input/output devices.

Some of the advice emerging from the literature recommends mainframe systems while others support stand-alone micro-systems. The importance of staff involvement, careful selection and planned implementation appeared evident in most recommendations, regardless of the system.

Computer activity in Canadian operating rooms

To idenify the trends and involvement of Canadian hospital operating rooms with regard to computer automation, a mail-out survey to operating room directors of nursing or operating room supervisors in 35 major (in excess of 500 beds) Canadian hospitals was conducted.

A short questionnaire reply card focussed on information pertaining to the types of system in use; what the system was being used for; general user experiences; and satisfaction with the system.

In addition to the mail-out survey, four major operating rooms were contacted directly by telephone. The following are the results of this survey.

Of these 37 hospitals responding to the survey, 17 indicated they were using, or in stages of implementing, some form of O.R. computer application. Eleven of these hospitals were using a mainframe system (five on-line, five batch system and one with a micro-mainframe link). Other systems included two microcomputers, two word processors and two network clusters (probably mini).

Seven operating rooms were using purchased software, while nine were using self-developed software. Fourteen operating rooms were using their system for statistical logging and reporting, nine

Table 1

Surveyed Canadian Operating Rooms Using Computers
(Total of 17 hospitals reporting O.R. computer use of 37 surveyed)

Computer system in use What systems used			Types of computer applications How the systems used			
System hardware & no. of hospitals indicating use	Software run on these systems (Number reporting use) Per/Com*	Self* develop	Information access only	Statistical log/reports	Surgical schedule	Plans for future application
Hospitals Mainframe						
On-line (5)	2	3	5	4	3	1
Batch (5)	1	4	-	5	-	3
Micro-link (1)	1	-	1	1	1	1
Microcomputer (2)	2	-	-	1	2	1
Word processor (2)	-	2	-	1	1	1
Network/Cluster (2)	1	1	2	2	2	1
TOTALS (17)	7	10	8	14	9	8

Pur/Com* = Purchase/Commercial
Self Develop* = Self-development or Homestyle

were doing surgical scheduling and another nine used their system only for assessing information. Eight of the 17 hospitals reported plans for future development of their systems. **(See Table 1)**

Of the 20 hospitals that indicated no computer usage in the O.R., only four reported the availability of a mainframe. There were six operating rooms interested in computer applications and an additional eight actively pursuing this technology. **(See Table 2)** Of three hospitals that used batch reporting systems, two indicated low ratings in user satisfaction with the system in meeting their needs and expectations.

Frustrations tended to arise from the inability to obtain desired statistical information, desirable formats, slow computer response time, inability to program and implement required changes, length of time required to obtain information, and concern for accuracy and generated information.

Ratings for ease of computer use were high, indicating satisfaction with entering and extracting routines. One system that appeared to rate very highly involved extensive user input into the development of the software resulting in a highly regarded program. Interest in microcomputer systems appears to be emerging with four of the hospitals indicating either stages of planning or implementation of these systems using commercially designed programming.

Computer expectations

The involvement of the user in identifying, developing, and implementing a computer system appears to be of paramount importance. In order to identify what is needed with regard to a surgical scheduling and reporting system, it is important to include the suggestions of those persons currently involved in this function. This study provides an opportunity for personnel directly affiliated with, or affected by the O.R. scheduling system, to express their ideas, expectations, and concerns pertaining to potential O.R. computer automation.

Interviews were conducted with various levels of O.R. staff including nursing administration, medical and clerical staff. In addition to arranged interviews, a letter and interview form were mailed to the chairman of each surgical service so that the

Table 2

Surveyed Canadian Operating Rooms Not Using Computers
(Total of 20 hospitals reporting no computer activity out of 37 surveyed)

Computer System			O.R. Development stage		
Resources available	No Activity	Interested	Planning/ Assessing	Selecting/ Developing	TOTALS
No computer	6	4	3	1	14
Hospital mainframe		2		2	4
Micro-computer		1	1		2
TOTALS	6	6	4	4	20

concerns of each surgical department could be identified. The response to these letters revealed considerable interest in computer automation. Following is a summary of the needs as identified by the 30 participants of this phase of data collection.

Responses to questions regarding factors affecting surgical scheduling were categorized into the following six categories:

1. patient related
2. procedural related
3. physician/surgeon related
4. anaesthesia related
5. facility related, and
6. equipment/resource related

There were several variables within each of these categories **(See Table 3)**. Expectations of the system as expressed by participants included:

- flexibility in scheduling
- data log and reporting functions
- source of patient information
- a mechanism for communication.

Data base information tracking should include:

- patient information
- anaesthesia/post anaesthesia
- recovery room information
- facility/schedule utilization, and
- equipment supply information.

Interdepartmental information access should allow communications between the surgical suite and 23 other identified hospital departments. Surgical slate features should include routine information plus sections for update, complication codes, special requests, diagnosis, and patient specific information.

Several concerns regarding computer implementation included a need for privacy and confidentiality of patient care information on the printed surgical schedule (slate), staff education regarding computers, computer information security, potential benefits, costs, and computer system functions.

Computer system alternatives

When considering implementation of an automated system, it is important to assess what is available by reviewing aspects of systems already in place, relating to the experience of others., evaluating what is emerging in this rapidly advancing technology and consulting with experts in this field.

Currently, there appears to be two possible computer selection choices available with the potential to meet the requirements of a major O.R. system. The advantages and disadvantages of each of these two alternatives - the mainframe computer or microcomputer - are discussed on the basis of the nine factors that follow:

1. Systems features - The mainframe computer is available throughout the hospital. It is

Table 3

Factors Affecting Surgical Scheduling as Identified by Project Interviews

Patient Related

1. Admitting information
   - routine demographic information
   - waiting lists
2. Patient care data
   - availability, readiness; consent; complications (debilitating disease); patient status (acuity); diagnosis; required documents, reports; special requirements
3. Booking category
   - elective, emergent, urgent

Physician surgeon related

1. Availability of surgeon
   - areas of potential conflict (official hours, meetings, conferences, teaching commitments, other departments); illness
2. Availability of surgical assistance

Facility Related

1. Scheduling policies
   - block/open scheduling; theatre allocations, theatre reallocations. bed closures, case cancellations
2. Altered booking routines
   - Christmas/summer hours, grand rounds, major conferences, medical staff luncheons
3. Theatre/procedure
4. Time allocation/procedure

Procedural related

1. Type of surgical procedure/service
2. Expected length of procedure
   - time allotment based on surgeon/ case accrued averages, and anaesthesia/ case averages
3. Case to case time (changeovers)

Anaesthesia Related

1. Availability of service
   - anaesthesia specialist; schedule conflicts (meets, other commitments)
2. Anaesthesia techniques or agents
   - epidurals, regional blocks, general anaesthetics
3. Induction/extubation time
4. Special equipment

Equipment/Resources Related

1. Availability of scarce/limited resources
   - equipment, supplies, drugs, prosthesis, instruments
2. Staff availability
   - expertise, specialty, illness vacation, other commitments
3. Co-ordination of resources
   - case carts, blood products, x-rays, instruments, prosthesis, positioning equipment
4. Inter-departmental dependency
   - radiology, blood bank, pathology

used in many departments identified as essential data source links for the operating room. This system would facilitate a centralized booking mechanism and have the capacity to process data at high speeds. However, the availability of information systems resources is limited and scarce due to high demand throughout the hospital and the requirement for specially skilled staff. On the other hand, the choice of a microcomputer provides control over one's own data and is generally easier to use. They also can be linked to a mainframe to act as a dual purpose terminal. Microcomputers tend to be slower in speed, and this is reduced even more by networking. Although the two systems could be linked to share logic with interface programming, this could be a very expensive venture, depending on the extent of interfacing.

2. Memory capacity

Mainframes appear to have almost unlimited memory capacity; however, data storage becomes expen-

sive. Microcomputer systems are becoming more powerful with data storage options on hard disk drives, floppy disks or streaming tapes. The annual operating room accrued data base would require a large memory capacity plus computer capability to manipulate and run comparative statistics on this information. Could a microcomputer actually store, retrieve and manipulate the volume of data generated by a 14-theatre, 15,000 caseload operating room?

3. Software design

Custom design "in-house" programming for the mainframe would require extensive services of a programmer/analyst plus a user group development team. The design could be developed on the patient care foundation base already in progress. The microcomputer option, with at least 18 IBM-compatible and commercially prepared operating room software packages to choose from, appears to be an attractive alternative. Many of these soft-ware packages claim to provide programming for almost every application an O.R. could dream of; however, because of the number of these applications, an in-depth assessment to ensure the suitability of these applications in the O.R. would seem essential.

4. Implementation

Request for operating room systems development would have to be priorized in the hospital's long range plan. The development would require extensive programming and implementation would be gradually phased in over a span of time. With a microcomputer commercial package, the program applications could all be introduced simultaneously; how-

ever, several months would be required to organize and load supporting data.

5. Security

Mainframe systems' security, controlled through sign-on authorization, may be lacking in microcomputer systems, although software security for certain versions of microcomputers is available. Without some form of security mechanism, anyone could access and manipulate the data. Also, data loss on the mainframe is protected by sophisticated data backup mechanisms where data on a micro system is more vulnerable to power surges or computer malfunction or human negligence to make backup copies.

6. Resource/cost factors

Mainframe costs would include hardware in the form of terminals, printers, peripherals and computering capacity with software costs arising from programming, maintenance and modifications. The hospital's information systems department would be responsible for the development and maintenance of "in-house" programs. The cost of a microcomputer system includes similar hardware but would probably be more expensive due to the need for memory, data storage and networking devices.

Software costs arise from the initial purchase price plus an additional annual maintenance fee of approximately 10-12% of the purchase price. System support could not be expected from the hospital's information systems, but rather the software vendor who may be thousands of miles away and accessible only by telephone.

Problems arising from both hardware and software would have to be resolved through the user department and contracted agreements rather than with the assistance of the 24-hour information systems resources. Failure to resolve problems via the telephone could result in prolonged system downtime and costly services.

7. Micro-mainframe link

The implementation of both systems could allow for partial program development on the mainframe such as surgical scheduling requiring integration with the hospital patient care system and the logging and statistics function development on the microcomputer. A link between the two systems for downloading, uploading or two-way information exchange would require computer programming specific for each transaction.

8. Training requirements

Well developed training programs are essential to the success of computer implementation. Information systems and nursing education and research can provide mainframe training programs, but these require many man-hours of time. Microcomputer training programs would have to be provided by the software vendor or microcomputer education courses. These programs, generally, are more user friendly with considerable on-line help, but still require extensive man-hours to learn. The cost of these microcomputer programs would be incurred by the user.

9. System expandability

The expansion of the mainframe system is the responsibility of information systems and new programs can be developed as resources allow. The technology of microcomputer systems is rapidly advancing, producing faster speeds, greater data capacity, better system security and superior networking capabilities. Microcomputer technology is beginning to appear almost as attractive as mainframe computer technology.

Conclusion

Probably the most important issue emerging from this project was that of cost justification for implementing computer technology. The costs associated with computer automation can be enormous, depending upon the degree of implementation and the computer system selected. Costs include hardware, software (purchased or developed) with continued maintenance and update of both hardware and software. This does not include the tremendous amount of manpower commitment for selecting, planning, developing, educating, implementing, monitoring and maintaining the system, all of which operating room nurses need to be involved in. In addition, there are costs associated with data storage, computer supplies and perpetual training needs.

How can these extensive costs be justified at a time when escalating health care costs are a major government concern, with every hospital striving for cost containment and reduced spending?

On the contrary, what is the cost of **not** proceeding with computer automation? Is this not the very tool that can ultimately facilitate cost containment through access to a wide varaiety of decision supportive information that can never be produced manually? In addition, a highly efficient computerized surgical scheduling system should result in effective utilization of a very expensive hospital resource - the operating room. ■

Importance of pre-operative dialogue in pelvic surgery

By Leslee Thompson, M.Sc.N.

A woman's ability to adjust psychologically and sexually to pelvic surgery depends in part on the type of information she is given prior to going into surgery, the way it is given and the frequency with which it is reinforced.

The experience of undergoing pelvic surgery gives rise to a variety of physical, psychological and sexual challenges with which the patients must cope. It is important for us as health professionals to understand more completely the nature of this experience so that we are able to address the concerns women have before and after pelvic surgery.

Information reinforced

At an address given to the Society of Pelvic Surgeons meeting in Toronto recently, this author told delegates that the patient's adjustment following pelvic surgery depended on the way in which these various concerns were addressed

We may be giving patients information, but because of the anxiety associated with undergoing (pelvic) surgery, a lot of the information is **not** retained. Because this information is not always retained, a lot of patients have unrealistic or distorted expectations about the outcome of the surgery.

Primary concern

For most women, it is not the type of surgery that is of primary concern, but rather the changes that will be imposed, be they real or imagined. A woman's confidence in her ability to deal with these changes, as well as her partner's ability to cope, has a great influence on her degree of adjustment - or distress postoperatively.

Some women who undergo pelvic surgery experience feelings of grief related to the loss of fertility and changes in sexual responsiveness. For others, the relief of pelvic pain can have a positive influence on their quality of life.

A number of women who undergo life-saving radical surgery experience a shift in what's important to them. For example, in some cases, sexual activity may no longer be essential to their sense of well-being. However, it is important to find out whether or not a decrease in sexual activity will be distressing.

Psychological needs

The degree of depression or anxiety a women may feel regarding pelvic surgery will be influenced by what she's learned about her body and her sexuality during the course of her life. The joy of sex for one patient may not be a joy for another. Thus, it's important to be attentive to the individual surgery patient's needs.

Research carried out with female pelvic surgery patients indicates that as many as 70% of them say they have received little or no information from their physician about sexual adjustment related to surgery. An even greater percentage - 85% - will not raise the subject because they don't want to take the time away from physical care. Often, the patient assumes that if the physician is male, he won't understand their feelings.

The rationalizations of physicians

Some physicians often rationalize not talking about sexual adjustment with their pelvic surgery patients by saying that such discussions are an invasion of the patient's right to privacy; or they'll say they don't have the time, or they'll think that sex is no longer a concern to the patient because of her age. Some physicians feel that by speaking about sexual adjustment to the surgery patient will "open up a can of worms," and that they won't have the resources to deal with it.

Better ways are needed to let pelvic surgery patients know that they are not the cervix or the vagina that was removed or reconstructed. It is imperative to remember that women undergoing pelvic surgery are sexual beings who have an identity beyond their sexual disease.

"It is imperative to remember that women undergoing pelvic surgery are sexual beings who have an identity beyond their sexual disease."

Critical factor

It needs to be pointed out that one of the most critical factors in the psychosexual rehabilitation of the pelvic surgery patient is the presence of an interested and educated sexual partner. Working with the patient and her partner to help them learn about the changes in their sexual function goes a long way toward their resumption of sexual activity.

Guidelines

We need to focus on developing programs so nurses and physicians can better educate their patients. We also have to make better use of our resources; and if they don't exist, then they must be developed. The following guidelines are recommended in order to help the female pelvic surgery patient prepare for surgery:

1. People experience events through their senses: by touch, smell, sight and sound. It is important that the information the pelvic surgery patient is given describes how she will feel before and after surgery. Don't make the mistake of only giving her a detailed outline of the surgery itself.

2. Allow opportunity for questions, and reinforce information on a regular basis.

3. Let the patient know that it's OK to talk about psychosexual concerns, and do so at a time when she has been afforded sufficient privacy to respond.

4. Clarify any misconceptions the patient may have about body functions and anatomy using simple, clear diagrams.

5. Describe the impact of the disease and treatment on normal functioning as well as on sexuality and sexual functioning.

6. Consider preoperative counselling so the patient can anticipate some of the effects of disease and treatment. After surgery, sexual counselling services can help deal with the more specific sexual dysfunctions that may become apparent after surgery, chemotherapy or radiation treatment.

7. Use a team approach to plan the psychological and sexual rehabilitation of the patient.

8. Talk to colleagues and other nurses and health professionals about the patient's prognosis. A better understanding of a patient's situation will help everyone deliver better quality care.

Conclusion

It is important to remember that men and women are sexual beings and that sexual response is developed through an entire history of psychological and sexual experiences that they have come to know throughout a lifetime. The more we learn about sexuality, the more we learn about human nature; and the better we understand that, the better we are able to care for our patients. ■

About the author

Leslee Thompson, B.Sc.N., M.Sc.N., is clinical nurse specialist, gynecology and oncology, Wellesley Hospital, Toronto. She received her B.Sc.N. from Queens University and her M.Sc.N. at the University of Toronto. This submission was taken from an address given at a recent meeting of the Society of Pelvic Surgeons in Toronto.

"No one can live forever! However, we have every right in the world not to be interfered with when the attempt is made."

Survey provides safety trends in use of video display terminals (VDTs) in the O.R.

With the technology advancing as rapidly as it is, the probability is high that many operating room nurses will be using video display terminals (VDTs) as part of the hardware associated with computerized information system.

Recently, the United Nations International Labour Organization published a survey of hundreds of current medical and industrial guidelines and policy statements on VDTs *(Conditions of Work Digest)*. The following are some of the worldwide trends on VDT safety derived from this United Nations publication:

VDT safety trends

• Radiation safeguards are recommended, including limiting VDT use, machine shielding, regular servicing and checking for radiation emissions, although no evidence exists VDTs emit dangerous radiation levels.

• Pregnant women should have the option of being reassigned to other work, although no evidence exists VDTs play a role in miscarriages or birth defects.

• VDT users should have regular eye tests with the costs of tests, glasses and contact lenses borne by the employer.

• There should be regular rest periods of 10-15 minutes after an hour or two of VDT use. Some regulations say VDT use should be limited to 5 or 6 hours a day.

• Employees should be informed of the introduction of the technology with jobs designed to alternate VDT use with other tasks.

Call for Abstracts
1990 ORNAC Conference

The Program Committee for the National Operating Room Nurses Conference, scheduled for Toronto in 1990, is calling for abstracts pertaining to research in the operating room nursing field.

The authors of those abstracts selected will be invited to participate as speakers at the National Operating Room Nurses Conference (11th National) which is scheduled for the Harbour Castle (Hilton) Hotel in Downtown Toronto, April 1st to April 6, 1990.

Deadline for presentation of abstracts is April 3, 1989. Abstracts should be sent to the following address on or before the above date:

Carol Lenox, Program Convenor
11th National Operating Room Nurses Conference
Mississauga Hospital
100 Queensway West
Mississauga, Ontario
L5B 1B8 (416) 848-7100

Coffee as you (should) like it... filtered not percolated

Brewing your coffee in a certain way can have a major impact on the risks associated with heart disease. A study from Finland recently showed that drinking eight cups of coffee per day for a month failed to boost cholesterol levels for either women or men - as long as the coffee was brewed by the filter method.

Cholesterol boosting

However, when the same subjects (42) drank percolated coffee, their cholesterol levels soared.

The Finnish researchers found that a cholesterol-boosting substance is either formed or extracted from the coffee during percolation, possibly as a result of the longer time the water has contact with the coffee grounds.

OR news

Hair loss now blamed on stress and poor nutrition

Losing your hair!

It could be that stress, combined with poor nutrition, is accelerating the loss of hair.

Accoridng to Dr. Walter Unger, assistant professor of medicine, department of dermatology, University of Toronto, the scenario causing the hair loss is..."a vicious cycle - the more you worry, the more tension you feel and the more hair you lose."

Dr. Unger agrees with other exsperts who say that relaxation is the best remedy. Vitamin B and scalp massages to stimulate circulation appear to help as well.

Happy faces for surgical masks - Why not?

Thanks to a nine-year old patient at the Hospital for Sick Children in Toronto, the humdrum look of surgical masks may become a little more colourful.

The patient, being treated for leukemia, decided to do something about the monotony of surgical masks. He contacted a major supplier of masks and asked why they couldn't be made more colourful. The firm responded by sending him 50 hand-painted masks - for patient use only. The letter accompanying the masks said that they are trying to find a way to manufacture more colourful - and acceptable - masks.

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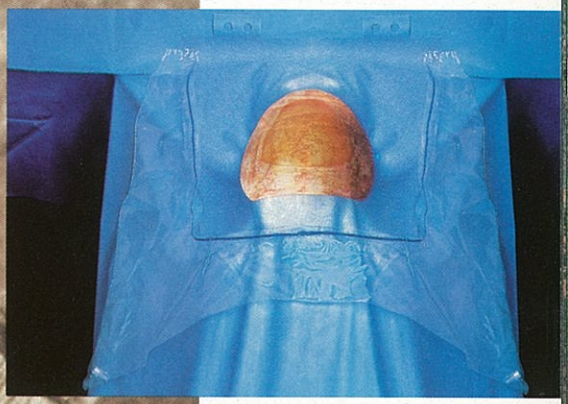

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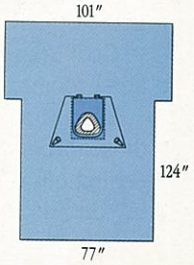

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General Journal Information

The Canadian Operating Room Nursing Journal, copyright, 1983, is published six time a year (February, April, June, September, October and December) for operating room nurses and related surgical nursing personnel across Canada.

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Liver research in Canada said to be abysmal

A recent conference of the International Association for the Study of the Liver had few accolades for Canada's contribution to liver research. According to figures mentioned, Canada has only 25 hepatologists to serve the entire country.

Liver disease is one of the leading causes of death in Canada. Alcohol-related diseases, for example, rank as the third largest cause of mortality from chronic disease. On top of this, between 2000 and 3000 Canadians die annually from fulminant viral hepatitis alone.

While hepatologists and those few centres where liver research is done are encouraged by the support from the pharmaceutical industry, government cutbacks and poor support from brewers and distillers remains disappointing. "Funding for liver research in Canada is abysmal...We are waiting for a more enlightened approach from industry," says Dr. Laurie Blendis, Professor of Medicine at the University of Toronto.

Dr. Blendis mentioned that raising funds for liver research is difficult due to its low emotional profile, the alcohol-related stigma attached to liver disease, and the fact that too many people see liver disease as an affliction of older people, "yet it affects babies and children as well."

It was emphasized that liver disease is the commonest form of cancer in the world and that hepatitis B alone kills 2,000,000 people in the world annually.

President's Message

As the Christmas season fast approaches, our lives rapidly become a blurr of running from one task to another. The holiday season is also a time for reflection, when we focus on where we have come from and where we will be going. At a meeting of the executive of the Operating Room Nurses Association of Canada held in Toronto recently, we did just that - we took a long, hard look at what the association has accomplished, and the direction that will be taken in the future.

ORNAC accomplishments

In the short time since ORNAC became a reality, a great deal has been accomplished:

- our bylaws have been ratified and are in the process of being translated;

- the creation and publication of two major documents has been achieved: "Recommended Standards for Operating Room Nursing Practice," and "Recommended Technical Standards." These two publications are available in English and French;

- an approval process has been agreed upon for operating room educational programs;

- the development of the position statement on operating room experience in basic nursing education which was presented to the Canadian Nurses Association (CNA) in June, 1988;

- the development of the position statement on staffing the operating room. This statement is to be sent to the CNA, to each provincial operating room nurse's association and interest group;

- the initiation of a "Rules and Regulation" book for ORNAC board members.

However great the accomplishments of ORNAC, we still have a number of important goals to strive for in the future. These will be listed and a priority assigned to each. Understandably, these goals will be considered and approved by the ORNAC board members at our Spring, 1989 meeting in Toronto. Following approval, there will be a report in this column to outline our established priorities.

Common goals

In the meantime, I suggest the following common goals:

1. To share - We have created a network which provides all operating room nurses in Canada with a wonderful opportunity to share common interests, concerns and achievements. Let us call on each other's talents, while at the same time sharing our own.

2. To strive - We constantly strive to improve patient care through our nursing practice. We try to measure up to the standards we have set for ourselves and to achieve a higher level of professionalism. We must never cease to strive and seek wider horizons.

3. To love - This goal, not to be misconstrued with the word "mushy," is meant in the true sense of caring for each other, our patients, our colleagues and ourselves. To quote from a former president of the American Operating Room Nurses Association, "to disagree does not mean to dislike." We can have our differences but still be friends and care. Take the time to care for yourself, as only then can you begin to be of value to others. If we share, strive and love, we will go a long way toward making 1989 a year to remember.

Season's Best Wishes,

Joan Donald
President, ORNAC

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