



March 2015  
Volume 33, Issue 1

# ORNAC JOURNAL



Courtesy: Fraser Health

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2015 ORNAC Conference

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Equipment QC Completed & Documented:	9. Antibiotics Given*	<input type="checkbox"/>	<input type="checkbox"/>
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# ORNAC JOURNAL

A peer-reviewed Journal published by Clockwork Communications Inc.  
for the Operating Room Nurses Association of Canada

Published Quarterly ✦ Volume 33, Issue 5, March 2015

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Outside Canada - \$70  
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\$22 outside Canada  
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GST/HST# 84200 7148  
ISSN 1927-6141

Indexed in CINAHL,  
Ebsco Publishing, and part of the  
EBSCOHOST suite of  
CINAHL programs.

Publications Mail  
Agreement No. 40951517  
Return Undeliverable Canadian  
Addresses to  
PO Box 33145 Halifax NS B3L 4T6

## ORNAC Journal

c/o Clockwork Communications Inc.  
PO Box 33145, Halifax, NS, B3L 4T6  
Tel: 902.442.3882 Fax: 888.330.2116  
E-Mail: Contact@ClockworkCanada.com  
www.ClockworkCanada.com

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## ORNAC MISSION

The Operating Room Nurses Association of Canada (ORNAC) is an organization of Perioperative Registered Nurses and Associates dedicated to the:

- Promotion and advancement of excellence in the provision of safe perioperative care for patients;
- Professional growth, competence and personal enhancement of the ORNAC membership; and
- Progression of perioperative professional practice at a regional, provincial, national & international level.

## MISSION DE L'AIISOC

L'Association des infirmières et des infirmiers de salles d'opération du Canada (AIISOC) est un organisme d'infirmières et d'infirmiers autorisés en soins périopératoires et d'associés se consacrant :

- A la promotion et à l'avancement de l'excellence quant à la distribution de soins périopératoires sécuritaires à nos patients;
- A l'amélioration des compétences tant sur le plan professionnel que personnel; et
- A la progression de la pratique professionnelle des soins périopératoires à l'échelle provinciale, nationale et internationale.



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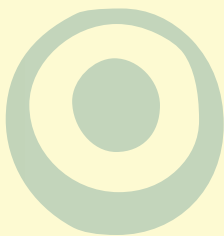
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## PRESIDENT'S MESSAGE

Rupinder Khotar RN, BScN, CPN(C), ORNAC President is the OR Nursing Supervisor at Providence Health Care – St. Paul's site, Vancouver, BC, and the Past Chair of the ORNAC Standards Committee.



I was asked to write my President's Messages from the heart and to inspire. Wow, I thought, me? So for the past couple of years I have used the President's Message to share my beliefs with you. I hoped they allowed you to reflect on how the themes applied to your life and, more importantly, to your practice. I have written about values that I live by daily, because I am compelled to do so, and that are deeply meaningful to me - service, gratitude, leadership and excellence. They are inherently a part of who I am. I am mindful of them even when I find myself challenged in living up to them. I thank all of you who have responded to my musings and I am grateful for the camaraderie and the knowledge that others are driven by similar callings. For this, my last, message I would like to touch on perhaps the strongest of my core values – love. The word may conjure up many images and memories in your mind while reminding you of wishes for future memories and experiences. There is power and influence in love and it provides determination, drive, humility, docility and strength. Greatness is harvested from it and, the best part is, it cannot be diminished.

Anne Chang and Esther Eng, the winners of the 2014 Perioperative Nurses' Week contest, beautifully articulated the concept of love inspiring excellence in perioperative nursing practice. Their submission highlighted how this value helps us to overcome challenges and be the best that we can be. My favourite part of the video states: love drives us to do our best; gives us energy when we are tired; it pushes us to do more and be more; excellence comes naturally when we love what we do, love those we work with and love those we help. The statements – short and succinct – when strung together created a powerful message. When I first watched the video I felt humbled and proud at the same time. I would like to thank Anne and Esther for their vision of what love can do in the perioperative environment. To view the video visit [www.ORNAC.ca](http://www.ORNAC.ca) (under News and Events click on Perioperative Nurses Week). Ann and Esther are also featured on page 36 of this Journal.

“Love many things, for therein lies the true strength, and whosoever loves much performs much, and can accomplish much, and what is done in love is done well.”  
- Vincent van Gogh

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As this is my last message I hope you will allow some self-indulgence. I have many people to thank for their contribution to my personal growth and professional achievements. I could never do justice to them in this message but I am confident that they know who they are as I tell them, on a regular basis, how important they are to me. For their time, effort, support and dedication, I am grateful – thank you.

I must also acknowledge my family – thank you Dad and Mum, Raj and Peter, Sukhi and Sarbjit for the support and encouragement that I needed. I will always love and honour you through my work and pray that I have made you proud. No one is as precious to me as you are – except my boys Devon and Rohin. They are my hope. For my boys, I aim to model the same strong work ethic that my parents showed me. I want to teach them that expressing and experiencing love is magic and that women have tremendous courage and strength and, despite what they like to believe, that I am the boss. 🌸

With fondest regards,

Rupinder Khotar

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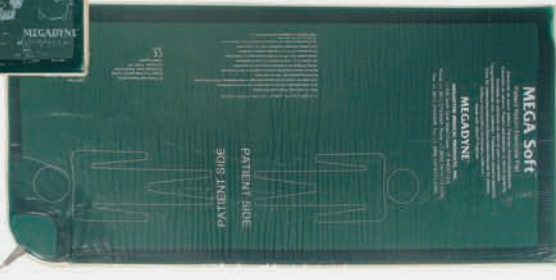
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## MOT DE LA PRÉSIDENTE

Rupinder Khotar, IA, B. Sc. Inf., CSP(C), présidente de l'AIISOC est infirmière surveillante du bloc opératoire de Providence Health Care – site de St. Paul, à Vancouver, en C.-B. et l'ancienne présidente du comité des normes de l'AIISOC.



On m'a demandé de rédiger un mot de la présidente qui viendrait du fond du cœur et qui vous inspirerait. Eh! Bien! Je me suis dit, quoi, moi? Donc, au cours des quelques dernières années, je me suis servie de cet intermédiaire pour vous faire part de mes convictions. J'espère qu'elles vous ont permis de réfléchir à la façon dont les thèmes s'appliquent à votre vie et surtout, à votre pratique. J'ai parlé des valeurs que je prône quotidiennement, parce que j'y suis contrainte et qui sont grandement significatives à mes yeux : service, gratitude, leadership et excellence. Elles font intrinsèquement partie de moi-même. J'y suis attentive même lorsqu'on me met au défi de les honorer. Je remercie tous ceux et celles qui ont réagi à mes songeries et je vous suis reconnaissante pour la camaraderie et le fait de savoir que des vocations semblables motivent d'autres. En effet, avec ce message, qui est mon dernier, j'aimerais aborder ce qui constitue peut-être la plus solide de mes valeurs de base : l'amour. Il se peut que ce mot fasse défiler dans votre esprit de nombreuses

images et souvenirs tout en vous rappelant des souhaits formulés pour des souvenirs et des expériences futures. L'amour est synonyme de puissance et d'influence et il vous incite à la détermination, au dynamisme, à l'humilité, à la docilité et à la force. Le mérite en est le fruit et le plus merveilleux est qu'il ne peut être amoindri.

Anne Chang et Esther Eng, les gagnantes du concours de la Semaine des infirmières et des infirmiers en soins périopératoires 2014, ont exprimé clairement le concept de l'amour inspirant l'excellence dans la pratique des soins périopératoires. Leur soumission soulignait comment cette valeur nous aide à surmonter les défis et faire de notre mieux. Ma partie préférée de la vidéo va comme suit : l'amour nous incite à faire de notre mieux, nous donne de l'énergie quand nous sommes fatigués, nous pousse à faire plus et à être meilleur; l'excellence vient de façon naturelle quand nous aimons ce que nous faisons, que nous aimons ceux avec qui nous travaillons et que nous aimons ceux que nous aidons. Les énoncés — courts et concis — créaient un message puissant une fois mis bout à bout. Lorsque j'ai regardé la vidéo pour la première fois, je me suis sentie privilégiée et fière à la fois. Je tiens à remercier Anne et Esther pour leur vision de ce que l'amour peut faire au sein de l'environnement des soins

« Il est bon d'aimer autant que l'on peut, car c'est là que gît la vraie force, et celui qui aime beaucoup accomplit de grandes choses et en est capable, et ce qui se fait par amour est bien fait.»

- Vincent Van Gogh

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## MOT DE LA PRESIDENTE (cont.)

périopératoires. Pour visionner la vidéo, veuillez visiter [www.AIISOC.ca](http://www.AIISOC.ca) (sous l'onglet Nouvelles et événements, cliquez sur Semaine des infirmières et des infirmiers en soins périopératoires). Ann et Esther sont également présentées à la page 36 de la présente revue.

Ce message étant mon dernier, j'espère que vous me permettrez que je me fasse plaisir. Je dois remercier de nombreuses personnes pour leur contribution à ma croissance personnelle et à mes réalisations professionnelles. Je ne pourrai jamais assez leur faire honneur par ce message, mais je suis sûre qu'elles savent se reconnaître quand je leur dis régulièrement quelle importance elles ont pour moi. Je leur suis reconnaissante de leur temps, de leurs efforts, de leur soutien et de leur dévouement — un gros merci.

Je tiens également à mentionner ma famille — merci papa et maman, Raj et

Peter, Sukhi et Sarbjit pour le soutien et les encouragements dont j'avais besoin. Je vous aimerai et vous honorerai toujours par le biais de mon travail et je prie pour que vous soyez fiers de moi. Personne n'est aussi précieux à mes yeux que vous l'êtes, sauf mes garçons Devon et Rohin. Ils sont mon espoir. Pour mes garçons, je me donne comme but de prendre exemple sur la même solide éthique de travail que mes parents m'ont appris. Je souhaite leur enseigner qu'il est magique d'exprimer et de vivre l'amour et que les femmes possèdent un courage et une force énormes et que, malgré ce qu'ils aiment penser, c'est moi qui décide. ✨

Salutations cordiales,

Rupinder Khotar

# EXECUTIVE DIRECTOR'S MESSAGE

Catherine Harley, RN, eMBA, ORNAC Executive Director  
[executivedirector@ornac.ca](mailto:executivedirector@ornac.ca)



Throughout the strategic planning process it was clear that membership is a priority for ORNAC.

## ORNAC Strategic Planning: 2015-2018

This past year has been full of changes, adjustments, and taking stock of where ORNAC is as an organization. A strategic planning process in November 2014 included participation by the ORNAC Board of Directors, the ORNAC National Exhibitors Advisory Committee (NEAC), the Canadian Patient Safety Institute (CPSI), a patient representative of Patients for Canadian Patient Safety, and an ORNAC member at large. Input was also provided by the Canadian Medical Association (CMA), the Canadian Nurses Association (CNA) in the area of certification for Perioperative Registered Nurses, contact has recently been made with the Canadian Anaesthesiologist Society (CAS). With this input from key stakeholders we have set the direction of ORNAC over the next three years.

Strategic Planning was important because it:

- Clearly defines the purpose and mission of ORNAC and establishes realistic goals and objectives that are consistent with that mission and can be achieved in a defined time frame that suits ORNAC's capacity for implementation;
- Communicates these goals and objectives to the ORNAC membership;
- Ensures the most effective use is made of ORNAC's resources by focusing future planning on the key priorities;
- Provides a base from which progress can be measured and establishes a mechanism for informed change when needed; and
- Brings together everyone's best and most reasoned efforts which have

important value in building a consensus about where ORNAC is going.

Some of the key priorities that are addressed in the next ORNAC Strategic Plan include:

- Focusing on the ORNAC membership;
- Patient Safety initiatives;
- Standardized continuing education;
- Political action/advocacy;
- Communication including a re-design of the website and additional French translation;
- Research validation of the ORNAC Standards;
- Building collaborative partnerships with aligned organizations; and
- Further development of the ORNAC Journal.

Throughout the strategic planning process it was clear that membership is a priority for ORNAC. Additional priorities include responding to the needs of the members through continuing education and other relevant programs, strengthening the Provincial Councils, and working together to create an even stronger national voice for perioperative nursing across Canada.

The new strategic plan will be presented at the ORNAC Annual General Meeting (AGM) on May 7, 2015 (during the ORNAC National Conference in Edmonton, AB) and will be posted on the ORNAC website by May 10th.

If you have any questions or comments we always want to hear from you. I can be reached at the e-mail at the top of this page. See you at the ORNAC National Conference in Edmonton! 🍁

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Perioperative Nurses Week is  
November 9-13, 2015

### ORNAC CONFERENCES [www.ORNAC.ca](http://www.ORNAC.ca)

24 <sup>th</sup> ORNAC National	Edmonton, AB	May 3 - 7, 2015
25 <sup>th</sup> ORNAC National	Niagara Falls, ON	Apr 30 - May 4, 2017

### INTERNATIONAL CONFERENCES

AORN ( <a href="http://www.aorn.org">www.aorn.org</a> )	Denver, Colorado	Mar 7 - 11, 2015
EORNA ( <a href="http://www.eorna.eu">www.eorna.eu</a> )	Rome, Italy	May 8 - 10, 2015

### RELATED PROFESSIONS

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# MESSAGE DE LA DIRECTRICE GÉNÉRALE

Catherine Harley, IA, M.B.A. pour cadres, directrice générale de l'AIISOC  
[executivedirector@ornac.ca](mailto:executivedirector@ornac.ca)



## Planification stratégique de l'AIISOC : 2015-2018

La dernière année a été parsemée de nombreux changements, d'ajustements et nous avons pu faire le point sur la situation de l'AIISOC en tant qu'organisme. Un processus de planification stratégique amorcé en novembre 2014 comptait la participation du Conseil d'administration de l'AIISOC, du comité consultatif national des exposants de l'AIISOC (CCNE), de l'Institut canadien pour la sécurité des patients (ICSP), d'un représentant des patients pour l'Institut canadien pour la sécurité des patients et d'un membre hors cadre de l'AIISOC. L'Association médicale canadienne (AMC) et l'Association des infirmières et infirmiers du Canada (AIIC) dans le domaine de la certification des infirmières et infirmiers en soins périopératoires ont également contribué. De plus, nous avons récemment forgé des liens avec la Société canadienne des anesthésiologistes (SCA). Grâce à la contribution de ces intervenants clés, nous avons déterminé l'orientation que prendra l'AIISOC pour les trois prochaines années.

Une planification stratégique s'imposait parce que cela :

- Définit clairement le but et la mission de l'AIISOC et permet de fixer des objectifs réalistes qui concordent avec la mission et qui peuvent être atteints en un délai déterminé convenant à la capacité de l'AIISOC pour leur mise en œuvre;
- Permet de communiquer ces objectifs aux membres de l'AIISOC;

Tout au cours du processus de planification stratégique, il était évident que les membres seraient une priorité pour l'AIISOC.

- Donne l'assurance que les ressources de l'AIISOC seront utilisées de manière efficace en ciblant la planification future sur les priorités clés;
- Fournit une base à partir de laquelle les progrès peuvent être évalués et met en place un mécanisme pour être en mesure d'apporter au besoin des modifications éclairées;
- Rassemble les meilleurs et la plupart des efforts de réflexion de tout le monde, qui sont importants pour forger un consensus concernant l'orientation de l'AIISOC.

Parmi les priorités clés abordées dans le prochain plan stratégique de l'AIISOC, notons :

- Se concentrer sur les membres de l'AIISOC;
- Des initiatives pour la sécurité des patients;
- Une formation professionnelle continue normalisée;
- Des actions politiques/la défense des droits;
- La communication, notamment un site Web avec conception renouvelée et davantage d'éléments traduits en français;
- La validation de la recherche des Normes de l'AIISOC;

- Le développement de partenariats de collaboration avec des organismes de l'industrie;
- Le développement de la Revue de l'AIISOC.

Tout au cours du processus de planification stratégique, il était évident que les membres seraient une priorité pour l'AIISOC. Parmi les autres priorités, nous nous efforcerons de répondre aux besoins des membres par le biais de la formation professionnelle continue et d'autres programmes pertinents, de solidifier les conseils provinciaux et de travailler ensemble afin de créer une voix nationale encore plus forte pour les infirmières et les infirmiers en soins périopératoires de partout au Canada.

Le nouveau plan stratégique sera présenté à l'Assemblée générale annuelle de l'AIISOC le 7 mai 2015 (lors de la Conférence nationale de l'AIISOC à Edmonton, AB) et sera publié sur le site Web de l'AIISOC à partir du 10 mai.

Nous apprécions toujours les questions ou les commentaires. Vous pouvez me rejoindre en m'écrivant au courriel ci-haut. Au plaisir de vous voir lors de la Conférence nationale de l'AIISOC à Edmonton! 🍁

# ÉVALUATION DE L'UTILISATION DE LÈVE-PERSONNES FIXÉS AU PLAFOND EN SALLE D'OPÉRATION

## Auteurs :

*Leah Thomas-Olson détient un baccalauréat en kinésiologie et travaille à la fois avec l'équipe spécialisée en ergonomie et l'équipe de recherche et d'évaluation de la santé en milieu de travail chez Fraser Health. Elle possède de l'expérience de travail en développement du programme « Manutention sécuritaire des clients » et a participé à toute une gamme de projets de recherche dans le cadre de programmes de santé et de sécurité au travail offerts par Fraser Health. Leah aime la complexité de l'ergonomie en soins de santé et aime collaborer avec le personnel en soins directs afin d'encourager la culture de la sécurité. Leah a effectué la recension de la littérature ayant contribué au sondage créé pour ce projet, tout en aidant à rédiger le sondage en tant que tel. De plus, elle a aidé à recruter le personnel pour la participation à l'étude, elle a analysé les données et a rédigé un rapport final pour pourvoir au leadership des salles d'opération participantes.*

*Melanie Gee détient un baccalauréat ès sciences (kinésiologie) et travaille en tant qu'ergonome au sein de l'équipe d'ergonomie en milieu de travail chez Fraser Health depuis 2008. Sa principale responsabilité consiste à appuyer le programme de « Manutention sécuritaire des clients » en aidant à fournir au personnel l'équipement nécessaire et en encourageant sa participation. Melanie aime se renseigner au sujet des processus actuels du système de soins de santé et collaborer avec le personnel afin qu'il s'améliore. Melanie a aidé à la rédaction du sondage de cette étude en plus de recruter le personnel pour la participation. Elle a également aidé les salles d'opération à aborder les obstacles à l'utilisation des lève-personnes fixés au plafond qui avaient été identifiés dans l'étude.*

*Deanna Harrison détient un baccalauréat ès sciences (kinésiologie), un baccalauréat en psychologie, elle est ergonome certifiée et possède plus de 20 ans d'expérience en application des principes ergonomiques pour prévenir les blessures et plus de 10 ans d'expérience dans le domaine des soins de santé. Pour le programme de « Manutention sécuritaire des clients », elle s'est concentrée sur les soins de courte durée, les soins en établissement et les soins à domicile. Les objectifs du programme visent à réduire les incidents et les blessures associés à la manutention des patients pour que les milieux de travail soient sécuritaires pour les fournisseurs tout comme les patients. Deanna aime la complexité et les défis associés à l'application de l'ergonomie dans les soins de santé. Son rôle pour ce projet a été de fournir des statistiques de blessures/d'incidents liés à la manutention dans les salles d'opération à travers la région et en comparaison avec l'unité d'intervention.*

*Nermin Helal détient un baccalauréat ès sciences (kinésiologie), détient le titre de CCPE (praticienne en ergonomie certifiée du Canada) et travaille dans le domaine de l'ergonomie en soins de santé depuis plus de 10 ans. Elle possède de l'expérience professionnelle en ergonomie dans le domaine minier et industriel. Nermin travaille actuellement en tant qu'ergonome chez Fraser Health et s'efforce d'élaborer des lignes directrices, des normes et des évaluations afin de maximiser la manutention sécuritaire des patients et l'ergonomie en milieu de travail dans le domaine de la conception des installations. Elle a contribué à élaborer les bases de ce projet et a aidé aux révisions du manuscrit.*

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés (11<sup>e</sup> édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AIISOC) d'avril 2013, section 4, p. 262-263 et p. 268 à 271; normes 4.15 et 4.18.

## RÉSUMÉ :

Les travailleurs en soins de santé représentent 11 % de la main-d'oeuvre de la Colombie-Britannique et, sur une base annuelle, cela représente plus de 7 500 demandes de congé, 300 000 jours de travail perdus et une dépense de plus de 50 millions de dollars en réclamations liées à la santé à la suite de blessures musculo-squelettiques survenant en milieu de travail et liées aux soins des patients, au surmenage, à des glissements, à des faux pas et à la violence.<sup>1</sup> Un nouvel hôpital de soins de courte durée a été construit à Abbotsford, C.-B. et a ouvert ses portes en 2008. Pendant sa construction, on a abondamment parlé

des lève-personnes fixés au plafond dans tout l'établissement, notamment dans les salles d'opération. En raison du manque de documentation et de recherche concernant cette importante solution d'ingénierie ergonomique dans l'environnement des salles d'opération,<sup>2</sup> un sondage à l'intention du personnel a été effectué afin de recueillir de l'information sur la familiarité, l'utilisation et la perception du personnel face aux lève-personnes fixés au plafond. Les conclusions se sont révélées positives et ont démontré que le personnel pensait que les lève-personnes fixés au plafond étaient une solution d'ingénierie ergonomique pratique et utile pour l'environnement des salles d'opération et que des tâches clés de

manutention des patients étaient dorénavant mises en œuvre pour l'utilisation des lève-personnes fixés au plafond.

## RÉFÉRENCES :

1. WorkSafeBC, Slips & Trips In Health Care And Social Assistance, Richmond, BC : WorkSafeBC; 2009.
2. AORN. (2014), AORN guidance statement: Safe patient handling and movement in the perioperative setting, In AORN Perioperative Standards and Recommended Practices, (éd. 2014), Denver, CO: auteur.

KEYWORDS: PERIOPERATIVE ENVIRONMENT, CEILING LIFTS, ERGONOMICS, INJURY PREVENTION.

# EVALUATING THE USE OF CEILING LIFTS IN THE OPERATING ROOM

## Authors:

*Leah Thomas-Olson, BKin, works with both the Ergonomics Team and the Workplace Health Research & Evaluation team at Fraser Health. She has experience working on the development of the "Safe Client Handling" program and assisting in a wide range of research projects within the occupational health and safety programs offered by Fraser Health. Leah enjoys the complexity of healthcare ergonomics and collaborating with direct care staff to foster a culture of safety. Leah did the literature review that informed the survey created for this project, as well as assisted in the survey creation. She also assisted with recruiting staff for study participation, did the data analysis and wrote a final report to provide to the leadership of the participating OR.*

*Melanie Gee, BSc (Kin), has worked as an ergonomist with the Workplace Health Ergonomics Team at Fraser Health since 2008. Her main responsibility is supporting the "Safe Client Handling" program by helping provide staff with appropriate equipment and promoting staff engagement. Melanie enjoys learning about the current processes in the healthcare system and collaborating with staff on improving them. Melanie assisted with the survey creation for this study as well as recruiting staff for participation. She also assisted the OR with addressing the barriers to ceiling lift use that were identified in the study.*

*Deanna Harrison, BSc (Kin), BA (Psych), CPE, has over 20 years' experience in the application of ergonomics principles to injury prevention and over 10 years' experience in healthcare. Her program focus is on "Safe Client Handling" within acute care, residential care and home health. The program goals are aimed at reducing the incidents and injuries associated with patient handling so that the workplace is safe for both care providers and patients. Deanna enjoys the complexity and challenges associated with applying ergonomics in healthcare. Her role for this project was to provide injury / incident statistics related to patient handling in the ORs across the region and in comparison to the intervention unit.*

*Nermin Helal, BSc (Kin), CCPE, has been working in the field of healthcare ergonomics for over 10 years and also has a professional background in mining, manufacturing, and industrial ergonomics. Nermin currently works as an Ergonomist for Fraser Health and has a focus on developing guidelines, standards and evaluations to optimize safe patient handling and workplace ergonomics in facility design. She was a contributor in the early stage framework for this project and assisted in the revisions of the manuscript.*

## ABSTRACT:

Healthcare workers make up 11% of British Columbia's workforce and, on an annual basis, they account for over 7,500 time-loss claims, 300,000 days of work lost, and a cost of more than \$50 million in health claims as a result of musculo-skeletal injuries (MSIs) that occur in the workplace relating to patient care, over-exertion, slips, trips and violence.<sup>1</sup> A new acute care hospital was constructed in Abbotsford, BC and opened in 2008. During this construction, extensive ceiling lift

coverage was provided throughout the facility including in the operating room (OR). Given a lack of literature and research, around this important ergonomic engineering control in the OR environment,<sup>2</sup> a staff survey was administered to capture information on the familiarity, usage, and perception of the ceiling lifts. Findings were positive and showed that the staff felt ceiling lifts were a practical and useful ergonomic engineering control, for the OR environment, and that key patient handling tasks were now being carried out with the use of ceiling lifts.

## INTRODUCTION:

Healthcare workers make up 11% of British Columbia's workforce and, on an annual basis, they account for over 7,500 time-loss claims, 300,000 days of work lost, and a cost of more than \$50 million in health claims from musculo-skeletal injuries (MSIs) that occur in the workplace relating to patient care, over-exertion, slips, trips and violence.<sup>1</sup> British Columbia's healthcare workers remain the third largest sector, in the province, for both the number of claims and the time lost.<sup>3</sup>

## CEILING LIFTS (cont.)

MSIs resulting from patient handling are the largest source of healthcare worker injury in BC. Workplaces with high MSI rates reported increases in lost work days, higher turnover, increased costs and adverse patient outcomes.<sup>2</sup> Many innovative advances in safe patient handling have, based on this high potential for injury, been developed to assist healthcare workers with their patient care and aid in minimizing healthcare worker injuries. Mechanical floor lifts and in-bed positioning aids have, for many years, been an ergonomic approach used to minimize manual patient handling. Ceiling lifts have, more recently, been introduced in many acute care and residential care areas as an ergonomic engineering control.

### DESCRIPTION OF THE PROBLEM:

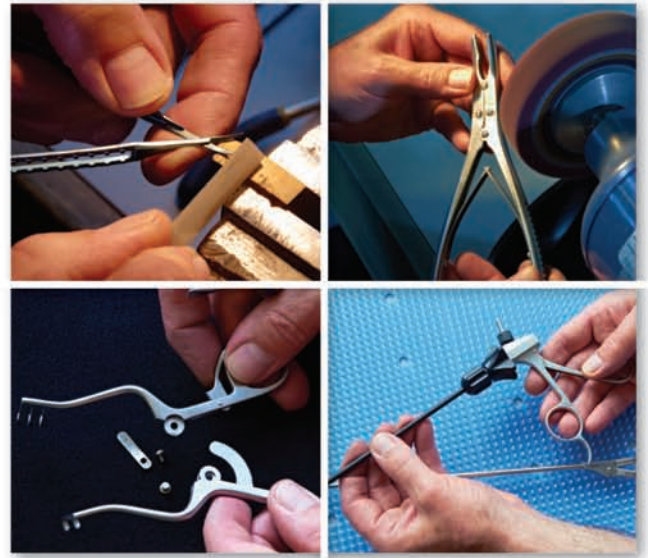
The reduction of manual patient handling and associated injuries can be achieved by ensuring all areas (beds), in acute and residential care, have ceiling lift coverage proportional to the patient handling dependencies of the clinical areas specific patient population. If, for example, 50% of the units' patients are typically dependent for transfers or in-bed positioning, 50% of the beds on the unit should be considered for ceiling lift coverage. Ceiling lift installation in acute and residential care is, however, a costly undertaking and, with the realities of stretched healthcare resources, the installation of ceiling lifts often occurs only in areas where high injury rates have been reported in the past. Using past injury rates is a good indicator to help predict where to direct future resources in most areas. There is, however, a key department within acute care that is often lacking in ceiling lift coverage – namely the operating room (OR). This deficit is likely the result of the costs and challenges associated with retro-fitting the equipment intensive and highly technical environment of an existing operating theatre. The operating room infrastructure, such as lights, monitors and gas lines embedded in the ceiling, make this environment much more cost-prohibitive when dealing with a retro-fit of ceiling lifts. In addition to the cost of installation there is also the cost of moving equipment which can more than double the cost as compared to an installation in a standard patient room. The perioperative environment does, nonetheless, pose injury risks related to manual patient handling especially given the fact that most patients are unconscious and often require the team to manually lift or reposition the patient, or the patients' extremities, both during and after a procedure.<sup>2</sup>

### DESCRIPTION OF THE PROJECT SETTING:

Fraser Health is one of six regional health authorities that operate in British Columbia. The Fraser Health region has over 26,000 staff, 2,500 physicians and 6,500 volunteers who serve more than 1.6 million people. Fraser Health operates 12 acute care hospitals, about 7,500 residential care beds, and provides mental health, public health, home, and community care services.<sup>4</sup>

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Patient handling is the number one cause of injury to Fraser Health staff.<sup>5</sup> Every year, in Fraser Health, there are over 600 incidents, 300 claims and 8,000 lost work days as a result of patient handling.<sup>5</sup> A recent analysis showed that over 50% of the patient handling incidents in Fraser Health are related to repositioning a patient in bed (e.g., boosting or turning), assisting a patient to manually transfer, or doing a lateral transfer. The ORs within Fraser Health have, typically, had a low rate of claims related to patient handling as compared to other programs (i.e. medicine, residential care) but incidents do occur. In the 3 year period from January 2011 through December 2013 there were, for all the OR departments within Fraser Health, an average of 5 injury claims per year related to patient handling with each claim resulting in an average of 21 days lost time.<sup>5</sup>

### PROJECT GOALS:

Providing a safe and healthy working environment for staff and patients is a priority. As such, substantial resources have been allocated by Fraser Health, over the past years, to address ergonomic issues in the healthcare environment. These resources include assessment tools, safe-work procedures, and patient handling equipment. To reduce the risk associated with patient

handling, and increase injury prevention, ceiling lift installations have been carried out in various units throughout the health authority. A newly constructed acute care facility in Fraser Health opened in 2008. It was determined, during the building design planning phase, that there should be extensive ceiling lift coverage throughout the new hospital including in the operating room. This cost was incorporated into the building design and the construction budget. The ceiling lifts were designed into the new build, alongside other building infrastructure, and they were subsequently installed during the construction phase.

The goal of this extensive ceiling lift coverage was to be pro-active about injury prevention in contrast to the usual retro-fit installations that take place after injuries have been reported. It should be noted that installing ceiling lifts, on an active unit, rather than in a newly constructed unit, is more costly (due to increased infection control precautions) and a retro-fit can also be very disruptive in terms of noise, vibration, and patient displacement on the unit and in neighbouring units. It has been noted in the literature,<sup>6</sup> and observed by this study group, that providing equipment is also not necessarily enough to generate equipment use. Other essential elements such as policy, assessment protocols, procedures, processes, and training and education will impact the adoption and usage of patient handling equipment as well as staff perceptions of the equipment. It has been demonstrated that staff perceptions of the equipment will strongly influence the rates of implementation and adoption<sup>6</sup> so the goal, with this project, was to capture and analyse those perceptions, by way of a staff survey. The survey was implemented both to measure the success of the project itself, identify barriers that needed to be addressed in order to ensure OR staff were effectively using the ceiling lifts, and, ultimately, see a reduction in patient handling injuries to OR staff.

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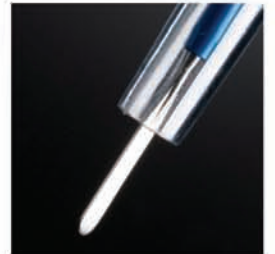
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## May 3rd – 7th, 2015 • Edmonton, AB

### EXHIBITOR LIST

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## Amanda Lindhout - LEADERSHIP

A House in the Sky: Empowerment in Somalia and Beyond

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## Master Corporal Paul Franklin - SURVIVAL

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## Jan De Boek - COMMUNICATION

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## Dr. Claude LaFlamme - INFECTION CONTROL

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## PRELIMINARY PROGRAM

### SUNDAY, MAY 3

1300 - 1500 **Opening Ceremonies**

1530 - 1700 **Keynote Speaker:**  
"A House in the Sky: A Remarkable  
Story of Courage & Resilience"  
Amanda Lindhout

1710 - 2030 **Grand Opening of  
Exhibits**

### MONDAY, MAY 4

0700 - 0830 **MEGA Breakfast** (sponsored  
by AMT) - Melissa Fischer, Topic TBD

0845 - 0945 **Building a Business Case  
in Perioperative Nursing: The  
Effectiveness of an Organized  
Voice** - Kay Ball

1000 - 1100 **Concurrent Sessions:**

- A) Cultural Safety: Indigenous Health Values & Principles - Dr. Alika Lafontaine (et al TBD)
- B) Successful Strategies for MDRC/OR Collaboration that Prevent Infections and Enhance Patient Care - Abdool Karim & Sharon Gordon

1100 - 1500 Exhibits, Posters, Lunch

1500 - 1615 **Concurrent Sessions:**

- A) Is It Time to Rethink the Way We Do Healthcare? - Dr. Stephen Genuis
- B) Theatre in Aussie Bush - Rachel Ellem
- C) Clinical Leadership in the Changing World of OR Supply Chain: The Clinical Perspective - Kelly Chapman (CORL)
- D) Managing Surgical Plume: A Facility Wide Approach - Robert Scroggins

E) Bridging the Operating Room and Medical Device Reprocessing (MDR) with Canadian Standards - Diane Trudeau

1630 - 1730 **Medical Device  
Reprocessing: Begins and Ends in  
the OR** - Gale Shultz & Kyle Eckhardt

### TUESDAY, MAY 5

0630 - 0800 **Breakfast Event - Breast  
Cancer Awareness** (sponsored by  
Medline) - Samantha Harris

0845 - 0945 **Feasibility and  
Applicability of Antibacterial  
Surgical Gloves** - Dr. Ojan Assadian  
(Ansell)

0930 - 1030 NEAC Meeting

1000 - 1100 **Concurrent Sessions:**

- A) ORNAC Standards: Guiding Excellence in Perioperative Practice - D. Bastone, D. Affleck, L. Faucher, C. Ferguson, D. Keough, L. Pfeuti & P. Willame.
- B) Meeting Standards in Non Hospital Surgery Facilities - Sue Lafferty

1100 - 1230 RNFA Meeting

1100 - 1500 Exhibits, Posters, Lunch

1500 - 1600 **Concurrent Sessions:**

- A) Updates on Malignant Hyperthermia - Dr. Sheila Riazzi; MHAUS
- B) The CNA Certification Program: Caring to be the Best in Perioperative Nursing - Lucie Vachon & Tracey Rice
- C) Quality: Sustaining Change OR to PACU Transfer Tool - Carol Kirkwood (CORL)

D) A Quality Improvement Journey in Ophthalmic Surgery - Christine Arde, Christian Buendia & Nurallah Rahim

1615 - 1715 **Concurrent Sessions:**

- A) Leadership: How to develop a successful multidisciplinary Team Hybrid Suite Experience - Kelly Chapman (CORL)
- B) Building a "Magnetic" Operating Room - Erin Robertson & Heather Lithgow
- C) Advanced Practice Nurses in the Operating Room - Shaindel Egit
- D) Practical Applications of LEAN Methodology to Manage Supplies in the Surgical Suites - C. Buendia, L. Ramos, N. Rahim, J. de la Pena, C. Koitsopoulos, and K. Chan.

### WEDNESDAY, MAY 6

0630 - 0830 **Breakfast Event - SSI  
Prevention: Mission Possible**  
#PatientSafety (Sponsored by 3M) - Dr.  
Claude Laflamme

0845 - 0945 **Concurrent Sessions:**

- A) Trans-Apical Aortic Valve Replacement: Last Surgical Option - Karin Gailer, Carol Miners & Anne Quick
- B) Cognitive Aids in the Perioperative Environment - Dr. Reuben Eng
- C) Necrotizing Fasciitis - Eugene Mondor
- D) Erecting Excellence- Building the OR of the Future - Tracie Scott & Tina Carr
- E) Malignant Hyperthermia Simulation - Sue Barnes

1000 - 1100 **Concurrent Sessions:**

# ORNAC National Conference May 3rd - 7th, 2015

- A) Perioperative Nurses: The Need for Strong Advocates in Patient Safety - Kapka Petrov, CPSI
- B) Elimination of Formalin in the Operating Room: A Safe Practice Initiative - Barbara McArthur & Helen Vandoremalen
- C) Emotion, Reason, Neuroscience and Resilience - Dr. Mike Jacka
- D) Implementing a Regional Hip and Knee Replacement Program - Maureen Sly-Havey
- E) Malignant Hyperthermia Simulation - Sue Barnes

1100 – 1300 Lunch Break

1130 – 1300 CORL Meeting

1130 – 1300 PNEC Meeting

1300 - 1400 **Concurrent Sessions:**

- A) Bullying & Incivility in the OR: Model Development & Preliminary Results - Dr. Alexander Villafranca & Lesia Yasinski
- B) How Early Should Prophylactic Antibiotics be Given to Patients Before Surgery? - Kathleen Kulyk & Kasia Kaluzny
- C) Embracing Patient & Family Centred Care: An Interprofessional Collaboration in the Perioperative Setting - Bonnie Knox & Stephanie Flemming
- D) From Paper to Wifi, Integration not Duplication: Examining the Impact of Wireless Electronic Health Records within the Perioperative Environment - Julie Zendehzadeh
- E) Malignant Hyperthermia Simulation - Sue Barnes

1430 - 1530 **Concurrent Sessions:**

- A) What is SSI? On the CUSP of Improving Safety Culture and Better Patient Outcomes - Maryann Deen

- B) Electronic Pathology Requisition- Bridging the Gap Between the Operating Room and the Lab - Harpreet Upal
- C) Leading Excellence in Total Joint Care - Tracie Scott
- D) Perioperative Practice and Practice Development - Carolyn Ellis
- E) Malignant Hyperthermia Simulation - Sue Barnes

1530 - 1630 **Concurrent Sessions:**

- A) Surgical Attire: What You Wear Does Matter - Dr. Lisa Spruce
- B) Intergenerational Leadership in Perioperative Nursing - Tracie Scott & Tina Carr
- C) Retrospective Evaluation of a Web-Based Surgical Site Infection Surveillance Tool - Corrine Mclsaac & Andrew Milligan
- D) Decreasing the Length of Stay for Total Hip & Knee Replacement Patients - Maureen Sly-Havey

## THURSDAY, MAY 7

0630 - 0800 Breakfast Event - Fluid Management in Operative Hysteroscopy: the Ins and Outs of Current Guidelines and Technologies (Sponsored by Hologic). *Speaker: TBD*

0815 - 0915 **Concurrent Sessions:**

- A) Electrosurgery Safety in Laparoscopic Cases - Dr. Paul Borgmeier

- B) Transanal Endoscopic Microsurgery: What's Up There? - Cindy Fulmore, Wendy Barristo & Lynn McAllister
- C) A Critical Inquiry into the Mandatory Disclosure of Blood Borne Pathogens by Health Care Providers: Implications for Nurses - Dr. Vera Caine, Margaret McGinn & Dr. Judy Mill
- D) Organizational Radicals: Making Changes for the Better! - Marlies van Dijk

0930 - 1100 **ORNAC Annual General Meeting**

1115 - 1215 **Concurrent Sessions:**

- A) Predicting Urgent Time Allocation - Joanna Schubert
- B) Complications of Laser Lead Extraction: A Case Study - Barbara Robert, Rita Wayne & Annalee Szabadi
- C) Blood Transfusion Safety: The Bloody Truth - Leonor De Biaso
- D) My Experience in Kandahar Airfield - Elizabeth Beck

1215 - 1300 Lunch Break

1300 – 1400 **How To Become a Surgeon Whisperer** - Jan De Boeck

1400 – 1630 **Closing Keynote Speakers**

**Master Cpl. Paul Franklin's Inspirational Story of Survival** - Paul Franklin

**Humour: The Power of Fun** - Debbie Elliot

**ORNAC Closing Ceremonies**

## Networking Events:

**Sunday:** Grand Opening of Exhibits (Shaw Conference Center)

**Monday:** Bollywood- East Meets West (Westin Hotel)

**Tuesday:** Edmonton Dine Around • West Edmonton Mall (registration required)

**Wednesday:** ORNAC Members Appreciation (Shaw Conference Center)

For additional details or to REGISTER visit [www.ORNAC.ca](http://www.ORNAC.ca)



Courtesy: Fraser Health

Ceiling lift motor and carry bar.

Survey questions were developed based on an extensive search related to recognized high-risk patient handling tasks as identified in the literature<sup>2,15-17</sup> and were aimed at capturing the use of the ceiling lifts in the OR for these specific tasks. The survey consisted of 10 open-ended and fixed questions, designed to measure prior use and confidence related to ceiling lifts and specific OR tasks involving the ceiling lift. Participants were also asked to indicate their views on the practicality and usefulness of ceiling lifts in the OR as well as their feelings regarding the number of OR theatres in which ceiling lifts had been installed. Response categories included yes/no options and reported percentages. The response from each question was reported separately.

#### EVIDENCE REVIEW:

There is a high rate of musculo-skeletal injuries (MSIs) within the healthcare industry, as compared to other industries, in British Columbia. The healthcare industry had 4,890 over-exertion claims in 2012 as compared to the manufacturing industry (2,750), the construction industry (2,580) and the transportation and warehousing industry (1,770).<sup>3</sup> The majority of MSIs experienced by healthcare workers occur in patient care environments while performing patient handling tasks such as transferring or repositioning. The OR poses unique injury risks related to patient handling and as the average size and weight of patients is on the increase there is a need for assistive devices to aid in patient handling in the OR.<sup>7</sup>

Literature regarding high-risk tasks in the OR has identified the moving, repositioning, and transferring of patients as well as holding patients' extremities, without assistance, as some of the main ergonomic stressors for staff in the OR.<sup>8-13</sup> King<sup>8</sup> and Waters et al<sup>9,11</sup> suggest the use of assistive devices to carry out these tasks but do not specifically go into any detail on how an engineering control, such as a ceiling lift, can be used to minimize the risk of injury. The Fraser Health project successfully identified that these high-

risk patient handling tasks could be carried out with the use of a ceiling lift in the OR.

Holding patients' extremities has been identified as an ergonomic stressor in the OR.<sup>7,10-12</sup> Bartlett et al<sup>7</sup> note the potential for injury to staff, due to the awkward body positioning that must occur in order to perform this task, and they outline a limb suspension technique using a bandage roll and a chain, suspended from a ceiling hook, in order to lift and hold a limb during surgical preparation. This common OR task (of lifting and holding a patient's limb during surgical preparation) is a prime example of a task that can be done, using a ceiling lift with an appropriate sling, in a way that would be more comfortable and safer for the patient as well as the OR staff.

No studies were found in the literature that specifically addressed the use of ceiling lifts in the OR. The AORN Guidance Statement on Safe Patient Handling and Movement in the Perioperative Setting<sup>2</sup> indicated a need for more research on mechanical lifting devices in the OR. The authors believe that the project discussed in this article has addressed some of the important missing evidence in the literature and will be useful information to many in the field.

#### METHODS:

Purposive sampling was used to gather data from any OR staff at the new hospital who agreed to participate. Criteria were that they worked in the new OR at the new hospital. Two members of the Ergonomics team administered the survey to the majority of the OR staff at a monthly staff meeting. Extra surveys were left with the department's Patient Care Coordinator for any staff who wanted to participate but had not been in attendance at this meeting. This project was deemed to be an internal evaluation and, as per Fraser Health Research Ethics Board guidelines, Ethics Board approval was not necessary. Staff participation was

No studies were found in the literature that specifically addressed the use of ceiling lifts in the OR.

voluntary and all answers remained anonymous. Staff were also informed that they were not required to answer any questions they did not feel comfortable answering.

**ANALYSIS:**

Survey responses were coded and then entered into a Microsoft Excel spreadsheet. The data were reviewed for quality and survey questions left unanswered, or indicated as not applicable, were not included in the final analysis. The survey response rate was calculated as the ratio of completed surveys to the number of regular staff on the unit. In total 29 surveys were collected from the unit (from a total of 34 Full Time/Part Time regular staff) resulting in an 85% response rate. Analysis of individual survey questions included summary descriptive statistics of frequency counts and proportions. Analysis of qualitative responses involved thematic analysis where respondent statements were read to identify categories and contextual themes.

**IMPLEMENTATION:**

Three logistical barriers to the use of ceiling lifts were identified from the results of the survey:

1. availability of ceiling lift slings (supply and laundry turn-around time);
2. the emergency (red) pull cord on the ceiling lift motor was too long and was therefore being inadvertently engaged (which causes the lift to stop operation); and
3. the location of docking station for the ceiling lift motor was in an awkward place.

Two of these barriers to using the ceiling lift were addressed by the unit in a timely manner. Sling inventory was increased which helped to address the lag in laundry turn-around time and the emergency pull cord was shortened.

The docking station of the ceiling lift motor was not relocated as it was determined, upon further investigation, that the

problem was not the docking station location itself but, rather, the fact that once it was docked staff were not raising the sling bar and therefore it was hanging down and getting in the way. Education was provided to increase staff awareness regarding raising the sling bar so it would not be in the way. It was considered critical to address these types of issues quickly in order to prevent negative feelings and perceptions about the equipment.

This study allowed for the actual staff experiences, once they used the ceiling lift for patient handling tasks, to be the facilitator for change. The ease, quickness, and convenience of use of the ceiling lift, as well as the safety aspect for staff and the patients, all reinforced a change in practice and increased use of this new patient handling equipment for the OR.

**RESULTS:**

The survey incorporated a total of ten questions and all ten were included in the analysis. Results of the questions included for descriptive statistics, of frequency counts, are shown in Table 1.

**Table 1. Descriptive Statistics of Frequency Counts**

Survey Question	n=29	Percent Response of Respondents
Used the ceiling lift in the OR	29	100%
Confident using the ceiling lift in the OR	29	100%
Indicate if you have used the ceiling lift for lateral transfers (i.e. stretcher to OR table)	23	79%
Indicate if you have used the ceiling lift for repositioning patients on OR table	11	38%
Indicate if you have used the ceiling lift for holding and lifting limbs	3	10%*
If indicated ceiling lift use for the above tasks, what is your perception of the percent (%) of time you use the ceiling lift for Lateral transfers? Repositioning? Lifting and holding limbs?	69% of the time 31% of the time 70% of the time	
Ceiling lift is a practical and useful safety control for the OR	29	100%
Recommend ceiling lifts for use in all OR environments	28**	100%

\* response reflective of clinical practice that limits use of the ceiling lift in the sterile field  
 \*\* one participant left this answer blank and that response was not included in the analysis



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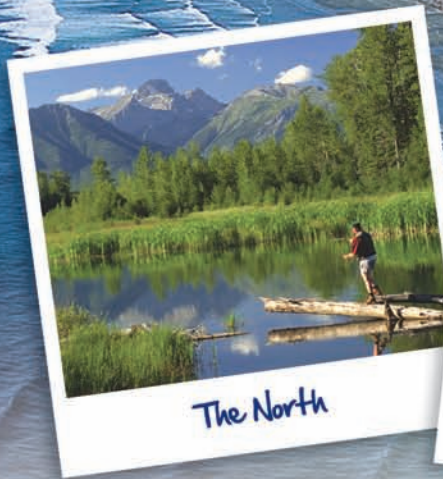
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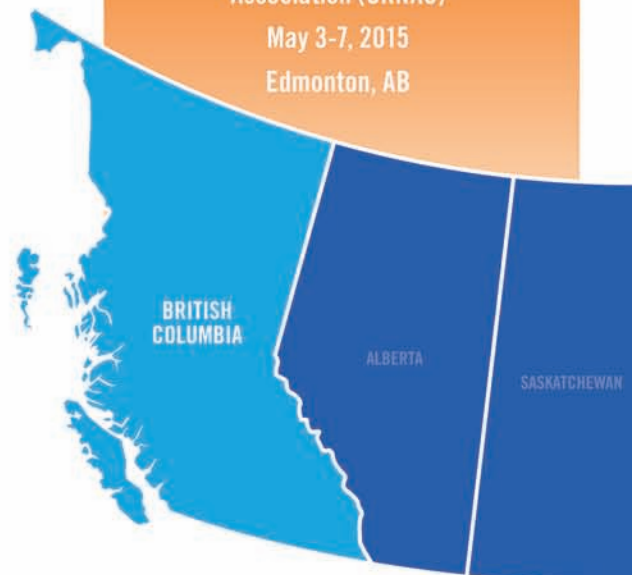
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The qualitative data, collected during this study, shows that the perception of the OR staff is that they believe high-risk tasks can be carried out in a safer manner when the ceiling lifts are used.

Thematic analysis of the qualitative questions is shown in Table 2.

**DISCUSSION:**

Results showed that the OR staff were very familiar and confident with using the ceiling lifts. It was positive to see that the staff indicated usage of the ceiling lifts both prior to surgery and post-surgery, for two of the main high-risk patient handling tasks (lateral transfers and repositioning). Lateral transferring appeared to be the task with the highest use of the ceiling lifts in the OR and this is an encouraging result. Staff reports regarding using the ceiling lift for repositioning the patient on the OR table, prior to and post-surgery, was also a positive result as repositioning continues to be a task that results in high rates of MSIs for healthcare staff.

Although the literature suggests a benefit to the use of ceiling lifts for lifting and holding limbs<sup>7</sup> general infection control and clinical practice can prevent the use of ceiling lifts in the sterile field of the OR based on the view that the open mechanism (rails, motor) of the ceiling lift equipment can harbour dust particles and contaminants and, as such, there is a potential for those dust particles and

contaminants to become dislodged during movement of the ceiling lift and to drop in to an open wound. The option of using a band sling, with the ceiling lift, in order to lift or hold a limb during surgery, as opposed to a staff member having to physically do this task, is not, as a result, allowed. Limb lifting and holding using the ceiling lift is only allowed pre- and post- surgery and, as a result, the survey results showed a very low response related to this task.

The perception of respondents, that ceiling lifts are safer and convenient for both the patients and themselves, as well as that they help prevent injuries, are very encouraging results. The members of this study group believe, as Ergonomists’, that this is the case. This has been shown through our personal positive experiences in various healthcare settings but there are often practical, or perceived, barriers to successful implementation for the front-line users of this type of ergonomic engineering control. The qualitative data, collected during this study, shows that the perception of the OR staff is that they believe high-risk tasks can be carried out in a safer manner when the ceiling lifts are used. This is a very positive result.

**Table 2. Thematic Analysis of Qualitative Survey Questions**

Question	Overall Themes
What makes the ceiling lift a practical and useful safety control?	<p><b>3 main themes:</b></p> <ul style="list-style-type: none"> <li>○ Safer &amp; more comfortable for the patient</li> <li>○ Safer for staff</li> <li>○ Prevents injuries to OR staff</li> </ul>
What is 1 thing you like about the ceiling lift?	<p><b>4 main themes</b></p> <ul style="list-style-type: none"> <li>○ Prevents injuries (specifically back injuries) to OR staff</li> <li>○ Convenient &amp; safer for patients</li> <li>○ Convenient &amp; safer for OR staff</li> <li>○ Fast and easy to use</li> </ul>
What is 1 thing you don't like about the ceiling lift?	<p><b>3 main themes:</b></p> <ul style="list-style-type: none"> <li>○ Slings (supply &amp; laundry time)</li> <li>○ Emergency (red) pull cord is too long</li> <li>○ Location of docking (charging) station</li> </ul>

## CEILING LIFTS (cont.)

The OR is not an area of Fraser Health that generally sees high rates of injury claims due to patient handling but data, as reported above, shows an average of 5 claims per year from January 2011 through to December 2013<sup>5</sup> among all the OR departments in Fraser Health. This OR with ceiling lifts has, in contrast, averaged less than one claim per year in the same three year period. There were a total of two claims during the first year (2011) and there were no claims in 2012 or 2013.<sup>5</sup> The authors believe this speaks to the safety benefit of having ceiling lifts in the OR and that the results of the survey data complement the injury data to illustrate that, once staff incorporate ceiling lifts into their safe client handling practice in the OR, the benefit to staff is evident.

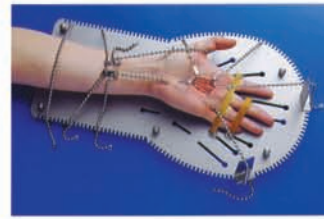
The perceptions of survey respondents, that the ceiling lift is a practical and useful safety control for the OR environment and that they would recommend ceiling lifts for use in all OR environments, is an extremely positive result and speaks to a change in practice that has optimized in this OR. The breadth of the ergonomic effectiveness and safety value of having ceiling lifts throughout the facility, including in this OR, also goes beyond this department. When the ceiling lifts are used in this OR the ceiling lift sling remains under the patient when they leave the OR unit thereby improving safe patient handling on other units, that have ceiling lifts, as the patient moves throughout the hospital. This is a positive benefit for all staff within the system and for the patients themselves.

The authors feel it is important to note that, although the survey tool created for this project contained identified high-risk OR patient handling tasks as addressed in the literature,<sup>2,15-17</sup> the survey tool itself was not tested and we acknowledge that the results from its use may not be reproduced in other settings. This is, therefore, a limitation of the project.

### CONCLUSIONS:

The survey results, overall, showed that staff feel the ceiling lifts are a practical and effective ergonomic engineering control in the OR environment. Staff reported that they like the ceiling lifts and are finding them very useful in carrying out OR patient handling tasks including, more specifically, lateral transfers and repositioning. These are both high-risk patient handling tasks, carried out in the OR, during which the use of the ceiling lift can reduce the potential for staff and patient injury. These project findings provided evidence to support the value and effectiveness of ceiling lifts in the OR and, as such, in the design planning phase of a new out-patient surgery facility in Surrey, B.C. that has since been completed (opened in June 2011). Ceiling lifts were installed in each OR theatre during the construction phase of the new Surrey, BC, build, with the cost incorporated in to the construction and design budget of the new build. Further evaluation of the ceiling lifts in these ORs will be forthcoming.

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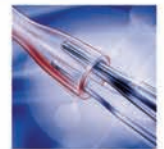
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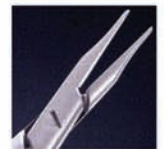
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The survey results, overall, showed that staff feel the ceiling lifts are a practical and effective ergonomic engineering control in the OR environment.

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ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (May 2013) *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (11th Edition) section 4, pgs 238 and 242-245, Standards 4.15 and 4.18.

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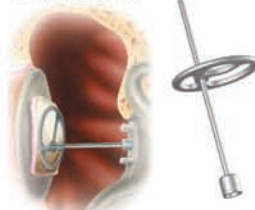


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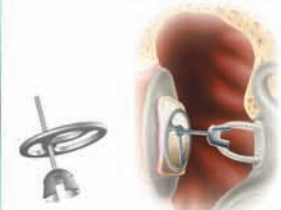
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# UNE ANALYSE RÉFLEXIVE SUR LES AVORTEMENTS EN SALLE D'OPÉRATION

**Auteur :** Hubert Murray, baccalauréat spécialisé en soins infirmiers généraux, infirmier en service interne et infirmier anesthésiste, Hôpital St-George, Londres, R.-U.

## RÉSUMÉ :

Cet article traite du concept de l'objection de conscience relativement aux interruptions chirurgicales de grossesse. Il se penche sur le devoir de vigilance de l'infirmière en service interne non seulement envers le patient, mais envers elle-même et souligne

l'importance d'être consciente de ses propres réactions morales et émotives face aux avortements en salle d'opération. Cette prise de conscience permet à l'infirmière/ODP (praticiens en salles d'opération) d'exercer de façon professionnelle et autonome et d'offrir des soins périopératoires de qualité supérieure tout en respectant ses droits personnels.

Réimpression tirée du *Journal of Perioperative Practice*, Volume 24, numéro 6, pp. 147-150. A reflective study on abortions in theatre, H Murray Droit d'auteur 2014, avec la permission de The Association for Perioperative Practice.

KEYWORDS: ABORTION, CONSCIENTIOUS OBJECTION, ETHICAL REASONING

# A REFLECTIVE STUDY ON ABORTIONS IN THEATRE

**Author:** Hubert Murray BSc (Hons) in General Nursing, Scrub & Anaesthetic Nurse, St George's Hospital, London, UK.

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## ABSTRACT:

This article discusses the concept of conscientious objection in relation to surgical terminations of pregnancy. It explores a scrub nurse's duty of care not only to the patient but to themselves. It highlights the importance of being self-aware of one's moral and emotional attitude towards abortions in theatre. Doing so enables the nurse/ODP to practice professionally and autonomously, and to deliver the

highest level of perioperative care whilst respecting their personal rights.

## INTRODUCTION:

As there are various methods of abortion, in this article I will use 'surgical terminations of pregnancy' (STOP) to refer to abortions. The operating theatre has become a crossroads at which vast cultural and ethical standpoints meet. At some stage theatre nurses and ODPs will

## Conscientious objection is a very real ethical dilemma in perioperative nursing (AfPP 2011).

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come into contact with an operation that will question their ethical viewpoint of what is right and wrong. Abortions are one example of this. In order to practice professionally we must know our rights and those of the patients. We must do everything we can to promote our work, strive for better care, act autonomously and be accountable for our actions.

With this in mind, how can we participate in abortions if we believe they are morally wrong? Can we object to participating in abortions and is it appropriate or even legal to object? Is there a guide for making difficult decisions like this? Will I be the recipient of criticism from other staff if I object? These questions bring challenging topics of discussion to the surface of our practice.

Conscientious objection is a very real ethical dilemma in perioperative nursing (AfPP 2011). In 2011 the number of abortions of resident woman in England and Wales was 189,931 (DH 2011). The potential amendment of the Abortion Act 1967 would mean that nurses and ODPs could be permitted to carry out surgical abortions (Lipp 2008) within the first trimester (TSO 2007 p8). Therefore, it is clear that at some stage in our career we will come into contact with STOP.

Two themes arise from this: how do we respect the decision of the patient if we believe that it is morally wrong, and how do we participate in a procedure if we are emotionally and religiously not comfortable with it? I believe that we can only answer these questions by reflecting on the scenarios of others or ourselves. I chose to use Gibbs' cycle of reflective practice which consists of six elements: description of the scenario, my involved feelings, evaluation, analysis, action plan and conclusion. Like Schoen (1991) I believe this to be the best model because it is easy to apply and can be applied both in-action and on-action, after an event has occurred.

### Description of the event

The allocations for the day had been made and I was to work in general

surgery. However, I was informed by the floor manager that I was reallocated to day surgery because one of the scrub team had become ill. I asked what the list consisted of and was informed that it was STOPS; the manager then went about his other duties before I could enquire what a STOP was. At this point I handed over to my colleagues what I had prepared in my theatre and what needed to be done in my absence. I went apprehensively to day surgery, not knowing what a STOP was.

Upon arrival at the new theatre, there were a few familiar faces and I asked what each case involved, what equipment was needed and if the patient had been sent for. I was given a brief overview of the list by the other scrub nurse. The list was four cases, all of which were surgical terminations of pregnancy (STOP). A STOP involves a woman being admitted to hospital for suction evacuation of the uterus at 14 to 16 weeks of pregnancy (RCOG 2011). I was not asked if I had any objections towards working in the list nor did I raise any concerns. With the other scrub nurse and assistant theatre practitioner we prepared for the procedures and successfully completed the list.

### Feelings

At first, when my manager approached me about being reallocated to a different theatre I felt apprehensive about joining a new theatre team that I may not be familiar with. When I found out what the cases were I felt worried as I had no previous experience in obstetrics and gynaecology. I was concerned that I would not have the appropriate scrub skills. Secondly, I felt somewhat confused because my religious background (Roman Catholic) does not permit abortions and here I was, participating in them. Thirdly, I felt that if I raised my concern about working in this theatre I would be seen as a burden to the department. Finally, I did not feel empowered or supported by the floor manager to raise any objection, therefore I doubted myself and my skills.

Conscientious objection is a term that describes a nurse's refusal to be involved in some or all of the patient's care (RCN 2008), and it is enshrined in the Abortion Act section two (HMSO 1967).

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#### Evaluation

During reflecting on-action later that day, I began by evaluating the situation from a positive perspective: all care given to the patients on the list was delivered professionally, efficiently and safely. No personal prejudices were imposed on them. Dawkins and Ingram (1998) found that it can be very difficult to respect the cultural and religious beliefs of a patient whilst in theatre because we have become blind to inherent diversity.

The WHO safer surgery checks were completed and there was a strong sense of cohesiveness and effective communication between the theatre team. Vats et al (2009) stated that, in stressful situations, we are prone to error. Having safety checks in place is only effective if there is a strong sense of cohesiveness in the operating team.

Due to my religious background I felt confused about working in this theatre, however I did not feel strongly enough either for or against participating in the abortions to make my feelings known. Therefore I decided that I needed to experience it to form my own opinion. As a result of this I learnt new skills and information about the procedures. The backbone of personal growth is to have the confidence to put oneself into new learning experiences (Woodhead 2000) so that we can increase our skills and knowledge base.

Looking at it from a negative perspective, I believe that the floor manager did not show a duty of care to me as he did not ask if I was comfortable with going into the theatre. On the other hand I felt as though I was not assertive enough to my floor manager. According to Woodhead (2000) if a leader or manager wants to promote an effective working team then they must meet the needs of the team members and ensure that they feel valued. This promotes an open environment for communication. Finally, I felt it would be unprofessional of me to object to work in the theatre; I

did not know if objecting was acting outside of my code of conduct and jeopardising my duty of care to the patient.

#### Analysis

In perioperative practice we are faced with difficult decisions every day that must be made quickly. To guide us in making the right decision we are influenced by the ethical standards that govern our profession; we have a duty of care to our patients (Kennedy 2004). This implies that we must act to protect the autonomy of patients and must respect their decisions in order to:

*'Make the care of people your first concern, treating them as individuals and respecting their dignity' (NMC 2008)*

These points enshrine caring for the patient, but in my scenario there is still an ethical conflict present. Pirie (2012) believes that we must respect patients' decisions even though they may not be in conjunction with our own. Although this author agrees with Pirie, I also believe that our own rights must be respected. AfPP (2011) stated that it is best practice to respect not only the values of our patients but also our own values.

Conscientious objection is a term that describes a nurse's refusal to be involved in some or all of the patient's care (RCN 2008), and it is enshrined in the Abortion Act section two (HMSO 1967). According to Pirie (2004) there are two distinct areas in which one can conscientiously object to being a part of a patient's care:

- participation in abortion as detailed in the Abortion Act 1967; and
- the right to refuse to be involved in technological procedure to achieve conception and pregnancy (Human Fertilization and Embryology Act of 1990).

The objection may be based on personal, moral or religious beliefs which can have an impact on the patient (Pirie 2004).

If a nurse/practitioner feels strongly about a situation and is aware of conscientious objection, their intuition would lead them not to participate. However, as I had no prior experience or enough knowledge regarding abortion, I could not make a truly informed decision on conscientious objection. Marshall and Raynor (2002) state that nurses must decide upon a course of action based on their intuition, and this may require reflecting on their own experiences or others in order to make this decision. Reflecting on this, I discussed how to manage this situation if it were to arise again. Two questions that further the discussion are: how could I have raised my conscientious objection?; and, how can I object in such a way that neither the patient's autonomy nor mine is disregarded?

Through researching these questions, I found that the code of professional conduct advises us to make known to the appropriate person any conscientious objection which may be relevant to our work (NMC 2008). Reflecting this, AfPP (2011) reinforced this by stating that a manager must be informed of a conscientious objection in sufficient time to manage the situation. If we voice our conscientious objection to the necessary people i.e. floor manager, and in a timely manner, alternative arrangements can be made, so that the patient's care is unaffected by our decision. This enables us to practice autonomously and to ensure that our duty of care to our patient is not compromised (Beauchamp & Childress 2009). The only time when

conscientious objection is not applicable is when the procedure is needed in a life threatening situation for either the mother or the foetus; this was not applicable in this situation.

The ethics of abortion create strong social debate and it can be difficult for the individual to form a decision that they are comfortable with. Having a good knowledge about ethical reasoning helps one make a difficult decision. It can encompass subjects such as exercising conscientious objection, cancelling a list due to lack of staff or lack of operating time. To make the best decision we need to have different methods for ethical reasoning. I believe that a better understanding of ethical reasoning would have helped me make an appropriate decision when deciding if I should partake in the abortions.

Fullbrook (2005) uses a principles' based framework to assist us in making difficult decisions in perioperative practice on whether or not to act:

- The first and second principles are to undertake a risk/benefit analysis of whether or not to act, and to reflect on what might happen if I do or do not act. In my case, if I chose to abide by my religious background I would not have participated in the STOPS. Therefore, the day surgery manager would have had to reallocate me and put somebody else into my position. Or, in the worst case scenario, under the local theatre policy my decision would have prevented the list from going ahead due to a lack of staff and the list may have been cancelled;
- Taking the third principle, what are the dangers of acting, or not acting? If I did participate in the list, did I have the appropriate skills, would I have been slower than other practitioners thus causing the list to overrun?;
- The fourth principle is: what is the cost of acting or not acting? My patients needed an abortion for reasons that I was unaware of, and by not proceeding, this could have been detrimental to their physical and/or psychological well-being; and
- The fifth principle is: what is the most

relevant current knowledge about the situation I am in? At that point, I did not feel I was in a position to look up the trust's policies on objecting to work in an operation list nor would I have had the time to do so.

I believe that applying Fullbrook's ethical framework to my situation would have been very beneficial for me in my scenario. Unfortunately, I was not aware of it when I encountered my first abortion and therefore I was not able to form a decision based on Fullbrook's framework. In view of this I decided that the best outcome would be to work through the list in the hope that I would learn from it. Pirie (2012) is of the opinion that a patient has a duty of care owed to them from a practitioner who has been allocated to care for them. Therefore, by simply agreeing to take the place of the sick member of staff, a duty of care was immediately established between myself and the patients on the list (Brazier 2003, in Pirie 2012).

The final aspect to this scenario is having the confidence to practice autonomy. If I was to exercise an objection would I have been subject to criticism by the theatre staff. This is understandable as the list would have been prevented from starting due to staff shortage and a reshuffle of staff would have been necessary thus causing a time delay to the list.

Reinforcing my views is a study of nurses' attitudes towards pregnancy and termination. Marek (2006) found that nurses were criticised by their co-workers for not participating in the care of women undergoing abortions. Griffith and Tegnah (2010) reflect this in their belief that, in some scenarios, our sense of autonomy can come under strain. I believe that this may be due to the multicultural society we are surrounded by at work. Any person being subjected to discrimination from other staff must remember that they have a right to exercise their rights and that we must all abide by our code, as set out by the NMC (2008), i.e. you must treat your colleagues fairly and without any

The ethics of abortion create strong social debate and it can be difficult for the individual to form a decision that they are comfortable with.

discrimination. If we are worried that we might be the recipients of criticism as a result of our decisions, we must have both good assertive skills and a firm understanding of our legal responsibilities in practice. We can then work both professionally and autonomously. Understanding the nature of conscientious objection and ethical reasoning enables us to promote the best possible care for ourselves and our patients.

#### CONCLUSION:

Using Gibbs' cycle of reflective practice I have discussed the concept of conscientious objection in relation to surgical terminations of pregnancy. I have explored a scrub nurse's duty of care, not only to the patient but also to themselves. I have highlighted the importance of being self-aware of one's moral and emotional attitude towards abortions in theatre. Doing so enables the nurse/ODP to practice professionally and autonomously, thus delivering the highest level of perioperative care whilst respecting their own personal rights.

Practicing conscientious objection is a difficult issue to manage, especially within current working conditions such as staff shortages and increasing workloads. There are a vast number of ethical issues that arise in the daily perioperative environment. Having tools to help us make difficult decisions are vital for our practice to thrive. Fullbrook's ethical framework can act as one tool to help us make these difficult decisions. Having a keen understanding of these ethical issues and ways to approach them ultimately improves our practice and promotes the

Duty of care is our primary purpose in healthcare, whether this involves caring directly or indirectly for our patients.

highest level of care possible for our patients. Partaking or not partaking in an abortion list draws upon our self-awareness skills, communication skills and demands high levels of assertiveness.

Duty of care is our primary purpose in healthcare, whether this involves caring directly or indirectly for our patients. I feel that duty of care to ourselves can sometimes be overlooked. We have a right to exercise autonomy and stand by our beliefs and values. Conscientious objection enables us to practice these elements safely without negatively affecting the patient's rights. This demonstrates that, if we have the appropriate knowledge, we can care for both our patients and ourselves.

#### Action Plan

My first recommendation would be to devise a questionnaire for both main theatre and day surgery staff to ascertain their personal or cultural views on abortions and their awareness of conscientious objection and whether they would feel comfortable exercising their right to object.

Secondly, I would like to devise a separate audit for team leaders to gain an insight into their perceptions of their staff's ethical and emotional views on abortion. Further to this, looking into staff perceptions about emergency abortions, where conscientious objection is not valid, would highlight any emotional or technical issues. This would demonstrate whether staff are being facilitated by team leaders to air any concerns about working in these procedures.

Next I would create a pamphlet about one's duty of care to oneself as well as to one's patient, emphasising conscientious objection, ethical decision making and assertiveness. I would present the results in a meeting to both day surgery and main theatre staff to highlight any areas of concern. I am of the opinion that bringing self-care and assertiveness to the forefront

of theatres could improve staff self-awareness on issues such as conscientious objection and difficult decision-making. This would create a more confident and skilled workforce. If we can uphold a strong self-value we can uphold a good morale and sense of leadership to make the right decisions for ourselves and our patients. Therefore, patients undergoing surgical terminations of pregnancy would receive the highest quality of care possible from our perioperative team.

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# SPOTLIGHT ON ORNAC MEMBERS

AN INTERVIEW WITH ESTHER ENG RN, BN, CPN(C) & ANNE CHANG RN, BN, CPN(C) WINNERS OF THE ORNAC PERIOPERATIVE NURSES WEEK CAMPAIGN CONTEST.

Esther and Anne won for their video “Excellence, every patient... every time.” The video can be viewed online at [www.ornac.ca](http://www.ornac.ca) or on ORNAC’s Facebook page.

**Submitted by:** Catherine Harley, RN, eMBA, ORNAC Executive Director.

Anne Chang graduated with a Bachelor’s of Nursing from the University of Calgary in 2004. She worked as a RN on a nephrology inpatient unit prior to being accepted in the Calgary Perioperative Nursing Program in 2005. She then spent the next 6 years working in the OR at the Peter Lougheed Centre in Calgary, AB, initially as a staff nurse and then as nurse clinician of General Surgery. In 2010 she received her CNA Certification in Perioperative Nursing. In 2011 she became the OR unit manager at Rockyview General Hospital (RGH) in Calgary, AB. In 2014 she made a career change and became a Clinical Safety Leader working with the Calgary Zone Patient Safety team within Alberta Health Services. Anne lives in Calgary with her husband and four children and during any spare time that remains she is committed to long-distance running.



Esther Eng RN, BN, CPN(C) & Anne Chang RN, BN, CPN(C).

Esther Eng graduated with a Bachelor’s of Nursing from the University of Calgary in 2004. After graduation she worked casual on a surgical unit focusing on colorectal/gynaecological surgeries. She then worked part-time on a medical unit with a sub-acute neurological focus as well as working in long term care. She was accepted into the Calgary Perioperative Nursing Program in 2006 and worked at the Peter Lougheed Centre (PLC) Operating Room as a staff member gaining experience in all services. She completed her CNA Certification in Perioperative Nursing and eventually became unit manager of the PLC Recovery Room and then the PLC Operating Room/Minor Surgery Clinic. In 2014 she moved to the South Health Campus and took on a staff role in the Minor Surgery Clinic. She has a passion for OR Nursing and is currently the President of the South Central Operating Room Nursing Association (SCORNA). She lives in Calgary with her husband in Calgary and enjoys traveling, quilting, and scrapbooking.

What inspired you to specialize in perioperative nursing?



**Anne:** I fell in love with perioperative nursing when I had the opportunity to visit the OR during my medical surgical rotation in nursing school. Two things that impressed me the most during this observation were the efficiency of the whole perioperative team and the high degree of patient advocacy. At that moment I knew the OR was where I wanted to work.

**Esther:** Actually, Anne encouraged me to come to the Operating Room! Once there I was impressed with the teamwork, fast-paced environment, the tangible patient outcomes, and the excellence in patient safety priorities. I think many nurses would benefit from an OR day in their nursing training especially if they want to focus in areas such as surgical nursing, ER, PACU, ICU, and L&D.

## SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH ESTHER ENG &amp; ANNE CHANG

Thinking of a stranger  
as your loved one  
makes you want to  
do your best.  
- Esther Eng

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What continuing education do you feel supports your specialization?

**Anne:** Being a member of ORNAC definitely helps with my continuing education. Our district council (SCORNA) always provides great speakers who present diverse topics throughout each year. We also look forward to upcoming perioperative nursing conferences. These conferences offer a great opportunity to learn about pertinent topics in perioperative nursing, catch up with past colleagues, and network with other perioperative nurses.

**Esther:** There are so many opportunities for continuing education once you have finished your formal training. As an Operating Room nurse I think it's really important to just be involved. In Calgary we are lucky to have weekly in-services provided by our OR educators. Certification such as CPN(C) and volunteering in local and provincial associations are also great ways to build your knowledge on the principals of our specialty, and create networks to learn, grow, and change. Attending conferences (provincial, national, European, American etc.), looking at learning modules from various medical companies, discussing procedures with resources (clinicians, medical reps, senior nurses, surgeons) are all ways that have helped me improve my practice.

Tell us about your first prize video for Perioperative Nurses Week.

**Anne & Esther:** The concept of the video came from the idea that you can do anything with love. We've all had days where we don't feel like working but knowing that someone depends on us to give our best changes everything. This is more significant if it is someone you know and even more meaningful if it is someone you love. Love drives us to do our best, uplifts us, and pushes us to do more and be more. When we love what

we do, love those we work with, and love those we help then perioperative excellence just comes naturally.

The music in this video is very impactful. What is the name of the song and why did you select it?

**Anne & Esther:** The name of the song is "Yellow Light from the album "My Head is an Animal" by Of Monsters and Men. We chose this song because we felt the music and lyrics fit so well with the imagery we wanted to use for the video.

Love is a main theme of your video. How has "love" impacted on your ability to administer safe patient care in the OR?

**Anne:** Love is at the heart of safe patient care. If the patient were someone you loved then you would do everything in your power to ensure they received the best and safest care. Although the patient before you may be a stranger they are loved by others. No matter how we feel that day, or whatever challenges we may be faced with, it is our responsibility to ensure every patient receives the safest care so that they can return to their loved ones.

**Esther:** Thinking of a stranger as your loved one makes you want to do your best. When you stop for a moment before getting your patient and think "what if this person was my grandmother, or mom, or dad, or brother, or best friend" you can make a connection, provide comfort, think of the small details that will make their experience safer and better.

Question: Did you have any challenges in putting this video together?

**Anne:** Our biggest challenge finding time to meet to discuss how to put the video together. Esther and I work at different sites, live on opposite ends of

## SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH ESTHER ENG &amp; ANNE CHANG

Everyone I've worked with throughout my career has played a role in teaching me the importance of patience, perseverance, and dedication  
- Anne Chang

the city, and have busy home lives. In the end we didn't meet face-to-face at all during the project but communicated by email and through phone conversations.

**Esther:** We faced challenges working with software that we weren't familiar with (iMovie and Dropbox) and finding the right way to document our picture references.

Any words of advice for Perioperative RNs who want to tackle a creative project?

**Anne:** The most important thing would be to create a group that works well together. Have a vision and make a plan to focus each person's strength(s) on different aspects of the project in order to get it done.

**Esther:** Planning a timeline helps in keeping your project moving forward to meet a specific deadline.

Your video has been viewed 6,000 times on ORNAC's website and Facebook page. How does that make you feel?

**Anne & Esther:** Wow, that's great! The video was made to celebrate the wonderful work done by perioperative nurses each and every day in this country. We think perioperative nursing is an amazing profession and hope those who have viewed the video feel the same way.

Who do you consider to be a mentor and how have they impacted you in your career?

**Anne:** It's really true that it takes a village to raise a child. I've been extremely fortunate to have learned and come from some phenomenal 'villages'. Everyone I've worked with throughout my career has played a role in teaching me the

importance of patience, perseverance, and dedication. I also know that there is something to learn from every new person I meet. The great thing about perioperative nursing is that my 'village' of mentors is constantly growing.

**Esther:** It's as Anne said. There are so many people who have influenced my career. I have always felt so blessed to have mentors who share their experience, to work with colleagues I can bounce ideas off of, and to have met so many people with a passion for the OR. As perioperative nurses we meet and learn from so many people (from the biomedical engineers and the medical processors to the educators, clinicians, and surgeons). With so many mentors I could not name just a few.

What do you see in the future for Perioperative RNs?

**Anne & Esther:** We think there is a strong future for the Perioperative RN as this is an area where a high level of critical thinking is required. With continuous advancements in technology and a patient population with increasing multiple co-morbidities, we think perioperative RNs are best suited to holistically care for the surgical patient. As there are, however, more pressures in health care to be budget conscious, and many ORs experimenting with their staffing models, we think it is important for RNs to advocate for their profession.

First prize for the Perioperative Nurses Week contest was 3 registrations to the 2015 ORNAC National Conference in Edmonton. What happened to the third registration and will we be seeing you there?

**Anne & Esther:** Yes, we'll definitely be there and can't wait! Our district council, SCORNA, will be awarding the 3rd registration to another member through a raffle.



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