March 2014
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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

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- A l'amélioration des compétences tant sur le plan professionnel que personnel; et
- À la progression de la pratique professionnelle des soins périopératoires à l'échelle provinciale, nationale et internationale.

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PRESIDENT'S MESSAGE

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

"As you navigate through the rest of your life, be open to collaboration. Other people and other people's ideas are often better than your own. Find a group of people who challenge and inspire you, spend a lot of time with them, and it will change your life."
- Amy Poehler

I find the above quote to be sound advice from an otherwise comic lady. Working with like-minded individuals can be easy and allow for quick decision making and immediate gratification. Profound and long-lasting changes that result in positive influence come, however, from ideas that have been developed, challenged and debated. In the pursuit of excellence there is nothing as rewarding as a good debate as long as it's honest, passionate, and thought-provoking. Individuals who apply themselves to the goal of achieving the best possible outcome are open to being challenged and to challenging others. They are the people who inspire others. The ORNAC Board is a reflection of this mindset and commitment to the best.

In accordance with the new ORNAC by-laws 5 provinces will be holding elections in March to select their ORNAC Board representatives. The new nomination and election process allows members at large, who meet the eligibility criteria, to run for positions in their respective provinces. There will also be an election for a new ORNAC Treasurer as well as two of the allied seats – Leadership and Education. All of these positions offer wonderful opportunities to be a part of the ORNAC team and influence the work of the association. The final slate of candidates will be voted upon in May. I look forward, with great anticipation, to working with the successful candidates.

The ORNAC AGM will be held in Ottawa this May. In addition to the ongoing work, of planning the biennial conference and updating the Standards, the Board has been working on many initiatives ranging from conducting CNA exam preparation webinars, to participating with CNA and the Canadian Federation of Nurses Unions (CFNU) to discuss workload and staffing models, and collaborating with CPSI to plan the National Surgical Care Safety Strategy Summit. Information shared with members at the AGM will include a financial status report as well as an update on all of the initiatives currently underway within the association. Attendance at the AGM will foster a greater awareness of ORNAC's work as well as allowing attendees to meet the Board members.

I encourage you to attend the AGM and give the ORNAC Board members the opportunity to meet you. 🍁

Rupinder Khotar

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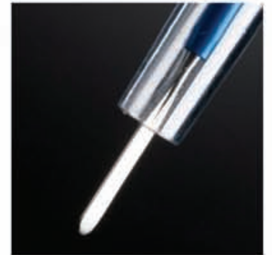

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MOT DE LA PRESIDENT

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.

« Tout au cours de votre parcours de vie, soyez ouvert à la collaboration. Les idées des autres personnes sont souvent meilleures que les vôtres. Trouvez un groupe de personnes qui vous stimulent et qui vous inspirent, passez beaucoup de temps avec ces dernières et votre vie en sera changée. »
\- Amy Poehler

Je considère cette citation comme un conseil judicieux de la part d'une dame autrement comique. Travailler avec des personnes qui partagent les mêmes idées peut être facile et favoriser des prises de décisions rapides ainsi que la reconnaissance immédiate. Des changements profonds et durables se soldant par une influence positive proviennent cependant d'idées ayant été développées, mises au défi et débattues. Dans la poursuite de l'excellence, il n'y a rien d'aussi enrichissant qu'un bon débat, pourvu qu'il soit honnête, passionné et qu'il suscite la réflexion. Les personnes qui s'appliquent à atteindre les meilleurs résultats possible sont ouvertes aux défis et désireuses de mettre les autres au défi. Elles sont celles qui inspirent les autres. Le Conseil d'administration de l'AIISOC reflète cet état d'esprit et cet engagement à ce qu'il y a de mieux.

Conformément aux nouveaux règlements administratifs de l'AIISOC, cinq provinces tiendront des élections au mois de mars afin d'élire leurs nouveaux représentants au conseil d'administration de l'AIISOC. Les nouveaux processus de mise en candidature et d'élection permettent aux membres hors cadre, répondant aux critères d'admissibilité, de présenter leur candidature à des postes dans leur province respective. Il y aura également une élection pour élire un nouveau trésorier de l'AIISOC ainsi que deux des sièges assignés aux représentants alliés, soit celui du leadership et de l'éducation. Tous ces postes offrent de merveilleuses opportunités pour faire partie de l'équipe de l'AIISOC et influencer le travail de l'association. La liste de candidatures finale sera votée en mai. Je suis impatiente de travailler avec les candidats qui seront élus.

L'AGA de l'AIISOC se tiendra à Ottawa en mai prochain. Outre le travail en cours pour planifier la conférence bisannuelle et mettre à jour les normes, le conseil d'administration travaille sur de nombreuses initiatives, allant de l'élaboration de webinaires pour la préparation à l'examen de l'AIIC, à la participation avec l'AIIC et la Fédération canadienne des syndicats d'infirmières/infirmiers (FCSI) à une discussion sur la charge de travail et sur les modèles de dotation en passant par une collaboration avec l'ICSP pour planifier le Sommet national de stratégies pour des soins chirurgicaux sécuritaires. Lors de l'AGA, les membres obtiendront de l'information, à savoir un rapport sur la situation financière ainsi qu'une mise à jour sur toutes les initiatives actuellement en cours au sein de l'association. Votre participation à l'AGA vous permettra de mieux comprendre le travail de l'AIISOC tout en vous donnant l'occasion de rencontrer les membres du conseil d'administration.

Je vous encourage à participer à l'AGA et à donner la chance aux membres du conseil d'administration de vous rencontrer.

Rupinder Khotar

EXECUTIVE DIRECTOR'S MESSAGE

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

"There is no magic in the word association . . . We must never forget that the 'individual' makes the association. What the association is depends on its members. A nurse's association can never be a substitute for the individual nurse. It is she/he who must, each in her/his own measure, give life to the association while the association helps her/him."
- Florence Nightingale

ORNAC's members are its most valuable asset. As ambassadors in your work place, as advocates for perioperative registered nursing practice and patient safety, as mentors to the next generation of students, and as involved supporters members are integral to ORNAC and vital to its success.

On September 15, 2013, the ORNAC national membership data base was launched and ORNAC is now able to directly process memberships. It was very exciting to see the rush of activity as members filled out the new registration form. The form has been designed to provide ORNAC with more information about members so that we can have a better understanding of how to serve you in the future.

Following the required provincial by-law revisions members from Saskatchewan, Ontario, New Brunswick, Prince Edward Island, and Newfoundland can now join ORNAC directly. Members from Alberta and Nova Scotia will be able to join as of July 1st and members from Quebec, British Columbia and Manitoba will be able to join ORNAC directly starting in January of 2015. A new ORNAC Membership Kit will be mailed to all individuals who join ORNAC directly. This kit will contain a membership card and information on benefits and other information related to being a member of ORNAC.

Kay Ball PhD, of the United States, wanted very much to be the first International ORNAC Associate and I am happy to report that she has taken this honour. We are also working on communicating to other potential Associates and encouraging them to register with ORNAC.

We all stand to gain from ORNAC's rich history advancing perioperative nursing practice, providing of Standards for Perioperative Registered Nursing practice, and facilitating continuing education through a National conference (and, in the near future, through on-line webinars). ORNAC also offers the opportunity for leadership development through positions on the ORNAC Board of Directors, provides information and research through the ORNAC Journal and website, and allows for communication with your peers through the on-line discussion forum. As members you have access to all these ORNAC resources!

Members will be kept informed, through ongoing communication, about ORNAC's achievements and challenges and ORNAC will continue to provide knowledge to advance Perioperative Practice and will continue to work to build collaborative partnerships. Career opportunities, through the website and Journal, will continue to support ORNAC's goal of promoting professional development and facilitating a strong and active relationship between the association and its members. Remember ORNAC is YOUR national association. We urge you to join, get involved, and make the most of the benefits that ORNAC can offer. I am also always open to feedback or suggestions so please don't hesitate to contact me.

Catherine Harley

MESSAGE DE LA DIRECTRICE GÉNÉRALE

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

Les membres de l'AIISOC constituent ses atouts les plus précieux. En tant qu'ambassadeurs au sein de votre milieu de travail, en tant que défenseurs pour la pratique des soins périopératoires et la sécurité des patients, en tant que mentors pour la prochaine génération d'étudiants et en tant que membres sympathisants et impliqués, vous faites partie intégrante de l'AIISOC et contribuez de façon essentielle à son succès.

Le 15 septembre 2013, la base nationale de données des membres de l'AIISOC a été lancée et l'AIISOC peut maintenant traiter directement les adhésions. La grande animation qu'a créée l'enthousiasme des membres à remplir le nouveau formulaire d'inscription a été très excitante. Le formulaire a été conçu pour fournir à l'AIISOC davantage de renseignements concernant les membres afin que nous pussions avoir une meilleure compréhension de la façon de les servir à l'avenir.

À la suite des révisions nécessaires apportées aux règlements administratifs provinciaux, les membres de la Saskatchewan, de l'Ontario, du Nouveau-Brunswick, de l'Île-du-Prince-Édouard et de Terre-Neuve peuvent dorénavant adhérer directement à l'AIISOC. Les membres de l'Alberta et de la Nouvelle-Écosse pourront y adhérer à compter du 1er juillet tandis que les membres du Québec, de la Colombie-Britannique et du Manitoba pourront y adhérer directement à compter de janvier 2015. Une nouvelle trousse d'adhésion à l'AIISOC sera envoyée par la poste à toutes les personnes adhérant directement à l'AIISOC. Cette dernière contiendra une carte de membre et des renseignements sur les avantages d'être membre de l'AIISOC ainsi que d'autres renseignements utiles.

Madame Kay Ball, Ph. D., des États-Unis, souhaitait fortement être la toute première associée internationale de l'AIISOC et je suis heureuse de vous aviser qu'elle a eu cet honneur. Nous travaillons également à rejoindre d'autres associés potentiels et nous les encourageons à adhérer à l'AIISOC.

Nous pouvons tous tirer profit du riche héritage de l'AIISOC qui fait avancer la pratique des soins périopératoires, fournit des normes pour la pratique des soins périopératoires et favorise l'éducation permanente grâce aux conférences nationales (et, très bientôt, grâce à des webinaires en ligne). L'AIISOC propose également des opportunités pour perfectionner votre leadership par le biais de postes au sein du conseil d'administration de l'AIISOC, elle fournit de l'information et des conclusions de recherche par l'entremise de la Revue et du site Web de l'AIISOC et vous permet de communiquer avec vos pairs grâce au groupe de discussion en ligne. En tant que membre, vous avez accès à toutes ces ressources de l'AIISOC!

Par le biais de communiqués réguliers, les membres resteront informés des réalisations de l'AIISOC et des défis auxquels elle fait face et l'AIISOC continuera d'offrir des connaissances aux membres en pratique avancée des soins périopératoires tout en continuant à s'efforcer de développer des partenariats de collaboration. Les opportunités de carrière, par l'entremise du site Web et de la Revue, continueront d'appuyer l'objectif de l'AIISOC visant à faire la promotion du perfectionnement professionnel et à former une relation solide et dynamique entre l'association et ses membres. N'oubliez pas que l'AIISOC reste VOTRE association nationale. Nous vous recommandons donc vivement d'y adhérer, de vous impliquer et de profiter de tous les avantages que l'AIISOC vous offre. J'apprécie également votre rétroaction ou vos suggestions, n'hésitez donc pas à me contacter.

« Il n'y a pas de magie dans le mot 'association'. Nous ne devons jamais oublier que ce sont les personnes qui forment une association. Ce que l'association devient dépend de ses membres. Une association d'infirmières/d'infirmiers ne peut jamais servir de substitut à l'infirmière elle-même. Ce sont eux, qui chacun à leur façon, donnent vie à l'association, alors que l'association les soutient. »
- Florence Nightingale

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Auteure : *Genelle Leifso, IA, M.Sc.Inf. a en quelque sorte pris sa retraite en septembre 2011 afin de pouvoir dire « oui » aux occasions présentées dans cet article qui s'offraient à elle à l'international. Elle maintient sa crédibilité clinique en continuant à travailler, de façon régulière, au sein de plusieurs cadres périopératoires et continue à participer à l'éducation de la future génération d'infirmières et d'infirmiers en soins périopératoires du Canada à titre de membre contractuel du corps enseignant pour le programme spécialisé en soins périopératoires de l'Institut de technologie de la C.-B. Elle est membre de la Canadian Association of International Nursing, de la BC History of Nursing Association, de la Perioperative Registered Nurses Association of BC, de Sigma Theta Tau International et siège au conseil d'administration du Canadian Network for International Surgery.*

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes de l'AIISOC pour la pratique des soins infirmiers périopératoires (11e édition) de l'Association des infirmiers et infirmières de salles d'opération du Canada (AIISOC) d'avril 2013, section 1, pp. 29 à 32 et section 3, p. 157, normes 3.2.6 et 3.3.1.

RÉSUMÉ :

La priorité donnée à la sécurité du patient et aux messages de communication tirés de la Liste de vérification d'une chirurgie sécuritaire de l'OMS (2008) sont largement acceptés. Dans plusieurs régions à faible revenu (tel que défini par la Banque mondiale et accepté par l'Organisation mondiale de la Santé), les infirmières en soins périopératoires ne possèdent que peu ou pas de formation officielle; la formation continue et en cours d'emploi sont pratiquement inconnues et aucune « culture de la sécurité » articulée n'existe.[1,2,3]

En 2009, le Canadian Network for International Surgery (CNIS) a testé un cours en soins périopératoires de deux jours à Addis-Abeba, en Éthiopie, dans lequel on exploitait les cours magistraux, les études de cas, les séances sur les compétences et les exercices de jeux de rôle basés sur le plan et les protocoles de la liste de vérification Les chirurgies sécuritaires sauvent des vies. Des instructeurs canadiens (ayant obtenu leur certification après avoir suivi le cours à l'intention des instructeurs parrainé par le Canadian Network for International Surgery) sont depuis ce temps revenus et ont enseigné à d'autres endroits en Éthiopie et en Ouganda. Parmi les participants au cours, nous retrouvons des infirmières en soins périopératoires, des anesthésistes et des résidents novices en chirurgie – reflétant le travail d'équipe interdisciplinaire qui est essentiel aux soins périopératoires sécuritaires apportés au patient. Les discussions animées du cours sont axées sur des questions dans le domaine du travail et de la pratique afin de permettre une évaluation et une planification appropriées des initiatives pédagogiques futures. Les participants remplissent des questionnaires avant et après le cours, qui évaluent leurs connaissances de base et leurs connaissances après le cours, puis un suivi est effectué quatre mois après la fin du cours.

Cet article explique le besoin qu'il y a à apporter de l'aide pour le développement des connaissances et des compétences en soins infirmiers dans les milieux à faible revenu. Il propose également le point de vue de l'auteure ainsi que son expérience à répondre à ce besoin. On y décrit son expérience à titre d'animatrice dans le projet pilote et pour le développement subséquent du cours. L'objectif de cet article est de discuter des façons dont les autres infirmières en soins périopératoires peuvent travailler pour faire une différence positive sur la pratique professionnelle et les soins apportés au patient dans les régions à faible revenu.

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3. Organisation mondiale de la Santé, « Evidence of unsafe care in developing and transitional countries », 2013. Téléchargé le 26 septembre 2013 de http://www.who.int/patientsafety/ research/evidence_of_unsafe/en/index.html

KEYWORDS: SAFE SURGERY CHECKLIST, PERIOPERATIVE NURSING EDUCATION, AFRICAN PERIOPERATIVE NURSING, INTERNATIONAL NURSING, LOW ECONOMIC/LOW INCOME HOSPITAL SETTINGS.

MAKING A DIFFERENCE: USING THE SAFE SURGERY CHECKLIST TO INITIATE CONTINUING EDUCATION FOR PERIOPERATIVE NURSES IN LOW-INCOME SETTINGS

Author: *Genelle Leifso RN, MSN 'sort of retired', in September 2011, so that she could say 'yes' to the international opportunities described in this article. She maintains her clinical credibility by continuing to work, on a casual basis, in several perioperative settings and remaining involved in educating the next generation of Canadian perioperative nurses as contract Faculty for the BC Institute of Technology Perioperative Specialty Nursing Program. She is a member of the Canadian Association of International Nursing, BC History of Nursing Association, Perioperative Registered Nurses Association of BC, Sigma Theta Tau International and serves on the Board of the Canadian Network for International Surgery.*

This article explains the need for aiding in the expansion of perioperative nursing knowledge and skill in low-income settings and provides the author's personal perspective and experience in responding to this need.

ABSTRACT:

The WHO *Safe Surgery Checklist* (2008) patient safety focus and communication prompts are widely accepted. In many low-income regions (as defined by the World Bank and accepted by the World Health Organization) perioperative nurses have little or no formal training; continuing and in-service education are virtually unknown; nor does an articulated "culture of safety" exist.[1,2,3]

In 2009 the Canadian Network for International Surgery (CNIS) piloted a two-day perioperative nursing course, in Addis Ababa, Ethiopia, using lectures, case studies, skills sessions, and role-play exercises based on the SSSL Checklist outline and protocols. Canadian instructors (who are certified after taking the Canadian Network for International Surgery-sponsored Instructor's Course) have since returned and taught at additional sites in Ethiopia and Uganda. Course participants now include perioperative nurses, anaesthetists, and junior surgical residents – mirroring the interdisciplinary teamwork that is crucial to safe perioperative patient care. The course's facilitated discussions focus on workplace and practice issues in order to allow for appropriate evaluation and planning of future educational initiatives. Participants complete pre- and post-course questionnaires, which evaluate baseline and post-course knowledge, and further follow-up is completed four months after course completion.

This article explains the need for aiding in the expansion of perioperative nursing knowledge and skill in low-income settings and provides the author's personal perspective and experience in responding to this need. Her experience as facilitator in a pilot project and subsequent course development is described. The objective is to discuss ways that other perioperative nurses can work to make a positive difference on professional practice and patient care in low-income regions.

INTRODUCTION:

As a post-graduate student, I had the honour of meeting, on several occasions, Helen Mussallem (1915 - 2012), a Canadian nursing icon who was the first Canadian nurse to receive a PhD. She

Practicing the SSL Checklist in Gondar, Ethopia

was passionate about the need to improve nursing education in Canada. During one visit I asked her how she reflected on her nursing practice. I expected she would share some scholarly approach but she, in fact, told me, "At the end of each day I ask myself, what did I do today that made a difference?"

I thought a lot about her words. Some days I felt I made a difference and some days I did not feel that way. I had the same mixed emotions when reflecting on the humanitarian surgical "missions" in which I had participated. I found myself unsettled by the lack of interaction with local perioperative/theatre nurses and impact on their everyday nursing practice during these trips. It brought to mind the Chinese proverb "Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime."

I was searching for another way to make a difference to professional practice and patient care in these low-income environments. Low-income environments are defined, by the World Bank and accepted by the World Health Organization, as countries where the per capita gross national income is $1,035 "international dollars" annually or less. International dollars are a designation used by the World Bank to evaluate one's purchasing power in that country in relation to that of a U.S. dollar in the United States.[1,4] While humanitarian aid in these settings is important, and worthwhile, I came to personally believe that providing **development** assistance was essential for sustainable change.

The Need:

The Canadian Network for International Surgery (CNIS), founded in 1995, is a non-governmental, non-profit organization that sends volunteer Canadian surgeons and obstetricians to Africa. Their goal is safer surgery, obstetrics, and communities in Africa (as well as other low-income settings, like Haiti and Guyana) and their mandate is to share skills with colleagues in these locations who are then able to pass the knowledge on to medical students and other healthcare trainees.

The perioperative environment is, however, one where skilled teamwork is essential. The CNIS recognized that nurses working within these surgical teams, in low-income settings are often lacking the basic skills and training that are considered standard in higher-income regions. This is because perioperative nurses in many low-income settings have little or no formal training. A 2005 issue paper, prepared for the International Council of Nurses, reported that only three African countries had formal post-basic perioperative nursing training programs – South Africa, Ghana, and Nigeria.[2] Of course, some degree of exposure to perioperative nursing practice and principles may take place during the basic nursing education provided by individual hospitals or programs. In such situations, however, evaluation of educational standards is difficult to achieve.

Following a 2007 CNIS-sponsored forum in Vancouver, that explored this need, discussions occurred with a core group of Vancouver perioperative nurses who had attended the event and with CNIS leaders. Later, following the introduction of the World Health Organization's "Safe Surgery Saves Lives (SSSL)" initiative in 2008, it was suggested that a perioperative nursing workshop, using the WHO Checklist, would help introduce African participants to a culture of safety within their operating rooms (OR). It would also allow for the gathering of information about local African perioperative practice problems and help identify potential local leaders to be involved in future educational initiatives.

Skilled communication and effective teamwork are key to providing safe patient care in the OR.[5,6] The WHO Checklist provides a tool whereby all surgical team members engage in a conversation, focused on providing safe perioperative patient care, while addressing key concerns related directly and specifically to the care of the individual patient.[7] But as a casual observer in a low-income setting OR, it was my perception that that these were hierarchical, patriarchal practice environments where collaboration between the perioperative nurse and the rest of the surgical team is uncommon.

The Pilot:

The 2009 pilot project (consisting of two workshops) took place at the Black Lion Hospital, a 560-bed university teaching hospital in Addis Ababa, Ethiopia, where a CNIS-funded surgical lab is located. Working with four Ethiopian nurses (a nurse anaesthetist, an OR head nurse, a staff nurse, and the CNIS skills lab manager), the two-day Safe Surgery Saves Lives (SSSL) Nursing Workshop, based on the Checklist components, incorporated lectures, case studies, skill sessions, role-play exercises, and group discussion.

In preparing the workshop material we were aware that, in Ethiopia, formal training for perioperative nurses did not exist. In addition it seemed that continuing and in-service education for perioperative nurses were virtually unknown. This personal perspective, based on observational experiences and close attention to conference speakers engaged in global surgery, was verified through consultation with professional colleagues (both surgeons and nurses) engaged in surgery in low-income settings. Further support for this perspective came from the perioperative nurses in the Addis Ababa pilot project.

Nor was there a "culture of safety" practiced at the Black Lion Hospital (which would be evidenced by compliance with the safety parameters identified in the Checklist). While hospitals and professional organizations have endorsed the use of the WHO Safe Surgery Checklist this doesn't mean that its practice has been embraced by all local surgeons or practiced consistently by the surgical teams.8

I communicated and consulted with these local nurses who compiled and presented the majority of the workshop content – with organizational support and funding provided by the CNIS. The workshops were presented successively which allowed the presenters an opportunity to test their presentations during the initial workshop and refine their materials for the second one.

As a perioperative nursing educator, my role was that of a content expert. I provided assistance and feedback in developing, and later improving, the presentations, offered encouragement to the local nursing leaders who were presenting, assisted with case study development, and

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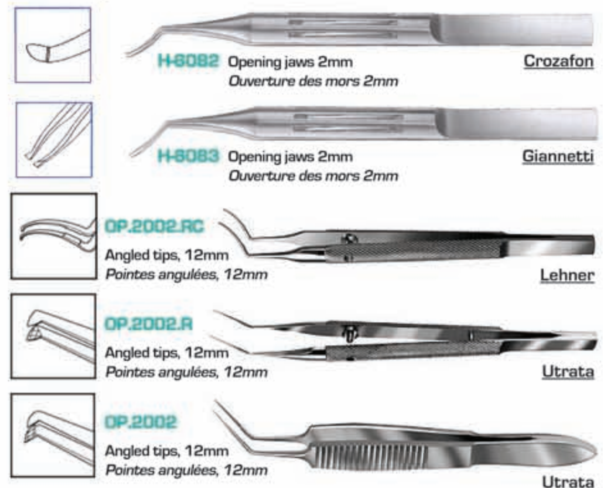

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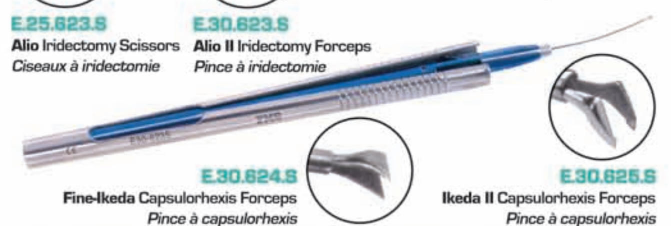

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Practicing "Before Induction" role play exercise in Addis Ababa, Ethiopia

suggested strategies to foster interactive learning. The local nurses and the nurse-anaesthetist also invited me to offer practical examples to the group and to share comments based on my own perioperative practice experiences. My goal was to help them focus on the basic principles that are the key to safe patient care in any practice context. As an example, recognizing and practicing asepsis and sterile technique are fundamental to any surgery. And so we spent time focused on the correct way to perform a surgical scrub and how to don sterile gowns and gloves using the closed-gloving method.

I debriefed with the presenters at the end of each day and worked with them to review the anonymous participant evaluations after each workshop. 59 theatre nurses and anaesthetists, in total, attended the two workshops and their evaluations were overwhelmingly positive. From an educator's perspective the attention, enthusiasm and participation of those in attendance was thrilling. They were particularly engaged during role-playing activities, participated eagerly in the discussions, and seemed to enjoy presenting their perspectives to the larger group when further discussion took place.

As a result of that experience I generated a lengthy post-workshop report. The Ethiopian nurses (with the assistance of Dr. Lett, the International Director of CNIS) used the report to develop a "14-Point Action Plan" targeting the following practices:

1. Surgical scrubbing;
2. Patient temperature monitoring;
3. Patient identification;
4. Surgical count and documentation;
5. Preoperative antibiotic prophylaxis;
6. Preoperative hair removal (shaving);
7. Surgical masks – types and use;
8. OR ventilation;
9. OR environmental cleaning;
10. Surgical site infection (SSI) monitoring;
11. Decontamination & sterilization - packs/instruments;
12. Surgical sponge use – non-radiopaque;
13. Instrument maintenance & repair; and
14. Implementation of SSSL Checklist.

It had become apparent to me that basic elements of perioperative nursing and "best practices" were not clearly understood, nor did the nurses recognize why these practices are considered so important. This is not surprising given the fact that there had been no formal training to prepare perioperative nurses. New nurses may have had some guidance in theatre practices, provided by a local surgeon, or the new staff may have learned their surgical skills simply by shadowing someone with more experience. Such exposure can be disorganized or inconsistent depending on the clinical preceptor. I was told that this workshop was the first continuing education or professional development that many of these nurses had received since completing their nursing education (anywhere from six weeks to 30 years previously).

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The Black Lion Hospital was not unique in this regard. Based on my subsequent experience at other sites in Ethiopia and Uganda where the SSSL Course has since been taught, these issues seem common in low-income settings.

The 14-point Action Plan was presented to the Black Lion Hospital's Chief of Surgery several months after the workshop. The Action Plan has not, however, been shared or implemented in the four years since it was presented. In spite of the fact that the pilot workshop had been presented to the majority of the Black Lion Hospital OR nursing and anaesthetist staff, no long-term change took place. Canadian nurses, involved with subsequent projects at the Black Lion Hospital, have confirmed this to me.

The Strategy:

Everyone involved in the pilot felt the dissemination of knowledge was very important. In order to share our experiences and recommendations my Ethiopian colleague, who had been involved in presenting a workshop, submitted an abstract, on this pilot project, to the local Surgical Society meeting but it was not selected. I also, on behalf of those involved in the pilot project, submitted similar abstracts in 2010 and was able to present at the Ethel John's Research Day in Vancouver and at the Bethune Round Table in Calgary (Canada's only conference dedicated to international surgery). Surgeons from Africa were present (including one from the Black Lion Hospital). They listened attentively and, in subsequent conversations, told me that they supported the recommendations.

Surgeons from various other hospitals in Ethiopia and from other parts of Africa

began to request this course following the Bethune Round Table exposure. It was my belief that the Ethiopian nurse leaders lacked the "expert" knowledge, confidence, and support to carry this initiative forward and advocate for practice improvements associated with the WHO Safe Surgery Checklist. For the project to move ahead it required preparation and support from those Canadian perioperative nurses who were willing to aid in empowering and building local capacity in Africa.

During 2010 I prepared the SSSL course materials for prospective Canadian instructors, providing resources that would enable expert Canadian perioperative nurses to skillfully deliver this course content (in which all principles taught are supported by the current ORNAC Standards) in a low-income setting. These resources, that include an instructor's manual and CD with PowerPoint presentations augmenting each lecture, are introduced, explained, and used in practice sessions during the interactive SSSL Instructors Courses. Certification through the Instructors Course is required to use and teach CNIS-sponsored curriculum. I also prepared an accompanying student manual for distribution to SSSL course participants. These tools enabled use of the "train-the-trainer" model that CNIS has successfully employed to deliver other structured courses in a variety of settings.

Although the course now looks quite different from the original pilot project, I very strongly acknowledge, to this day, the Ethiopian nurses who contributed to that endeavour. Today, In addition to explaining the importance of each of the Checklist components during the course, specific skills associated with safe patient care are also taught. These include cricoid pressure application and assisting with laryngeal maneuvering; surgical scrub, gowning, and closed gloving; performing a surgical count; and surgical specimen care.

The first (of five) Instructor's Course was held in Vancouver in October 2010. New instructors are, in keeping with CNIS practice, mentored while teaching for the first time in a low-income setting. SSSL courses are, in addition, only taught at the invitation of a local patron – commonly the head of the hospital's department of surgery.

And so, a participant from the first Instructor's Course came to Ethiopia with me in February 2011. We then taught three courses at the teaching hospitals in Gondar and Hawassa, both similar university-affiliated referral hospitals.

Gondar University Referral Hospital has 400 beds, four ORs, and conducts more than 6,000 surgeries and 2,000 deliveries annually. It is a teaching hospital that was built in the 1950s and now serves a population of five million people as the referral centre for four outlying district hospitals.

While Hawassa University Referral Hospital is a much newer facility, built in 2003, it also has a 400 bed capacity and four ORs. It is also a teaching hospital and is the major referral hospital for 13 district hospitals in the southern region of Ethiopia with a population of around 17 million people.

The Canadian instructors, prior to teaching the course at a site, are given a tour by the local head nurse or matron and allowed to observe surgical practices. This tour provides relevant contextual information and confirms that patient safety in these ORs can be improved. In Gondar and Hawassa, for example, some unsafe practices that were observed included patients not identified; surgical site marking not performed; and pulse oximetry not used for every patient undergoing surgery. The sterilization process and maintenance of instruments, anaesthetic equipment, and supplies also needed improvement.

Using the SSSL materials, the course was presented to a total of 54 theatre nurses and anaesthetists at the two facilities. The experiences at these hospitals was considered a replication project that, when evaluated, validated our original conclusions. We were able to confirm, as had been learned during the pilot project, that the Checklist could be used as the basis for perioperative nursing continuing

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education and provide a starting point for introducing participants to the idea of a culture of safety in their ORs.

But, "doing" the checklist doesn't mean that patient safety is assured. Fundamental problems became evident as the discussions explored local challenges (personnel and environmental issues) that did not support safe perioperative practice.

Mulago Hospital Nurses and Theatre Attendants who completed the SSSL Course, October, 2013.

Photo by/par N. O'Hare

Hawassa, for example, had only one BP cuff, pulse oximeter, and suction for four ORs. Anaesthetists reported circulating this equipment between the ORs (trying to have it available during induction and emergence). In Gondar there was suction and BP cuffs in each theatre but only two oximeters for four ORs. The anaesthetists gave priority to paediatric and critically ill patients. These solutions, while creative, are fraught with potential disaster. The patient where no one expects difficulty can quickly run in to problems. This was critical information, for the instructors, as it not only helped to identify further educational needs and course requirements, but also allowed them to advocate for adequate supplies of these essential, basic monitoring tools being a priority over obtaining more sophisticated surgical equipment or supplies.

During the courses, potential perioperative nursing leaders were also identified, based on their observed ability to absorb, understand, and re-frame the material within the discussion groups, as potential champions for moving the practice issues forward. It was believed that these leaders could help with ongoing dissemination of this information and the delivery of future educational initiatives. We also learned that limiting the number of attendees to 20-24 per course was essential in order to support engagement and participation throughout the course.

When I expressed curiosity about how long an initiative like this might be needed in any particular practice setting, Dr. Lett informed me that, on average, only 30% of those who receive additional education or training are in the same practice setting three years later. They most often become economic migrants (seeking better opportunities, either within their own country or beyond its borders, and a better life for themselves and their families).[2] Therefore, it seemed that providing these Ethiopian perioperative nurses with ongoing support and encouragement would be necessary to facilitate change in their practice settings.

> A theatre nurse, in Uganda, is now teaching the surgical scrub, gown and closed glove technique she learned in the SSSL Course to nursing students preparing to visit the OR.

I maintained personal contact with the nurse leaders identified to work on the Addis Ababa pilot project and learned that within one year all of them had left the Black Lion Hospital, taking their knowledge and skill to other settings. When I returned to Gondar, in 2012, only three nurses of the 24 who had taken the course the previous year were still working in the main OR. When I asked what had happened to the other nurses I was told by those remaining that the other nurses left due to salary, workload, and quality-of-work/life issues. In addition, perioperative nurses are regularly reassigned to other hospital wards. Hospital administrators explained to me that Ethiopian nurses were "generalists" (not like the Canadian "specialists"). This offered an excellent opportunity to explain the need for nursing expertise in the complex perioperative care environment and to suggest that encouraging their nurses to use their increased knowledge and allowing them to remain in the OR could support safer and more efficient patient care during surgery.

As a perioperative nurse educator and nursing advocate, I have insisted that most of the course participants are nurses because of the disparity that exists in continuing education opportunities. Even a casual observer can see that many more opportunities exist for continuing education and professional development, both at home and abroad, for surgeons and anaesthetists than for nurses. Foreign surgeons travel for conferences or residencies while nurses rarely have this opportunity.

Still I recognize that providing safe perioperative care is a team effort. While the concept of "team training" is embraced in Canada, it is new to low-income settings like Ethiopia. When we deliver the course to an interdisciplinary group – comprising nurses, anaesthetists, and surgeons – I have learned that the opportunity to understand other perspectives and to practice appropriate communication is facilitated. Surgeons, residents, nurses, and anaesthetists must all embrace the importance of a culture of safety and be willing to recognize problems and work toward solutions. Team training can help this happen.[5]

As the course continues to be taught we welcome additional opportunities to share knowledge. These have included presenting morning sessions to surgical and orthopaedic residents on the Safe Surgery Checklist (and its supporting evidence), reviewing principles of asepsis with Ugandan 3rd year orthopaedic officer students, and teaching closed gloving to orthopaedic residents.

Course participants are also encouraged to share their knowledge. In an environment where nurses complain that they are not respected this encouragement can be professionally empowering. A theatre nurse, in Uganda, is now teaching the surgical scrub, gown and closed glove technique she learned in the SSSL Course to nursing students preparing to visit the OR. She uses information from the course manual to support this teaching.

As of October 2014 Canadian instructors will have taught nine SSSL Courses in Ethiopia and Uganda. It continues to evolve because of ongoing and increasingly rigorous evaluation. The inclusion of post-course coaching days was our first response to course participants' evaluation feedback. Participants now also complete pre- and post-course knowledge tests so that their level of understanding can be assessed immediately. Any misconceptions participants may have, as they put that knowledge into practice, is clarified during our coaching days.

After the Course:

During the course, participants collaboratively compile a list of low-cost or no-cost changes to their practice and environment that they are able to immediately initiate. This list is then presented to the head nurse who posts it in their unit to serve as a reminder of these goals. More recently participants have been asked to select two items on their list as the first priorities for change. Focusing on a few practice changes can be easier than considering many changes at once.

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As a result we have learned that, following completion of the course, the perioperative nurses consider their practice to be more informed, patient-focused, and collaborative.

A debriefing takes place, at the conclusion of each course, with the course instructors and OR leadership (e.g. head nurse, chief anaesthetist, chief surgeon/course patron, hospital director). Positive and negative feedback are shared and positive change that has taken place since the previous course is highlighted. A detailed report is then provided to the funding organization to outline important practice problems that were identified during the course. Our recommendations focus on initiatives that involve low or no cost.

Further evaluation is then sought through telephone interviews or paper-based surveys. Four-months after the course completion, local coordinators contact course participants in an effort to learn, in more detail, how the course content and skills have changed their practice and what challenges they are experiencing in using this knowledge and skill. They are also asked to describe additional nursing education they would like to receive. This information is reviewed by the course instructors and collated by the CNIS evaluation coordinator and then stored by the CNIS.

As a result we have learned that, following completion of the course, the perioperative nurses consider their practice to be more informed, patient-focused, and collaborative. They begin to see themselves as making a stronger contribution to the surgical team. Comments have included the following:

"After the training, our team spirit became stronger when it came to sharing ideas and discussing surgical complications."

"Patients are prepared in time and we bring the correct patient for surgery now."

"I am aware of what might happen if something is not done."

"I became much more concerned about anticipated events. All in all, we started to plan and prepare ourselves for each surgery."

"It has saved the life of a patient."

"Because the operation room was new, the training taught us a lot of skills that we didn't have before (e.g. closed gloving, gowning)."

There are always challenges, in any environment, as participants attempt to enact their new knowledge and skills. Having course participants articulate these problems allows course instructors to address the issues in future visits. For example, participants reported "Our autoclave continues to break down which makes SSSL procedures difficult to follow." In each site, where I have taught, the decontamination and sterilization process has been problematic. Some of the problems I have observed include:

- Surgical instruments assembled and sterilized with "locked" jaws;
- Items removed from sterile sets with lifting forceps, whose sterility cannot be confirmed;
- Instruments sterilized in asculap pans with broken or missing hinges and no filters (or cloth filters that have not been washed);
- "Sterile" instrument pans with debris present – evidence of not having been cleaned between sterilization cycles;
- Cloth wrappers with holes or rips used to wrap surgical supplies for sterilization;
- Improper loading of sterilizers;
- Incorrect use of indicator tape (e.g. using ETO tape for steam autoclaved supplies);
- Used surgical equipment disinfected before cleaning;
- Inconsistent use of personal protective equipment when decontaminating used surgical equipment;
- Cautery cords soaked in Cidex for 10 minutes before introducing them to the sterile field; and
- Wet packs and instruments used in the sterile surgical field.

SURGICAL SAFETY cont. on page 25

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Photo by/par G. Leifso

SSSL Instructors Course, Ottawa, April 2013

Proper sterile processing is a basic, non-negotiable, practice essential.[9] Addressing the issues, with those responsible at the local level, is vital and has been part of our debrief process at each teaching site. In Uganda we were invited to discuss these concerns with the hospital's practice leaders. After all we, as visitors, can share knowledge and make suggestions but it remains up to the resident professionals to make the essential changes to improve practices in their environment.

Perhaps you recall how negative attitudes towards the Checklist process challenged its adoption in your hospital. I believe that a personal outlook that values each team member, and the professional contributions that they make during surgery, is key to changing attitudes. I remind our students that no surgeon works alone – surgeons require the support of the team, including the anaesthetist and perioperative nurse, in order to operate. Safe patient care is a team effort and if any participant isn't practicing safely then the team will have difficulty delivering the care we want for our patients and that we would want for ourselves.

Emergency situations pose another challenge. Many participants report that the Checklist is not followed during emergency procedures because of time and staffing shortages. But it is precisely when critical events are occurring that errors are more likely to happen and when the use of the Checklist is especially important.[10]

> *"We are never justified in doing an unsafe thing to be more efficient."*
>
> - Dr. Doug Cochrane, personal communication, September 19, 2012.

Perhaps the most valuable evaluation occurs when instructors return to the site to teach both new staff and to provide "refreshers" to those who have already taken the course. Without this first hand assessment the lack of progress in Gondar could be very discouraging. But given the lack of staff retention and the abandonment of the physical environment (because a new hospital is under construction) it was still obvious that some of the skills we had taught were being practiced. New nurses, who had learned the skills from their peers, were closed-gloving and were trying to use the count sheet and Checklist. We found this to be very encouraging. Our return visit also allowed us to correct some practices (e.g. cavity closure counts were not being done) and offer explanations to support the changes we wanted them to make.

Continuing the relationship with the nurses in Africa helps us to reinforce the importance of the course content and our commitment to our less-advantaged colleagues. They see many people come once, and never again, so it is often when we return that they really begin to listen and form a relationship that can be transformative.

Continuing the Work:

Obtaining funding for independent perioperative nursing initiatives is difficult. I have realized that working collaboratively with Canadian surgeons, who were already going to low-income settings, might make it possible to provide further perioperative nursing education. UBC affiliated surgeons have been going to Mulago Hospital, a 1500 bed National Referral Hospital in Kampala, Uganda for more than four years. They have taken Canadian nurses but have been unable to offer organized continuing education for the Ugandan nurses. Without this structured approach there has been little ability to track improved practice initiatives or to communicate between teams about nursing issues.

In response to concerns identified by perioperative nurses accompanying the

Imagine the impact on perioperative practice if all of the visiting teams of experts "sang the same song" while working with the same Ugandan nurses.

2012 UBC trauma orthopedic (USTOP) team, collaboration with CNIS was proposed. The plan involved offering the SSSL course to Mulago Hospital nurses beginning with those working in the ORs where the USTOP teams work.

The proposal was accepted and 24 Ugandan nurses attended their first SSSL course in September 2012. CNIS certified instructors reviewed the practice environment and then taught the course, subsequently providing ongoing mentoring and coaching to the Uganda perioperative nurses, while working with Canadian surgeons (who also had a teaching focus). A team approach to safe perioperative patient care was modeled, including consistent implementation of the WHO 2009 Checklist,[7] during their two-week visit.

Imagine the impact on perioperative practice if all of the visiting teams of experts "sang the same song" while working with the same Ugandan nurses. UBC surgical teams plan to continue working with Ugandan professionals for three more years. The course will be offered to those who have not taken it and practice audits, shared by the returning teams, will provide data regarding practice changes occurring as a result of the course content.

Initial data suggests that this collaboration is proving beneficial in providing both education and practice support. For more information on this perioperative nursing initiative see the USTOP Nursing reports which can be accessed through links at http://ustop.orthopaedics.med.ubc.ca/trip-reports. The success of this venture may serve as a prototype for partnerships, with other Canadian university-based surgical groups, whereby CNIS nursing courses can be included when they are teaching in low-income settings.

I believe that partnerships within the Canadian perioperative and educational community are essential if we are going to efficiently and effectively assist our less-advantaged colleagues. This not only expands our sphere of influence as perioperative nurses, but also demonstrates the collaboration that is so important to perioperative nursing practice. As a perioperative educator engaging in development work it would be unacceptably patronizing to suggest that poor practice is "good enough" in low-income settings. In discussion with hospital leaders and front line nurses I often summarize my comments by saying "It is never right to do the wrong thing. If "best practice" is not possible yet, what can be done to begin moving in that direction?"

As a result of this work more than 200 nurses, anaesthetists, surgical residents and orthopaedic officers have, to date, received both knowledge and practical perioperative skills training. But this project is far from finished! The SSSL Course is simply the first step. Additional courses will be written in response to the needs identified. While teaching in Mulago Hospital, for example, instructors identified critical issues with sterile processing. Following discussions with the Chief of Surgery he requested that further education pertaining to sterilization be provided to their nurses. Seminars on Asepsis and Sterilization were, as a result, prepared and attended by more than 110 Ugandan nurses. A course on Sterilization (applicable to low-income practice environments) is being planned and will be written in collaboration with practice experts.

It all started with an idea. And with the support of perioperative nurses and other medical professionals who knows where it will end! If you are interested in getting involved in this professionally

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 1, pg(s) 28 – 31 and Section 3, p.144, Standards 3.2.6 and 3.3.1.

expanding and rewarding experience you can find more information at www.cnis.ca. Support is also welcome through donations, proposal of new projects, or even becoming involved as an instructor. I believe this is how we can all make a difference!

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LA NORMALISATION : PRATIQUES EXEMPLAIRES POUR DES SOINS PÉRIOPÉRATOIRES AUX POINTS DE SERVICE

Auteure : *Muriel Shewchuk, IA, B.Sc.Inf., CSP (C), possède plus de cinquante ans d'expérience en soins périopératoires cliniques exhaustifs, en enseignement, en administration et en consultation. Elle a travaillé de près avec les conseils d'administration de l'AIISOC et de l'ORNAA, notamment pour la planification des conférences nationales et provinciales, le développement des normes de la pratique, la publication d'articles sur le leadership en plus d'avoir été conférencière lors de conférences internationales, nationales et locales sur les soins périopératoires. Muriel occupe actuellement le poste de coprésidente du Canadian Operating Room Leaders Group (CORL) qui se concentre sur l'éducation en matière de leadership au Canada.*

La normalisation est utilisée pour développer, mettre en œuvre et maintenir les pratiques techniques répétitives au sein des membres d'une équipe. La normalisation suppose l'utilisation personnelle d'un ordre et d'une séquence d'étapes précis, documentés, bien compris et cohérents afin d'entreprendre et de progresser à travers un processus technique. La normalisation laisse entendre qu'il existe des objectifs communs de sécurité, d'exactitude, d'efficacité et de qualité. Le personnel de blocs opératoires/de salles d'opération accomplit des millions d'actes techniques répétitifs, chacun ayant un impact potentiel sur les résultats pour le patient et les membres de l'équipe. Lorsque les étapes de chaque tâche sont exécutées, la diversité individuelle ouvre la porte à un risque d'erreur accru, à des risques pour le patient, à du temps perdu et à de la frustration pour les membres du personnel. Imaginez seulement si l'industrie permettait les variations individuelles apportées aux processus.

Il incombe à la direction des établissements, aux éducateurs et aux chefs cliniques de s'assurer que des politiques, des procédures précises, des aides visuelles et des attentes bien définies sont à jour et qu'elles sont disponibles pour l'orientation, la formation continue et la pratique quotidienne. De plus, tout le personnel doit se conformer aux directives de l'établissement, mettre en œuvre et maintenir des activités prédéfinies afin d'optimiser la sécurité du patient, d'améliorer le fonctionnement de l'équipe et de favoriser un environnement de travail positif et coordonné.

STANDARDIZATION: PERIOPERATIVE POINT OF CARE BEST PRACTICE

Author: *Muriel Shewchuk RN, BScN, CPN(C), has over five decades of comprehensive perioperative clinical, teaching, administrative and consulting experience. She has been extensively involved with ORNAC and ORNAA Boards including National and Provincial Conference Planning, Standards of Practice development, publication of leadership articles, and presenter at international, national and local perioperative conferences. Muriel is currently Co-Chair of Canadian Operating Room Leaders Group (CORL) that focuses on leadership education in Canada.*

Introduction

Standardization is used to develop, implement and sustain repetitive technical practices among team members. Standardization presumes personnel use a detailed, documented, well understood, consistent order and sequence details for initiating and progressing through a technical process. Standardization infers a common goal of safety, accuracy, efficacy, efficiency and quality. Personnel in Surgical Suites/Operating Rooms (OR's) perform millions of single repetitive technical skills, each with a potential impact on patient outcome and team members. Individual diversity, when performing the details of each task, opens the door to increased error, patient risk, wasted time and inter-staff frustration. Just imagine if industry allowed individual variances in processes.

Facility's management, educators and clinical leaders have the obligation to ensure specific policies, procedures, visual aids and defined expectations are current and available for orientation, on-going training and day-to-day practice. In addition, all personnel are required to comply with the facility direction, implement and sustain defined activities to maximize patient safety, enhance team function, promoting a positive and coordinated work environment.

Risks Associated With Non-standardization and Independent Technical Variations

Practices, related to common repetitive technical skills, vary greatly from one OR to another and often based on personal preferences and independent decision making. Areas of challenge include:

Nomenclature, labeling and location: Wide variation in naming conventions, labeling of products, instrument sets and reprocessed goods exists within the Department as well as within surgical specialties. Lack of standards, compliance and supervision results in OR personnel stress, misunderstanding, widely varied Procedure Cards and ongoing communication issues with Medical Device Reprocessing (MDR). Delays, inability to locate items, wasted time increased team stress. The need for OR supply cabinets to contain standard supplies, specific quantity and locations are highly varied, further wasting team members time and adding stress.

Noncompliance with instrument (back) table and Mayo stand set ups: Noncompliance with original teaching/orientation protocols increases the stress for new staff, as they encounter different teammates daily demands. A wide variety of individualized instrument table and Mayo stand set ups exist. Many instrument tables and Mayo stands are chaotic, disorganized and vary among each scrub nurse. Soiled items may be mixed with sterile instruments, sponges in multiple locations, hidden or loose. Sutures and needles located in several areas, loose, hidden, secured /or not. Increased surgeon frustration results when the scrub nurse has difficulty locating items, combined with the detraction of focus from the surgical site and team needs. Lack of compliance with standardized practice increases the risk of error, wrong counts resulting in negative patient outcome.

Stress, Intimidation and Fear for Trainees, Rotators and Team: New staff learning the complexities of scrubbing and table setups struggle with the multiple individualized demands. Classroom teaching, focus, and clear thinking is threatened with the commands and demands of senior team colleagues. Senior staff may be heard to say: "I don't care what you were taught, when you are in my room, you will do it my way." The OR is the patient's room, not the nurse's room. Secondly, the setup is for the patient and surgeons, not the individual nurse. It is important to remember our sole reason for being in the OR is patient care! The facility and staff have an obligation to the patient to ensure compliance

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with check-stops to provide the safest care possible.

"Handoff" Issues: Multiple circulating staff may be involved with each case between the set-up, various counts, relief for breaks, and shift changes. The higher the number of staff, and increasing case length, the greater the risk of error, if standardized practices are not followed in detail by both scrub and circulating members.

Closing Count Risks: It is noted that as the case progresses toward closing counts and disassembly the chaos and risk often increases. Difficulty performing an efficient and accurate closing count occurs when items are spread in multiple locations. In some rooms it is not uncommon to see instruments piled and mixed with sponges. The risk for errors during needle counts increases with disorganized needle placement, lack of security and visibility. Individualized or disorganized practices increase the risk of injury and increases the time required for an efficient change over.

Standardization Process:

Management, Educators, Clinical Leaders, Quality Improvement and Safety designates must work as an integrated, unified team to establish the framework, content for Policy, Procedures and practices. Delineation of roles, responsibility, accountability, expectations, audit process and consequences for sustained outcomes shall to clear to all employees.

Management, QI and Safety Requirements:

- Review/update, approve and communicate expectations of the Department's documented standardization requirements, using facility, ORNAC, IPC Standards and evidence based information;
- Approve the establishment of an effective Clinical Practice Committee(CPC) consisting of educators, clinical leaders and point of care staff with various experience levels; include MDR leadership as required;
- Ensure support for CPC work time, decisions, and follow-through for sustained quality improvement;
- Provide and support the communication tools/ process and implementation of CPC decisions for sustainability;
- Exam root cause of errors/ incidents for lack of standardization, inadequate, outdated information/ process and noncompliance;
- Establish and role model Guiding Principles for patient safety, risk reduction, best practices, team efficiency and a positive work environment;
- Review the Surgical Count Policy and Procedure to ensure detailed sequences are defined for compliance by all point of care nurses. A high rate of count errors can result. Chaotic tables and individual practice are a significant cause of the risk rate; and
- Include compliance of standards within the performance management process.

Educators and Clinical Leaders:

- Document and maintain current practices and expectations being taught during orientation, on-going training, and daily OR/Theatre staff performance, regardless of seniority;
- Assess the current level of standardization and compliance among point of care personnel, referring substandard performance, process issues, environmental implications to management;
- Supervise staff for compliance and ongoing practice maintenance;
- Determine the review/audit process to monitor effective change and ultimate success;
- Post plastic-covered photographs, on the OR/Theatre walls, in standardized theatres setup areas. Pictures should depict the required left and right instrument table, Mayo stand setups for Basic Minor, Abdominal Open, Laparoscopic, Perineal, Orthopaedic (for Basic Limb, Arthroscopic, and Total Joint), ENT, and Ophthalmology; and
- Standardize base theatre supply cabinets by item, quantity and shelf location for all rooms.

Clinical Practice Committee:

- Determine the issues, and prioritize levels of safety risk, noncompliance and personnel frustration within the Department;
- Determine the specific projects to be standardized at one time. The project must be manageable in order to achieve successful sustained outcomes. Failure to implement and sustain standardization allows the resistant and cynical to cast doubt and as a result justify a continuation of individualized practice;
- Standardize the setup order of case carts from MDR, using consistent placement principles that promote an organized, efficient sequential theatre setup as well as the return of soiled case carts to MDR;
- Develop a process to list, change and communicate the key concerns and rationale of the "naysayers"/non-compliant staff;
- Establish the best practice standard with valid rationale; and
- Ensure all communication teaching strategies are in place and implemented, to reduce the "nobody told me" factor.

Communication Strategies:

- Use stories from actual events to demonstrate the need to change as a means to depersonalize the non-compliant activities;
- Post the projects, process changes and audit results in the education posting/staff lounges/ congregation areas,
- Communication/report materials/ computer using posters, email, Newsletters, education sessions, report books etc.; and
- Celebrate and acknowledge sustained success for positive motivation!!

All Staff:

- Professional responsibility includes reading and being informed of Department and specialty Policies, Procedures and Communication;
- Continuing education is a daily, lifelong requirement;
- Teach, support, mentor teammates to maintain the standardization requirements; and
- Communicate with and take part in the CPC to promote, implement and sustain standards.

Conclusion:

A process of firm, supervised, standardization should be taken in all Theatres for the safety of the patient, staff and efficiency of the surgical team. Reduction of error risks, supporting an effective sustained training tool, improved time and efficiency, creating quality improvement and reduction of staff conflict is essential for a safe and positive work environment. Standardization however, takes a commitment to best practice, a clearly documented and publicized plan with a progressive time line, firm and positive leadership with sustained monitoring activity. The patients and the team expect this as a best practice measure!

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ORNAC CONFERENCES www.ORNAC.ca

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LE LEADERSHIP AUTHENTIQUE : POUR DÉVELOPPER LE LEADER EN VOUS

Auteur : *Lesia Yasinski, IA, B. S. Inf., M. Sc. Ad., travaille en soins de santé depuis plus de 20 ans. Elle est infirmière en soins périopératoires et a travaillé dans le domaine des soins cliniques en tant qu'infirmière en soins périopératoires pour les ressources cliniques, infirmière éducatrice en soins périopératoires et infirmière gestionnaire en soins périopératoires. Elle occupe actuellement le poste de chef des initiatives des infirmières pour la Winnipeg Regional Health Authority, où elle aime les opportunités dont elle bénéficie de guider d'une manière authentique et qui lui tient à cœur.*

Lesia a été membre exécutif de la Manitoba Operating Room Nursing Association (MORNA), et a participé à la planification de nombreuses formations en cours d'emploi, d'ateliers et de conférences. Elle a été membre du comité pour la planification des conférences nationales de l'AIISOC en 2003 et conférencière aux conférences de l'AIISOC de 2011 et de 2013. Les soins périopératoires ainsi que le rôle que jouent les infirmières de salles d'opération pour fournir des soins de qualité aux patients constituent une grande passion pour Lesia.

Cet article se base sur la présentation que Lesia a faite lors de la conférence nationale et internationale de l'AIISOC en 2013 avec l'IFPN qui a eu lieu à Ottawa, ON.

RÉSUMÉ :

Un grand leadership repose habituellement sur la bonne volonté, une attitude positive et le désir de faire une différence. Dans l'environnement de soins de santé d'aujourd'hui, il est important d'avoir un leadership solide afin d'assurer des résultats optimaux pour les patients et d'encourager des générations futures d'infirmières en soins périopératoires compétentes, motivées et enthousiastes. Cet article examinera les principaux éléments nécessaires au développement du leadership authentique. Outre l'accent qu'il mettra à souligner le rôle joué par le développement personnel dans les aptitudes de leadership, cet article discutera également des façons de cultiver l'authenticité dans le leadership. On y adressera les questions suivantes : En quoi consiste le leadership authentique? Comment une personne peut-elle devenir un leader authentique?

Cet article examinera les principaux éléments nécessaires au développement du leadership authentique.

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes de l'AIISOC pour la pratique des soins infirmiers périopératoires (11e édition) de l'Association des infirmiers et infirmières de salles d'opération du Canada (AIISOC) d'avril 2013. Normes et compétences professionnelles de l'infirmière gestionnaire en soins périopératoires, section 1, pages 54 à 64; Normes et compétences professionnelles de l'infirmière enseignante en soins périopératoires, section 1, pages 65 à 72 et Compétences de l'infirmière en soins périopératoires, section 1, pages 36 à 47.

KEYWORDS: AUTHENTIC LEADERSHIP, PERIOPERATIVE LEADERSHIP, HEALTHY WORK ENVIRONMENTS.

AUTHENTIC LEADERSHIP: DEVELOP THE LEADER WITHIN

Author: *Lesia Yasinski RN, BN, MSA, has been working authentically in health care for over 20 years. She is a perioperative nurse who has worked in clinical care, as a perioperative clinical resource nurse, a perioperative nurse educator and a perioperative nurse manager. In her current role as Manager of Nursing Initiatives for the Winnipeg Regional Health Authority, she enjoys the opportunity to lead authentically and with heart.*

Lesia was an executive member of Manitoba Operating Room Nursing Association (MORNA), and has been involved with the planning of many in-services, workshops, and conferences. She was a member of the ORNAC 2003 National Conference Planning Committee and presented at the 2011 and 2013 ORNAC Conferences. Lesia is passionate about perioperative nursing and the role OR Nurses play in providing quality patient care patient care.

This article is based on Lesia's presentation at the 2013 ORNAC National & International Conference with IFPN in Ottawa, ON.

ABSTRACT:

Great leadership usually starts with a willing heart, a positive attitude, and a desire to make a difference. Strong leadership is important, in today's health care climate, to ensure optimal patient outcomes and the fostering of future generations of knowledgeable, motivated and enthusiastic perioperative nurses. This article will explore key elements necessary for the development of authentic leadership. While highlighting the role that personal development plays in leadership skills, this article will also discuss ways to cultivate authenticity in leadership. The following questions will be addressed: What is authentic leadership? How does one become an authentic leader?

What is authentic leadership?

George (2003) describes authentic leadership as an individual in a position of responsibility who is genuine, trustworthy, reliable and believable. Leaders who are authentic conform to fact or speak the truth and are, therefore, worthy of trust, reliance or belief.[1]
A conceptual definition of authentic leaders was proposed by Avolio et al (2004) as "those who are deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspective, knowledge and strengths, and aware of the context in which they operate. These leaders are confident, hopeful, optimistic, resilient and high on moral character."[2]

According to George, authentic leaders have five key characteristics:

1. The ability to understand their own purpose;
2. Practice solid values;
3. Lead with heart;
4. Establish enduring relationships; and
5. Practice self-discipline.

Authentic leaders, **in understanding their own purpose**, search for meaning at every stage of life's journey. Authentic leaders are able to find passion in life and are able to articulate it. Authentic leaders need to "walk the talk" by following behaviours they want repeated or actions they'd like matched.

Practicing solid values involves testing one's fortitude. An individual's values may be challenged in difficult situations. Practicing solid values involves being steadfast with one's values, making difficult decisions, and acting in a manner consistent with those values to

The process of becoming an authentic leader is a journey rather than a destination.

ultimately demonstrate integrity and inspire trust and respect.

Leading with heart requires compassion, presence, and vulnerability. Authentic leaders are open to having close personal relationships and to embracing the full range of life's challenges, hardships, and difficulties. Authentic leaders develop heart and compassion in those around them by getting to know the life stories of those with whom they work and by engaging coworkers in shared meaning and cultivating mentoring relationships. As the quote by Maya Angelou "You may not remember what someone says or does, but you'll never forget how they made you feel."

Leaders with heart have the opportunity to influence and bring out the best in others. A great leader does make a difference to the people they are leading through their presence and their ability to inspire and encourage the best from the people they work with.

Establishing enduring relationships requires a sense of connection and shared purpose in working toward a common goal. Authentic leaders build a sense of connection by remaining vulnerable enough to share life's stories as a way of developing trust and intimacy. Relationships built on strong connection grow stronger in the face of pressure and adversity. Authentic leaders build relationships through values and not merely through a desire to please.

Practicing self-discipline involves incorporating balance into one's personal and professional life in order to deliver consistent results. Fundamental to authenticity is the notion of an individual remaining true to these five core characteristics and values. This understanding helps explain the evolution of authentic leadership: the more an individual remains true to his or her core values, identities, preferences, and emotions, the more authentic these individuals are believed to become.[1]

How does one become an authentic leader?

The process of becoming an authentic leader is a journey rather than a destination. It requires the pursuit of a continuous personal journey of self-discovery, self-improvement, reflection, and renewal.

In order to become an authentic leader an individual must develop a leadership style that is consistent with his or her personality, values, and character regardless of the circumstances he or she is faced with.

Becoming an authentic leader requires the courage to commit to a process of personal transformation 'from the inside out'. Mastery of both the professional and personal are needed for success as an authentic leader. The ability to understand one's own strengths and weaknesses, while simultaneously accepting one's 'shadow or dark side', is an essential component of becoming an authentic leader.

Healthy work environments are supportive of the whole human being, are patient-focused, and are joyful workplaces. A good litmus test is how often do you hear joyful laughter in the rooms and corridors? A healthy work

PERSONAL DEVELOPMENT STRATEGIES – BECOME AN AUTHENTIC LEADER

The following are some suggestions from the author based on her experiences and knowledge:

- Read books, articles, and anything and everything related to leadership;
- Seek internet sources to enhance authenticity in leadership;
- Volunteer to serve in the community and give back to others;
- Participate as a team member in an organization or in an affiliated mission trip to an underdeveloped country or community;
- Initiate a personal program of self-renewal;
- Complete a self-assessment of personal strengths and weaknesses;
- Mentor a future leader;
- Devote time to family, friends, colleagues and self;
- Find a new hobby or rediscover an old one;
- Celebrate and express gratitude in life;
- Insert appropriate humour in to all aspects of life; and
- Commit to a philosophy of lifelong learning.

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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). Perioperative Registered Nurse Manager Standards and Competencies (RNMS and RNMC) Section 1, pages 51-60; Perioperative Registered Nurse Educator Standards and Competencies (RNES and RNEC) Section 1, pages 61-68; and Perioperative Registered Nursing Practice Competencies (RNS and RNC) Section 1, pages 35-50.

environment offers a work setting in which policies, procedures, and systems are designed so that employees are able to meet organizational objectives and achieve personal satisfaction in their work.[3]

The key to a successful organization is to have empowered leaders at all levels including those at the front lines. To be a strong leader is to inspire others, develop them, and create change through them. As a perioperative nurse you can lead by flipping that switch and understanding that it's about serving the patients and the colleagues on your team.

Authentic leaders are perceived as hopeful and optimistic, as practicing with a high ethical standard, ensuring that their values are made transparent, and focusing on the priorities of their staff.**2** Leaders are defined by their unique life stories and the way that they frame these stories to discover their passions and the purpose of their leadership. The test of an authentic leader's values is not what they say but the values they practice when under pressure.

A sense of 'family' and an atmosphere of cheer within the team are commonly reported by those in healthy work environments. In healthy and effective work environments employees are treated in a respectful and fair manner. Concern and value for each person, as an individual, are apparent.[3]

Healthy work environments also exhibit a strong sense of trust between management and employees. These organizations engage and empower employees in decision-making, risk-taking, and personal and professional growth. Authentic leadership is described as the "glue that holds together a healthy work environment."[4]

Authentic leadership style is crucial in the creation of positive work environments and the professional growth and development of perioperative nurses. In order to have thriving work environments we need to cultivate the authentic leaders within all our work places.

Growing and developing as a leader is a journey that often spans one's entire career. Authentic leaders are comfortable in their own skin. They know who they are, where they came from, and how to build rapport with others.[5] Great leaders understand that their reputation for authenticity needs to be painstakingly earned and carefully managed.[6]

Are you your authentic self? Carefully consider how you approach your workplace and how you are perceived by those around you so that you can begin or continue your journey toward life-long authentic leadership! Be patient with yourself… everyone makes mistakes and often it is through our mistakes that we learn our greatest lessons in life.

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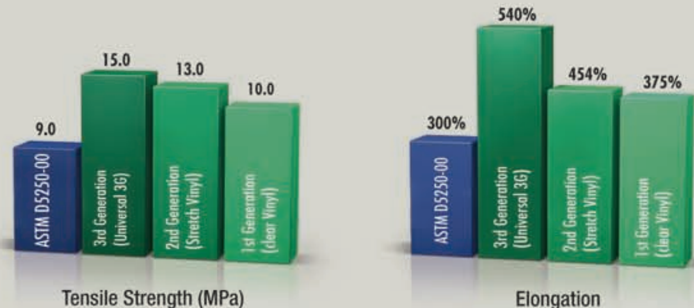

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