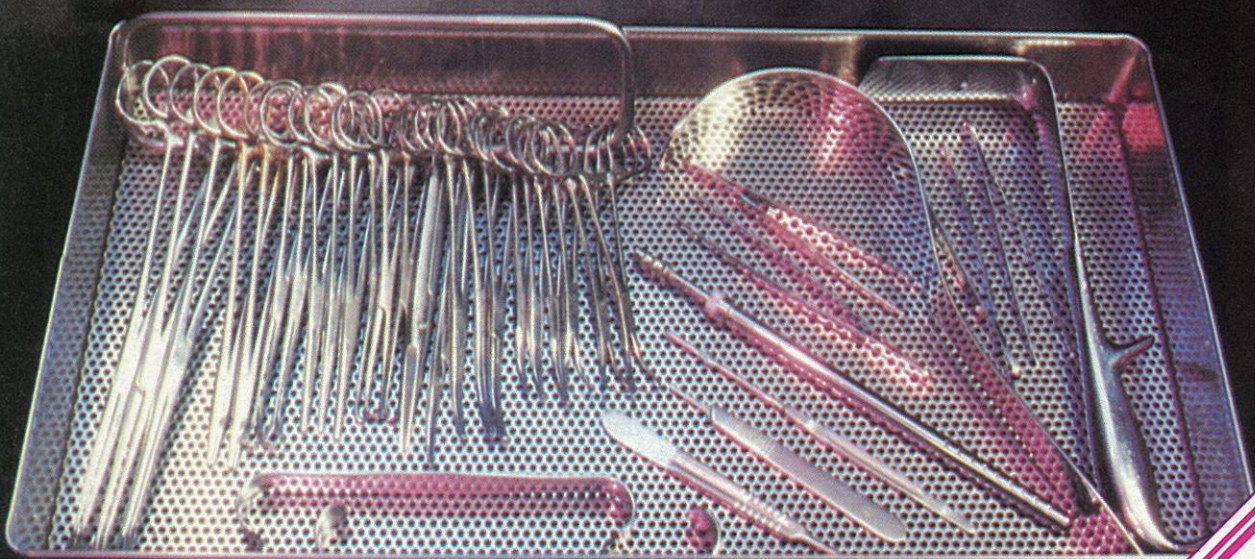


CANADIAN

# Operating Room Nursing Journal

Volume 6, Number 3, June, 1988

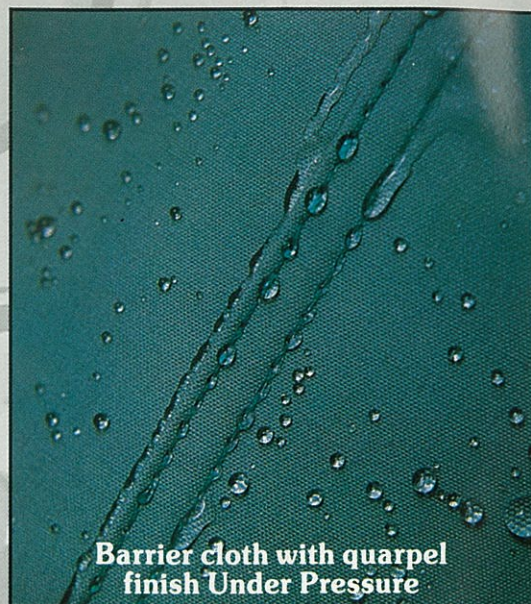


**Steam sterilization systems  
(How they work)**

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# Operating Room Nursing Journal

Volume 6, Number 3, June, 1988

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Canadian Operating Room Nursing Journal

## Feature Articles

### 9 Steam sterilization systems

Sterilization to ensure that materials for use at the operative site are free of micro-organisms is a complicated, technical process. Knowing how a sterilizer functions is the first step in solving problems when a sterilizer malfunction occurs. In this submission, the author details how the steam sterilizer works. It is the first of a two part series.

By Barbara Bolding, R.N., B.S.N.

### 14 Caring - the essence of nursing

Caring is an essential human need, and in nursing, it is the very essence of the profession. Understanding the true meaning of caring, its importance and the issues it involves is the gist of this submission taken from one of the keynote addresses delivered at the Vancouver National O.R. Nurses Conference.

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### Highlights of the 10th National Operating Room Nurses Conference...

- Organizers of the 10th National Operating Room Nurses Conference, the British Columbia Operating Room Nurses Group (BCORNG), were hoping for a record number of participating delegates. Total delegate attendance was just under 900, making the '88 national conference the largest in its 20 year history.

- A new ORNAC executive took office: president, **Joan Donald**; 1st vice-president, **Gloria Stephens**; 2nd vice-president, **Carol Lenox**; treasurer, **Carole Starr**; secretary, **Muriel Shewchuk**; past president, **Ann Robinson**.

- Winner of the Isabel Adams Award of Excellence was **Gloria Stephens**. Gloria became the first recipient of this award, which will be presented by ORNAC at each national conference.

- The Surgikos Drake/Thompson Memorial Editorial Award for 1987 went to **Mary Kubasiewicz** from Seven Oaks Hospital in Winnipeg. Her winning submission entitled "*Controlling Anaesthetic Gas Exposure in PACU,*" appeared in the April, 1987 issue of this journal (Volume 5, Number 2).

- Delegates interviewed mentioned how impressed they were with the medical/surgical product exposition. The exhibitors, for their part, reported how pleased they were with the interest shown by delegates. There were a record number of participating exhibitors at the Vancouver National O.R. Conference. Over 100 different medical/surgical supply companies participated.

- The next National O.R. conference will be held in Toronto, April 2 - 6, 1990 at the Westin Harbour Castle Hotel and Convention Centre. National Co-ordinator for the 1990 event is **Sharon Corbie**, Scarborough General Hospital.


- Detailed coverage of the 88 National Conference in September.



### A pictorial rendering of some of the delegates at the 10th National Operating Room Nurses Conference held in Vancouver, B.C., May 29 to June 3.



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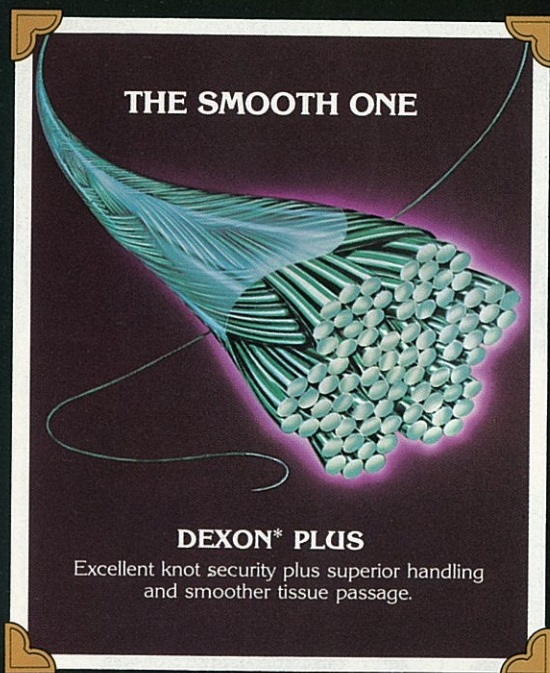


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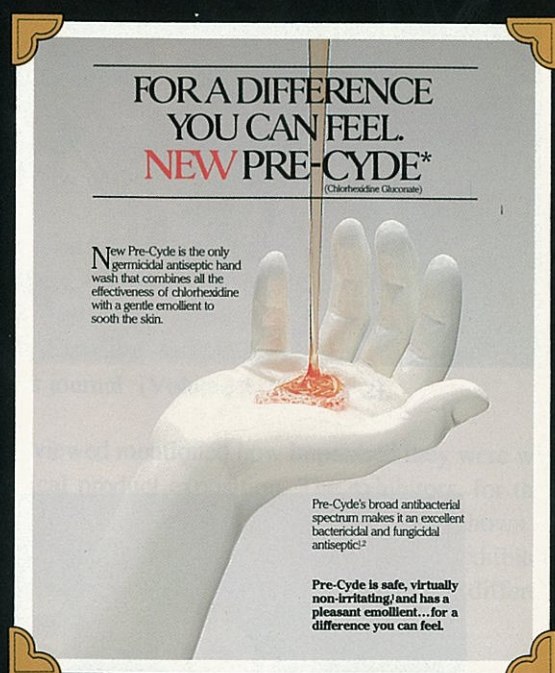
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# Steam sterilization systems

## How they work (Part 1)

By Barbara Bolding, R.N., B.S.N.

When a hospital sterilizer fails to function as it should, the sterility of materials for use at the operative site cannot be ensured. Thus, it is important that operating room nursing staff know as much as possible about the sterilizers they use and how the sterilizing system works. In this submission, the first of two parts, the author reveals that sterilization consists of more than just closing a door on a load and then pressing the operating button.

### Objective of sterilization

When sterilizing, the objective is to kill all microorganisms that may be present on instruments and other devices and materials used during surgery. Heat is used to do this. Heat over time will kill microorganisms, and the greater the heat, the shorter the time required.

Hospital sterilization aims at reducing the time as much as possible. To minimize sterilization time we do two things:

**One,** we add moisture to heat. Moisture in the form of steam improves heat transfer and therefore killing efficiency. Moist heat kills faster than dry heat.

**Two,** we increase the temperature of the moist steam.

Steam normally has a temperature of 212°F (100°C), the boiling point of water. The only way to increase its temperature is to put it under pressure. To achieve a steam temperature of 250°F (121°C), a pressure of 15 pounds per square inch must be applied. 270°F (132°C) requires a pressure

of 27 pounds per square inch. The relationship between temperature and pressure is fixed. If one is known, the other can be predicted.

A hospital steam sterilizer puts all of these requirements together. It provides moist heat (steam) under pressure (which increases temperature) to shorten the time required to kill microorganisms.

### How they work

Hospital sterilizers work in one of two ways:

- gravity displacement, or
- vacuum

These names describe the way in which air is removed from the chamber prior to actual sterilization. Most operating room flash sterilizers operate by the gravity displacement method.

### Gravity displacement sterilization

In using this method during sterilization, steam enters the chamber at the top, back of the sterilizer. Air, which collects in the bottom of the chamber is forced out the drain line as more and more steam is injected. Once all air has been removed from the chamber, the steam trap, which is heat sensitive, closes the drain line. With the door and drain line shut tight, a pressure-tight vessel is created. As steam continues to be injected, pressure, and hence temperature in the chamber, rise. Gravity sterilization usually operates at a temperature of 250°F.

It is important to remember that this air removal is part of the conditioning (preparatory) phase of sterilization. Actual sterilization cannot begin until all air has been removed from the chamber. Air acts

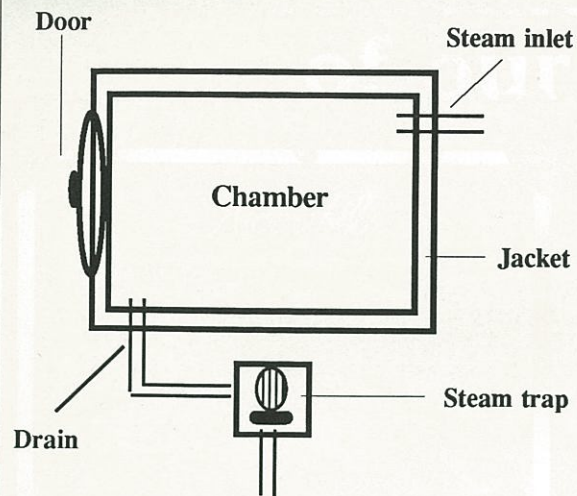


Diagram of sterilizer with gravity displacement

as a barrier to the direct contact of each item by the steam. If air remains trapped in the chamber or within items of the load, sterilization cannot occur.

#### Vacuum assisted

Air removal by the gravity process can be time consuming, especially in sterilizers with large chambers. An improvement on the speed of a gravity cycle is the vacuum assisted method of sterilization. Rather than waiting for air to flow out of the chamber, a vacuum pump sucks it out. With all air gone from the chamber, steam penetration to all parts of the load is almost instantaneous. Total sterilization cycle time is significantly reduced. Vacuum-assisted sterilization usually operates at a temperature of 270°F.

In the 1950s, John Perkins in "Principles and Methods of Sterilization in Health Sciences" defined steam sterilization standards that still apply today. Table 1 summarizes these standard requirements.

Table 1	250° (Gravity)	270°F (Vacuum)
Wrapped hard goods	20 min.	4 min.
Wrapped fabrics	30 min.	4 min.
Liquids	Time varies with volume	Not sterilized by vacuum method

Some examples of wrapped hard goods are instrument trays and basin sets; wrapped fabrics include linen bundles or gown packs.

#### Flash sterilization

Operating room nurses are often required to "flash sterilize" items. The Association for the Advancement of Medical Instrumentation (AAMI) have published a set of recommended practices pertaining to flash sterilization.

What is flash sterilization? Simply put, it is the sterilization of unwrapped items. Flashing allows us to reduce the total cycle time. Sterilization time is reduced because steam can contact items quicker as there is no wrapper to penetrate. Drying time is reduced or eliminated because there is no wrapper to dry.

Flash sterilizers most often operate by the gravity method. However, as chambers are relatively small, air drains out quite quickly. These sterilizers also operate at a higher temperature (270°F) than do standard gravity sterilizers (250°F).

#### Emergency procedure only

The most important thing to remember about the flash method is that it is an emergency procedure. In all instances, wrapped sterilization is preferred because it ensures that sterility can be maintained during delivery to the sterile surgical field.

What is an emergency? An individual surgical item for which there is no sterile replacement, dropped to the floor during a surgical procedure is an emergency. Flash sterilization is required.

Flashing of complete instrument sets is strongly discouraged because there is a reported increased incidence of sterilization failure by this method. If flash sterilization is absolutely necessary, AAMI outlines four criteria which should be met:

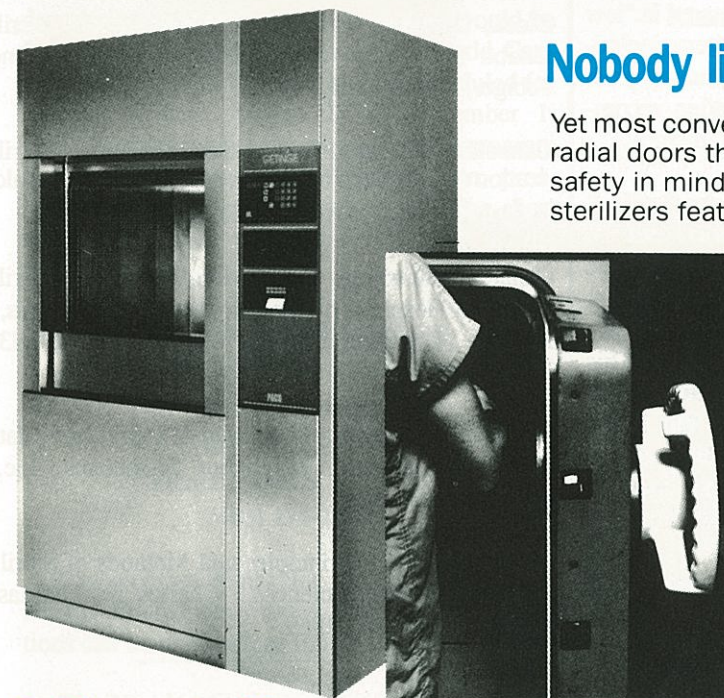
1. There is an urgency for the method to be used.
2. The environment ensures direct delivery of the flashed item to the sterile field.
3. Proper cleaning, inspection and arrangement of instruments into the pan must occur prior to sterilization being initiated.
4. Implants must never be flashed.

#### AAMI recommendations

The standard time and temperature for flash sterilization varies with the sterilizer operating method (gravity or vacuum), and with the item to be sterilized (porous or non-porous). The recommendations on the following page are from the AAMI:

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Table 2	270°F (Gravity)	270°F (Vacuum)
Non-porous	3 Min.	3 Min.
Porous	10 Min.	4 Min.

**Standards recommended by the AAMI for time and temperature variables in flash sterilization**

Examples of porous items are rubbers, plastics, items with lumens such as suction tips, tubings, needles and towels ( for padding instrument trays).

Besides flash sterilization, the other variation in sterilization methods sometimes encountered is "low pressure" sterilization. Manufacturers of items including certain dermatomes, power guns, mammary prostheses, and cardiac valve measurers often recommend using the low pressure sterilization method.

**Low pressure sterilization**

Low pressure sterilization is sterilization by the gravity method at a temperature of 250°F. Steam at this temperature has a fixed pressure of 15 psi, which is much lower than the 27 psi of 270°F. This lower temperature could be the difference between an item melting or not. Also, because this is the gravity method, there is no vacuum in the cycle. A vacuum could possibly draw lubricant out of motorized parts, or it could rupture sealed gas or liquid pouches within an item.

Sterilization time by the low pressure method will vary. Device manufacturers should supply this data. Keep in mind though, that without a vacuum, air removal will be slow and air entrapment can easily occur. If air removal is incomplete, sterilization cannot be ensured.

In short, steam sterilization can be accomplished in one of three ways:

1. Standard gravity displacement at a temperature of 250°F.
2. Vacuum assisted at a temperature of 270°F.
3. Flash - which is gravity displacement at 270°F.

**Conclusion**

Sterilization is a complicated, technical process. Effectiveness depends on more than closing the sterilizer door on a load then pressing the button. Knowing how a sterilizer functions is the first step in solving problems when it doesn't function properly.

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**About the author**

Barbara Bolding, R.N., B.S.N., studied nursing and operating room nursing at the British Columbia Institute of Technology in Burnaby, B.C. She received her B.S.N. from the University of British Columbia.

Currently, she is co-ordinator/instructor for the Sterile Supply Processing Training Program at Vancouver Community College, and instructor in the British Columbia Institute of Technology post-basic nursing program.

The content of this article on steam sterilization was taken from a major address the author presented at the 10th National Conference for Operating Room Nurses held recently in Vancouver. The second part of this submission on steam sterilization systems will be presented in the September issue.

**PRESENTATION OF PAPERS  
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  - Digit and limb reconstruction after trauma
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  - Reconstruction after burns
3. **Perioperative Nursing Research**
  - Findings of four researchers and how the findings have been implemented in practice
4. **Influencing Practice Through Speaking and Writing in the Workplace.**
  - Influencing through speaking
  - Presenting yourself, framing things

- Influencing through writing: business, communication

**5. New Advances in Surgery: Implications for Nursing Care**

- Second generation lithotriptors: gall bladder/kidney
- Intervention radiography: cardiovascular applications
- Endoscopic laser interventions

**6. Developments in Pain Management**

- Conventional drug therapy/epidural
- Patient controlled analgesics
- Alternative approaches/pain management:
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  - Music
  - Preparation through teaching
  - Relaxation

**7. Professional Accountability in the Team Setting**

- Patient care planning
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- Day surgery
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**9. Infectious Diseases: Universal Care**

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- Protection of the healthcare worker
  - Mandatory protection steps, economics of protection, different codes for different countries.
  - Include HTVL, all AIDS virus designations, hepatitis B)

**10. Managing for Success**

- Interviewing and selection of staff
- Motivation
- Counselling of staff

**11. Conflict in the Workplace**

Confrontation, Negotiation, Mediation

**Note:** Deadline for submitting brief details on subject interested in speaking on, plus short biographical note to above address is July 15, 1988.

# Caring

## The essence of nursing

By Jessie Mantle, R.N., M.S.N.

Times of change, while stimulating, are also unsettling. One seeks to find some stability - a constant - that can ground us as we seek to cope with and embrace new ways of being. The idea of caring, one of nursing's most fundamental notions, does that for us.

Today's world, particularly the world of operating room nursing, is one of high technology. In the book *Megatrends*, Naisbitt, the author, comments that to survive in such a world (of high technology), one must balance **high tech** with **high touch**.<sup>1</sup>

It seems that it is not by accident that during the last ten years of this high tech age, there has been a great increase in the study of caring and what it means to be humane. It also comes as no surprise that nurses, who know only too well the impact of technology on the human condition, have participated in this exciting work (ie., the study of caring).

### Capitalizing on our skills

As a rule, we nurses have looked at the caring quality of our practice as it bears on the relationship which occurs between a nurse and each individual client. But today, we practice nursing in a health care system which rarely capitalizes on the full potential of nursing skills. Staffing shortages and burnout are the buzz words of private and public conversations. In 1988 our caring activities must not only include our familiar nurse-patient-family contacts, but also encounters in many areas beyond

that of direct patient care. It is this broad but crucial orientation to caring that will be discussed under the following headings:

1. Orientation to caring
2. Results of caring
3. Nursing self-care
4. Action
5. Commitment to competence

### 1. Orientation to caring

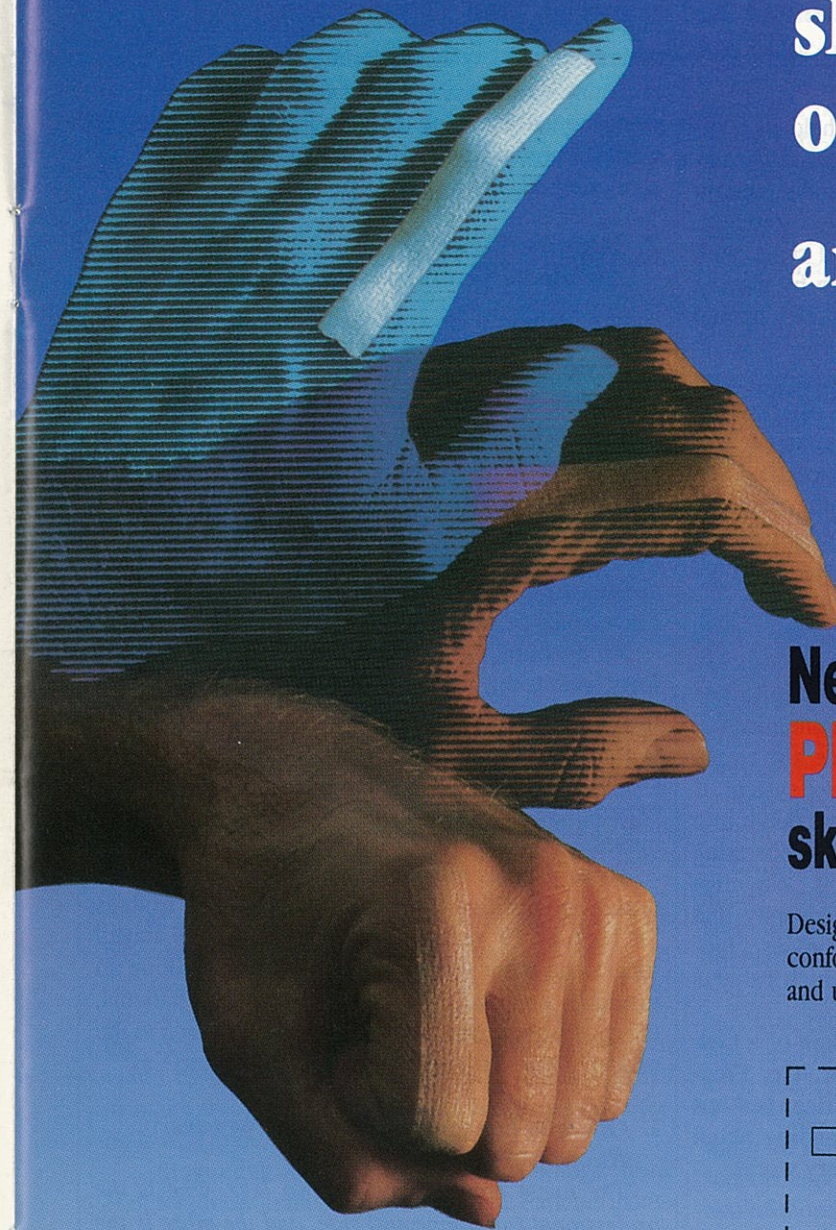
Care, caring, health care, nursing care...What do we mean when we use these words, words that have been in the language of nursing for nearly a century?

I begin by stating boldly that caring is not the sole property of nursing, but rather it is a shared

### About the author

Jessie Mantle, R.N., M.S.N., is a professor in the School of Nursing, University of Victoria and Clinical Nurse Specialist at the Juan de Fuca Hospitals, Victoria, B.C. She is a graduate of Royal Jubilee Hospital, Victoria B.C.; McGill University, Montreal; University of California and University of Washington.

Her article on "Caring" was edited for publication from a keynote address presented at the 10th National Operating Room Nurses Conference held in Vancouver this Spring.



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**"Uncaring encounters stayed longer and more vividly in their (the patients') memory making an indelible impression on them." For these patients, the caring nurse had a special kind of approach."**

concept derived from a belief system held in common with many. Nurses contribute a particular understanding of the need for caring under certain human circumstances. We have perfected some exquisite skills which we can and should share with others. Even so, we have much to learn by placing our ideas within the larger context of the human enterprise.

Some years ago, I was asked to give a paper on caring to an audience comprised of hospital chaplains. You can imagine my surprise as I felt as though I were taking coals to Newcastle. The chaplain who asked me to participate, read the nursing version of caring. Down the edges of my paper are his notes about my ideas - many of which infuse this paper on caring.

His notes reminded me that at the core of caring is a set of philosophical beliefs about what it means to be human, both alone and in relationship to one another. Our nursing standards, communication techniques and policies and procedures are empty without this driving (philosophical) belief system. If we want to learn about caring, we must delve into the study of material well beyond that of operating room nursing or even general nursing. We must move to the humanities and arts, philosophy and theology. We learn from novels, movies, biographies, poetry and the experiences which patients share with us.

If you saw either of the films "Children of a Lesser God," a story about being deaf, or "Cry Freedom", a story of courage in South Africa, perhaps you will have added to your understanding about what it means to care in our contemporary world.

### Knowledge and understanding

This kind of knowing is in the ballpark of what Donna Diers has written about:

*"...the kind of knowing that prepares one for civilized life - the content and experience that allows one to participate in the life of one's times, with an appreciation for history, ideas, the arts and sciences, the explorations and the frontiers of thinking."* <sup>2</sup>

She goes on to note that this may be a kind of understanding that needs experience in living and

work to yield meaning. It is the kind of learning that would appropriately fall within the context of continuing life-long education.

### 2. Results of caring (or the hidden dimension of outcomes)

How often as nurses have you wondered if what you have said or done, has helped or hindered - for you rarely see your patients again under conditions that allow for discussion of such matters. While we have a number of books and articles on caring from our (the providers) point of view, few studies have been done that have investigated patient's views on the topic. When nurses and clients' perceptions about caring are compared, there is frequently a discrepancy between the two.

An encouraging development in identifying patients' points of view on this topic is found in a recent nursing master's thesis done at the University of British Columbia. Sigrid Halldorsdottir interviewed former recipients of nursing care about their experiences in caring and uncaring encounters with nurses.<sup>3</sup>

These patients vividly recalled their contacts with nurses and positive encounters were recalled from as far back as 19 years. Uncaring encounters stayed longer and more vividly in their memory making an indelible impression on them. For these patients, the caring nurse had a special kind of approach to the patient. They saw the professional caring nurse as:

#### I. One who has compassionate competence

As one patient put it:  
*"The nurse has to stand on two legs. One is the professional (or competent) side, and the other is the human (or compassionate) side, and the two of them have to belong to the same person."* <sup>4</sup>

#### II. One who administers care with genuine concern for the patient as a person.

As Halldorsdottir comments:  
*"It's not only what is said and done but also how things are said and done."* <sup>5</sup> This is captured in a patient's own words:

*"I remember going through situations of pain and there was almost as if you asked for a pain medicine,*

*you weren't strong enough, that you really sort of ought to grin and bear it. I remember one particular nurse, (where) it was never that way. If you said, 'I really have pain,' right away she would respond to that. And there was no judgement or any sense of criticizing you because you were doing that. She accepted the fact that you were having pain and she better do something about it. So, there was this sense of acceptance and non-judgement."* <sup>6</sup>

#### III. One who gives the patient full attention when with him/her.

This was how these patients described a nurse who was right there for them:  
*"really listening," "really hearing."* <sup>7</sup>

#### IV. One who constitutes a genuine cheerful presence for the patient within an often grim reality of their hospital situation.

The interviews revealed that patients found it helpful to have in their presence someone who is cheerful, enjoys nursing, enjoys working with people, and manages to convey that joy clearly to the patients.<sup>8</sup>

It would be helpful if we knew how closely these patients' experiences matched those of persons who are undergoing experiences in surgery. Further, it would be helpful if we knew what operating room nurses believed to be caring acts within the context of their practice.

Madeleine Leininger is a nurse-anthropologist who has pioneered the formal study of caring in nursing. She has studied caring phenomena in some 30 cultures of the world. It is her view that caring is the essence of nursing and of health. Leininger views caring as a very complex idea which appears to make the difference in human health services for both well and sick people.<sup>9</sup>

Supporting her views are the findings from Halldorsdottir's study discussed above. Patients identified the following responses to caring encounters:

1. A sense of acceptance and self-worth
2. A sense of encouragement and support
3. A sense of confidence and control
4. A sense of well-being and healing
5. A sense of gratitude and liking <sup>10</sup>

In a world of rising consumer demands and a need for cost constraints, it behooves health care managers and policy decision-makers to pay careful attention to this untapped and unrecognized resource.

### Caring for ourselves

Our caring is also made manifest by activities in which we demonstrate caring for ourselves. While many of us were probably raised on the notion that to care for oneself was an act of supreme selfishness, it is now recognized that in order to care for others, care-givers must be cared for.

I would like to highlight one area which is under our direct control and which has a high degree of payoff in caring for ourselves. I am referring to the need to create supportive working environments.

### Supportive environment

In the late 1980s, caring for oneself meant being concerned about the working environment of nurses. Through the media, the quality of the working life of nurses and its impact on nurse retention has been brought to the attention of all Canadians.

Two of my colleagues, Attridge and Callahan,<sup>11</sup> have received federal funding to study work environments of nurses. It is their belief that in order for nurses to care, they must be cared for - that is, they deserve a quality work environment. They have begun to uncover nurses' views of what constitutes such an environment by going to the nurses themselves. (This is very comparable to the approach used by Halldorsdottir in her research on patient perceptions).

Important to us was their finding that the most highly ranked item in a quality work environment was having supportive colleagues. This item doubled the score of any other item. For those of you who are managers, you will be interested in the fact that receiving emotional support of superiors was rated in the top ten of 48 items that were found to be quality items.

Lindsay, in a study in process, has interviewed some 30 staff nurses to examine the support/lack of support experiences of nurses.<sup>12</sup> Let me share just two of those incidents with you...

*"I had a very sick child to care for. I developed a special relationship with the child and his parents. He was very special, moreso to me than to the other nurses. He had a brain tumour and was in hospital on and off for two years. I watched him go downhill during that time. I loved him so much. I used to take him with me when I went to coffee breaks.*

*When he died, I was allowed to go to the funeral (note, "allowed"). After that, the head nurse and other staff members would periodically check with me and ask how I was doing. Just knowing*

that people cared, that they acknowledged that I had a special relationship with the child and that they cared about how I felt, it meant so much." 13

Given this story, it is not hard to see why collegial support is so important to nurses. As Attridge has noted: "Support provides reward, value, respect and caring to professionals who, working in difficult and demanding work situations at the best of times, badly require it." 14 Now contrast this example of support with the following...

"We had a patient who was terminally ill. He was going down-hill fast. He was in extreme pain and we couldn't control it. He was barely responding. It really hurt for him to change position. This patient was supposed to go for ultra-sound on his kidneys. I was going off shift, but I told ultra-sound and the day staff that we should postpone the ultra sound until we had the patient's pain under better control. I went home and was no sooner through the door, when the phone rang and the head nurse said, 'What do you think you're doing, cancelling patient's tests, you're not a doctor; it's not your responsibility to do that. Who do you think you are?' The head nurse never let me explain my rationale, or that I had postponed it, not cancelled it." 15

How different and how devastating this last story is compared to the other. The negative impact of lack of support in the work environment is compelling. Lindsay's preliminary analysis suggests the following negative consequences: 16

- compromised nursing values
- reduced communications among nurses
- reduced communication with doctors
- reduced communication with patients and families
- increased caution in nursing work
- time consciousness to the detriment of the patient
- reduced sensitivity to emotional needs of patients
- inability to cope
- reduced communication with nursing hierarchy
- avoidance of selected nurse peers
- inability to concentrate on patient care

In addition, there was a negative impact on career decisions by the nurses involved:

- 17/30 nurses reported quitting their jobs
- four were thinking about leaving the profession.

These nurses also reported a variety of negative self-views such as self-destructive feelings, power-

lessness and self-doubt. This data suggests then that one of the most potent ways in which we can care for each other is to be supportive and sensitive to each other as we go about our daily work.

### Nursing care actions

Gaunt has commented that caring is "...not a basic action that can be accomplished directly but rather is a mediated action, accomplished through many other activities." 17

Reference has been made to several caring actions. In this section, I would like to look at two actions in which nurses join together in community to care for clients, themselves and the health care system:

1. assuring clients of continuity in nursing and health care services
2. by working to provide nursing input into health care decisions

### Continuity of service

We are dependent on each other in order to achieve goals which demonstrate caring for a client's total experience in health and illness. The present health care system is a fragmented one and clients move in and out of compartments. Because nurses work in all segments of that system we have the capacity to reduce that discontinuity provided we can function as a nursing team.

I invite nurses to form action-oriented nursing communities in the cities and villages in which they live. Let us establish linkages with each other and develop a nursing task force which sees as its goal the development of procedures to help clients make the most effective use of the health care system. Let us take on the challenge of teaching the public the fine art of moving through the entire health system of their community with the least amount of energy expenditure and in an informed manner.

### Commitment to competence

Halldorsdottir's patients saw compassionate competence as an essential characteristic of a caring nurse. Attridge's nurses wanted supportive, competent colleagues.

I am not able to talk to you about particular aspects of competence in the sphere of operating room nursing practice. But I do ask that you talk about it. Caring competence represents a very special challenge. Consider the following:

1. You work with patients who are vulnerable and powerless in a way that is frightening. For example,

your patients are about to give up control of their body and often their conscious states to people whom they scarcely know. What an act of trust!

2. You have a very short time span in which to establish a relationship with patients.

3. You encounter patients in an environment which is abnormal for most of us. For example:

- You are clothed in ways that distance you as a human being
- You conduct intimate acts such as body exposure in an area lacking the usual privacy associated with those acts.
- You work in an environment which is both strange and frightening.

4. Much of your caring occurs without the patient being aware and you must maintain a commitment to a person with whom you have little interaction.

Pat Benner, an American nurse researcher, would say that much of your caring skill lies imbedded in the practice of your expertises. 18 When expert nurses tell their stories (or paradigm cases as Benner would call them) their skill becomes visible and we can all learn from that. To understand competence in O.R. nursing, we must hear the stories of excellence from that practice. We must understand that competence is the flip-side of the caring coin.

### Conclusion

Implicit in all that I have said is that the nurse must be a caring person. Caring comes from a commitment to a way of being human. Perhaps our greatest act of caring for our clients is that we undertake the nourishment of those qualities within ourselves that make us caring people and then we can translate this caring into professional skills directed to clients in our case loads, our colleagues in nursing and other disciplines, our health care systems and our community.

Let me end with a quotation from a Canadian whose caring impact has reached society's rejects far beyond Canadian boundaries:

In his book, "Tears of Silence," Jean Vanier identifies that impact which caring has but which we cannot describe or feel:

*In some mysterious way  
the quality of my presence, my look  
brings to you life  
that look  
that hand  
calls forth  
life...hope...joy. 19*

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# Managing conflict in the OR setting

By Paul Preston, Ph.D.

Usually, conflicts are associated with the concepts of aggression or hostility. The term itself conjures up negative and unproductive behaviour which must be avoided.

For today's operating room manager/supervisor, conflict can have some very positive outcomes - if properly managed.

Conflict, if it is creative - for example, individual differences in policies, guidelines or management technique - can result in better planning and organization. Within any hospital surgical setting, properly managed conflict between an OR manager and his or her staff can help encourage employees to show more commitment toward patient care. Creative conflict can also keep the staff members "on their toes" and aware of their responsibilities.

From the above, dealing with conflict may sound like a risky undertaking. However, it is often better than dealing with a lethargic 'who cares' attitude that can spread and infect other employees, and even the welfare of patients.

## What is conflict?

Conflict is any situation in which the goals, methods, aims or objectives of two or more parties are in opposition or appear to be in opposition. It is also a situation where potential solutions appear to be, or in fact are, mutually exclusive. Each party in the conflict has a number of options or alternate strategies that can be used to create an imbalance.

Conflict management involves dealing with a conflict in a way that minimizes the negative aftermath of a conflict. It also involves attempting to maximize the chance to create a good working relationship in the future. Conflict management involves taking a long-term view.

Many conflicts arise over the allocation of scarce resources. If the director of nursing in a hospital wants a major educational program this year, and management believes this year is the time for a major renovation, conflict is likely over how to spend the hospital's/department's limited time and money. The choice of spending for education may mean little or no funding for renovations, and vice versa.

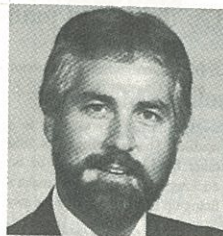
Conflicts may develop over anything: employee performance standards, or standards of patient care; location of meetings; handling budgets; the roles of various supervisors and managers; even the colours used to paint the staff room. While some of these conflicts have (or could have) a major impact on the organization, and others may seem trivial, none can be completely ignored for any length of time.

## Lingering nature of conflict

As dedicated operating room supervisors and managers, your goal should be to manage the conflicts facing you. We tend to think that when a

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conflict is settled, it goes away and is no longer a concern. The truth is, few conflicts are ever really resolved with no trace or aftermath.

Throughout history, the "resolution" of one conflict became the basis for a subsequent conflict. The Treaty of Versailles "ended" World War I. Yet, many historians feel that the treaty's conditions and stipulations created the springboard for the rise of Hitler and World War II in Europe.

Many of these same historians would suggest that the way the Allies handled the conclusion of WWII is an excellent example of a positive, constructive aftermath of a conflict. The challenge to you as an O.R. nurse/manager is to behave in a way that minimizes the damaging, negative effects of conflicts. Fortunately there are a number of strategies to help one manage the long-range and short-range aspects of conflict.

### Strategies for managing conflict

How you manage conflict will depend on a number of obvious factors: your personality, the other people involved in the conflict, the pressures everyone is under in a conflict situation, the organizational setting, the hidden agendas of all the parties involved, and the list could go on.

There is no "one best way" to manage conflict any more than there is a "best way" to manage a surgical floor. However, there are some things that will influence how you proceed in the management of conflict situations:

- Your past experience, with management and with conflict experiences;
- Your assessment of the person(s) with whom you are dealing;
- Your perceptions and metaperceptions (your perceptions of their perceptions of you);
- Your unconscious patterns;
- The reactions of your "opponents."

Of the conflict management strategies we will examine here, two (avoidance and smoothing) are passive, three are active. All are appropriate in some situations, acceptable in others and dangerous or disastrous in others:

#### • Avoidance ("I don't want to talk about it...")

Avoidance is simply doing nothing about a conflict. An ostrich with its head in the sand makes an enemy disappear to the same extent that ignoring a

conflict makes it go away. Yet, avoidance can be a useful short-range strategy if it is used to gain an advantage by allowing for a better time, place or situation for confronting the conflict.

It can also be useful when people are too emotional or when you are facing several simultaneous conflicts, and certain lower priority conflicts must be put aside for later. It can be effective if confronting the present conflict head-on will divert your time and energy or resources, and make you vulnerable to a larger conflict later. The key is "short-range."

Conflict avoidance must be limited, since too much avoidance can add to the negative feelings that can destroy an effective and caring organization.

#### • Smoothing ("One big, happy family")

In some conflicts, we respond by pointing to the futility or risk of an open battle by trying to smooth-over or gloss-over the conflict in hopes it will go away. Smoothing-over a conflict may involve getting the "antagonists" to lower their voices, shake hands, issue joint statements pledging mutual understanding and appreciation for each other's position and organizational concerns. This strategy is based on the assumption that, by emphasizing the positive, you can defuse the conflict and make it go away.

In the short-range, smoothing-over may actually work - in the same way a cease-fire stops the shooting on a battlefield. However, smoothing-over does little to get at or deal with the cause of the conflict, and it rarely leads to a long-term solution.

When you smooth-over a conflict, you are stalling, perhaps in hopes that things will change and that the need for a more active approach to the conflict will disappear. Smoothing-over may even add to the conflict by creating feelings of anger and resentment in those who might feel their legitimate concerns are being ignored or that they are being patronized. Taken at the extreme, smoothing-over a conflict becomes appeasement. World and management history has demonstrated the dismal record of appeasement in handling conflict.

#### • Competition ("We'll do it my way, or else!")

The competitor in a conflict takes a "win-lose" approach. He or she tries to force a victory at the expense of the other parties. The winner has more power and can force the loser to accept whatever solution he or she decides to impose. But a forced

solution can also lead to some serious negatives, such as the following:

- the loser is inclined to sabotage
- the exploration of other alternatives is blocked
- positions become hardened
- left unchecked, the hostility created by competition in the operating room environment can make the organization unable to work cooperatively against an external threat.

There are a number of tactics one can use to beat the other party in negotiating a conflict. These tactics work, and they are used comfortably and frequently by 'tough' opponents. You as a manager may have to deal from time to time with such people, and you will need to at least adopt your preferred style of conflict management to combat the tactics being used against you.

However, you may actually not want to use competitive tactics voluntarily, simply because you would find it difficult to live with them. Yet, competition in conflict management may be a necessity.

If you are in a situation where losing is not acceptable, you must play to win. At best, a forced win-lose solution to a conflict may result in the loser promising co-operation at "gunpoint." With little or no enthusiasm for, or commitment to the principles or positions of the winning side, it won't be much of a victory. A succession of losses can stifle creativity and motivation, thereby weakening an otherwise productive organization.

#### • Compromise ("Let's see if we can make a deal...")

Compromise involves conflicting interests reaching an agreement by splitting the differences that divide them. The role of compromise in conflict management is interesting. Often we use compromise to try to manage a conflict. Both parties agree they can't get everything they want, so they settle for something instead of nothing.

A well-designed compromise that benefits both parties and reduces hostility is an effective way to manage conflict. However, a compromise does not guarantee that future conflicts will not develop, or that parties to an agreement will remain happy with any agreement reached.

When bargaining is used as a strategy for managing conflict, there is always a danger that the bargain will come unstuck and that the conflict will flare again. If each party to a bargain trusts the other, the compromise will hold for a while. If there is a strong third party involved (such as upper

management), he or she will be able to keep the parties faithful to their bargain. However, the very nature of a bargain (giving a little to get a little) means that each party in the conflict wins and loses something. Thus, a perception of what could have been, may be the factor that gets in the way of future bargains.

### Optimizing conflict...

#### • Problem solving ("Let's see if we can all win...")

All the strategies we usually associate with conflict have advantages and appropriate uses. The common disadvantage that conflict strategies share is their potential for future conflict, the so-called "hidden agenda" or latent conflict in the short-run. In other words, these strategies may help you handle conflict in the short term, but they may cost you in the long run.

The best overall solution for conflict management on a long term basis is problem-solving, also known as optimizing, confrontation or collaboration. It involves changing the focus of a conflict away from blame, starting points, causes and specific solutions, toward an overall remedy for the problem at hand.

It is often called problem-solving because it requires the participants to seek common points of agreement while focusing on the mutual problems they face and the needs they share. This approach produces a "win-win" outcome. It minimizes the negative aftermath of a present conflict. This means that all parties to a conflict commit themselves to an optional solution instead of grudgingly agreeing to a "half-a-loaf" compromise while waiting for a chance to "get it all."

### Conflict and problem-solving

Listed on the next two pages are ten guides to managing conflict through problem-solving. Each guide can be used by itself, although it's better when several can be used in concert. The best results are possible only when both (or all) conflicting parties are willing to behave in a mature manner, without the need to be surrounded by layers of defenses.

### Adaptation and reality

When facing a conflict situation, assess yourself as well as the others involved. Assess also the stakes and the setting. Determine how important the conflict is to you and to the department. Keep

in mind that no one strategy works best in all situations. Remember that an optimum strategy for confronting conflict head-on may still result in a bargain between the involved parties. The goal in problem-solving is to minimize the negative aftermath of a conflict and thereby keep the conflict and the interpersonal relationships manageable and productive.

## Conclusion

The one who takes on the responsibility of managing a conflict must be realistic and realize that some conflicts can and will cause permanent damage despite your best efforts and the best efforts of all others involved. Conflict management can be

thought of as a sort of "forest-fire management." This manager doesn't try to put out every fire or save every tree. They plan their battles and calculate their possible losses, always with the goal of considering what's best for the entire forest. If success is achieved, damage to the forest is minimized and use of the forest resources is maximized.

## Seeds of future growth

In carrying this analogy further, consider this: after a bad burn, new trees spring to life and the forest goes on. If you handle your conflicts in an open, creative manner, you'll still maintain control of the seeds of growth and productivity. ■

## Guidelines for managing conflict through problem solving

### 1. Direct confrontation between opposing parties is essential

This is the key element in an optimizing approach to conflict. The opposing sides must be willing to face each other head-on. There can be no opportunity allowed for ducking issues, smiling to make things 'appear' friendly, or lining up bargaining chips for swapping later.

### 2. Personal feelings, hidden agendas and relationship issues should be acted upon first

In your first contact with your opponent, try to talk about how you feel about each other. Often conflicts are heightened and solutions are made more difficult because there is a "hidden agenda" in the conflict. If one can handle the relationship conflict first, the road to an agreement over substantive issues is made easier.

Personality issues rarely go away when an issue being conflicted is settled. Regardless of the settlement reached, relationship issues will remain as a sort of "aftermath." They will form the basis of the next conflict. By reducing the potential for these future conflicts, as you do when you deal with the personality issues, you are taking a systems view of the conflict. You won't necessarily change your opponents feelings about you, but at least you will be better able to separate their feelings about you from their feelings about your position on an issue. Naturally, your opponent receives the same benefit. However, if the comments you make about your hidden agendas concerning the other person are likely to offend, it's better not to bring them up directly.

### 3. Minimize status difference

When confronting a conflict head-on, it is best to keep the opposing parties on a reasonably equal footing. In working out conflicts with your staff, the status difference can be important. Imagine your superior, sitting in her office behind a huge, executive-type desk, while you sprawl in front of the desk on a too-low sofa chair.

You can hardly communicate as equals and ignore the status differences when they are so pronounced. Using your status symbols can be useful when you are trying to win in a conflict. But when you use them in a situation where you are trying to problem solve, you will likely only succeed in making the other person inferior - which is not an atmosphere conducive to open, shared trust and quality communication.

A better approach is to find a neutral site for the discussions if your objective is to work out an optimal solution to the conflict. On the other hand, if the objective is to reinforce your position, your status is important. But, if you are more interested in problem solving than winning, neutrality is better.

### 4. Don't try to place blame

In most conflicts, the participants spend a lot of time trying to shift the blame for a problem from one side to the other. If one side can successfully fix blame on one of the opponents, it's possible for them to "win" the conflict.

Keep in mind, however, that in a problem solving approach, placing blame (except for educational purposes) serves no useful purpose.



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## 5. Deal with conflict at the lowest possible level

Too often, nurse managers get themselves involved in conflicts that should be handled by the nursing staff themselves, or by unit or department supervisors. When this happens, the objectivity of the manager is questioned, and the outcome may not be as productive as it could be. The real conflict between the two employees may be more on the level of their communications with one another, their "hidden agendas," than on the apparent issue that makes them adversaries.

As a manager, you can only deal with the facts, and the facts may not tell the whole story nor reveal the optimal solution to the problem. Clearly, there are times when you must get involved in subordinate conflicts. But if it is done too often, a dependency will be created in your subordinates.

## 6. Delay commitments to specific solutions

When we try to solve a conflict, we often contribute to the difficulties by holding out for a specific solution. A better approach is to delay as long as possible before committing yourself to a certain course of action. Of course, too much procrastination can give you the appearance of a poor leader; but a "tolerable" delay may help all participants in a conflict to hold open their options and remain flexible.

## 7. Identify areas of mutual agreement

An optimizing solution to a conflict is one that minimizes the aftermath that leads to future conflicts. It is also an approach that focuses on an overall solution to a problem, rather than one identifying a winner and a loser.

To achieve this outcome, try to identify early in the confrontation the areas where all parties can agree. This is often called a "commitment to superordinate goals." Simply put, it means focusing the attention of the conflicting parties on some larger goals that they share.

For example, in a conflict between factions in a group, members can perhaps focus on what is best for the overall department or hospital. Both sides can agree that "the hospital (or patient) comes first" and that their respective positions are what is best for the hospital (patient). But, rather than having everyone involved agree that the hospital (patient) comes first and then resume fighting, keep the attention on the mutual goal for as long as possible.

When one side or the other starts to slip back into a discussion of a "favoured" solution to the conflict, bring the discussion back to the larger, super-ord-

inate goal. When the parties to the conflict can evaluate their common goals and how these goals might be achieved rather than defending their predetermined positions, an optimal outcome to the conflict is possible.

## 8. Emphasize mutual benefits

When a natural disaster hits a community, the usual basis for conflict within the community disappears. The politics, skin colours, economic and historical differences separating people seem so unimportant. Restoring order and taking care of people in need become the goals of everyone. On a personal level, such a mutual benefit is possible only if past feelings and differences are put aside.

## 9. Use "non-evaluative" language

Our language reveals our feelings about people without our always being aware that the revelation is occurring. For example, when we make a mistake, we label it "an honest mistake." Yet, when someone else makes a similar mistake, we may label what they did a "stupid mistake." Same error, but a clearly different impression. We do the same thing in our dealings with people. Consider the effects of the following statements...

**Evaluative:** "Cheryl, you're crude, boorish and over-bearing."

**Descriptive:** "Cheryl, there are times when some patients feel you come across crude, boorish and overbearing."

The semantic difference is slight, but significant. Using descriptive or non-evaluative language, you are more likely to have Cheryl respond by asking... "What do you mean by that? Give me an example."

At this point, you are able to focus on Cheryl's behaviour, rather than risking a defensive response to the evaluative comment, which Cheryl may take as an affront.

## 10. Examine your own biases and feeling first

Before confronting a conflict, take a close look at your own feelings, hidden agendas and attitudes about the other person and the conflict that confronts you. If you know about your own attitudes, you may be better able to get them "up front," and thus keep them from interfering with your desire to get a problem-oriented solution to the conflict. ■

# Calendar of Events

**August 31, Montreal, Quebec:** "Meeting the Challenge of the Chronic Wound: Clinical Perspectives," Queen Elizabeth Hotel. This symposium is sponsored by Sancell Inc. (For more information: Terry Munday, Sancell Inc. (514) 685-2901.)

**September 16 - 17, Regina, Saskatchewan:** Saskatchewan Operating Room Nurses Group Provincial Conference, Sheraton Hotel, Regina. (Contact Ann Kristoff, 10 Dunsmore Drive, Regina, Sask. S4R 7G2 (306) 543-2175.)

**September 17, Toronto, Ontario:** 3rd Annual Ontario Post Anaesthetic Nurses' Association Conference, Metro Convention Centre. (Doug Moore (416) 847-7100 ext. 2784.)

**September 30 - Oct. 1, Grand Falls, Newfoundland:** 9th Provincial Newfoundland & Labrador Operating Room Nurses Association Conference, Mount Peyton Hotel. (Contact: Debi Cashin, Chairperson, 9th Annual Provincial Conference, 15 Forest Road, Windsor, Newfoundland A0H 2H0.)

**September 30 - October 1, London, Ontario:** London & District Operating Room Nurses Association Fall Conference, Lamplighter Inn, Wellington Road, London. (Contact Connie Adams, c/o Operating Room, University Hospital, 339 Windemere Road, London, Ontario N6A 5A5 (519) 663-3310.)

**October 21 - 22, Hamilton Area:** 4th Annual Regional Conference, Operating Room Nurses Association of Hamilton and District, Prudhommes Inn, Vineland and Q.E. Way. (Contact Gale Mitchell, Program Committee, ORNAH&D, (416) 648-8076.)

**November 3 - 6, Calgary, Alberta:** 11th Annual Operating Room Nurses Conference, Calgary Convention Centre. (Contact Julie Matt-Hamilton, 723 Strathcona Dr., Calgary, AB T3H 1S1 (403) 242-8747.)

**November 4 - 5, Haliburton, Ontario:** 11th Annual Fall Seminar, Operating Room Nurses of South Central Ontario, Pinestone Inn, Haliburton, Ontario. (Contact Carol Findly, Operating Room, Ross Memorial Hospital, Lindsay, Ontario K9V 4M8 ((705) 324-6111).)

**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.)

## Narcotic nose spray makes pre-surgical children more manageable

A narcotic, according to a recent study, administered into the nose as a nose spray over a period of 15-20 seconds quickly calms upset children about to undergo surgical procedures.

The narcotic, sufentanil, was used in a study of 80 children aged six months to seven years of age. The study was designed to test how well the drug facilitates the separation of children from their parents prior to being anaesthetized for elective surgery.

Half the patients were randomly assigned to receive sufentanil and the other half received a chemically inert placebo.

Eighty-two percent of the children receiving sufentanil separated willingly from their parents within 10 minutes compared to only 53 percent of those receiving a placebo, said Dr. Jane Henderson, an anaesthesiology researcher at the University of California, San Francisco.

Half the sufentanil patients willingly separated from their parents at four minutes compared to only 21 percent receiving the placebo, said Dr. Henderson in a report during the annual meeting of the American Society of Anaesthesiologists held in Atlanta earlier this year.

Patients given sufentanil were more likely to be judged as calm when separated from their parents, and fewer of the sufentanil recipients required painkillers in the recovery room. Also, they had more normal appetites one day post operatively.

## General Journal Information

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The Canadian Operating Room Nursing Journal is published by Health Media Incorporated, 214 Merton Street, Toronto, Ontario M4S 1A6 (416) 481-2244.

# When nurses can draw the line in the O.R.

By L. E. and F. A. Rozovsky

The nurse may dislike working with the surgeon who has a reputation of being verbally abusive of staff in the O.R. The nurse has been on the receiving end of the surgeon's childish but violent tantrums. The nurse has heard that the physician threw a used syringe across the O.R. last week because the nurse assisting him was not "quick enough." Several staff nurses have reported feeling "ill" after their last several shifts in a particular operating room. Some O.R. nurses feel that they are not qualified to assist in a particularly delicate operation. A few O.R. nurses strongly disagree with their supervisor over scheduling on the basis that staff are stretched to the limit. They are tired and bound to "make mistakes," jeopardizing patient care and safety.

In each of these cases, nurses may be quite justified in their concerns for their own safety and the well-being of patients. But do these "concerns" merit a refusal to participate in scheduled operative procedures? On what basis can staff say "no" to fulfilling their responsibilities without jeopardizing their positions? Are there any practical solutions which can be put in place that can avert litigation? The answers to these questions suggest that in fact practical solutions can be found which offer the hope of averting labor disagreement, securing patient well-being and patient safety.

## The legal limits of "drawing the line"

There are several legal principles which govern the duties of operating room nurses. These include:

- provincial nursing practice acts
- nursing collective agreements
- occupational health and safety laws
- provincial hospital acts and regulations
- health facility guidelines

- common law or case law regarding the requirements for negligence litigation
- selected federal legislation such as the Narcotic Control Act and the Criminal Code.

## Guidelines vary

Knowing when O.R. nurses can draw the line requires familiarity with each of these sources of law. For example, does relevant provincial law permit nurses to refuse to carry out specific tasks demanded of them by physicians? If so, under what circumstances may they do so? Under the provincial nursing practice act when can nurses decline to carry out specific assigned tasks? Does the collective agreement between the union and the health facility include provisions governing the right of nurses to refuse to work in operating rooms which are suspected of being unsafe? If the collective agreement is silent on this issue, do provincial occupational health and safety laws contain provisions on these matters? Has the department of nursing or of surgery issued their own guidelines on refusal to participate in procedures deemed hazardous to staff?

The answers to these questions may not be the same across the country. Indeed, given the differences from facility to facility, the answers may vary within a province. Operating room nurses, therefore, are not in a position to take for granted that what is the prevailing legal view in one facility or province applies to them in their health facilities.

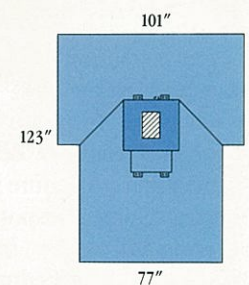
That it may be appropriate to "draw the line" in one situation and not another is reinforced by yet another legal principle: the law of negligence. The law measures the conduct of O.R. nurses by prevailing standards of care. The law will ask whether it was average, reasonable and prudent care for nurses to refuse to participate in operative procedures. If

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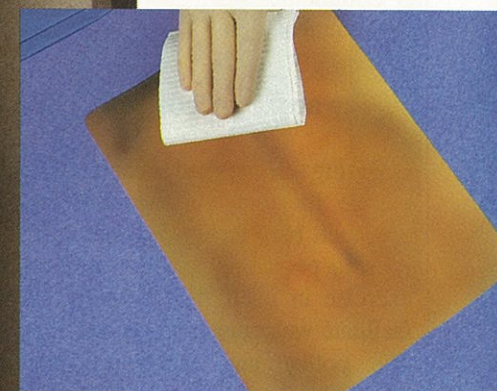
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the answer is no, the law will ask whether the failure of nurses to take part in surgery resulted in reasonably foreseeable harm.

### Not a clear-cut issue

The same questions can also be asked from a different perspective. For example, was it average, reasonable and prudent care for nurses in these circumstances to participate in specific operations? If the response is negative, the law will ask whether the nurses conduct resulted in reasonably foreseeable harm to ensue.

From a legal point of view "drawing the line" is not a clear-cut matter. It requires examining the issue from many legal perspectives and then attaining a resolution that provides a practical answer to the question.

A better response would be to anticipate these problems and to develop a flexible, responsive policy and procedure to address these issues as they occur. Such a response comes within the category of preventive law or risk management. Such a policy and procedure would take into account nursing practice acts, occupational health and safety laws, labor agreements, and the legal requirements found in the rules of negligence.

### The practical side

In developing a practical response to concerns about "drawing the line," four factors should be addressed. These are:

- Policy and procedure
- Education
- Communication
- Documentation

### Policy and Procedure Formulation

Gaining wide-spread acceptance of a policy and procedure for any purpose requires a participatory approach between management of a health facility, nursing personnel and the medical staff. Such an exercise in itself may help to "clear the air" and facilitate welcomed and needed change.

The policy and procedure should address the reasonable limits of nurses taking part in operative procedures, staff health and safety, etc. It should delineate the mechanism by which nurses can refuse to take part in surgery. By the same token, the policy and procedure should pinpoint the consequences of refusing to take part in operations in which such a decision is unacceptable under the policy.

In shaping such a policy and procedure, it is important to obtain practical legal advice. This is particularly useful in transforming broad legal provisions into relevant internal management requirements.

### Education

Once policy and procedure have been developed, there should be practical in-service and orientation programs on the content and on the mechanism for "drawing the line." This is particularly important so that staff nurses know when and how they can decline to take part in operations or when they can refuse to work in certain operating room suites.

### Communication

The policy and procedure should outline how the desire to "draw the line" should be communicated, when and to whom. This information should be made clear during educational programs.

### Documentation

The refusal to work under specific circumstances should be documented in a manner outlined in the policy and procedure manual. It should be consistent with collective labor agreements, provincial occupational health and safety laws as well as relevant institutional rules and procedures. This is as important for safeguarding the rights of the operating room nurse as it is for securing the position of the health facility.

It is understandable that O.R. nurses are often frustrated by what they encounter in their work. Situations will occur in which they feel that they must "do something" about it. Sometimes "doing something" is for their own well-being or that of their patients. However, when nurses "draw the line" and say that they refuse to work in particular circumstances, they should do so with a view towards their legal rights and responsibilities. By implementing a practical policy and procedure for "drawing the line" health facilities and nurses can establish better working relations and avoid legal entanglements. In the end, patients, health facilities and staff will all benefit from such measures. ■

**Lorne Rozovsky** is a Halifax lawyer, adjunct associate professor of law and medicine at Dalhousie University and a principle in Lefar Health Associates, Inc., a management consultant firm. **Fay Rozovsky** is president of Lefar Associates and visiting lecturer in health law at Harvard School of Public Health.

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## Sancell!a Inc. to sponsor chronic wound clinic in Montreal in August

On Wednesday, August 31, a symposium entitled "Meeting the Challenge of the Chronic Wound: Clinical Perspectives," will be held at the Queen Elizabeth Hotel in Montreal.

The symposium, sponsored by Sancell!a Inc. will be chaired by Dr. David Gratton of the Montreal General Hospital and the faculty will include clinicians from across Canada in the field of wound healing.

Topics to be discussed include the pathophysiological and cellular activity in chronic wounds in the wound healing process, the etiology, diagnosis and treatment of leg ulcers and the surgical treatment of post traumatic wounds.

This symposium, which has proven popular elsewhere in Canada, is a half-day in length and will be held in the afternoon. Operating room nursing personnel, according to a Sancell!a spokesman, will benefit from the content of the symposium.

For further information contact Mr. Terry Munday, Sancell!a Inc. (514) 685-2901.



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## Post anaesthetic nurses schedule Annual Conference for Toronto

The Ontario Post Anaesthetic Nurses Association (OPANA) has reserved the Toronto Convention Centre September 17, for its 3rd Annual Conference. Some of the agenda topics to be presented include:

- The legal implications of AIDS
- Pain control in PACU
- PACU standards of practice
- The dynamics of recovery room care
- Neurological assessment of post-op patients

This conference, according to the organizers, will provide an opportunity for post anaesthetic nurses to network with fellow specialty nurses. OPANA president, Pat Smith, invites and welcomes all PACU nurses in Ontario to attend.

Registration fee for OPANA members is \$75.00; non-members, \$100.00. This entitles registrants to all educational sessions, coffee and lunch and a wine and cheese reception.

When registering, enclose your cheque payable to OPANA, c/o Gail Skene, 44 Trench Street, Richmond Hill, Ontario L4C 3W5. Be sure to enclose name, address, postal code, and telephone number.

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### Study shows sleep loss and grave yard shifts have close bond with human error

- At 4:00 in the morning the most serious nuclear accident in North America occurred at Three Mile Island in Pennsylvania.
- At 1:23 in the morning, the Chernobyl nuclear disaster began.
- Poor judgement related to lack of sleep and shift work contributed to the cause of the Challenger space shuttle accident.

Sleep and sleep-related factors

appear to be involved in broadly disparate types of disasters, ranging from the most widely publicized events (Chernobyl, Three Mile Island, etc.) to such small catastrophes as motor vehicle accidents, according to the Association of Professional Sleep Societies.

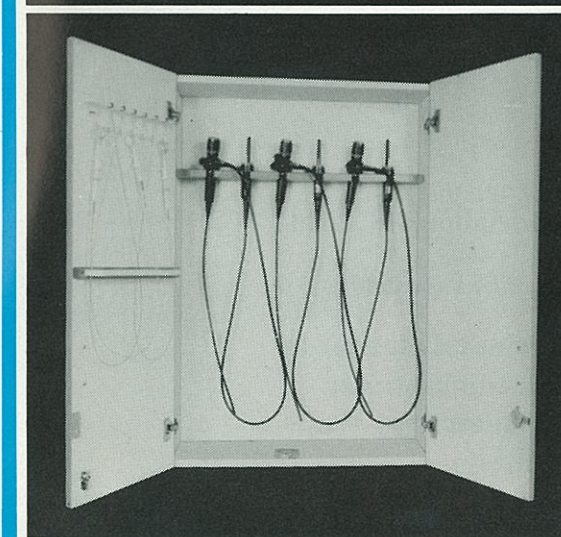
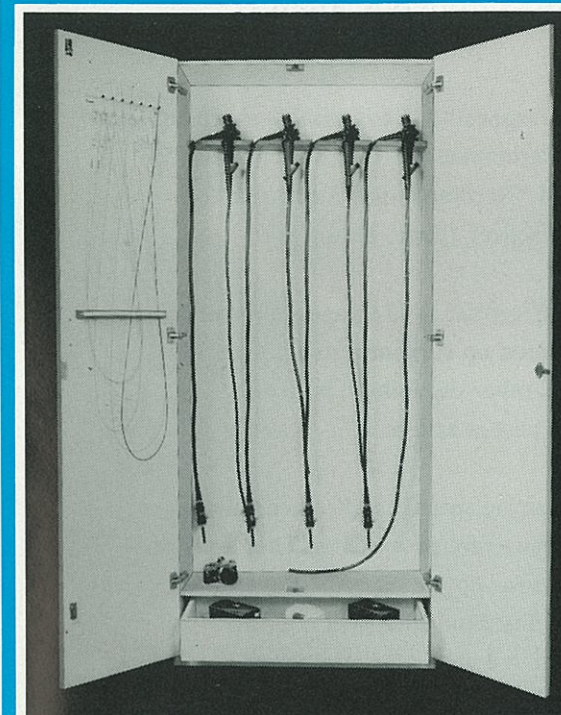
Their studies conclude that medical catastrophes are far more likely to occur between 11:00 in the evening and 8:00 in the morning. A committee from this association evaluated scientific and technical reports on the hour-by-hour

distribution of such major and minor medical accidents as heart attack, stroke, prescription errors, etc., as well as performance failures, including vehicle accidents and human errors in technical and industrial operations which can affect public safety.

The Professional Sleep Society noted that as little as one or two hours less sleep than usual can greatly exaggerate the tendency for error. Also, sleep loss combined with stress can lead to personality changes and irrational behaviour. ■

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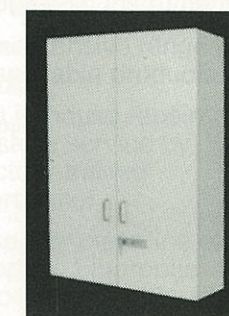


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# RECOMMENDED TECHNICAL STANDARDS

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This document represents the profession's responsibility to promote excellence in operating room nursing practice. The "Recommended Technical Standards" are an adjunct to the already published "Recommended Standards for Operating Room Nursing Practice" (June, 1986).

The "Recommended Technical Standards" consist of 114 pages in a sturdy, ring-bound cover. These standards are based on current nursing practice, nursing/medical literature, research, other disciplines, informed opinions and accepted past practices.

Technical standards are those practices requiring specific skills, medical devices and instrumentation when performing nursing care procedures. They provide a basis for uniform acceptable practices for operating room nurses in Canada. As an integral part of a quality assurance program, the ORNAC technical standards will contribute to the established norm in formulating the required policies and procedures, thereby improving operating room nursing practice.

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*The ORNAC Recommended Technical Standards  
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