December 2014
Volume 32, Issue 4

ORNAC JOURNAL

© mediaphotos

Culture of Collaboration

ORNAC Awards

National Conference Highlights

WWW.ORNAC.CA

PM40951517

KEEPING SAFETY IN CHECK

*PRESENTING THE TIME OUT BOARD

- CUSTOMIZABLE
- VARIABLE SIZE BOARDS
- WALL MOUNTABLE
- 1/4" CLEAR ACRYLIC
- DRY ERASABLE
- STURDY EASY SLIDE SWITCHES
- IMPROVES COMMUNICATION
- IMPROVES TEAM WORK
- CREATES A SAFER PATIENT ENVIRONMENT

WORLD HEALTH ORGANIZATION PERIOPERATIVE ENVIRONMENT

TIME OUT BOARD PROVIDES A BACKUP TO HUMAN MEMORY DURING ROUTINE AND EMERGENCY PROCEDURES. THEY SERVE AS A FORMAL REMINDER TO HELP PREVENT ERRORS OF OMISSIONS CONTRIBUTING TO A SAFER ENVIRONMENT.

Time Out Board

All items must be confirmed by 2 team members.

Patient's Name: ______________

DOB: ________ Procedure: ________

		Green Confirmed	Red Not Confirmed
Family Update:	1. Patient Identified Using Two Identifiers		
	2. Procedure Confirmed		
	3. Site Marked		
	4. Completed Consent Signed		
ATB Redosing	5. H&P Updated		
	6. Patient Positioned		
	7. Diagnostics/Images Reviewed		
Equipment QC Completed & Documented:	8. Allergies Noted		
	9. Antibiotics Given*		
	10. Medication/Irrigation Available		
	11. Implants /Equipment Available		
*If Applicable	12. Safety Precautions In Place		

24" x 48"

ONCE THE TEAM IS IN 100% VERBAL AGREEMENT

FLIP THE SWITCH !

KEEPING SAFETY IN CHECK

*STERILE MEDICATION LABELS "ON" THE STERILE FIELD

- WATERPROOF LABELS
- STRONG BUT REMOVABLE RESIDUE FREE ADHESIVE
- GUARANTEED LOWEST PRICING
- LATEX FREE
- 100% SATISFACTION

CHOOSE AND CUSTOMIZE THE MEDICATION LABELS YOU NEED AT NO ADDITIONAL CHARGE

MEDICATION LABELS

SINCE 1996, RMAC SURGICAL INC. HAS BEEN PROVIDING PHARMATAGS STERILE MEDICATION LABELS TO OPERATING ROOMS, CARDIAC CATH LABS, INTERVENTIONAL RADIOLOGY SUITES, AND AMBULATORY SURGICAL CLINICS THROUGHOUT THE UNITED STATES AND CANADA.

RMAC SURGICAL TOLL FREE: 1.888.299.2661 WWW.PHARMATAGS.COM

SPONSOR OF THE RMAC SURGICAL PATIENT SAFETY AWARD!

ORNAC JOURNAL

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

Published Quarterly ✦ Volume 32, Issue 4, December 2014

TABLE OF CONTENTS

© mediaphotos

17 Developing a Culture of Collaboration in the Operating Room: More than Effective Communication
BY/PAR: PATRICIA WADE, RN, MN, CPN(C).

30 STOP Talking Over Patients
BY/PAR: CHANTAL GAGNÉ, RN, BSCN, MSCN, CPN(C).

ORNAC NETWORK / RÉSEAU DE L'AIISOC

12 24th ORNAC National Conference Highlights

13 ORNAC Awards / Prix de l'AIISOC

27 Spotlight on ORNAC Members: An Interview With Barb Sawatsky, RN
BY/PAR: CATHERINE HARLEY RN, EMBA, ORNAC EXECUTIVE DIRECTOR

24 Upcoming Events

SUBSCRIPTIONS:

Canada - $45 plus GST/HST
Outside Canada - $68
Single Copies - $15 + tax in Canada
$22 outside Canada
subscriptions@clockworkcanada.com

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

EDITOR:
Deborah McNamara
ART DIRECTOR:
Sherri Keenan
TRANSLATION:
Jocelyne Demers-Owoka
EDITORIAL CHAIR:
Barbara Mushayandebvu

ADDRESS CHANGES:

ORNAC members / Membres de l'AIISOC:
www.ORNAC.ca for address changes / pour effectuer un changement d'adresse.

Non-member Subscribers:
send address changes to subscriptions@ClockworkCanada.com or fax to 1.888.330.2116. Please provide your old and new address as well as an e-mail or telephone contact.

ORNAC Executive

PRESIDENT - Rupinder Khotar RN, BScN, CPN(C) - North Vancouver, BC - president@ornac.ca

PRESIDENT ELECT- Cathleen Ferguson RN, BScN, RNFA, CPN(C), CNOR - Antigonish, NS - presidentelect@ornac.ca

TREASURER - Elizabeth Beck RN, CPN(C) - New Minas, NS - treasurer@ornac.ca

SECRETARY - Anita Esson RN, BScN, RNFA, CPN(C) - Sault Ste. Marie, ON - secretary@ornac.ca

EXECUTIVE DIRECTOR - Catherine Harley RN, eMBA - Ottawa, ON - executivedirector@ornac.ca

ORNAC Board Members

BRITISH COLUMBIA
Marlene Skucas RN, CPN(C)

ALBERTA
Lucia Pfeuti RN, BN, CPN(C)

SASKATCHEWAN
Donna Marin RN, BScN, CPN(C), MHRD

MANITOBA
Karen Sagness RN, RNFA, CPN(C)

ONTARIO
Debra Bastone RN, BScN, CPN(C)

QUEBEC
Philippe Willame RN, BScN

NEW BRUNSWICK
Lynne Larivee RN, BScN, CPN(C)

NOVA SCOTIA
Ida Berry RN, CPN(C)

PRINCE EDWARD ISLAND
Cathy Griffin RN, BScN, CPN(C)

NEWFOUNDLAND & LABRADOR
Corenia Price, RN, CMDRT, CPN(C)

LEADERSHIP
Kelly Chapman RN, MHS, BSN,CPN(C)

ADVANCED PRACTICE
Aline Gagnon RN, BSc, RNFA

EDUCATION
Kristina Creuss RN, RNFA, BA, BScN, MST, CPN(C)

For information about the Board visit **www.ORNAC.ca**

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.

Advertiser Directory / Annuaire des annonceurs

Product Advertisers / Annonceurs de produits

AMT Electrosurgery	7, 21	Instrumentarium	19, 29, 31
Cardinal Health Canada	39	Medline Canada	40
Ecolab	23	RMAC Surgical	2

Career Opportunities / Possibilités de carrière

Alberta Health Services	26	Vancouver Coastal Health	26
Health Match BC	25		

Looking For Information About Advertising In This Journal?

Vous Cherchez L'Information Pour Mettre Une Annonce Dans Cette Revue ?

contact@ClockworkCanada.com

or / ou

902.442.3882

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.

"The best way to find yourself is to lose yourself in the service of others."
- Mahatma Gandhi

Service is a concept that is dear to me so I speak of it often. At the end of the year I, like many people, reflect on the year gone by. My work, my family and my friends are part of my inventory. I review my relationships and hope that I have served well in all aspects of my life. The kinship and fellowship experienced over the holidays strengthens these connections and amplifies their importance. Following the holidays I dream of opportunities as I stopped making resolutions many years ago.

2014 has been another busy year for ORNAC. There were a couple of firsts for the association and some new opportunities for members to provide service to the association.

ORNAC hosted its first Annual General Meeting and implemented a transition of the Board structure along with a change that allowed for member participation in the voting process. ORNAC also brought all provinces in to the central database following the annual national membership drive. This database will, in the future, allow for timely and regular communication with members. The membership drive for 2015 is nearly complete so renew now if you have not already done so!

The ORNAC Board continues to conduct its work under the five pillars of Marketing, National Conference Planning, Professional Practice, Advocacy/Governance, and Research & Informatics. The Board has also begun work, with support from other key stakeholders, on a new three year strategic plan. This process provides an exciting opportunity to engage with many groups that are involved in the perioperative patient experience. I direct you to the Executive Director's message, on page ____, for further information. The election of the new Board is currently underway so watch for updates in the near future.

This year ORNAC conducted a contest on the theme of perioperative nurses week – Excellence. Every Patient. Every Time. There were a number of submissions for review and I would like to thank everyone who sent in their creative work. The theme will be carried forward into the 2015 conference in Edmonton demonstrating the depth and value of the concept of individualized, excellent patient care.

ORNAC will, in 2015, implement the next steps in the three year strategic plan that will be outlined, in detail, in the 2015 annual general report. In May 2015 ORNAC will host its 24th National Conference in Edmonton, AB. Members will, at this conference, have access to the ORNAC Board through the annual general meeting and an open forum designed to communicate the strategic plan and give members the opportunity to volunteer with one of the Pillar groups. Please look for areas where you can contribute your time, energy, and knowledge. ORNAC needs your participation and support!

I hope to see many familiar faces and to meet many new ones at the Edmonton conference. Networking with my peers is my favourite part of the conference so please come by and say hello!

I wish you and yours a safe and healthy holiday season and every success in your service throughout 2015. 🍁

Kind Regards,

Rupinder Khotar

The perfect tool gets even better with the re-designed PENEVAC™

REDUCED TORQUE

The PenEvac™ has a redesigned 45 degree swivel adapter positioned at the proximal end which significantly reduces torque on the tubing making it effortless to use smoke evacuation.

NO BLADE CHANGES

The PenEvac™ is the only device with a telescopic extension to facilitate a full spectrum of surgical procedures with optimal access. It eliminates the need forExtended Blades while efficiently capturing smoke in all ranges of extension.

INTEGRATED CORD IN TUBING

The PenEvac™ has an integrated electrosurgical cord with suction tubing creating a more streamline set-up and eliminating the need for clip-on attachments.

For more information call **1-888-803-6799**

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.

Le service est un concept qui m'est cher, j'en parle donc souvent. À la fin de l'année, comme beaucoup d'autres personnes, je repense à l'année qui s'achève. Mon travail, ma famille et mes amis font partie de mon inventaire. Je passe en revue mes relations et j'espère avoir été bien utile dans tous les aspects de ma vie. Les liens de parenté et d'amitié que nous resserrons durant les Fêtes renforcent ces connexions et mettent en relief leur importance. Après les Fêtes, je rêve d'opportunités, car j'ai arrêté, il y a plusieurs années, de prendre de bonnes résolutions.

2014 a été une autre année bien remplie pour l'AIISOC. L'association a vécu quelques premières en plus d'offrir à ses membres un certain nombre d'opportunités pour que ces derniers proposent leurs services à l'association.

L'AIISOC a tenu sa première Assemblée générale annuelle et a effectué la transition de la structure du Conseil d'administration, tout en y a apportant une modification pour permettre la participation des membres au processus de vote. L'AIISOC a également transféré toutes les provinces dans la base de données centrale suite à la campagne d'adhésion annuelle des membres à l'échelle nationale. À l'avenir, cette base de données permettra de communiquer de façon opportune et régulière avec les membres. La campagne d'adhésion de 2015 tire à sa fin, donc renouvelez maintenant si vous ne l'avez pas déjà fait!

Le conseil d'administration de l'AIISOC continue de gérer son travail sous cinq piliers, soit celui du marketing, de la planification des conférences nationales, de la pratique professionnelle, de la défense des droits/de la gouvernance et de la recherche/de l'informatique. Le conseil a aussi commencé à travailler, avec le soutien d'autres intervenants clés, sur un nouveau plan stratégique de trois ans. Ce processus offre une belle occasion de collaborer avec de nombreux groupes participant à l'expérience périopératoire des patients. Je vous conseille de lire le message de la directrice générale à la page ____ pour obtenir de plus amples renseignements. L'élection du nouveau conseil d'administration est en cours, alors surveillez les mises à jour qui seront communiquées sous peu.

Cette année, l'AIISOC a organisé un concours sur le thème de la Semaine des infirmières et des infirmiers en soins périopératoires – L'Excellence. Pour chaque patient… à chaque moment! Nous avons reçu un certain nombre de soumissions et je tiens à remercier toutes les personnes nous ayant fait parvenir leur œuvre. La Conférence de 2015 à Edmonton conservera ce thème pour démontrer la profondeur et la valeur du concept des excellents soins individualisés aux patients.

« La meilleure façon de vous retrouver, c'est de vous oublier au service des autres. »
- Mahatma Gandhi

En 2015, l'AIISOC mettra en oeuvre les prochaines étapes du plan stratégique de trois ans qui seront expliquées en détail dans le rapport annuel de 2015. En mai 2015, l'AIISOC animera sa 24e Conférence nationale à Edmonton, AB. Lors de cette conférence, les membres auront accès au conseil d'administration de l'AIISOC grâce à l'Assemblée générale annuelle et un groupe de discussion ouvert conçu pour communiquer le plan stratégique et donner aux membres l'occasion de s'impliquer en faisant du bénévolat au sein d'un des piliers. Ne manquez pas d'offrir votre temps, votre énergie et vos connaissances à l'un de ces groupes. L'AIISOC a besoin de votre participation et de votre soutien!

J'espère voir de nombreux visages familiers et d'en rencontrer des nouveaux lors de la conférence d'Edmonton. Le réseautage avec mes collègues est la partie que je préfère des conférences, alors venez en grand nombre et passez me saluer!

Je profite de l'occasion pour souhaiter, à vous et aux vôtres, joie, sécurité et santé en ce temps des Fêtes ainsi que beaucoup de succès dans vos services tout au cours de 2015.

Bien à vous,

Rupinder Khotar

EXECUTIVE DIRECTOR'S MESSAGE

Catherine Harley, RN, eMBA, ORNAC Executive Director
executivedirector@ornac.ca

ORNAC has been in transition during the past year. The ORNAC Board has been very busy focusing on three key areas:

1. Implementation of the new ORNAC By-laws which were aligned with the new Canada not for profit act in May 2013;
2. Solidifying the Pillar structure under which the work of the Board of Directors will be accomplished; and
3. Building a new national ORNAC membership database.

It is now time, with many of the foundational governance projects completed, for the Board to focus its attention on the completion of a new three year strategic plan.

During the second weekend of November the ORNAC Board met to discuss a strategic planning process. In order to strengthen its commitment to perioperative registered nurses, allied health professionals, and patients across Canada ORNAC invited the National Exhibitor Advisory Committee (NEAC) Executive to participate alongside representatives from Patients for Patient Safety Canada, Canadian Nurses Association (CNA), Canadian Medical Association (CMA), and Canadian Anesthesiologists' Society (CAS). The group of representatives met to discuss issues facing ORNAC, identify strategic directions, and developing a preliminary work plan to address the issues. The ORNAC Board will now take the lead and begin work on the strategic plan which includes reviewing and re-affirming ORNAC's programs and services, enhancing its communications and marketing efforts, addressing risk management issues, identifying human resource needs, and considering beneficial partnerships.

The Board has also spent considerable time developing and approving a new set of Governance Policies and

"People are like stained glass windows. They sparkle and shine when the sun is out, but when darkness sets in their true beauty is revealed only if there is light from within."
- Elizabeth Kubler-Ross

MESSAGE DE LA DIRECTRICE GÉNÉRALE

Catherine Harley, IA, M.B.A. pour cadres, directrice générale de l'AIISOC
executivedirector@ornac.ca

Au cours de la dernière année, l'AIISOC a vécu une période de transition et le conseil d'administration de l'AIISOC a été très occupé à mettre l'accent sur trois domaines clés :

1. La mise en œuvre des nouveaux règlements administratifs de l'AIISOC qui se conforment depuis mai 2013 à la nouvelle loi canadienne régissant les organismes à but non lucratif;
2. La consolidation de la structure des piliers sous lesquels le travail du conseil d'administration sera réalisé;
3. La création d'une nouvelle base de données nationale des membres de l'AIISOC.

Maintenant que plusieurs projets essentiels en matière de gouvernance ont été réalisés, il est temps pour le conseil de se concentrer sur l'élaboration d'un nouveau plan stratégique de trois ans.

Pendant la deuxième fin de semaine de novembre, le conseil d'administration de l'AIISOC se réunira pour discuter d'un processus de planification stratégique. Dans le but de renforcer son engagement envers les infirmières en soins périopératoires, les professionnels de la santé alliés et les patients de partout au Canada, l'AIISOC a invité la direction du Comité consultatif national des exposants (CCNE) (National Exhibitor Advisory Committee (NEAC) à participer en compagnie de représentants de l'organisme Patients for Patient Safety Canada, de l'Association des infirmières et infirmiers du Canada (AIIC), de l'Association médicale canadienne (AMC) et de la Société canadienne des anesthésiologistes (SCA). Le groupe de représentants s'est rencontré pour discuter des enjeux auxquels l'AIISOC fait face, pour déterminer une orientation stratégique et pour élaborer un plan de travail préliminaire afin d'aborder les enjeux. Le conseil d'administration de l'AIISOC prendra maintenant la relève et commencera à travailler sur le plan stratégique qui comprend la révision et la réaffirmation des programmes et des services de l'AIISOC, l'amélioration de ses efforts dans les domaines de la communication et du marketing, la prise en charge des problèmes de gestion du risque, l'identification des besoins en ressources humaines et l'analyse de partenariats bénéfiques.

Le conseil d'administration a également consacré beaucoup de temps à élaborer et à approuver une nouvelle série de politiques et de procédures en matière de gouvernance. Ces dernières traitent de toute une gamme de problèmes de gouvernance, y compris les processus en matière de gouvernance et les rôles et responsabilités du conseil d'administration de l'AIISOC, des présidents de piliers et des bénévoles. À l'avenir, le plan stratégique ainsi que les nouvelles politiques et procédures en matière de gouvernance guideront le

« Les gens sont comme des vitraux. Ils brillent et resplendissent quand il fait soleil, mais quand l'obscurité s'installe, leur véritable beauté jaillit seulement s'il y a de la lumière à l'intérieur. »
- Elizabeth Kubler-Ross

conseil de l'AIISOC, lorsqu'il assumera un certain nombre de fonctions clés, notamment de fournir l'orientation générale de l'AIISOC, d'élaborer des politiques de façon continue, de suivre de près les programmes et les services, de gérer le rendement, les communications et la défense des droits.

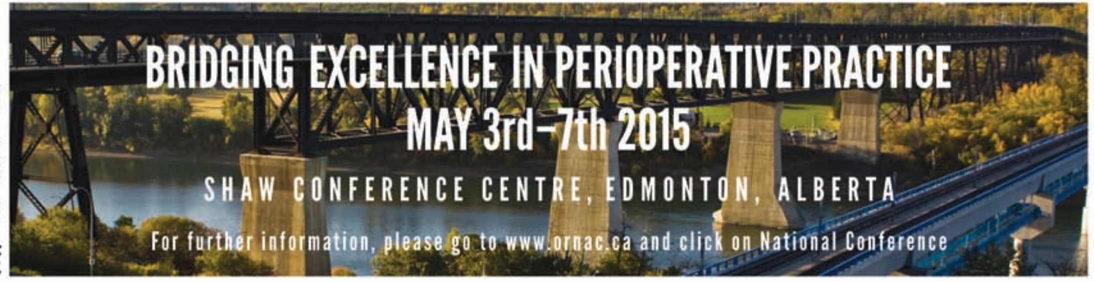
L'accent mis sur la sécurité du patient reflète la prise de conscience croissante que tout le monde a droit à une chirurgie sécuritaire. Le conseil d'administration de l'AIISOC continue de se vouer à fournir de véritables opportunités pour améliorer la sécurité du patient et pour appuyer la prestation de soins chirurgicaux sécuritaires pour chaque patient.

Alors que l'AIISOC et ses membres continuent d'évoluer, une communication et une collaboration solides deviendront encore plus importantes afin de s'assurer que l'AIISOC remplit sa mission et instaure avec succès ses nombreux processus. L'AIISOC a besoin de vos suggestions et commentaires et les apprécie. D'ailleurs, nous invitons tous les membres à passer en revue le rapport annuel 2014 de l'AIISOC qui sera disponible en avril 2015. Nous tenons à remercier tous les membres et associés, les entrepreneurs, les bénévoles, les partenaires et les bailleurs de fonds. Grâce à votre engagement continu, l'AIISOC a hâte de connaître une année encore plus enrichissante. Vous êtes la lumière en nous! N'hésitez surtout pas à nous envoyer vos commentaires ou suggestions à l'adresse électronique en haut de cette page.

Procedures. They cover a wide range of governance issues including governance processes and the roles and responsibilities of the ORNAC Board, Pillar Chairs, and volunteers. The Strategic Plan, in addition to the new Governance Policies and Procedures, will guide the ORNAC Board in the future as it performs a number of key functions including providing the overall direction for ORNAC, on-going policy development, monitoring of programs and services, performance management, communication, and advocacy.

The focus on Patient Safety reflects the growing understanding that the right to safe surgery belongs to everyone. The ORNAC Board of Directors continues to be committed to providing real opportunities for improvement in patient safety and supporting the provision of safe surgical care for every patient.

As ORNAC, and its members, continue to evolve it will be even more important to have strong communication and collaboration to ensure ORNAC fulfils its mission and successfully administers its many processes. ORNAC needs, and values, your suggestions and comments and invites all members to review the 2014 ORNAC annual report that will be made available by April 2015. Thank you to all Members and Associates, contractors, volunteers, partners and funders. With your continued involvement ORNAC looks forward to an even more rewarding year. You are our light from within! Please do not hesitate to send any comments or suggestions to the email address at the top of this page.



MOTIVATIONAL KEYNOTE SPEAKERS

Opening Keynote: Amanda Lindhout

A House in the Sky: Empowerment in Somalia and Beyond

In 2008 Canadian Amanda Lindhout traveled to Somalia as a freelance journalist to research a story on the millions of people affected by two decades of war, drought, and famine. She was kidnapped, along with an Australian Journalist, her driver, and her translator, by teenage Islamist insurgents and spent 460 days enduring unimaginable hardships as a hostage.

Following her release, in November 2009, she became an unlikely and passionate advocate for the people of Somalia. Four months after returning home, Amanda founded the Global Enrichment Foundation (GEF), to ignite leadership in Somalia through education and economic initiatives, and has since raised millions of dollars to support development and aid in the war-torn country. She captured international headlines when she returned to Somalia, in 2011, to lead famine relief efforts.

Amanda has been a guest on on many media shows and featured in a range of publications. Her memoir, *A House in the Sky*, is a New York Times bestseller that is in development as a major motion picture.

Closing Keynote: Master Corporal Paul Franklin

The Long Walk Home: Paul Franklin's Journey from Afghanistan

Canadian Master Corporal Paul Franklin lost both his legs, above the knee, in a 2006 suicide bombing that left one Canadian diplomat dead and two comrades in arms wounded. Thanks to the heroic help of soldiers on the scene and a medical team abroad to keep the promise he had made to his wife to come home alive. He underwent 26 surgeries in the month after his injuries but returned home determined to walk again.

Within four months of his injury, and against the odds and predictions of doctors, Franklin learned to walk on artificial legs. He worked to rebuild his life at home with his wife Audra and their young son, Simon. As a family on a journey to recovery, they were determined to stand, and walk, together. His story is one of loss, courage, love and hope and it inspires all of those - military and civilians alike - who wonder how they will take that next step when tough times challenge the body and the spirit.

Other topics being presented by Canadian & International Experts include:

Patient Safety/Patient Advocacy
How to Create Effective Inter-professional Perioperative Teams
Engaging in Research
Management - Healthcare Delivery & Efficiencies

Operating Room Leadership
Perioperative Nursing Education
Infection Prevention and Control
Operating Room Standards

Experience the latest in technologies/products for the OR on the Exhibit Floor
'Bollywood – East meets West' Dinner • 'Denim & Diamonds' Members Appreciation Event
Register today at www.ORNAC.ca and click on National Conference

Lorne Flower Memorial Award

Prix Commémoratif Lorne Flower

The Lorne Flower Memorial Award was established in 2003 on the initiative of Lorne's son, John Flower. Lorne Flower was a medical industry representative, outstanding citizen, and fervent supporter of ORNAC. The purpose of this award is to recognize a past or present ORNAC Board member for their remarkable contribution to the ORNAC Board and to perioperative nursing in Canada.

The award, in the amount of **$400**, is presented at the ORNAC National Conference. The next nomination deadline is January 15th, 2015.

For details visit www.ORNAC.ca and click on Bursaries, Grants & Awards.

Le Prix commémoratif Lorne Flower fut créé en 2003 par John Flower, le fils de Lorne. Lorne Flower était représentant de l'industrie médicale, citoyen de premier ordre et appuyait vivement l'AIISOC. L'objectif de ce prix est de reconnaître la contribution extraordinaire d'un membre actuel ou ancien du conseil administratif de l'AIISOC relative au conseil et aux soins périopératoires au Canada.

Le prix de **400 $** est décerné lors de la Conférence nationale de l'AIISOC. La date limite de nomination est le 15 janvier 2015.

Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca et cliquer sur Bursaries, Grants & Awards (en anglais seulement).

The **RMAC Patient Safety Award** recognizes nursing leaders who are innovative in the area of patient safety – leaders who have developed and/or described relevant and practical patient safety strategies.

This award will be presented to a perioperative registered nurse who makes an outstanding presentation, dedicated to safety concerns, in one of several formats. Issues addressed can include system innovations, education, communication, advocacy, or research focusing on safety-related outcomes.

The award of $1,000 will be presented at each ORNAC National Conference. For more information visit www.ORNAC.ca and click on Bursaries, Grants & Awards.

Le **Prix de sécurité des patients RMAC** reconnaît les leaders en soins infirmiers faisant preuve d'innovation dans le domaine de la sécurité des patients, c'est-à-dire des personnes ayant développé ou décrit des stratégies de sécurité des patients pertinentes et pratiques.

Ce prix sera décerné à un(e) infirmier(ère) autorisé(e) périopératoire ayant présenté un discours exceptionnel au sujet de la problématique de la sécurité des patients dans un des formats suivants. Les sujets traités peuvent inclure les innovations touchant aux systèmes, à la formation, à la communication, à la revendication ou à la recherche dans le domaine de la sécurité des patients.

Le prix de 1 000 $ sera présenté lors de chaque conférence nationale de l'AIISOC. Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca, cliquez sur Bursaries, Grants & Awards.

Muriel Shewchuk Leadership Award

The **Muriel Shewchuk Leadership Award** is presented by ORNAC to a perioperative registered nurse whose leadership has made an outstanding contribution to the profession of perioperative nursing at the local, provincial/territorial, national or international level. The recipient of the Award shall receive $2500, a certificate, and an Award pin.
Nomination deadline is January 15th 2015.
For more information visit www.ORNAC.ca and click on Bursaries, Grants & Award.

Prix de leadership Muriel Shewchuk

Le **Prix de leadership Muriel Shewchuk** est remis par l'AIISOC à un infirmier ou une infirmière autorisé(e) en soins périopératoires qui, par ses qualités de leader, a contribué de façon exceptionnelle à la pratique des soins périopératoires au plan local, provincial, national ou international. Le ou la récipiendaire du prix se verra remettre un montant de 2 500 $, un certificat ainsi qu'une épinglette de récompense.
La date limite pour soumettre les formulaires de mise en candidature est le 15 janvier 2015.

Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca et cliquer sur le lien Bursaries, Grants, & Awards
(*disponible en anglais seulement*)

Isabelle Adams Award for Excellence in Perioperative Nursing

More details can be found at www.ORNAC.ca. Nomination deadline is January 15th 2015.

This award is presented at the National Conference, if there is a suitable candidate, to an outstanding nurse who through major commitment has made a significant contribution to perioperative nursing in Canada. The Award winner will reflect the practice and ideals of Mrs. Isabelle Adams of Montreal. The Award was established on the initiative of the Operating Room nurses of Quebec in 1987 and is one of a high-profile recognition with no monetary award.

Le Prix d'excellence en soins périopératoires Isabelle Adams

Veuillez visiter le site Web de l'AIISOC www.AIISOC.ca pour plus de détails (disponible en anglais seulement). La date limite des soumissions est le 15 Janvier 2015.

Ce prix est décerné lors de la Conférence nationale de l'AIISOC à un candidat qualifié qui s'est distingué par son engagement et par sa contribution significative au domaine des soins périopératoires au Canada. Le récipiendaire sera une infirmière ou infirmier de salle d'opération dont la pratique professionnelle suit les principes de Mme Adams de Montréal. Ce prix hautement reconnu, mais ne comportant aucune récompense monétaire, fut créé en 1987 par l'Association des infirmières de salle d'opération du Québec.

3M Canadian Infection Prevention Champion Award

The **3M Canadian Infection Prevention Champion Award** was established in collaboration with ORNAC to acknowledge perioperative nurses dedicated to improving the lives of surgical patients through infection prevention and control. The award is presented at each ORNAC National Conference to a nurse who is recognized by peers as having made significant contributions that improve the lives of surgical patients through awareness of and reduction/prevention of infection. The recipient of the award shall receive a certificate, an Award pin and a cheque from 3M for **$2,000**.

For more information visit www.ORNAC.ca. Nomination deadline is January 15, 2015.

Prix-étoile 3M pour la prévention de l'infection au Canada

Le **Prix-étoile 3M pour la prévention de l'infection au Canada** a été créé en collaboration avec l'AIISOC afin de reconnaître les infirmiers et les infirmières en soins périopératoires se vouant à améliorer la vie des patients opérés par le biais de la prévention et du contrôle des infections. Ce prix est remis lors de la conférence nationale de l'AIISOC à un infirmier ou une infirmière qui a été reconnu(e) par ses pairs comme ayant contribué de façon significative à améliorer la vie des patients opérés en faisant de la sensibilisation et en s'efforçant de réduire/prévenir les infections. Le ou la récipiendaire du prix recevra un certificat, une épinglette de récompense ainsi qu'un chèque de **2 000 $** de la part de 3M.

Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca (disponible en anglais seulement). La date limite pour soumettre les mises en candidature est le 15 janvier 2015.

Gloria Stephens Award

The Gloria Stephens Award for Excellence as an Educator of Perioperative Nursing was established at the suggestion of Ms. Gloria Stephens. The $1,000 award, donated by Ms. Stephens, will be presented during National Conference years. It celebrates a nurse recognized by his/her students, peers, and managers as an outstanding educator and role model in the field of perioperative nursing.
Nomination deadline is January 15th 2015.

For more information visit www.ORNAC.ca and click on Bursaries, Grants & Award.

Prix d'excellence Gloria Stephens

Le Prix d'excellence Gloria Stephens à titre d'éducateur(trice) en soins périopératoires a été créé à la suggestion de Madame Gloria Stephens. Le prix d'un montant de 1 000 $, généreusement versé par Madame Stephens, sera remis lors de la conférence nationale annuelle. Il vise à reconnaître un infirmier ou une infirmière qui a été identifié(e) par ses étudiants, collègues et superviseurs comme une(e) éducateur(trice) exceptionnel(le) et modèle de rôle dans le domaine des soins périopératoires.
La date limite pour soumettre les mises en candidature est le 15 janvier 2015.

Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca et cliquer sur le lien Bursaries, Grants, & Awards. *(disponible en anglais seulement)*

DÉVELOPPER UNE CULTURE DE COLLABORATION EN SALLE D'OPÉRATION :

MIEUX QUE LA COMMUNICATION EFFICACE

Auteure : *Patricia Wade, IA, M.S.Inf., CSP(C) est infirmière en soins périopératoires depuis 15 ans. Elle a commencé en tant qu'infirmière de soins généraux et, plus tard, est devenue adjointe à l'infirmière-chef en neurochirurgie et ophtalmologie pédiatriques. Récipiendaire du Prix de rédaction Drake-Thompson de l'AIISOC et Johnson & Johnson Medical Products de 2013 et du Prix RMAC pour la sécurité des patients 2013, elle se passionne pour la sécurité des patients et la collaboration interprofessionnelle. Elle a été infirmière-éducatrice dans un bloc opératoire pédiatrique d'un hôpital universitaire à Montréal jusqu'en juin 2013. L'opportunité de participer au sein de comités provinciaux et nationaux sur la sécurité des patients et la collaboration interprofessionnelle l'a amenée à devenir consultante pour le développement professionnel continu (DPC) au sein de la Fédération des médecins spécialistes du Québec. Elle est membre de la Corporation des infirmières et infirmiers de salle d'opération du Québec (CIISOQ).*

RÉSUMÉ :

Le but de cette revue de la littérature était d'examiner l'état actuel des connaissances sur les pratiques collaboratives fructueuses en salle d'opération. À l'aide des déterminants de pratiques collaboratives fructueuses, développés par San-Martin-Rodriguez, Beaulieu, D'Amour et Ferrada-Videla,[1] la littérature actuelle traitant de la collaboration en salle d'opération a été examinée afin d'identifier les lacunes en matière de connaissances ainsi que les avenues futures pour la recherche. La revue a mis l'accent sur le fait que les modèles de communication parmi les membres des équipes en salle d'opération étaient l'aspect du travail d'équipe ayant le plus fait l'objet de recherches. D'autres aspects, comme la volonté de s'engager dans la pratique collaborative, la confiance, le respect, les facteurs sociétaux et culturels, étaient absents de la littérature. La recherche future devra être axée sur ces lacunes en matière de connaissances afin d'optimiser nos ressources limitées en recherche et d'améliorer la sécurité des patients.

REFERENCES

1. San-Martin-Rodriguez L., M. Beaulieu, D. D'Amour et M. Ferrada-Videla, The determinants of successful collaboration: A review of theoretical and empirical studies, J Interprof Care, 2005; supplément 1, pp. 132 à 147.

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 (11e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AIISOC) d'avril 2013, section 4, p. 225 à 228; normes 4.1.1 à 4.1.31.

KEYWORDS: INTERPROFESSIONAL EDUCATION, COLLABORATIVE PRACTICE, OPERATING ROOM TEAMWORK

DEVELOPING A CULTURE OF COLLABORATION IN THE OPERATING ROOM:

MORE THAN EFFECTIVE COMMUNICATION

Author: *Patricia Wade, RN, MN, CPN(C) has been a perioperative nurse for 15 years. She began as a staff nurse and later became an assistant head nurse in paediatric neurosurgery and ophthalmology. Recipient of the 2013 ORNAC/Johnson & Johnson Medical Products Drake-Thompson Writing Award and of the 2013 RMAC Patient Safety Award she is passionate about patient safety and interprofessional collaboration. She was the nurse educator in a paediatric surgical suite at a university hospital in Montreal until June 2013. The opportunity to participate in provincial and national committees on patient safety and interprofessional collaboration has led her to become a consultant for Continuous Professional Development (CPD) with the Fédération des médecins spécialistes du Québec. She is a member of the Corporation of Operating Room Nurses of Quebec (CORNQ).*

The purpose of this article is to explore the determinants of successful collaboration among healthcare teams, review the current literature on collaboration in the operating room, and make recommendations for future research in order to improve patient safety in the surgical environment.

ABSTRACT:

The purpose of this literature review was to examine the current state of knowledge on successful collaborative practice in the operating room. Using the determinants of successful collaborative practice, developed by San-Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla,[6] the current literature on collaboration in the operating room was reviewed in order to identify the gaps in knowledge and identify future research avenues. The review highlighted that communication patterns among operating room team members was the most extensively researched aspect of teamwork. Other aspects, such as the willingness to engage in collaborative practice, trust, respect, societal factors, and cultural factors, were absent from the literature. Future research will need to focus on these gaps in knowledge in order to maximize our limited research resources and improve patient safety.

INTRODUCTION:

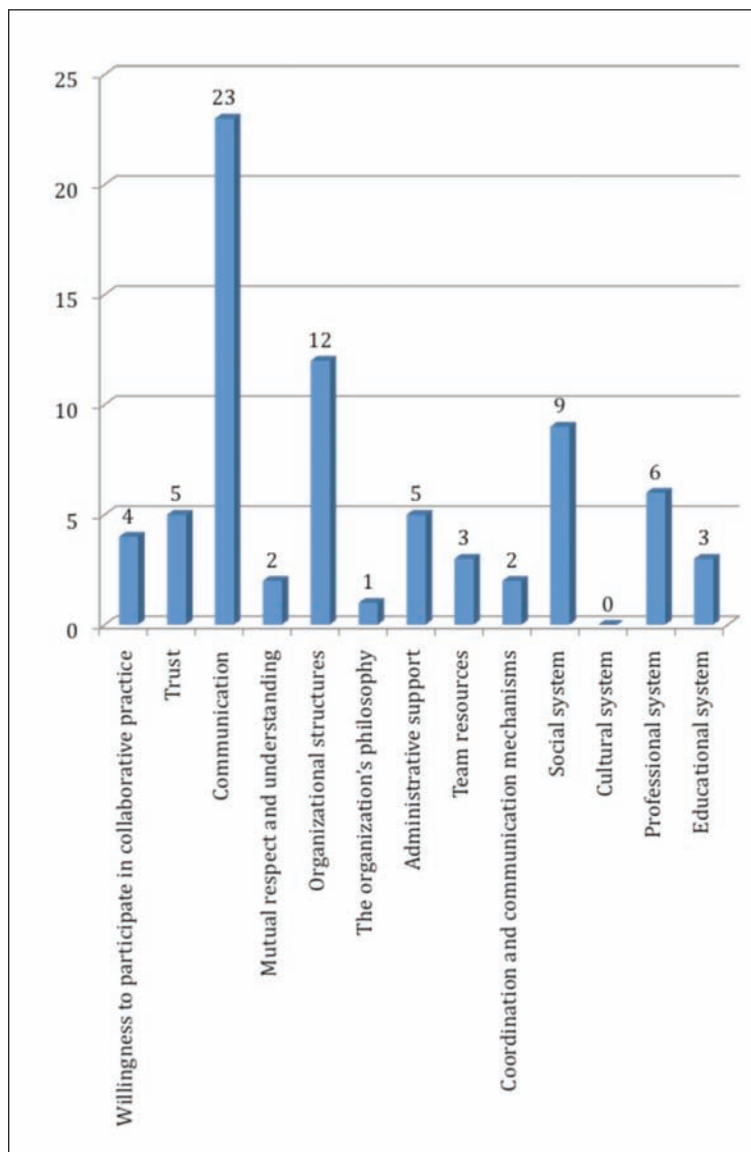
Patients entering the operating room expect positive surgical outcomes and to return to their families and activities. We strive, as professionals, to provide the highest quality and the safest of care. From 1995 to 2005, however, the American Joint Commission sentinel event statistics database ranked wrong site surgery as the second most frequently reported event with 455 of the 3548 reported sentinel events (12.8%).[1]

The need to prevent negative patient outcomes, such as infections, and to decrease medical errors, such as wrong site surgeries, has led to an increased awareness about the importance of collaborative practice among surgical team members. Organizations such as the World Health Organization (WHO) and the Canadian Interprofessional Health Collaborative (CIHC) have, over the past decade, developed frameworks to guide and promote collaborative practice and interprofessional education in the health care setting.[2,3] In North America nursing professional associations, such as the Association of perioOperative Registered Nurses (AORN) and the Operating Room Nurses Association of Canada (ORNAC), have developed position statements and made collaborative practice part of their missions.[4,5]

As collaborative practice becomes an organizational and professional priority, the concept raises many questions. What is it? What determines the success of collaborative practice among healthcare professionals? How is it being understood and developed in the operating room? Resources are being invested in to research in order to attempt to answer these questions. But what have we learned? What are the knowledge gaps? Where can we focus future research efforts and resources so that we can maximize our limited resources and improve the safety of our patients.

The purpose of this article is to explore the determinants of successful collaboration among healthcare teams, review the current literature on collaboration in the operating room, and make recommendations for future research in order to improve patient safety in the surgical environment. The determinants of a successful collaborative practice, developed by San-Martin-Rodriguez, Beaulieu, D'amour, & Ferrada-Videla,[6] will be used as the framework for this paper. A review of the current literature, discussing these determinants in the operating room, will be presented in order to identify the current knowledge gaps in effective operating room team collaboration and to guide future perioperative nursing research.

Figure 1
Number of articles addressing the specific determinants



Patient safety and collaborative practice: Definition of terms

The concept of patient safety and collaborative practice are often discussed when organizations or professional associations want to improve the quality of a healthcare system. It is important, in order to understand these concepts, to examine the current definitions as presented in the literature.

The Canadian Patient Safety Institute (CPSI) defines patient safety as "the reduction and mitigation of unsafe acts with the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes".[7] Although, CPSI does not provide a definition of what constitutes optimal patient outcomes they do define harm as "an outcome that negatively affects the patient's health and/or quality of life".[7]

International healthcare stakeholders are also participating in patient safety initiatives. The World Health Organization (WHO), in an effort to standardize the definition of the concept, defines patient safety as "the reduction of the risk of unnecessary harm, associated with healthcare, to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment".[7] For the purpose of this paper, patient safety will be defined as per the CPSI definition[7] as it best reflects Canada's access to technology and other healthcare resources in comparison to underdeveloped countries.

The Canadian Interprofessional Health Collaborative (CIHC) defines collaborative practice as something that occurs when "healthcare providers work with people from within their own profession, with people outside of their profession, and with patients/clients and their families"[3] (p.1). This definition,

although adequate, is too vague to apply to the complex interprofessional relationships that exist among surgical team members. The WHO defined collaborative practice as "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings".[2] This definition was obtained from an extensive review of the literature[2] and is appropriate for the purpose of this paper as it relates to health care professions. Collaborative practice, in the operating room, is also referred to as teamwork and so this synonym will also be used in this literature review.

The operating room is a highly technological, technical, and dynamic environment that is in a constant state of evolution. Despite continuing efforts by health organizations and the advances in research surgical site infections remain, in Canada, the most common health care associated complication for surgical patients.[8] Effective and safe patient care requires complex interdisciplinary interactions between surgeons, nurses, anaesthetists, and other allied health professionals.[9] In 2005 and 2010 studies involving perioperative and critical care nurses highlighted the role of poor teamwork and ineffective communication in contributing to patient harm.[10] 2013 evidence indicates, furthermore, that this past decade's efforts and financial investments have not succeeded in systematically improving patient safety and some American hospitals actually demonstrated higher rates of preventable harm.[11] Surgical teams, in order to ensure a reduction of unsafe acts in the operating room, need to develop a culture of patient safety centered on effective collaborative practice.

What determines successful collaboration?

San-Martin-Rodriguez et al.[6] conducted a literature review of the elements that affected successful collaboration among health care teams. Using keywords, such as "collaboration", "interprofessional team", "interdisciplinary team", "determinants", and 'factors", they searched the Medline, CINAHL and Sociological Abstracts Database for the period 1980-2003. They included only empirical studies and excluded anecdotal articles and editorials.[6] Only ten articles, meeting the inclusion criteria were identified which demonstrates the lack of empirical studies at the time. In the analysis three determinants of successful collaborative practice were identified (interactional, organizational, and systemic factors) which were then subdivided into thirteen sub-elements (see Figure 1).[6] Systematic reviews of empirical studies are considered to be the highest form of evidence[12] and thus support the use of this review, by this author, despite the limited amount of literature available.

All the factors and sub-elements developed by San-Martin-Rodriguez[6] must be examined when organizations and healthcare professionals attempt to foster collaborative practice.[6] This is particularly important in complex

If it's too good to be true... There must be a reason why!

This short sentence properly summarizes a reality we are regularly faced with. Instruments available at ridiculously low prices, repair services without workshops or specialists, stainless steel of uncertain quality, questionable manufacturing quality, unreputed businesses without experience, cheap products...

Do you really feel like taking such risks? Can you afford it?

There's a price to be paid for quality, and often "inexpensive" means that costs will be higher on the long-term.

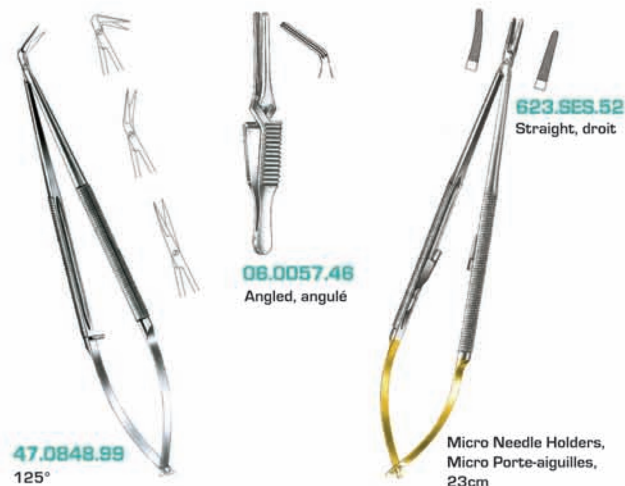
Si c'est trop beau pour être vrai... c'est vrai

Cette courte phrase résume bien une réalité à laquelle nous sommes régulièrement confrontés. Des instruments à des prix ridiculement bas, un service de réparation qui n'a pas d'atelier, ni de spécialiste, de l'acier inoxydable de qualité incertaine, une qualité de fabrication douteuse, une entreprise sans histoire et d'une réputation inconnue, des produits pas chers....

Croyez-vous vraiment avoir le goût et les moyens de prendre de tels risques?

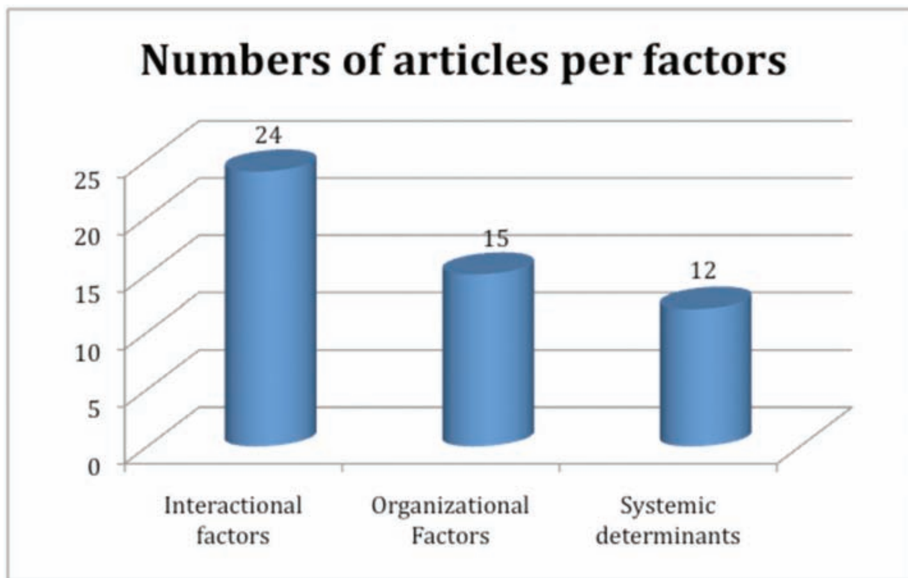
La qualité a un prix et souvent « pas cher » signifie des coûts importants à plus long terme.

Contact us for all your **THORACIC VASCULAR** needs
*Contactez-nous pour tous vos besoins **VASCULAIRES THORACIQUES***



1273, St-Louis, Terrebonne, QC,
J6W 1K6, Canada
T : 450.471.1379 • 1.800.361.1502
F : 450.471.1030
instrumentarium-online.com
info@instrumentarium-online.com

Figure 2



environments such as critical care areas and the operating room where multisource approaches must be developed in order to change behaviours.[13]

Collaborative practice & teamwork in the OR

Although much is being written about collaborative practice[2,3,4,5,7] the author of this paper set out to retrieve and analyze the literature available for the perioperative setting that specifically addressed the determinants discussed by San-Martin-Rodriguez et al.[6] The review of the literature was conducted using a multisource database search (Ovid, PubMed, CINAHL and Google Scholar) with the keywords "collaborative practice and operating room", "teamwork and surgical environment", and different combination of these terms. Search terms were later expanded to include the specific determinants of "collaborative practice" and the "operating room/surgical environment". Relevant articles, dating from the 2000-2013 period, were first examined by reviewing their titles, abstracts, and key words. Articles' relevancy was established using the specific determinants of collaborative practice and with the criteria that they address, specifically, operating room or surgical teams. If the article specifically mentioned one or more of the determinants then the full text article was retrieved and reviewed. The key findings, relevant to the purpose of this paper, were then extracted and summarized. Research articles, including limited randomized control studies, were reviewed first but, due to the lack of such studies, the inclusion criteria were broaden to include other types of evidence such as observational or comparative studies and review articles.[14] Books, letters to editors, opinions, editorials and literature addressing patient safety, but not the specific determinants, were excluded.

The screening process yielded 22 articles that were divided into the three factor groups (interactional, systemic, and organizational) and then categorized according to the specific elements they addressed. Some articles addressed more than one factor or element.(See Figure 2) Each element or factor was addressed separately in the body of the review. The next section of this paper will present the summary of the author's findings. A discussion of the main findings, and recommendations for future practice, will follow.

DETERMINANTS OF SUCCESSFUL COLLABORATIVE PRACTICE IN THE OR

INTERACTIONAL FACTORS

The first determinant addressed by San-Martin-Rodriguez et al.6 was the Interactional factors. They are the positive and constructive interpersonal relationships upon which successful collaborative practice is dependent.[6] These are the human factors that must be developed and fostered in order to promote effective collaborative practice and improve patient outcomes.[6] These interactional factors were sub-divided into the following four elements: the willingness to participate in collaborative practice; trust; communication; and mutual respect and understanding.

Willingness to participate in collaborative practice

How many more reasons do you need to switch to Mega Soft®?

55,000,000

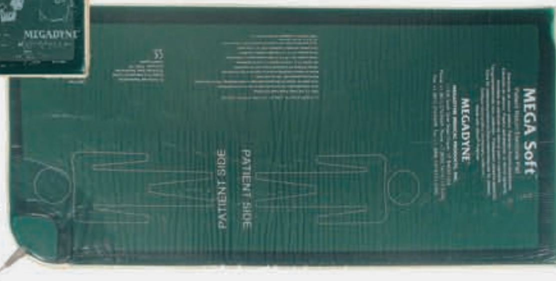
Procedures Using Mega Soft®

zero

Pad-Site Burns

MEGA SOFT® PATIENT RETURN ELECTRODE

* Mega Soft® Pediatric Patient Return Electrode



* Mega Soft® Patient Return Electrode

MEGA SOFT® IS PROVEN SAFER THAN "STICKY PAD" ELECTRODES

Patient safety is your top priority and Mega Soft® has been proven safer for patients than REM® "sticky pads". If you are still using sticky pads, switching to Mega Soft can help make your O.R. a safe zone.

AMT:ELECTROSURGERY
INTEGRATING SAFETY AND PERFORMANCE

TO LEARN MORE CALL: 1-888-803-6799

> Trust, in the context of the operating room, is built by working with the same people over an extended period of time and developing a feeling of belonging to a competent team.[21]

Collaborative practice, though shown to be beneficial, remains a voluntary process where each professional may choose whether, or not, to participate.6 Although positive attitudes about teamwork have been associated with improved patient outcomes and greater job satisfaction, nurses and surgeons' individual perceptions of teamwork vary greatly.[15]

The literature does not explore which aspect of teamwork, in the context of the operating room, needs to be improved.[16] Discussion regarding the willingness of professionals to work as a team is no exception to this knowledge gap. The willingness to share information and learn new things, both in the academic and practical settings, is, however, discussed as a possible facilitator to teamwork.[17,18]

Trust

It requires time, effort, patience, and positive past experiences to build trust in a team. Trust is required, in the context of team work, not only in relation to others' competency but also of one's own abilities.[6] Self-efficacy beliefs (the belief in one's ability to succeed) can increase a nurse's ability to cope with a dynamic and stressful environment and potentially lead to increased team commitment and improved collaborative practice.[19,20]

Trust, in the context of the operating room, is built by working with the same people over an extended period of time and developing a feeling of belonging to a competent team.[21] This is consistent with the findings of the literature reviewed by San Martin-Rodriguez et al.[6] Novices from many health professions come to observe, and learn, in the surgical theater and the clinical supervision of these learners is a professional responsibility.[22] This implies a certain level of trust among team members that remains unexplored by the literature. Time and resources can be a source of tension in nurse-surgeon communication and an interpersonal relationship that includes trust could possibly reduce this tension.[23]

Communication

Effective and respectful communication is an important aspect of collaborative practice[2,18] Qualitative and quantitative studies have been conducted on nurse/surgeon communication[18,23,24], organizational and individual factors that affect communication during surgery[9,25], and on the most current types of communication failures and their effects on patient safety and the socialization of novices.[22,26] Other studies have also demonstrated that the operating room team's perception of "good or positive" and "bad or negative" communication patterns was very subjective. Nurses most often perceived communication patterns as negative while the surgeons perceived the same communication patterns as more positive.[16,18,24,28] These studies have reported that nurse/surgeon communication patterns were affected by multiple complex factors. Hierarchical power structures, professional socialization, gender, stereotyping, and different professional priorities of patient care are all barriers that inhibit communication.[22,23,29,30] Others have also studied the effects of tense communication on the clinical education of novices and the role it plays in the development of professional identities.[31]

The most recent studies on communication focus on the relationship between effective communication and patient safety in the operating room.[21,32,33,34] The implementation of a surgical safety checklist is proving beneficial by creating a culture of patient safety through improving communication and collaboration among operating room team members.[35,36]

Mutual Respect and Understanding

Respect is a part of all positive human exchanges. In collaborative practice it is essential for all team members to recognize others' competencies as well as their contribution to patient care in order to create a respectful working

Equipment Drapes.
Ecolab Covers Every Need.

With one of the broadest product portfolios in the industry, the Microtek® brand has long been a leading name in draping across multiple categories such as Surgical Microscope, C-Arm, Endoscopic Video Camera, Microscope Laser Arm, Ultrasound and other accessories. Supported by dedicated sales and customer service teams, including on-site assistance, Microtek® Brand Equipment Drapes help reduce risk of infectious disease transmission and contribute to improved clinical outcomes.

Microtek brand innovative surgical equipment draping is trusted worldwide. Ecolab has you covered.

For more information: 800 824 3027
www.microtekmed.com
www.ecolab.com/healthcare

ECOLAB®
Everywhere It Matters.™

CULTURE OF COLLABORATION (cont.)

environment.[4] A lack of such recognition is a real barrier to collaborative practice.[6] This degree of mutual respect is inherent to effective teamwork.[9] The operating room environment is, however, highly dynamic and professionals must adapt quickly to new technologies. In a meta-analysis, of sixteen qualitative and quantitative researches, it was found that mutual respect, coaching, and the ability to speak up played an important role in the successful implementation of new technology in cardiac surgery.[37] The use of rapidly changing, highly technological, surgical equipment can be challenging for team members. A lack of respect can be evident during the stressful times involved in introducing new equipment. The relationship between the work climate, during periods of change, and patient safety issues has not yet been fully explored in research.

ORGANIZATIONAL FACTORS

The second determinant presented by San-Martin-Rodriguez et al.[6] is organizational factors. They include the structure, philosophy, and administrative support of the organization as important factors that can support or undermine collaborative practice.[6] Healthcare organizations must promote collaborative practice by developing supportive structures that will create a positive cultural environment for professionals.[6]

Organizational Structures

To promote shared decision-making for patient care the organization must promote a shift from a hierarchical structure to a more horizontal power structure.[6] In the operating room, hierarchy has been studied at the

cont. on page 32

UPCOMING EVENTS / PROCHAINS ÉVÉNEMENTS

For details visit www.ornac.ca

Perioperative Nurses Week is November 9-13, 2015

ORNAC CONFERENCES www.ORNAC.ca

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

INTERNATIONAL CONFERENCES

AORN (www.aorn.org)	Denver, Colorado	Mar 7 - 11, 2015
EORNA (www.eorna.eu)	Rome, Italy	May 8 - 10, 2015

RELATED PROFESSIONS

CAS (www.cas.ca)	Ottawa, Ontario	June 19 - 22, 2015
IPAC (www.ipac-canada.org)	Victoria,BC	June 14 - 17, 2015
NAPANc (www.napanc.org)	Moncton, NB	June 12 - 14, 2015
CNSA (www.cnsa.ca)	Regina, SK	Jan 28 - 31, 2015

Peer-reviewed feature articles appearing in this publication have undergone a double blind peer review process. The views or opinions expressed in the editorial or articles are those of the authors and do not necessarily represent the policies or views of the Operating Room Nurses Association of Canada (ORNAC). Although reasonable efforts are made to ensure accuracy ORNAC, and its agents, take no responsibility whatsoever for errors, omissions or any consequences of reliance on material or the accuracy of information.

Publication does not constitute ORNAC endorsement of, or assumption of liability for, any claims made in advertisements.

This publication is copyright in its entirety. Material may not be reprinted without the written permission of ORNAC. Contact through www.ORNAC.ca.

Les articles de chroniques évalués par un comité de lecture qui apparaissent dans cette publication ont été soumis à un processus d'évaluation par les pairs en double aveugle. Les points de vue ou les opinions exprimés dans l'article de tête ou les autres articles sont ceux des auteurs et ne représentent pas nécessairement les politiques ou les points de vue de l'Association des infirmières et infirmiers de salles d'opération du Canada (AIISOC). Bien que tous les efforts aient été mis en œuvre pour assurer l'exactitude des articles, l'AIISOC et ses représentants ne sont en aucun cas responsables des erreurs, des omissions ou de toutes conséquences pouvant découler de l'utilisation du matériel ou de la justesse de l'information. En cas de doute quant à la traduction des articles, la version originale anglaise prévaudra.

La publication des annonces publicitaires ne signifie en aucun cas que l'AIISOC n'approuve ou n'assume la responsabilité de toute revendication faite par ces dernières.

L'intégralité de cette publication est protégée par la loi sur le droit d'auteur. Les documents ne peuvent être réimprimés sans l'autorisation écrite de l'AIISOC. Communiquez avec www.AIISOC.ca.

Discover the perfect place to call home.

The Interior

Vancouver Island

The North

Enrich your career. Enhance your quality of life.

Join the many operating room nurses who have moved to British Columbia (BC), Canada to enjoy a quality of life that is envied around the world. Find out how our nurse services team can assist you in matching your lifestyle interests with exciting career opportunities. **Visit our website to view current opportunities.**

REGISTER TODAY!
healthmatchbc.org

PHYSICIANS | NURSES | ALLIED HEALTH

healthmatchbc.org

FIND A JOB IN BC

Health Match BC is a free health professional recruitment service funded by the Government of British Columbia, Canada

TOLL-FREE: 1.877.867.3061 • TEL: 1.604.736.5920 • EMAIL: welcome@healthmatchbc.org

Photo Credit: Picture BC

Registered Nurses – Operating Room
Vancouver General Hospital (VGH)

Exciting • Complex • Challenging

VGH is a tertiary level organization and the provincial trauma, neurosciences, spinal cord injury and cancer treatment referral centre for the province of B.C. Our perioperative services include trauma, lung, liver and kidney transplants as well cardiac surgery, thoracic, vascular, neurosurgery, spinal cord, orthopedic, plastics, urology, gynecology, ENT, ophthalmology and general surgery. Two of our 20 ORs are dedicated to robotics.

We have full time positions available for **Registered Nurses**.

We are looking for RNs with two (2) years' recent, related experience in an acute care operating room environment who have completed an accredited Perioperative Nursing Specialty Certificate Program that are ready to take the step to the ultimate level. These positions offer you the opportunity to work alongside experts in their fields both nationally and internationally.

Make the move to Vancouver and be part of one of the most innovative, fast paced and challenging Operating Room environments in the country at VGH, a part of Vancouver Coastal Health.

Apply today by visiting:

jobs.vch.ca

Phone: 604.675.2500
Toll Free: 1.800.565.1727

Come for the **job.**
Stay for the **team.**

JOB OPPORTUNITIES
Operating Room Nurses

Alberta Health Services provides the highest quality patient care by placing the needs of our patients, families and communities first. At AHS, you'll discover a culture of care based on collaboration and values. Working at AHS enables a better quality of life, not only for our staff, but for their families. AHS values the diversity of the people and communities we serve and is committed to attracting, engaging and developing a diverse and inclusive workforce.

We are looking for Operating Room Nurses to join our growing workforce. AHS offers competitive wages, great benefits, and flexible hours so that you can live a superbly balanced lifestyle.

New grads – nursing in rural communities could qualify you for up to $20,000 in Canada Student Loan Forgiveness.

- excellent wages and benefits
- opportunities for growth
- work/life balance
- make a meaningful difference

what's your reason?

www.albertahealthservices.ca/careers

For more information email careers@albertahealthservices.ca or search and apply for positions on our website

SPOTLIGHT ON ORNAC MEMBERS

AN INTERVIEW WITH BARB SAWATSKY, RN

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

Barb Sawastsky is a Perioperative Registered Nurse who has worked in the operating room setting since 1990. She is originally from St. Catharines but began her career at the Toronto General Hospital in Toronto, ON. In 1992 she returned to St. Catharines to work at the St. Catharines General Hospital which has since become part of the Niagara Health System (NHS). Over the years she has worked in the OR, in Recovery, and in the ICU. In the OR she has worked as a staff nurse, charge nurse, and in 2008 she became the Regional Educator for the NHS. She was involved in the planning of the OR, for a new hospital site, from 2006 to 2013. Barb is a member of ORNAC and the Perioperative Nurse Educators of Canada (PNEC). She is married with 2 children and enjoys spending time at her cottage on the French River.

Barb Sawastsky, RN

Can you tell us a bit about the role that you play in the NHS?

The Niagara Health System has six sites and three of them have perioperative services - Niagara Falls, Welland, and St. Catharines. Since 2008 myself and another educator have shared the education responsibilities for these three sites. I cover St. Catharines and the other educator covers Niagara and Welland. We are regional educators with 80 percent program responsibilities and 20 percent corporate responsibilities. Our program covers operating room, PARR post anaesthetic recovery room, and day surgery.

In addition to my regular role I had the pleasure of being actively involved in the planning of the OR at our brand new facility. My role in the planning also crossed-over in to other departments as needed.

What was your involvement in the design of an operating room?

I had the opportunity during this project's planning to work with a great perioperative team (the perioperative director, perioperative manager, nurses from the three departments, and a physician). The planning stages for this state-of-the-art hospital involved many steps.

Functional plan: In the beginning we put together a plan that was submitted to the government for approval. This is the "bible" upon which all future decisions will be based. The functional plan needs to have all the details in writing and is used as a basis for design.

Courtesy Niagara Health System

SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH BARB SAWATSKY, RN

Courtesy Niagara Health System

Design and build: This was a fun stage but involved lots of late night meetings. We worked with the builder and architect to look at all the flows (patient, work, supplies, waste, codes) and with the equipment planner (who organizes the equipment for each room). These design meetings also involved representatives from the building trades such as electrical and plumbing.

Equipment procurement: This stage was quite a learning experience. We learned all about RFPs (Request for Proposals) and Broader Public Sector (BPS) guidelines. Our first RFP was for the OR integration, lights and articulating arms, and the articulating arms for the ER, ICU, labour & delivery, and endoscopy. We worked with purchasing, finance, the builder, and the end users to write this RFP. It was then posted for vendors to submit supply proposals. All submissions were first reviewed by the project planning team and then by the clinical RFP team. We travelled to different sites to see equipment and talk with users at each site. The scores from the project planning and RFP teams were tallied and then the successful vendor was announced to us by the project planning team. We then began to work to put all the details in place.

Operational readiness: The Manager of the OR had the role of Operational Readiness Manage. This stage of development involved a focus on creating an environment of operational readiness that was conducive to care. Our focus became creating "a million square feet of care." We participated in LEAN events (to reduce waste), there was planning of instrument and supply location and flow, the addressing of human resource issues, the ramp down and ramp up plans for elective surgery and emergency coverage, and the provision of education and support from the vendors.

Move plan: This stage involved the most people. A company was hired to plan and implement the move and our role was to organize what was moving, and to which room, and then label everything. We had emergency case carts at both sites as we had to provide emergency operating service to both sites during the move. It was amazing to watch how well organized this team was.

Staff and physician education: For this stage we used some different methods of educating staff and physicians including:

- Education manuals were developed for general orientation and program orientation.
- General orientation to all staff and physicians with a PowerPoint presentation outlining the features of the new hospital and then tour through the hospital;
- Several Program Orientations were held:
  - Physician program orientations included a PowerPoint describing the new department features, and a tour that showed all of the features and new equipment of the OR, PARR, Day Surgery and MDR; and
  - There were 2 mandatory orientation days for staff at the new site. We did some team building and an amazing race throughout the department and surgical areas. There was a PowerPoint session describing the features of the department and sessions with vendors and new equipment. Staff were also encouraged to come to department tours that were held in the evening.

What are some of the challenges that you faced?

It is important to have all the important details in the Functional plan and

SPOTLIGHT (cont.)

AN INTERVIEW WITH BARB SAWATSKY, RN

Courtesy Niagara Health System

Project Specific Output Specifications (PSOs). This is what is approved by the government and is your design "bible"… if it's not in there it can't happen.

There was a very large time commitment especially during the design phase when many hours were spent in meetings discussing everything from layout to electrical outlets.

It was quite a learning curve – not only were we looking at planning but we also to learn, very quickly, all about RFPs, equipment procurement, and BPS guidelines. The level of detail was quite important as we had to ensure that everything about each specific piece of equipment was included in the RFP.

Any words of advice for anyone taking on the design or redesign of an OR?

Details early in the functional plan are very important. And having a mock up, to help visualize the room layout, is also very important.

What is next in your career?

I would like to have the opportunity to do this again. I found it challenging and stimulating to be involved in this design and would love to find other ways to utilize what I have learned and help others benefit from my experiences.

Any words of wisdom for our readers?

No words of wisdom, old people are wise…. I haven't grown up yet. Well perhaps those are my words of wisdom… remember there is always more wisdom to acquire!

Reliable products and advice

We provide catalogues that are practical, reliable and continually updated, in order to respond to your specific needs. Our catalogues are valuable work tools reflecting the experience, seriousness and know-how of the business. Do not hesitate to ask for them.

When a need arises, you can always count on our qualified and experienced team to guide you efficiently and with integrity, while taking into account your budgetary priorities.

We are there for you, and will take just as much care in responding to every request.

Des produits et des conseils fiables

Nos catalogues sont pratiques, fiables et nous nous faisons un devoir de les tenir constamment à jour afin qu'ils répondent précisément à vos besoins. Ces catalogues sont des instruments de travail précieux et représentent l'expérience, le sérieux et le savoir-faire de l'entreprise. N'hésitez pas à les demander.

Au besoin, vous pouvez toujours compter sur une équipe qualifiée et expérimentée qui pourra vous conseiller avec intégrité et efficacité tout en tenant compte de vos priorités budgétaires.

Nous sommes là pour vous et nous traiterons toujours vos demandes avec le même soin.

Contact us for all your needs in **OPHTHALMIC TRAYS**
Contactez-nous pour vos besoins en ***CABARETS OPHTALMIQUES***

E45.111
1/1 Size - *Format*
275 x 178 x 24mm

E45.112
1/2 Size - *Format*
178 x 140 x 24mm

E45.113
1/3 Size - *Format*
178 x 90 x 24mm

L (mm)	B (mm)	H (mm)	Lid Color / Couleur de couvercle: silver	gold
310	190	40	HE.1250.40	HE.1251.40
310	190	65	HE.1250.65	HE.1251.65

1273, St-Louis, Terrebonne, QC,
J6W 1K6, Canada
T : 450.471.1379 • 1.800.361.1502
F : 450.471.1030
instrumentarium-online.com
info@instrumentarium-online.com

STOP TALKING OVER PATIENTS

By: *Chantal Gagné, RN, BScN, MScN, CPN(C) is the manager of the perioperative services at the North Bay Regional Health Centre in Ontario. She manages the perioperative patient's journey from preadmission, to day surgery, to OR to the Post-anaesthetic care unit thus allowing her and her team to focus on a seamless journey for the patient having surgery. This article was originally written for her hospital's blog.*

sTOP during anesthetic induction
sTOP during anesthetic emergence

Have you been at a grocery store when a cashier is talking about last night's party to another cashier as she is running your order through? It happened to me recently and wasn't sure if I felt left out because I was never invited to the party or because I didn't know what they were talking about.

Have you had the adventure of travelling to a foreign country where the service people are speaking another language to each other in front of you? It has happened to me and I couldn't help but wonder what they were talking about and actually suspected it may be about me.

Have you brought your vehicle in for repairs and heard the service people speaking about the extensive repairs required to another vehicle as you are standing at the counter? It has happened to me and it made me fear what kind of repairs my vehicle would require and ultimately what it would cost me.

Have you ever had your child in for medical testing for which the results could ultimately change your entire family's life and had to endure the exchange of recipes of last night's pot luck super among the health care professionals? It has happened to me and I could only listen enough to decipher my son's name as my heart pounded.

Have you ever had surgery and as you were going to sleep you worried about what news you would hear upon waking up but felt equally worried about the nurses and surgeon's discussion about the missing equipment for surgery?

If you've answered yes to any of the situations above you know how uncomfortable it may feel to have people talking over you. Because our hospital can become like our second home, we tend to become complacent and forget that we are talking over patients and mostly we forget how harmful this may be. Sometimes it has become part of our culture and how we relate to each other. But there is hope if we kindly remind ourselves and each other to STOP (Stop Talking Over Patients) it can become the new normal.

Perhaps we will all remember that:

We are guests into the lives of the patients we care for.

Inspired by Flegel, K. (2008) "Talking over patients: sTOP" CMAJ. 178(10), May 6, 2008, p 1388.

Editorial Review Panel

If you're interested in joining the ORNAC Editorial Review Panel review panel e-mail journal@ornac.ca for more information.

Betty Barrett, RN, BN, CPN(C), Manager Surgical Suite Chinook Regional Hospital, and Content Expert for Curriculum Development of Perioperative Program Lethbridge College, Lethbridge, AB.

Audrey Cook, RN, CPN(C), BN, B.Sc, BA, Staff Nurse, South Shore Regional Hospital, Bridgewater, NS.

Chris Downey RN, CPN(C), MSc, RNFA, CMLSO, Registered Nurse First Assistant, Clinical Practice Leader, Perioperative Services, Clinical Educator-Operating Room, Kingston General Hospital, Kingston, ON

Margaret Farley, RN, CPN(C), Perioperative Clinical Development Educator, Regina Qu'Appelle Health Region, Regina, SK.

Kimberly Ferguson, RN, BSN, CNOR, Surgical Services Program Manager, BC Children's Hospital, Vancouver, BC.

Donna Gramigna, RN, BSN, CPN(C), VIHA Regional Clinical Nurse Educator, Royal Jubilee & Victoria General Hospitals, Victoria, BC.

Trudy Hebb, RN, BSCN, MHI, CPN(C), Perioperative Nursing Program Instructor, Registered Nurses Professional Development Centre, Halifax, NS.

Antoniette Labricciosa, RN, BScN, MEd, CPN(C), Staff Nurse, Mount Sinai Hospital and Trillium Health Centre, and Faculty, at Centennial College, Toronto, ON.

Diana Mabbett, RN, BScN, CPN(C), MDRT, Manager of Inpatient Surgery, Day Surgery, and Pre-Admission Clinic, Queen Elizabeth II Hospital, Grande Prairie, AB.

Alicia Oucharek, RN, BScN, MN, CPN(C), Staff Nurse - OR, St. Paul's Hospital, Saskatoon, SK.

Karin Page-Cutrara, RN, MN, Faculty, School of Nursing, York University, Toronto, ON.

Sarah Pelletier, RN, BScN, CPN(C), RNFA, Quinte Healthcare Corporation (QHC), Belleville, ON.

Joan Porteous, RN, BN, CPN(C), Nursing Educator, Adult OR, Health Sciences Centre, Winnipeg, MB.

Sue Styles, RN, MSN, CPN(C), Perioperative Nursing Instructor, Grande Prairie Regional College, Grande Prairie, AB.

Lesia Yasinski, RN, BN, MSA, Manager of Nursing Initiatives, Winnipeg Regional Health Authority, Winnipeg, MB.

The price of quality

Did you know that there are various levels of quality in stainless steel? In fact, though we believe they are comparable, not all instruments are identical.

Our instruments are manufactured in factories that employ cutting-edge technology and German stainless steel, by qualified workers. We fully support the process, through offering a warranty that is completely respected.

Our instruments are durable, repairable or refurbished — due to their high quality. You can count on them.

So, can you afford to buy cheap instruments?

La qualité a un prix

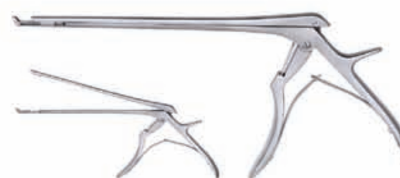
Saviez-vous qu'il existe des niveaux de qualité dans l'acier inoxydable? En fait, tous les instruments ne sont pas identiques même si on les croit comparables.

Nos instruments sont fabriqués dans des usines à la fine pointe de la technologie, par des ouvriers qualifiés et avec de l'acier inoxydable allemand. Nous les endossons entièrement en offrant une garantie que nous respectons en tout point.

Nos instruments sont durables, réparables ou remis à neuf parce qu'ils sont de qualité. Vous pouvez avoir confiance.

Avez-vous les moyens d'acheter des instruments à bas prix?

Contact us for all your **ORTHOPEDIC** needs
*Contactez-nous pour tous vos besoins **ORTHOPÉDIQUES***



HB.1489.03
Dismantable Rongeurs
Pince à disques vertébraux démontable

HB.3595.10
Bone Curette
Curette tranchante

HB.2293
Wire Cutter
Pince à couper le fil

1273, St-Louis, Terrebonne, QC, J6W 1K6, Canada
T : 450.471.1379 • 1.800.361.1502
F : 450.471.1030
instrumentarium-online.com
info@instrumentarium-online.com

The prevention of surgical errors can also be supported, at the organizational level, by providing staff with a more flexible work schedule, ensuring good management of resources and team conflict, promoting competency among professionals, and providing an adequate physical work environment.[27]

interpersonal level[28,29] and at an organizational level.[9,37] Ineffective team communication, throughout the pre-, intra-, and post-operative phases, was found, on the interpersonal level, to be a major contributor to patient injury.[26] Health organizations, in an effort to improve this situation, modeled the aviation industry and developed the surgical checklist.[30] This checklist has allowed for structured and dedicated time for team communication and has been proven to decrease surgical events such as wrong site and side surgery, time and resource issues, and post-operative infections.[30,38,39,40]

Gillespie, Chaboyer, Longbottom, Wallis[9] discussed what they called "the culture of blame" at an organizational level. When negative incidents occur the resulting incident reports and other organizational policy requirements appeared to cause conflicts among team members.[9] This prevents the team from learning together and is an obstacle to the interprofessional communications that is required for team members to learn from the incidents. The authors also noted that the "haphazard implementation of a pre-briefing protocol and finite resources" were an example of the negative effects of the bureaucratic approach on operating room team communication.[9] This demonstrates that lifesaving initiatives, such as the surgical checklist, can actually inhibit collaborative efforts when the organizational support is insufficient. Edmondson also found that organizational leaders who promoted a more horizontal power structure created a work environment that allowed operating room teams to integrate new technology in a safer and more efficient way.[37]

The prevention of surgical errors can also be supported, at the organizational level, by providing staff with a more flexible work schedule, ensuring good management of resources and team conflict, promoting competency among professionals, and providing an adequate physical work environment.[27]

Organization's Philosophy

In order to foster collaborative practice the organization's philosophy must emphasize justice, freedom of speech, and interprofessional collaboration.[6] Surgical team members must feel safe, without fear of negative consequences, to denounce patient-care situations that they perceive to be unsafe.[41] They must also believe that their care institution favours and promotes collaborative practice.[41] Although the role and value of the organizational mission and value statement is widely discussed in the literature only one article was found to discuss the effects of a positive work environment on nurse/surgeon communication[18] and no literature was found that expressly discussed the impact of the organizational philosophy on surgical teamwork.

Administrative Support

Good leadership is essential for the creation of an environment that promotes collaborative practice. Leaders must, in order to support collaborative practice at an organizational level, have a clear organizational vision and the ability to share it with others.[6] Effective organizational leaders can develop a supportive environment, in the operating room, where staff feel comfortable speaking up, asking questions, and constructively managing intra-surgical team conflicts.[37,40] The positive influence of transformational leaders and learning organizations has been documented to increase job satisfaction, patient safety, and effective teamwork.[42,43,44]

Team Resources

Teams must, in order to develop successful collaborative practices, be given time and space to meet and interact.[6] The surgical checklist was developed to provide this dedicated time, in the operating room, for team communication and to standardize the exchanges during shift change.[30] Time to meet and interact must also be provided for the purposes of interprofessional

education. Interprofessional education is discussed, as an option to improve communication and collaboration among surgical team members,[22,45] the literature on the subject is, however, sparse.

Coordination and Communication Mechanisms

According to San-Martin-Rodriguez et al.6 collaborative practice can benefit from:

> "standards, policies, and interprofessional protocols; unified and standardized documentation; and sessions, forums or formal meetings involving all team professionals."[6] (p.140)

The surgical checklist is a standard communication protocol.[26,40] Implementing standardized communication tools and avoiding "case irrelevant communications" can prove beneficial for collaborative practice and patient safety in the operating room.[46]

SYSTEMIC FACTORS

The final determinant presented by San-Martin-Rodriguez et al.[6] is the Systemic Factors that are defined as the systems outside the organization that also influence collaborative practice. Social, cultural, educational, and professional systems will have an impact on a professional's ability to engage in collaborative practice.[6] Below are some examples of how these systems were studied in the context of the operating room.

Social System

The social system relates to the power imbalances created by gender stereotyping and different social status among professionals.

The social system relates to the power imbalances created by gender stereotyping and different social status among professionals. These factors can directly impede collaborative practice[6] The imbalances, and resulting inequalities, between nurses and surgeons have been the source of much research and publication.[15,18,22,24] These inequalities have been found to be the source of interprofessional conflict, ineffective communication patterns, disrespectful and abusive behaviour, and job dissatisfaction that can all lead to adverse patient events.[9,23,24,25,30] Although the literature discusses these events and their consequences no research was found discussing the development of educational interventions or organizational policies in order to mitigate this barrier to effective collaboration.

Cultural system

The cultural beliefs held by individual practitioners may affect collaborative practice.[6] The effects of these cultural beliefs on operating room teamwork have not, based on the literature found in this paper, been studied. In an increasingly multicultural society, such as Canada's, this type of research could help organizations to develop culturally-sensitive educational activities and thus improve collaboration.

Professional system

Over the course of their pre-graduate studies, during their professional socialization phase, health professionals are immersed in their respective professional philosophies and patient-care models. This immersion results in the fragmentation of patient care, the creation of interprofessional conflict, and poor collaboration.[6] In the operating room this socialization pattern is particularly evident in looking at surgeons, nurses, and anaesthetists. Each of these health professions has its own distinct professional identity, defines its role and scope of practice according to the teachings of its own speciality, and generally socializes only among its own group.[18,24,26,40]

Although these factors are discussed in the literature there were no studies available that specifically discussed the factor of professional socialization and its effect on patient safety. Interprofessional educational activities have been discussed as effective

opportunities for different professionals to engage in more efficient communication and thus improve patient safety.[47,48]

Educational system

Interprofessional education is one of the main determinants of successful collaborative practice and the educational system is the principal level for the development and promotion of this concept.[6] The benefits of integrating interprofessional education into health professional curriculum are well documented and supported by Canadian and American collaborative initiatives.[3,49] It is not within the scope of this paper to review this literature. Health discipline students could, however, possibly benefit from an operating room clinical placement. It would support the early development of their communication skills and leadership abilities as well as expanding their professional socialization into a collaborative environment.[22,40,47]

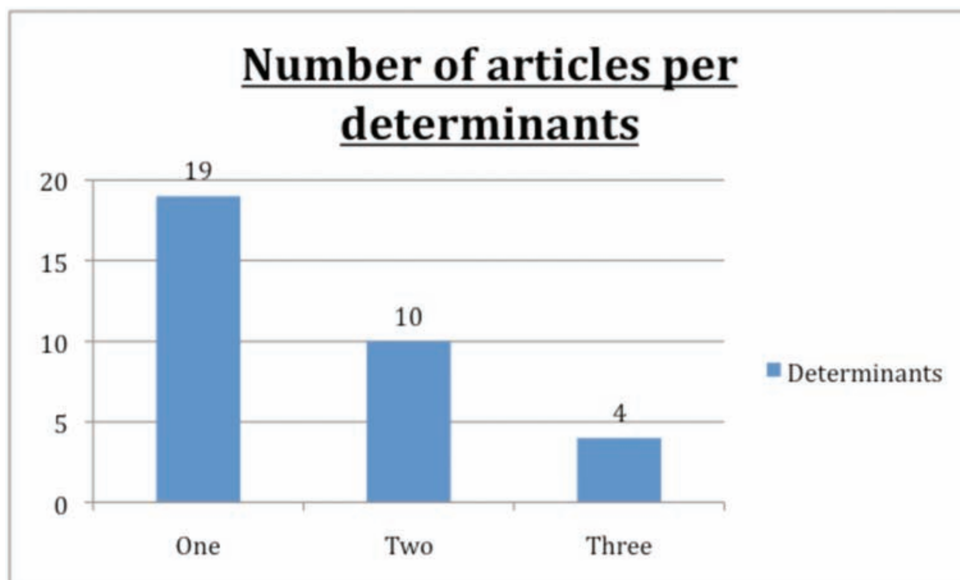
DISCUSSION AND IMPLICATIONS FOR FUTURE RESEARCH

This literature review demonstrates the amount of research and knowledge that has been developed from 2000 to 2013. Although the majority of research has focused on one determinant of collaborative practice[16,17,19,20,21,31-36,38,39,42-45,47,48] some have combined two [15,23-29,37,40] or all three determinants [9,18,22,30] in order to better understand the development and promotion of team work in the operating room setting (see Figure 2) (see Figure 3). Communication is the most researched aspect of collaborative practice and teamwork in the operating room with over 23 referenced articles including several quantitative and qualitative studies.[9,22,24,26,28] The influence of the personal and organizational cultural systems on operating room team cohesion has not been a focus of research.

Interactional factors such as individuals' willingness to participate in collaborative practice and the importance of mutual respect and understanding are important indicators of successful teamwork[6] but there is a need for further research into operating room team members' personal motivation to participate in the process. The lack of study in this area may be related to the difficulty of accurately researching and interpreting such personal motivation.

The majority of communication studies are qualitative designs such as focus groups and observational studies. Dr Lorelei Lingard has performed extensive research in Canada on the communication patterns and the socialization of novices in the surgical setting.[26,30,40,50] She and her team developed an instrument to empirically measure the quality of communication in the operating room.[51] The development, and validation, of a standard measuring tool to assess team communications could prove beneficial to future research. More research is needed to demonstrate empirical relationships between effective team communication, increased positive surgical outcomes, and the development of a culture of patient safety.

Figure 3



Interactional factors such as individuals' willingness to participate in collaborative practice and the importance of mutual respect and understanding are important indicators of successful teamwork[6]

However, as San-Martin-Rodriguez et al.[6] demonstrated, successful collaboration is more than effective communication. Many factors remain unexplored and multiple research avenues are yet to be developed. Research on interactional factors such as the willingness to work together, interprofessional respect, and the factors that promote and develop trust and build stronger relationships among surgical team members, could support the development of a culture of patient safety in the operating room.[16,52] Research is needed to qualitatively and empirically study the effects of trust on team cohesion and patient outcomes. Such studies could support the development of activities to promote both personal and professional responsibilities associated with collaborative practice and its role in patient safety.

Sexton et al. (2006) developed a teamwork climate scale that measures operating room team members' ability to speak up, conflict resolution skills, physician-nurse collaboration, feeling of peer support, safety to ask questions, and heeding of nurses' input by the surgical team.[53] This tool has proven to have a high degree of reliability and validity in measuring these domains among professional groups.[53] This team climate assessment tool could guide future research projects to empirically determine the relationship between a positive work climate and patient safety. Interprofessional educational activities, aimed at developing trust and respect among team members, could possibly improve collaborative practice and teamwork. More research is needed to examine the relationships between interprofessional education, effective collaboration, and patient safety.

Further research on organizational factors, such as the influence of the organizational philosophy including the review and understanding of its mission and value, could prove valuable in healthcare as demonstrated by the literature in business and leadership.54 Developing transformational nursing leaders, both formal and informal, who can speak up and advocate for their patients, could support operating room nurses in promoting and enforcing patient safety. Research into the relationships between leadership nursing education and the development of a culture of patient safety could support the development of leadership educational activities.

Systemic determinants that affect collaborative practice, among operating room team members, have been greatly understudied. Interprofessional education is being increasingly developed in academic curriculums[55] and students must be able to continue developing and using those skills after they enter practice.

Today's healthcare organizations are multicultural environments where practitioners enter the operating room from different social systems and cultural beliefs that have an influence on their social interactions.[56] Developing effective collaboration without being conscious of these differences is nearly impossible. Effective collaborative practice in the operating room, and on other healthcare teams, starts with education. The development of technical skills is an important aspect of healthcare training but more emphasis on interprofessional education and effective collaborative practice could change the current culture of working in 'silos' and could promote patient safety and improve patient outcomes.[2] This author believes that organizations must address gender inequalities, cultural sensitivity, and professional status issues that are currently impeding the development of collaborative practice. Interprofessional education has the potential to support the development of competencies that could change the hierarchical power structure of the operating room. Further studies are needed to examine the effects of cultural differences on teamwork. These studies could develop a cultural awareness among team

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (April 2013) *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (11th edition), section 4, pg(s) 204 - 208, Standard(s) 4.1.1 to 4.1.31.

members and facilitate better interprofessional communications.

CONCLUSION:

In conclusion successful collaborative practice in the operating room is dependent on more than just effective communication. It is influenced by a set of complex interactions between interpersonal, organizational, and systemic factors. Professionals must have the willingness to engage in collaborative practice and develop a sense of belonging to a strong and competent team. Organizations must make interprofessional collaboration and education a part of their mission and values and support its development by investing the human and financial resources needed to allow professionals to develop strong communities of practice. The foundations of collaborative practice must be developed early in the professional socialization of healthcare professionals. This includes interprofessional educational activities both at the pre and post graduate levels.

The research on effective collaboration, among operating room teams, has mainly focused on communication skills. Other research avenues, such as the development of interprofessional educational programs and the influence of organizational and personal factors on team cohesion, have been discussed in this paper and warrant further research to improve the culture of patient safety in Canadian hospitals. Future research resources would be maximized by focusing on these lesser studied aspects of successful collaborative practice.

In conclusion successful collaborative practice in the operating room is dependent on more than just effective communication.

REFERENCES

1. Devine J, Chutkan N, Norvell D, Dettori J. Avoiding Wrong Site Surgery: A Systematic Review. J Spine. 2010; 35 (9S): S28-S36.

2. World Health Organization. Framework for action on interprofessional education & collaborative practice. [Online] Available from: http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf [Accessed 9 Oct 2013] p. 7, p.55

3. Canadian Interprofessional Health Collaborative. What is collaborative practice? [Online] Available from http://www.cihc.ca/files/CIHC_Factsheets_CP_Feb09.pdf

4. Association of periOperative Registered Nurses. Key Components of a Healthy Perioperative Work Environment. [Online] Available from: http://www.aorn.org/search.aspx?searchtext=collaborative%20practice [Accessed 9 Oct 2013].

5. Operating Room Nurses of Canada. Mission, Vision, & Values. [Online] Available from: http://www.ornac.ca/mission.phtml [Accessed 9 Oct 2013].

6. San-Martin-Rodriguez L, Beaulieu M, D'Amour D, & Ferrada-Videla M. The determinants of successful collaboration: A review of theoretical and empirical studies. J Interprof Care. 2005; Supplement 1: 132-147.

7. Canadian Patient Safety Institute. What is Quality and Patient Safety? [Online] Available from: http://www.patientsafetyinstitute.ca/english/toolsresources/governance_patientsafety/pages/whatisquality_andpatientsafety.aspx [Accessed 9 Oct 2013]. P.1

8. BC Patient safety & Quality Council. Surgical site infection. [Online] Available from: http://bcpsqc.ca/clinical-improvement/surgical-site-infections/ [Accessed 9 Oct 2013].

9. Gillespie B, Chaboyer W, Longbottom P, Wallis M. The impact of the organizational and

individual factors on team communication in surgery: A qualitative study. *Int J Nurs Stud*. 2010; 47: 732-741

10. Vital Smart. The silent treatment: Why safety tools and checklists aren't enough to save lives. *Agency for Healthcare Research and Quality*. 2011. Available from http://www.aacn.org/WD/hwe/docs/the-silent-treatment.pdf. [Accessed 10 Oct 2013]

11. Shekelle P, Wachter R, Pronovost P, Schoelles K, Mcdonald K, Dy S. *An Updated Critical Analysis of the Evidence for Patient Safety Practices*. Agency for Healthcare Research and Quality U.S. Department of Health and Human Services. Making Health Care Safer II. 2013. [Online] Available from: http://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyII-full.pdf. [Accessed 10 Oct 2013]

12. Fitzpatrick J. Finding the research for evidence-based practice - Part two: Selecting credible evidence. *Nurs Times*. 2007; 103 (17): 32-33a. Available from: http://www.nursingtimes.net/nursing-practice/clinical-zones/management/finding-the-research-for-evidence-based-practice-part-two-selecting-credible-evidence/201888.article [Accessed 10 Oct 2013].

13. Patterson K, Grenny J, Maxfield D, Mcmillan R, Switzler A. Influencer: The Power to Change Anything. USA: McGraw-Hill; 2008.

14. Khan K, Kunz R, Kleijnen J, Antes G. Five steps to conducting a systematic review. JRSM. 2003; 96 (3): 118-121.

15. Makary M, Sexton J, Freischlag J, Holzmueller C, Rowen L, Pronovost P. Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder. *J Am Coll Surg*. 2006; 202 (5): 746–752.

16. Manser T. Teamwork and patient safety in dynamic domains of healthcare: A review of the literature. *Acta Anaesthesiol Scand*. 2009; 53: 143-151.

17. Silen-Liponen M, Tossavainen K, Turunen H, Smith A. Learning about teamwork in the operating room clinical placement. Br *J Nurs*. 2004; 13 (5): 244-253.

18. Silen-Lipponen M, Turunen H, Tossavainen K. Collaboration in the operating room: The nurses' perspective. *J Nurs Adm*. 2002; 32 (1): 16-19.

19. Gillespie B, Grimbeek P, Wallis M, Chaboyer W. Resilience in the operating room: developing and testing of a resilience model. *J Adv Nurs*. 2007; 59 (4): 427-38.

20. Leblanc P, Schaufeli W, Salanova M, Llorens S, Nap R. Efficacy beliefs predict collaborative practice among intensive care unit nurses. *J Adv Nurs*. 2009; 66 (3): 583-594.

21. Alfredsdottir H, Bjornsdottir K. Nursing and patient safety in the operating room. *J Adv Nurs*. 2007; 61 (1): 29-37.

22. Lingard L, Reznick R, Espin S, Regehr G, Devito I. Team communication in the operating room: Talk patterns, sites of tension, and implication for novices. *Acad Med*. 2007; 77 (3): 232-237.

23. Espin S, Lingard L. Time as a catalyst for tension in nurse-surgeon communication. *AORN* J. 2001; 74 (5): 672-682.

24. Weeks M. Nurse physician communication- Discourse analysis. *Can Oper Room Nurs J*. 2004; 22 (4): 33-36.

25. Clement D, Dault M, Priest A. Effective Teamwork in Healthcare: Research and Reality. *Healthc Pap*. 2007; 7 (SP): 26-34. Available from: http://www.longwoods.com/content/18669 [Accessed 11 Oct 2013].

26. Lingard L, Espin S, Regehr G, Baker G, Reznick R, Bohnen J. Communication failures in the operating room: An observational classification of recurrent types and effects. *Qual Saf Healthc*. 2004; 13: 330-334.

27. Silen-Lipponen M, Tossavainen K, Turunen H, Smith A. Potential errors and their prevention in the operating room teamwork as experienced by Finnish, British, and American nurses. *Int J Nurs Stud*. 2005; 11 (1): 21-32.

28. Nestel D, Kidd J. Nurses' perceptions and experience of communication in the operating theatre: a focus group interview. *BMC Nurs*. 2006; 5 (1) [Accessed 11 Oct 2013].

29. Booij L. Conflicts in the operating room. *Curr Opin Anaesthesiol*. 2007; 20: 152-156. Available from: http://www.uwoanesthesia.ca/documents/Conflict%20in%20Operating%20Theatre.pdf [Accessed 11 Oct 2013].

30. Haynes A, Weiser T, Berry W, Lipsitz S, Breizat A, Dellinger P. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med*. 2009; 360: 491-499. Available from: Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMsa0810119 [Accessed 11 Oct 2013].

31. Lingard L, Reznick R, Devito I, Espin S. Forming professional identities on the health care team: discursive constructions of the 'other' in the operating room. *Med Educ*. 2013; 36 (8): 728-734.

32. Christian C, Gustafson M, Roth E, Sheridan T, Gandhi T. A prospective study of patient safety in the operating room. *Surg*. 2006; 139 (2): 159–173.

33. Gillespie B, Gwinner K, Chaboyer W, Fairweather N. Team communications in surgery – creating a culture of safety. *J Interprof Care*. 2013; 27 (5): 387-393. Available from: http://informahealthcare.com/doi/abs/10.3109/13561820.2013.784243 [Accessed 11 Oct 2013].

34. Runy L. Patient Safety in the Operating Room. *Hosp Health Netw*. 2007; 81 (3): 49, 51-54.

35. Papaconstantinou HT, H, Jo C, Reznik S, Smythe W, Wehbe-Janek H. Implementation of a surgical safety checklist: impact on surgical team perspectives. *Ochsner J*. 2013; 13 (3): 299-309.

36. Haynes A, Weiser W, Berry W, Lipsitz S, Breizat A, Dellinger E. Changes in safety attitude and relationship to decreased postoperative morbidity and mortality following implementation of a checklist-based surgical safety intervention. *BMJ Qual Saf*. 2011; 20: 102-107.

37. Edmondson A. Speaking up in the operating room: How team leaders promote learning in interdisciplinary action teams. *J mang Stu*. 2003; 40 (6): 1419-1452.

38. Lingard L, Regehr G, Orser B, Reznick R, Baker G, Doran D. Evaluation of a preoperative checklist and team briefing among surgeons, nurses, and anesthesiologists to reduce failures in communication. *Arch Surg*. 2008; 143 (1): 12-17. Available from: http://clinicalhumanfactorsgroup.org/resources/08_qrt04/Lingard_et_al_Evaluation_of_a_checklist_briefing_ArchSurg2008.pdf [Accessed 11 Oct 2013].

39. Hurlbert S, Garrett J. Improving operating room safety. *Patient Saf Surg*. 2009; 3 (1): 25. [Accessed 11 Oct 2013].

40. Lingard L, Garwood S, Poenaru D. Tensions influencing operating room team function: does institutional context make a difference. *Med Educ*. 2004; 38 (7): 691-699.

41. Mahajan R. Critical incident reporting and learning. *Br J Anaest*. 2010; 105 (1): 69--75.

42. Laschinger H, Wong C, Mcmahon L, Kaufman C. Leader Behavior impact on staff nurse empowerment, job tension, and work effectiveness. J Nurs Adm. 1999; 25: 28-39.

43. Firth-Cozens J. Cultures for improving patient safety through learning: the role of teamwork. *Qual Health Care*. 2001; 10 (supl II): ii26-ii31. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1765756/pdf/v010p0ii26.pdf [Accessed 11 Oct 2013].

44. Shortell S, Singer S. Improving Patient Safety by Taking Systems Seriously. *JAMA*. 2008; 299 (4): 445-447. Available from: http://jama.jamanetwork.com/article.aspx?articleid=1149150 [Accessed 11 Oct 2013].

45. Lingard L, Whyte S, Espin S, Baker R, Order B, Doran D. Towards safer interprofessional communication: Construction a model of "utility" from preoperative team briefings. *J Interprof Care*. 2006; 202 (5): 471-483.

46. Sevdalis N, Healey A, Vincent C. Distracting communications in the operating theatre. *J Eval Clin Pract*. 2007; 13 (3): 390-394.

47. Collin K, Paloniemi S, Mecklin J. Promoting interprofessional teamwork and learning: The case of a surgical theatre. *J educ wk*. 2010; 23 (1): 43-63.

48. Barnsteiner J, Disch J, Hall L, Mayer D, Moore S. Promoting interprofessional education. *QSEN*. 2007; 55 (3): 145-150.

49. Aihc-us.org. *Home - American Interprofessional Health Collaborative*. [Online] Available from: http://www.aihc-us.org/ [Accessed 11 Oct 2013].

50. Lingard L. The rhetorical 'turn' in medical education: What have we learned and where are we going? *Adv Health Sci Educ Theory Prac*. 2007; 12: 121-133. [Accessed 11 Oct 2013].

51. Lingard L, Regehr G, Espin S, Whyte S. A theory-based instrument to evaluate team communication in the operating room: balancing measurement authenticity and reliability. *Qual Saf Health Care*. 2006; 15 (6): 422-426.

52. Kunzle B, Kolbe M, Grote G. *Ensuring patient safety through effective leadership behaviour: a literature review*. Safety Science. 2010; 48 (1): 1-17.

53. Sexton J, Makary M, Pryor D, Hendrich A, Holzmueller C, Knight A. Teamwork in the operating room: frontline perspectives among hospital and operating room personnel. *Anesthesiol*. 2006; 105 (5): 869-870.

54. Daft R. *The leadership experience*. 5th ed. South Western: Cengage Learning; 2011.

55. Deschênes B, Jean-Baptiste A, Matthieu É, Mercier A, Roberge C, St-Onge M. *Guide d'implantation du partenariat de soins et de services: Vers une pratique collaborative optimale entre intervenants et avec le patient*. Montreal University. 2013. Available from: http://www.ruis.umontreal.ca/documents/Guide_implantation.pdf. [Accessed 13 Oct 2013].

56. Giger J, Davidhizar R. When the operating room has a multicultural team. Today's surgical nurse. 1996; 18 (5): 26.

40 years of experience. Used more than 1 billion times. Trusted.

Medi-Vac® Fluid Management

Medi-Vac® Fluid Management — a global leader — offers a complete portfolio of products to provide everything you need, all in one place. Our single-use canister systems deliver exceptional performance and provide hygienic, safe and efficient disposal of liquid medical waste.

Full portfolio available

- Rigid, semi-rigid and flexible canister systems
- Suction tubing and yankauers
- Solidifiers, floor mats and floor suction
- SAF-T Pump™ Waste Disposal System

CardinalHealth

Essential to care™

Let us help protect you. For more information, please contact your Cardinal Health Canada representative or call us at 888.291.5033.

cardinalhealth.com/medi-vac

© 2014 Cardinal Health. All rights reserved. CARDINAL HEALTH, the Cardinal Health LOGO, ESSENTIAL TO CARE, MEDI-VAC and SAF-T PUMP are trademarks or registered trademarks of Cardinal Health. All other marks are the property of their respective owners. Lit. No. 2PERI14-23177 (10/2014)

Restore™

WITH COLLOIDAL OATMEAL USP
SKIN PROTECTANT

NITRILE GLOVES

Restore Gloves help protect the most valuable instruments in your practice, the hands of your staff.

TREATED WITH COLLOIDAL OATMEAL TO HELP RELIEVE SKIN IRRITATION DUE TO RASH

Protect the hands of caregivers with Restore Gloves. For caregivers, nitrile gloves are an ongoing necessity to ensure the health of themselves and their patients. But gloves also create a continuous wet/dry cycle that irritates skin and can lead to other problems like rash and dry skin. Colloidal oatmeal, like that found in Restore Gloves, is a known treatment to help protect and relieve the ensuing itching and irritation.

Take care of the most valuable instruments in your practice, the hands of your staff, with soothing effects of colloidal oatmeal found in Restore Gloves.

TRY A FREE SAMPLE

Contact your Medline Sales Representative today for a free sample and see the difference that Restore Gloves can make.

©2014 Medline is a registered trademark and Microstop and Restore are trademarks of Medline Industries, Inc. Manufactured for: Medline Industries, Inc., Mundelein, IL 60060 USA