June 2012
Volume 30, Issue 2

ORNAC JOURNAL

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ORNAC/IFPN Conference

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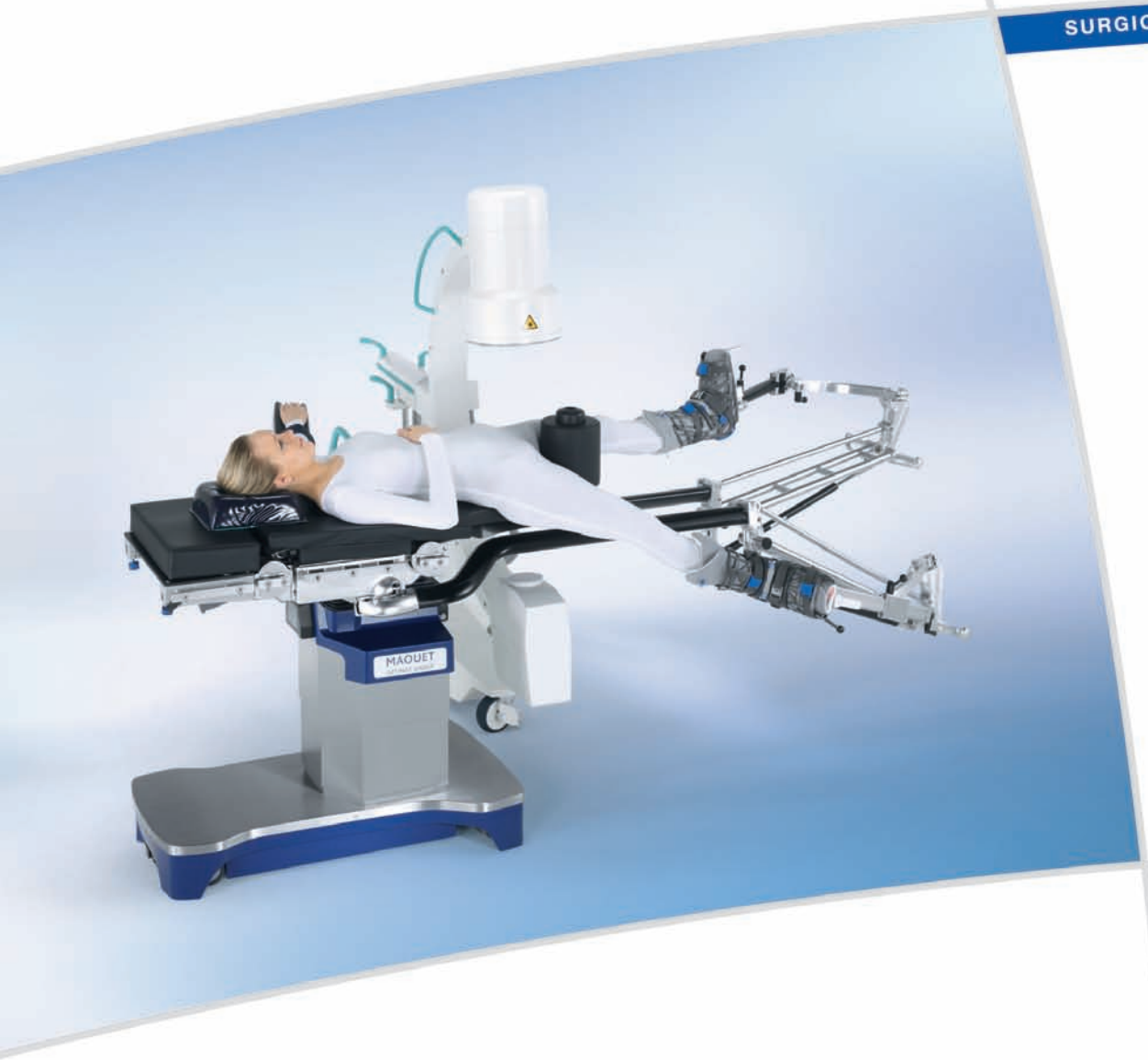

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ORNAC JOURNAL

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ORNAC MISSION

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

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

MISSION DE L'AIISOC

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

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

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PRESIDENT'S MESSAGE

Karen Frenette, RN, BN, MN, CPN(C), ORNAC President is the Surgical Suite Nurse Manager at Chaleur Regional Hospital, Bathurst, NB, a part time instructor for the University of New Brunswick Faculty of Nursing, Bathurst Campus, and the past Chair of the ORNAC Research Committee.

The arrival of the month of June marks the completion of the first year of my term as your ORNAC President. It has been a year of transition. June also brings with it the warmth of the summer sun and the beautiful colours of the summer season and is the opportune time to reflect upon the accomplishments and challenges that we have all faced over the past year.

As perioperative practice faces challenges, in this period of economic and fiscal restraint, its impact on ORNAC cannot be ignored. The timing of change within ORNAC is perfect! We must continue to move forward with the implementation of our strategic plan to meet the needs of perioperative registered nurses and create a strong future for perioperative practice. These changes are also required to conform to the new Canada Not-For-Profit Corporations Act. With change comes uncertainty as we enter unchartered waters and leave the comfort of shore. As a united body, sharing a common vision, we will accept the challenge and reach new and exciting destinations!

As perioperative leaders we are responsible for setting an example and inspiring others to work collaboratively toward a shared vision for the future. I attended a leadership institute, several years ago, and recently reflected on the knowledge that I acquired. The information provided insight into my previous years of practice, as a perioperative registered nurse, and has had a positive impact on the way I have since practiced. Perioperative registered nurses should all be leaders. It is the manner in which we practice, as registered nurses, that develops and maintains our credibility in the eyes of others. We must promote our profession and be able to articulate the importance of the care we provide to our patients, in the operating rooms across our country, and how we do it in a safe and efficient manner.

Change and challenges are not new to the profession of nursing. Perioperative Nursing is, as a result of ongoing advances in technology and new surgical developments, a dynamic and continually changing field. But with change comes tension and uncertainty. As we venture further from the security of the shore, tension mounts. Kouzes and Posner stated:

> *Without tension, there is no energy, without energy there is no movement, and without movement there is no progress.*[1]

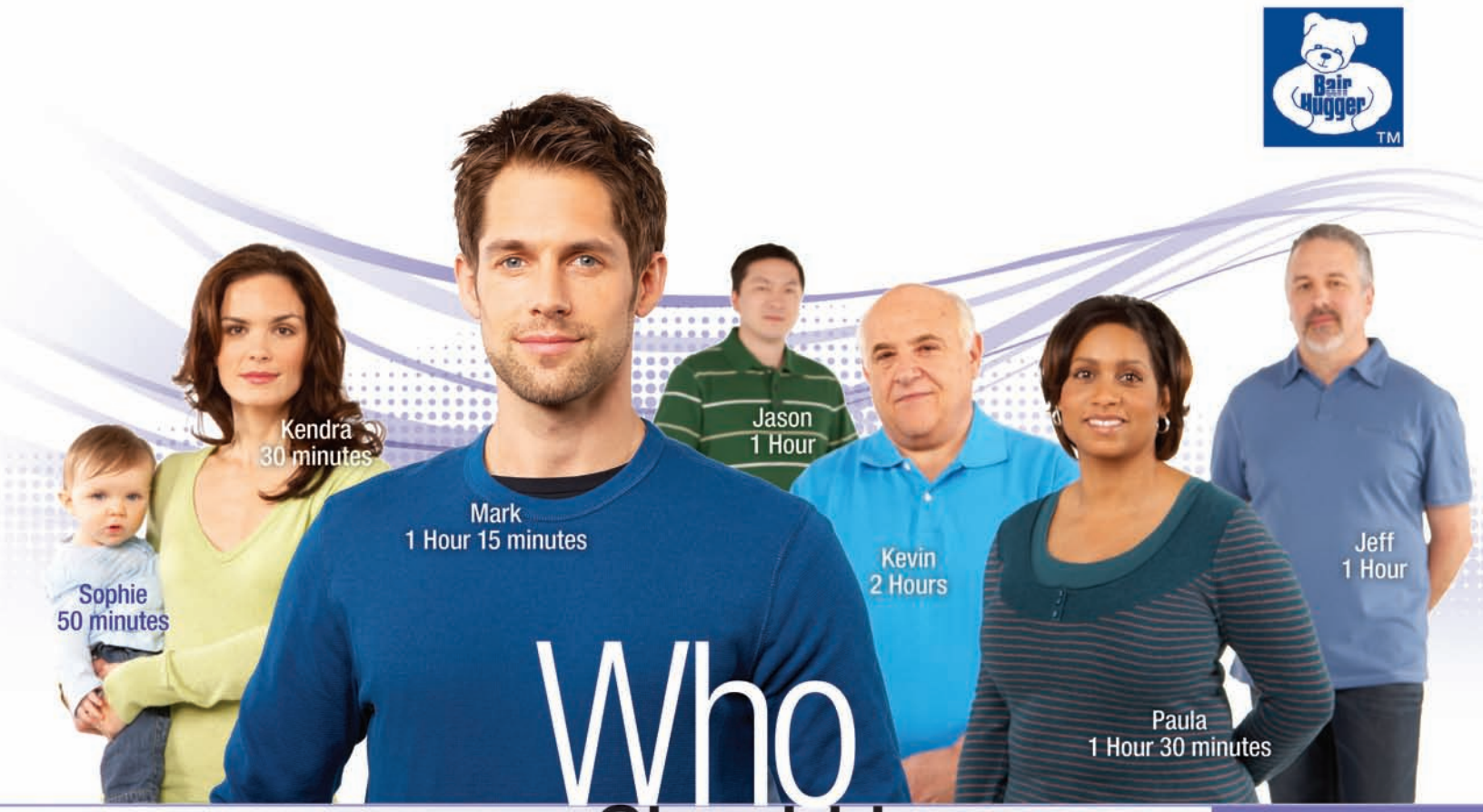
ORNAC is moving forward. With each step in the transition process we make progress and raise new questions. It is a challenge to look at things from a different perspective. The members of the ORNAC Board are your representatives during this transition. Please communicate with them. If you feel that the shared vision is inconsistent with your personal vision what should you do? The first step is to ask for clarification. Openness and transparency is required throughout each step. ORNAC is, as an organization, looking forward with a common sense of direction (as established in our strategic plan) and a concern for the future of our organization. We are positive about our future! Get involved!

Many operating rooms, from coast to coast, reduce services in the summer months. This will hopefully provide the opportunity for perioperative nurses across the country to reflect upon the opportunities that lie ahead. It is a time to rejuvenate and reflect. Have a safe and enjoyable summer!

REFERENCES:

1. Kouzes, J. & Posner, B. Credibility. New York: Jossey-Bass 1993. P 249.

As perioperative leaders we are responsible for setting an example and inspiring others to work collaboratively toward a shared vision for the future.



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MOT DE LA PRESIDENT

Karen Frenette, IA, B.Sc.Inf., M.Sc.Inf., CSP/C, la President de l'AIISOC est infirmière-gestionnaire du bloc opératoire de l'Hôpital régional Chaleur, à Bathurst, au N.-B., chargée de cours à temps partiel pour la faculté de soins infirmiers de l'Université du Nouveau- Brunswick au campus de Bathurst et ancienne présidente du Comité de recherche de l'AIISOC.

L'arrivée du mois de juin marque l'aboutissement de la première année de mon mandat à titre de présidente de l'AIISOC. Juin amène aussi avec lui la chaleur du soleil estival et les belles couleurs de l'été. C'est également le moment idéal pour réfléchir aux réalisations et aux défis auxquels nous avons fait face au cours de la dernière année qui fut une année de transition.

En cette période de contraintes budgétaires, la pratique des soins périopératoires brave des défis dont les répercussions sur l'AIISOC ne peuvent être ignorées, mais ces changements arrivent au moment opportun pour l'AIISOC! Nous devons continuer à progresser dans la mise en œuvre de notre plan stratégique afin de combler les besoins des infirmières et des infirmiers autorisés en soins périopératoires et de créer un avenir solide pour la pratique des soins périopératoires. Ces changements sont également nécessaires pour se conformer à la nouvelle loi canadienne concernant les sociétés à but non lucratif. Le changement est cependant souvent synonyme d'incertitude : avancer en mers inconnues et laisser le confort du rivage font peur. En tant qu'organisme uni, partageant une vision commune, acceptons ce défi pour découvrir de nouvelles et trépidantes destinations!

Dans notre rôle de leaders en soins périopératoires, il nous incombe de montrer l'exemple et d'inspirer les autres à travailler ensemble vers une vision commune de l'avenir. Il y a quelques années, j'ai participé à un atelier sur le leadership et, tout récemment, j'ai réfléchi aux connaissances que j'y avais acquises. L'information m'a permis de faire un retour sur mes années de pratique antérieures, en tant qu'infirmière autorisée en soins périopératoires, et a eu une influence positive sur la façon dont je pratique depuis ce temps. Les infirmières et les infirmiers autorisés en soins périopératoires devraient tous et toutes être des leaders. C'est la façon dont nous pratiquons, en tant qu'infirmières et infirmiers autorisés, qui nous permet de développer et de maintenir notre crédibilité aux yeux des autres. Nous devons faire la promotion de notre profession et être capables de justifier l'importance des soins que nous fournissons à nos patients, dans les salles d'opération à travers le pays, ainsi que la façon sécuritaire et efficace que nous travaillons.

Les changements et les défis ne sont pas une nouveauté au sein de notre profession. Les soins périopératoires sont donc, en raison des progrès continus dans le domaine de la technologie et des nouveaux développements en chirurgie, un domaine dynamique et continuellement en évolution. Mais encore une fois, le changement est cependant souvent synonyme de tensions et d'incertitude : quitter la sécurité du rivage accroît les tensions. Kouzes et Posner ont déclaré :

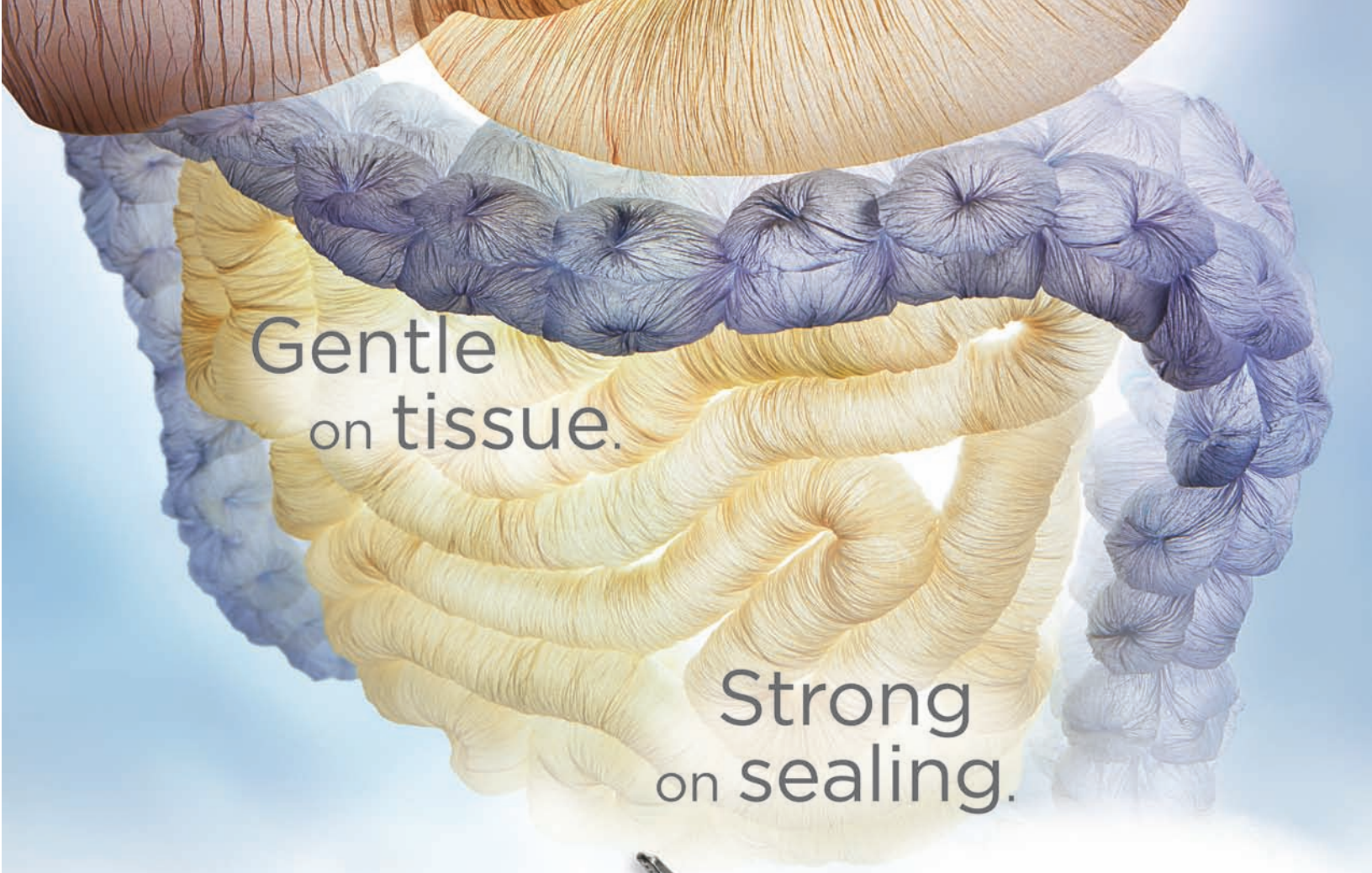
> Sans la tension, l'énergie n'existerait pas, sans énergie, il n'y aurait pas de mouvements et sans mouvement, le progrès ne serait pas possible .[1] (Traduction libre)

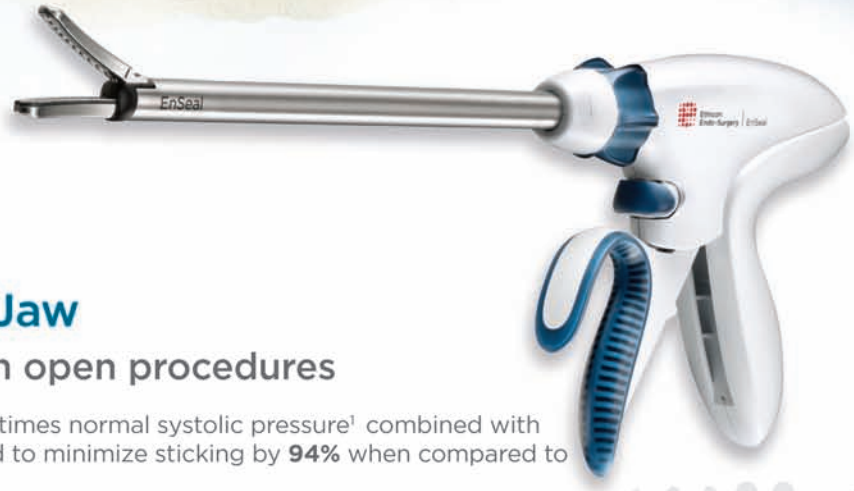
L'AIISOC continue d'avancer. Avec chaque étape du processus de transition de l'AIISOC, nous faisons des progrès et nous soulevons de nouvelles questions. Regarder les choses d'un autre point de vue présente un défi. Les membres du conseil d'administration de l'AIISOC vous représentent au cours de cette transition, alors n'hésitez pas à communiquer avec eux. Que faire si vous avez l'impression que notre vision commune ne correspond pas à votre vision personnelle? Tout d'abord, nous vous conseillons de demander une clarification. L'ouverture d'esprit et la transparence sont nécessaires dans chaque étape. En tant qu'organisme, doté d'un sens de l'orientation commun (tel que déterminé dans notre plan stratégique), l'AIISOC attend avec fébrilité et s'inquiète de l'avenir de notre organisme. Restons positifs quant à notre avenir et impliquons-nous!

Dans notre rôle de leaders en soins périopératoires, il nous incombe de montrer l'exemple et d'inspirer les autres à travailler ensemble vers une vision commune de l'avenir.

De part et d'autre du pays, de nombreuses salles d'opération réduisent les services qu'elles offrent au cours de l'été. Nous espérons que cette période permettra aux infirmières et aux infirmiers en soins périopératoires de réfléchir aux opportunités qui s'offrent à eux. Profitons-en pour se régénérer et réfléchir. Passez un bel été!

RÉFÉRENCES :
1. Kouzes, J. & Posner, B. Credibility. New York: Jossey-Bass 1993. P 249.





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EXECUTIVE DIRECTOR'S MESSAGE

Catherine Harley, RN, eMBA, ORNAC Executive Director

ORNAC at Work!

The ORNAC Board of Directors has been actively addressing the future of ORNAC through strategic planning, the Board Governance Initiative, and the development of the ORNAC Pillars (through which the work of the Board will be implemented in future). The Chairs of the five ORNAC Pillars have, during the past few months, been appointed by the ORNAC Board. They are Margot Walsh, St. John's, NL, for National Conference Planning; Tracie Scott, of Markham, ON, for Professional Practice; Pat Pocock of Lucan, ON (By-laws and Nominations) and Bonnie McLeod of Maple Ridge, BC (Collaborative Initiatives) will Co-Chair the Advocacy pillar; Christina Bilopavlovic of Hamilton, ON, for Research and Informatics; and Charlotte Roach of Aroostook, NB, for Marketing. ORNAC is in the process of completing the Terms of Reference, for each Pillar, for review/approval by the Board.

The **National Conference Planning Pillar** is progressing with the exciting plans for the 2013 ORNAC National and International Conference, with IFPN, taking place in Ottawa, ON, April 21-25, 2013. National Exhibitors Advisory Committee (NEAC) has been actively involved in the planning discussions and has provided support to the National Conference Planning committee. Conference registration will be available soon at www.ORNAC.ca.

In the **Professional Practice Pillar** there has been strong emphasis on the *Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice* (known informally as the ORNAC Standards) and around completing an updated French version. The next version of the ORNAC Standards will be available at the 2013 ORNAC/IFPN Conference.

The **Advocacy Pillar** has been focused on aligning ORNAC within the *new Canada Not-For-Profit Corporations Act* that was announced in October 2011. Draft Articles of Continuance have been formulated and the ORNAC By-laws are being rewritten to incorporate the new Governance structure. ORNAC participated in the December *Canadian Patient Safety Institute* Board Meeting and has been involved in three *Canadian Nurses Association* teleconferences for associate groups including discussion around the Request for Proposals for rewriting the RN Exam and the successful bid of the American-based National Council of State Boards of Nursing (NCSBN). Further information on this issue can be found at www.cna-aiic.ca.

The **Research and Informatics Pillar** has been working on maintenance of the ORNAC website and future plans for website development to better meet the needs of Perioperative Registered Nurses and Associates across Canada.

The **Marketing Pillar** has supported the development of a document called "Who is a Perioperative Registered Nurse" as well as the new *ORNAC Mission, Vision and Values*. Both documents were used to promote ORNAC and Perioperative Nursing at the Canadian Student Nurses Association meeting in February 2012. The new ORNAC Journal was successfully launched in March of this year. We have been receiving feedback and will continue to refine the Journal as we move into the future. Thank you to our ORNAC Journal Committee Barb Mushayandebvu, and Tracie Scott, as well as our Editor, Deborah Murphy, and her team at Clockwork Communications, for their outstanding contributions to the launch.

We want to receive your input on anything related to ORNAC and its future. Please do not hesitate to contact me at catherine.harley@sympatico.ca. Your involvement will help create the strongest future for ORNAC and contribute to enhancing patient safety and advancing the profession of perioperative registered nursing.

Your involvement will help create the strongest future for ORNAC and contribute to enhancing patient safety and advancing the profession of perioperative registered nursing.

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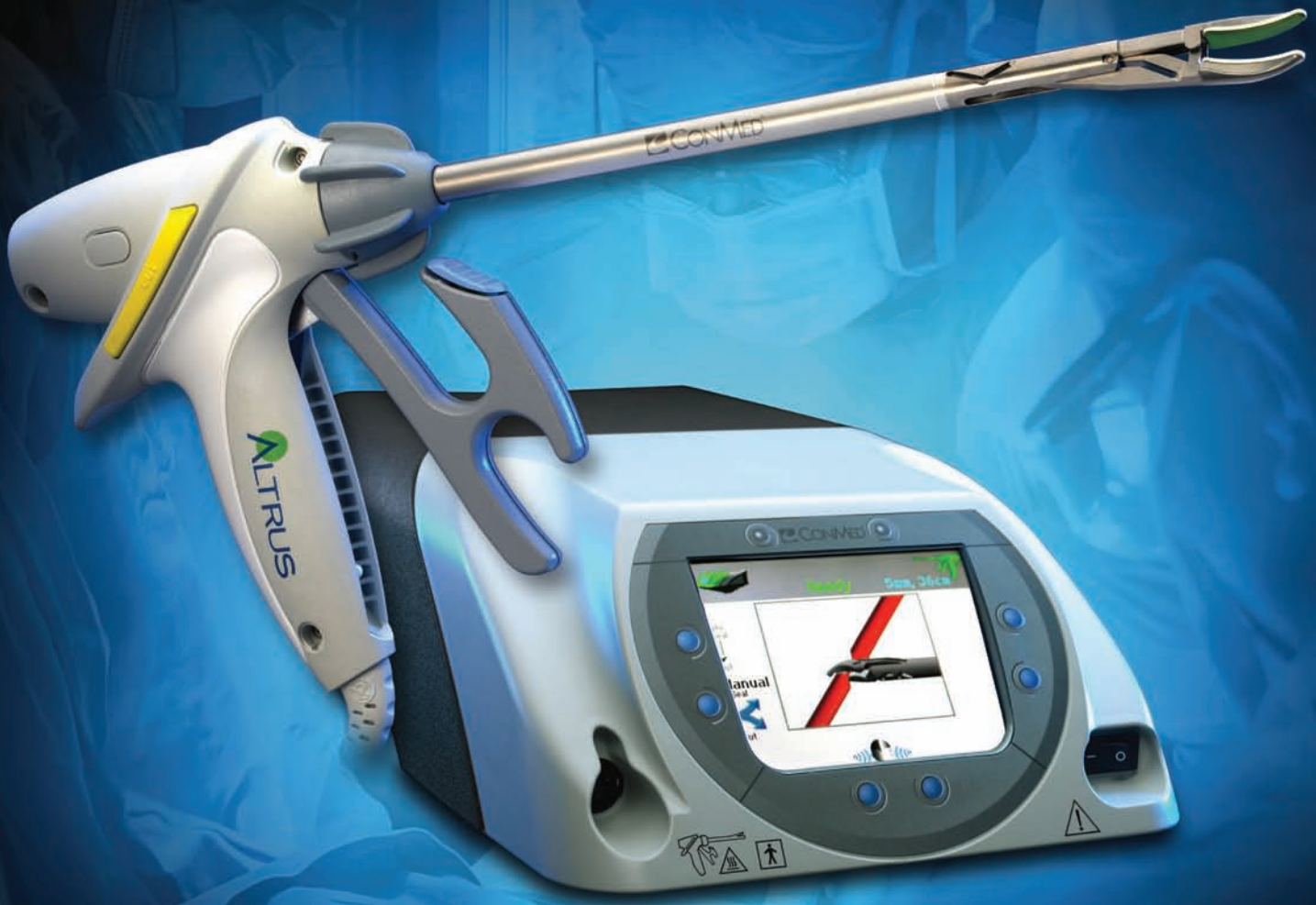

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MESSAGE DE LA DIRECTRICE GÉNÉRALE

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

L'AIISOC au travail!

Le conseil d'administration de l'AIISOC aborde activement depuis quelque temps l'avenir de l'AIISOC par le biais de son plan stratégique, de l'initiative de gouvernance du conseil et de l'élaboration des piliers de l'AIISOC (par l'entremise desquels le travail du conseil sera mis en œuvre à l'avenir). Les présidentes des cinq piliers ont, au cours des derniers mois, été nommées par le conseil d'administration de l'AIISOC et les voici : Margot Walsh, de St. John's, T.-N., pour la planification des conférences nationales, Tracie Scott, de Markham, ON, pour la pratique professionnelle, Pat Pocock de Lucan, ON (règlements administratifs et mises en candidatures) et Bonnie McLeod de Maple Ridge, C.-B. (initiatives de collaboration) coprésideront le pilier de la défense des droits, Christina Bilopavlovic d'Hamilton, ON, pour la recherche et l'informatique ainsi que Charlotte Roach d'Aroostook, N.-B., pour le marketing. L'AIISOC achève actuellement de développer les mandats de chaque pilier qui seront soumis au conseil d'administration aux fins de révision et d'approbation.

Le **pilier de la planification des conférences nationales** va de l'avant avec des projets trépidants pour la conférence nationale et internationale 2013 de l'AIISOC avec l'IFPN, qui aura lieu à Ottawa, ON, du 21 au 25 avril 2013. Le National Exhibitors Advisory Committee (NEAC) s'est impliqué de façon dynamique dans les discussions concernant la planification et a offert son soutien au comité de la planification des conférences nationales. Vous pourrez vous inscrire à la conférence à compter en visitant www.AIISOC.ca.

Dans la cadre du **pilier de la pratique professionnelle**, nous avons mis l'accent sur le document Normes, *lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés* (connu de façon non officielle comme les normes de l'AIISOC) que nous avons mis à jour en version française. La prochaine version des normes de l'AIISOC sera disponible lors de la conférence de l'AIISOC/IFPN de 2013.

Le **pilier de la défense des droits** s'est quant à lui concentré sur les mesures nécessaires pour adapter *l'AIISOC à la nouvelle Loi canadienne sur les organismes à but non lucratif* qui a été annoncée en octobre 2011. Des ébauches des clauses de prorogation ont été exposées et les règlements administratifs de l'AIISOC sont en train d'être à nouveau rédigés afin d'y incorporer la nouvelle structure de gouvernance. En décembre, l'AIISOC a participé à la réunion du conseil d'administration de *l'Institut canadien pour la sécurité des patients* et a participé à trois téléconférences de *l'Association des infirmières et infirmiers du Canada* en tant que groupe associé et qui comprenaient des discussions concernant les demandes de propositions pour développer un nouvel examen d'autorisation infirmière et l'offre retenue du National Council of State Boards of Nursing (NCSBN), une entreprise

Votre participation nous aidera à créer un avenir plus solide pour l'AIISOC, contribuera à améliorer la sécurité des patients et à faire progresser la profession des infirmières et des infirmiers autorisés en soins périopératoires.

américaine. Pour de plus amples renseignements à ce sujet, veuillez visiter : www.cna-aiic.ca.

Le **pilier de la recherche et de l'informatique** s'efforce de maintenir à jour le site Web de l'AIISOC et prévoit des projets ultérieurs pour le développement du site Web afin qu'il réponde mieux aux besoins des infirmières et des infirmiers en soins périopératoires et des associés à travers le Canada.

Le **pilier du marketing** a appuyé l'élaboration des documents intitulés : « Who is a Perioperative Registered Nurse » (en anglais seulement) ainsi que Nouvelle *mission, nouvelle vision et nouvelles valeurs de l'AIISOC*. Ces deux documents ont été utilisés pour faire la promotion de l'AIISOC et des soins périopératoires lors de la réunion de *l'Association des étudiant(e)s infirmier(ière)s du Canada* en février 2012. Enfin, la nouvelle revue de l'AIISOC a été lancée avec succès au mois de mars de cette année et nous avons reçu vos commentaires dont nous nous servirons pour peaufiner la revue au fur et à mesure. Je tiens à remercier le comité de la revue de l'AIISOC, soit Barb Mushayandebvu et Tracie Scott ainsi que la rédactrice en chef Deborah Murphy et toute l'équipe de Clockwork Communications pour leur contribution exceptionnelle au lancement de la revue.

J'aimerais beaucoup que vous me faissiez part de tout commentaire concernant l'AIISOC et son avenir. N'hésitez pas à communiquer avec moi en m'écrivant à l'adresse suivante : catherine.harley@sympatico.ca. Votre participation nous aidera à créer un avenir plus solide pour l'AIISOC, contribuera à améliorer la sécurité des patients et à faire progresser la profession des infirmières et des infirmiers autorisés en soins périopératoires.

LE RÔLE DES INFIRMIÈRES ET DES INFIRMIERS EN SOINS PÉRIOPÉRATOIRES DANS LE FINANCEMENT AXÉ SUR LE PATIENT

Auteure : *Leanne Thain, IA, B.Sc.Inf., M.Sc.S., est membre de la PRNABC et a travaillé en tant qu'infirmière en soins périopératoires et gestionnaire de programme chirurgical. Tout récemment, elle a occupé le poste de gestionnaire de la mise en œuvre stratégique et a mis en place avec succès un système informatique normalisé unique pour les salles d'opération, y compris une restructuration opérationnelle, à travers douze hôpitaux dans la région où les soins de santé sont le plus en demande en C.-B. En mettant au centre des efforts l'importance d'offrir aux patients des soins de qualité, Leanne a bon espoir que les données utilisées pour le « financement axé sur le patient » (FAP) se développeront et serviront à faire la promotion d'une approche basée sur les soins de santé primaires grâce à l'éducation du public et à de la collaboration pour obtenir des résultats.*

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L'auteure a déclaré n'avoir aucune affiliation qui pourrait être perçue comme un conflit d'intérêts.

RÉSUMÉ :

Toutes les provinces de part et d'autre du Canada font actuellement face à de longues périodes d'attente pour les chirurgies. La Colombie-Britannique (C.-B.) a récemment mis en œuvre une stratégie améliorée, appelée le financement axé sur le patient (FAP) au moyen de laquelle les autorités sanitaires obtiennent des fonds supplémentaires pour effectuer des chirurgies additionnelles. Les changements à travers tout le système, lorsqu'ils sont apportés sans que tous les partis impliqués ne s'engagent, produisent rarement les résultats prévus, ce qui porte à croire que le FAP bénéficierait de la participation de toute l'équipe de salle d'opération. Les infirmières et les infirmiers en soins périopératoires, dans leur rôle de porte-parole des patients, sont bien placés pour observer et signaler les résultats axés sur le patient, limitant ainsi les conséquences imprévues et négatives associées aux changements proposés. Cet article vise à renseigner les infirmières et les infirmiers en soins périopératoires du Canada au sujet du FAP et à leur expliquer la raison pour laquelle il est important qu'ils participent. Au moment d'écrire cet article, les provinces de l'Ontario et de l'Alberta avaient également annoncé des projets afin de mettre en œuvre une forme ou une autre de FAP. On s'attend à ce que, si elle s'avère fructueuse, l'expérience de la C.-B. soit probablement reproduite dans d'autres provinces.

KEYWORDS: PATIENT-FOCUSED FUNDING, ACTIVITY-BASED FUNDING, PATIENT ADVOCATE, CHANGE, UNINTENDED CONSEQUENCES.

THE PERIOPERATIVE NURSE'S ROLE IN PATIENT-FOCUSED FUNDING

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The author declares no affiliation which could be perceived as a conflict of interest.

ABSTRACT:

All provinces across Canada are currently struggling with long surgery wait times. British Columbia (BC) has recently implemented an improvement strategy called Patient Focused Funding (PFF) whereby health authorities are offered additional money for completing extra surgeries. System wide change, when made without engagement by all involved parties, rarely achieves expected outcomes suggesting PFF would benefit from the participation of the entire operating room (OR) team. Perioperative nurses, in the role of patient advocate, are well suited to observe and report patient focused outcomes thereby limiting the unintended and negative consequences associated with proposed changes. This article seeks to inform Canadian perioperative nurses about PFF and explain why it is important for nurses to participate. At the time of writing, Ontario and Alberta had also announced plans to implement some form of PFF. It is anticipated that, if proven successful, BC's experience will likely be duplicated in other provinces.

INTRODUCTION:

The health care system is under pressure to improve quality and increase efficiencies yet many of the initiatives for change that are introduced fail to deliver anticipated results.[1] In 2010, British Columbia (BC) introduced patient focused funding (PFF) as a new incentive program to increase the number of surgeries performed using existing resources. PFF is, however, at great risk of falling short of expectations without the support of the entire perioperative team. The purpose of this article is to provide information about what PFF is and to summarize recommendations for the perioperative nurse's consideration in order to increase the likelihood that PFF will achieve successful outcomes. This article does not discuss the issue of whether PFF should, or should not, be implemented.

Background

Developments in Operating Room (OR) department data collection systems have provided the BC Health Ministry with valuable information that has been used to design and implement evidence-based change. PFF represents a significant shift in the way hospitals will receive funding for patient surgeries both now and in the future. PFF is designed to create a competitive environment and offers financial incentive directly to health care providers who are able to increase productivity by making improvements to surgery effectiveness and efficiency.[2,3] Today's efficient ORs are described as those able to produce higher surgical volumes from their present staff through methods such as reducing patient length of stay and by increasing the number of staff to patient contacts on a daily basis.[4]

Perioperative nurses identify patient advocacy as a core competency.[5,6] PFF results in a significant change in the OR environment and the impact to patient care remains mostly unknown. Changes made to complex, dynamic systems, such as those used in the OR, can result in unintended and negative

consequences.[7] Increasing patient access to surgery is a complicated multi-system issue. It would, therefore, benefit from a collaborative and multi-stakeholder approach in order to provide the opportunity for an expert panel to review solutions, prior to implementation, and thereby reduce negative outcomes.[7] PFF provides the opportunity for perioperative nurses to act as the patient advocate during a significant system wide change thus ensuring the surgical patient's best interests are identified and protected.

What is PFF?

PFF, as outlined in Table 1, is a model based on the combination of activity-based funding plus payment for performance.[8] Both of these funding models directly relate the health care provider's performance to levels of financial compensation.[9] Activity-based funding pays bonuses for extra procedures performed but the addition of pay for performance means PFF also pays extra money for supporting both quality and efficiency improvements within the OR environment.[2,3,8]

PFF is designed to promote best practice patient care by providing additional funding for some health services. Service performance levels are measured using six quality dimensions: acceptable; appropriate; accessible; safe; effective; and efficient health care provision.[8] PFF is, under the BC model, expected to improve patient access to surgery by paying health authorities extra money for completing more surgeries as well as offering additional incentives to contain costs and introduce further innovation into the OR while preserving quality patient outcomes.[2,3]

PFF differs greatly from block funding models that have traditionally been used in Canada. Block funding provides an annual, upfront, lump sum payment to cover anticipated operational expenses.[10] Block funding has been criticized for contributing to long surgery wait times because each surgery performed is considered an expense with every patient taking money out of the budget. As the year progresses and block budgets begin to run short, OR closures are often applied to save money until the next funding cycle begins. A described advantage of block funding is its ability to control costs.[10] PFF removes the incentive behind these OR closures.

What are the objectives of PFF?

The objectives of PFF include reducing wait times for some surgeries and increasing the volume of same-day surgeries by decreasing the number of overnight hospital stays.[2,3] Participating health authorities (HAs) will, under the PFF model, receive additional funding when they successfully complete more targeted surgeries and shift overnight patient stays to same day surgery. Some patients benefit from priority access to surgery, some physicians benefit from increased access to OR time, and HAs are paid directly for the extra work.

Gaming

An often discussed risk associated with PFF is known as gaming. Gaming is said to occur when health providers attempt to increase their earnings by changing patient scheduling and selection practices.[9,10] Examples of gaming in the OR occur when PFF surgeries are favoured over non PFF surgeries and when simple, less complex surgeries are chosen over lengthy, complex surgeries to maximize patient throughput.[10]

Table 1

Patient Focused Funding = Activity-Based Funding + Pay for Performance[8]	
Activity-Based Funding • Payment for a unit of work • Rewards efficiency within existing resources	Pay for Performance • Payment for quality dimensions • Rewards timely access to care

Australia was the first country to introduce activity-based funding initiatives in the early 1990s as a strategy to reduce wait times.

The extent of gaming in the BC experience remained unclear at the time of this writing because the initiative was still new and publicly reported data was limited. PFF surgery payments do not, however, occur until the hospital meets its annual, block-funded expected volume of surgeries.[8] This is expected to minimize gaming because only those surgeries performed over and above normal volumes are eligible for additional PFF payments.

Where else has PFF been introduced?

Australia was the first country to introduce activity-based funding initiatives, in the early 1990s, as a strategy to reduce wait times.[2,11] Reports indicate that, within a year of making the funding change, waitlists dropped by 16%.[2,11] In 2006, Norway shifted 40% of health funding to activity-based funding and has since reported a very small improvement in hospital activity.[2,11] The United Kingdom reported that their similar model, payment-by-results, has positively contributed to improving hospital efficiencies.[2,11]

In Canada, PFF experiences are still very new and somewhat limited. In 2010, Alberta initiated activity-based funding for nursing homes and Ontario reported activity-based funding as a method to increase procedures in designated priority areas.[11] In 2011 Ontario announced further plans to increase activity-based funding within larger hospitals.[11] BC's experience with PFF has not been limited to the OR and also includes other priority areas such as bonus pay for increasing access to magnetic reasoning imaging (MRI) procedures and increasing patient through-put in the emergency department (ER).[8]

Who are the stakeholders in PFF?

At this time, the primary stakeholders in BC's PFF program are the BC Health Ministry, represented by the office of the Health Services Purchasing Organization (HSPO), and the participating HAs.[2,3,8] Each HA works on behalf of its individual hospitals and contracts directly with the HSPO to complete a number of additional PFF surgeries.[2,8] Once contracts are signed, it is up to each hospital OR department to perform the extra PFF surgeries.

In 2010, the British Columbia Medical Association (BCMA) developed a policy paper on PFF. In it the BCMA recommended more direct collaboration should occur between the BCMA and the HSPO in the design, implementation, and measurement of PFF outcomes.[11] The BCMA has also recognized the absence of the patient as stakeholder and recommends patient representatives should actively participate in developing PFF success measures.[11]

Limiting the stakeholders who are involved in the development and implementation of PFF may result in not all potential program benefits being achieved.[4] Each member of the perioperative team can provide a unique perspective on system improvements.[12] Engaging directly with the entire perioperative team can result in additional opportunities to improve overall quality and efficiency. Frontline perioperative nurses offer a diverse and patient focused background that is well suited to championing many quality improvements.[12] Perioperative nurses also have, in the early stages of change, the unique opportunity to participate in PFF planning by identifying system improvements that ensure a high level of quality patient care.

When is PFF occurring?

PFF for surgeries in BC was introduced in 2010 at twenty-three hospitals throughout the province.[2] Not all hospitals are currently participating and the impact to those communities that were not included has not yet been reported. In the future PFF will likely spread to all communities because the Ministry of Health has announced plans to change funding proportions further in order to have an overall ratio of 80% block funding and 20% PFF by 2012/2013.[3]

Determining Priority

Surgery wait times are assigned an anticipated and acceptable number of

weeks to wait called a wait time target.[2,3,8] Hospital Administrators, Surgeons, HAs, and the Ministry of Health actively monitor and compare patient actual wait times to the wait time target. The surgeries eligible for PFF are the ten procedures where patients are waiting the longest for their surgeries, as well as surgeries where the HAs feel priority should be placed, and this list is adjusted on an ongoing basis.[2,3,8]

The impact on patients waiting for non PFF surgeries remains unknown. Non PFF surgeries are completed within the traditional block funding model and, as a result, continue to remain at risk for long wait times. Because PFF targeted surgeries are adjusted based on wait times, however, surgical procedures with long waits will likely be moved up to the top ten list and therefore become eligible for PFF.

Some HAs have struggled to balance expected block activity with the additional PFF contracted cases. Some of these HAs have, in order to address shortages, sub-contracted out PFF surgeries to private surgery centers. These contracted out surgeries continue to count towards the HA's overall PFF surgical volumes and therefore indicate program success.[8]

How can nurses prevent unintended consequences?

Change rarely occurs without unintended consequences.[4,7] Nurses can help to minimize some of the risks associated with PFF by arming themselves with information. Hospitals are required to report data describing trends such as post-operative infection rates, numbers of patients waiting for surgery, and how many surgeries were actually completed. Nurses can ask their managers to share information at regular staff meetings so they can become involved in outcomes and track progress. This also provides an open forum for peer-recognition and to celebrate successes. When access to program information and outcomes is limited the frontline perioperative nurses may not even be aware of the objectives for PFF or the role they can play in its success.

PFF programs have been criticized for shifting the emphasis from quality to quantity.[9,10] In the early stages of PFF implementation it appears that the priority quality dimension measured is limited to patient access.[8] Front line nurses are well situated to identify changes in quality patient care during the surgical procedure. Perioperative nurses can, by understanding the selection process used for PFF surgeries, help to protect against risks, such as gaming, by ensuring non PFF cases are also part of the regular OR workload. In Canada all patients should receive equal access to health care regardless of whether or not they are on a PFF surgery list.

Frontline perioperative nurses are also well situated to identify OR efficiencies. PFF pays a set fee for each surgery and, to demonstrate accountability, HAs will need to identify if they are able to perform surgeries within the fee budgeted. Perioperative nurses will likely be asked to audit, review, and report items used in patient surgeries in order to calculate surgery costs. This information is important because it will determine which surgeries are able to be completed within the set fee budgeted and can even identify some surgeries which could generate a profit. Perioperative nurses have the unique opportunity to have a direct impact on their hospitals' financial future.[12]

CONCLUSION:

Activity-based and patient-focused funding incentive programs have arrived in Canada's healthcare system. Improvements in OR data collection systems have provided the basis for BC's Health Ministry to implement PFF. PFF, as a quality improvement strategy, will increase some patients' access to surgery. Because of the isolated approach in design and implementation PFF remains, however, at significant risk of not achieving expectations and may even cause unintended and negative consequences. Perioperative nurses will, by being aware of the changes associated with PFF, be well positioned to serve as change participants and patient advocates by helping to ensure program successes do not occur at a cost to quality patient care.

Activity-based and patient-focused funding incentive programs have arrived in Canada's healthcare system.

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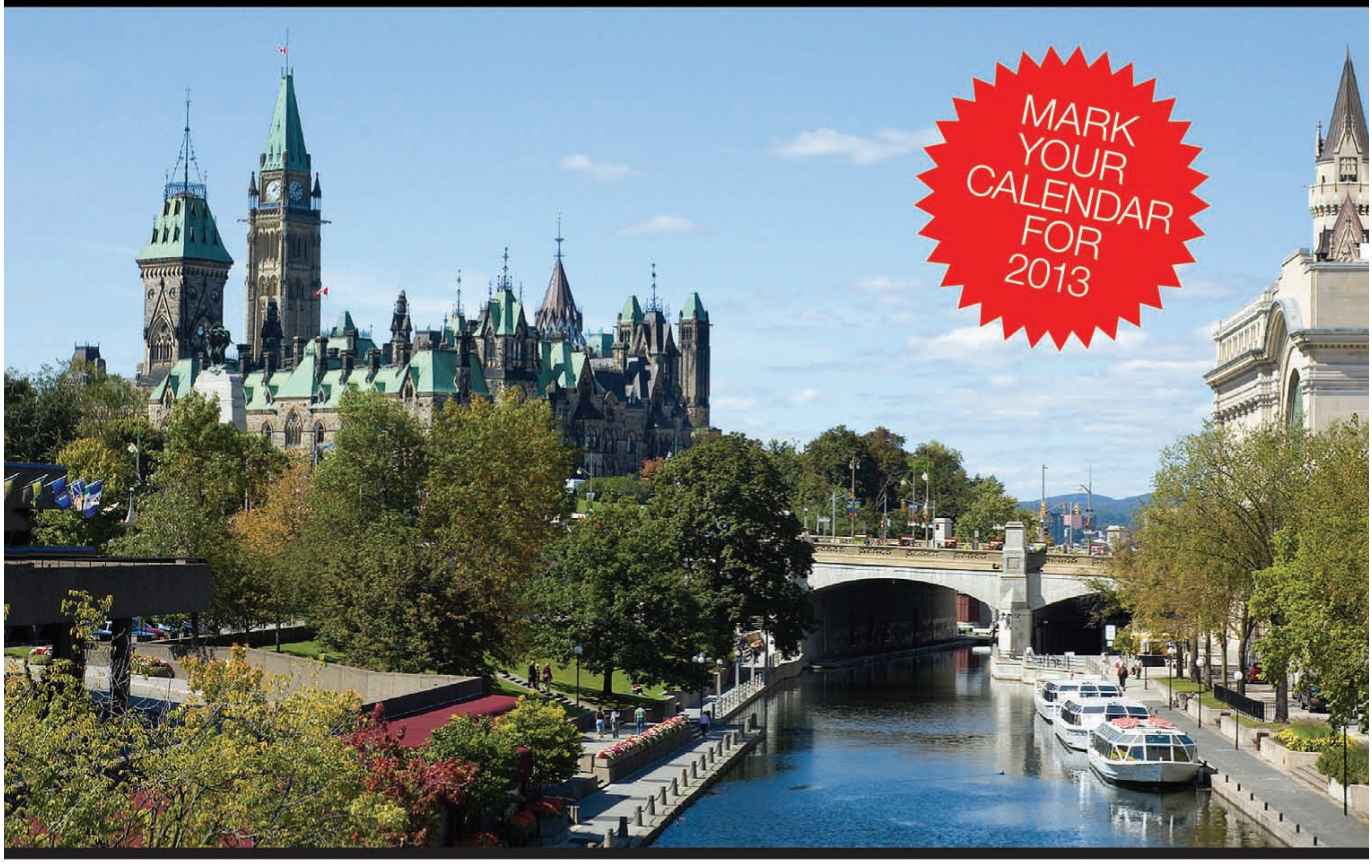

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LES TENDANCES HISTORIQUES INFLUENCENT LE FUTUR DE LA PRATIQUE DES SOINS PÉRIOPÉRATOIRES

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RÉSUMÉ :

Cet article examine les tendances historiques qui ont façonné la spécialité des soins périopératoires. Nous nous pencherons sur l'influence exercée par l'éducation, la société et la politique à travers différentes périodes historiques. Après avoir été la première spécialité à être reconnue dans le domaine des soins infirmiers, les soins infirmiers de salles d'opération ont par la suite été supprimés du programme d'éducation en soins infirmiers. Il s'ensuivit un débat qui continue de battre son plein à ce jour à savoir si les soins périopératoires sont simplement une spécialisation ou véritablement des soins infirmiers en tant que tel. De nos jours, le manque d'exposition des étudiants aux salles d'opération, les programmes de préceptorat médiocres et les mauvaises conditions de travail engendrent d'importants défis sur le plan du recrutement et de la rétention. En raison du fait que ces tendances historiques ont mené au déclin des soins périopératoires, il est essentiel que les infirmières et les infirmiers actuels comprennent les facteurs influençant notre pratique et qu'ils s'efforcent tous ensemble d'influencer de manière positive l'avenir de notre spécialité.

KEYWORDS: EDUCATIONAL TRENDS, SOCIETAL TRENDS, POLITICAL TRENDS, PERIOPERATIVE NURSING.

HISTORICAL TRENDS INFLUENCING THE FUTURE OF PERIOPERATIVE NURSING

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ABSTRACT:

This paper explores the historical trends that have shaped the perioperative nursing specialty. The educational, societal, and political influences are examined through different historical periods. After, initially, being the first recognized nursing specialty operating room nursing was later removed from the nursing education curriculum. A debate as to whether perioperative nursing was simply a technical skill or actually "real" nursing was beginning and it continues to this day. Today, students' lack of exposure to the operating room, unsuccessful preceptorship programs, and poor working conditions are creating major recruitment and retention challenges. Because these historical trends have led to the decline of perioperative nursing, it is crucial for modern nurses to understand the factors that are influencing our practice and to make collective efforts to positively influence the future of our specialty.

INTRODUCTION:

The operating room is a mysterious and fascinating environment. There is evidence of surgery dating back to pre-historic times. In 1966, a child's skull dating back from the Iron period (1100-800 BC) was found in Iran. It showed evidence of having had a trepanning procedure (burr holes).[1] However, it was not until the late 1800s that medical advancements such as anaesthesia, aseptic techniques, antibiotics, and antisepsis made surgery a beneficial and safer option.[2] As surgery became more complex the need for qualified assistants developed. With the advent of modern medicine, and the scientific paradigm, nurses were considered the most qualified professionals to become surgical assistants. McGarvey, Chambers, & Boore[2] report that by the end of the 19th century, operating room nursing was of such prestige that it had become recognized as nursing's first specialty.

Today perioperative nursing is no longer part of the basic nursing education curriculum and there is a higher average of nurses eligible for retirement.[3] Both the American and the Canadian operating room nurses' associations (AORN and ORNAC) have recently reported major decreases in membership levels.[4,5] With the increase in retirements, and the challenges of recruiting and retaining nurses in nursing specialties, perioperative nursing is at risk of becoming extinct.

This paper will discuss the historical trends that have affected Perioperative nursing and their long-term impact on the recruitment and retention of perioperative nurses. For each historical period, we will review the long-term effects of the educational, societal, and political influences on the perioperative nursing specialty. Nurses should understand these trends to prevent further loss of registered nurses in the operating room and to protect the future of perioperative nursing.

Perioperative nursing was introduced as part of the nursing education curriculum as early as 1880.

1880-1960: The Golden Years of Perioperative Nursing

As surgery gained popularity, in the late 1800s, so did perioperative nursing. The specialty could boast social and professional prestige. In 1947 the operating room nurse's monthly wage was $110.50 as compared to $100.00 for the General Duty Nurse.[6] The additional monetary compensation demonstrates the value placed on perioperative nursing. McPherson[6] noted that only nurses were able to assist in the operating room. They had ultimate responsibility for anything related to the operating room from sterilization of the instruments to assisting the surgeons. During this period various educational, societal and political influences were beginning to shape perioperative nursing's future for years to come.

Perioperative nursing was introduced as part of the nursing education curriculum as early as 1880.[2] Working in the operating room demanded a rigorous aseptic technique and the strict adherence to the asepsis principles. Because of the high technical knowledge, needed to assist in surgery, working in the operating room was considered a reward for senior student nurses. Surgeons expected only staff nurses to assume the role of scrub nurse.[6] In a medical hierarchy, that situated the surgeon at the top, and the operating room nurses had power over the medical staff. Describing an incident in an operating room, during World War I, McPherson recalls "Even if the officer corps had yet to appreciate the principles of sterile surgical conditions, the nursing staff certainly did." (p.85)[6] After the Second World War, however, the graduate nurse's role in the operating room began to be questioned. To nursing educators, and managers, the perioperative nurse's role appeared to be a technical one. By focusing on the technical skills, such as scrubbing, gowning, gloving, and the use of highly technical surgical instruments, the caring aspect of perioperative nursing was overlooked. Students' rotation time to the operating room started, in consequence, to decrease and the specialty began to lose some of its prestige.[2]

In 1965, to ensure high standards of practice and protect the public, AORN introduced the national standards of practice.

1960-2000: The Decline of Perioperative Nursing

In the early 1960s the debate, about perioperative nursing being a purely technical skill, intensified. The technological focus of the specialty was, and still is, considered by many as incompatible with the caring aspect of nursing.[7] During this period the perioperative nurse also began to be stereotyped as the "handmaiden" of the surgeon and thus perioperative nursing became second-class.

In 1965, to ensure high standards of practice and protect the public, AORN introduced the national standards of practice. To promote patient safety, and validate perioperative nursing competence, AORN also introduced the perioperative nursing certification. In 1983, in order to defend Canadian perioperative nurses' interest, ORNAC was inaugurated. In 1986, it published the first Canadian standards of practice and today supports the perioperative nursing certification offered by the *Canadian Nurses Association* (CNA).

During this period, students' perioperative nursing training was centered on technical skills such as the aseptic technique, scrubbing, gowning, gloving, and basic instrument knowledge. This emphasis on the technical aspects of the specialty further fostered the perception that OR nursing was a technical trade and not a genuine nursing specialty.[8] In the late '60s and early '70s nursing education started moving from hospital-based training programs to Colleges and Universities. During this period operating room rotation was abandoned from the academic curriculum.[9] Because students were not being exposed to the specialty they were less likely to choose perioperative nursing as a career after graduation.[10]

Because perioperative nursing was no longer included in the basic nursing curriculum, hospitals were forced to create in-house training programs based on the preceptorship model. These training programs varied in length and quality from hospital to hospital. These preceptorship programs were modeled after the hospital-based training programs of technical skills acquisition. They were not taught as part of a holistic practice based on nursing theory. This further reinforced the idea that perioperative nursing was a technical trade.

In the early 1980s Canadian professional associations set the goal to make the 4 year baccalaureate mandatory as the entry-to-practice education by the year 2000.[11] Misunderstandings about the role of the perioperative nurses had some nursing leaders and managers questioning the value of a highly educated, and more expensive, nursing professionals. Discussions about replacing the RN with other, less trained and less expensive, professionals began.

While these changes in nursing education were happening the reality of nursing employment was also going through some changes. Cyclical nursing shortages, an increased work pace, and generally poor working conditions were, as in all areas of nursing, affecting the operating room's working conditions.[6,12] Willemsen-McBride opined, "Specialty areas, such as the operating room, are even more vulnerable due to the stressful working environment and critical skill set." (p.8)[12] As early as 1997 Beitz & Houck theorized "Perioperative nursing may be self-destructing because new perioperative nurses are not being prepared to replace our generation when we retire."(p.119)[13] Many institutions, blaming the nursing shortage and budget constraints, introduced the role of the operating room technician.[10] Because this is still an emerging trend, and hospitals do not report on the number of operating room technicians (ORT) they hire, there are no precise statistics available on the number of ORTs in Canada. By the beginning of the year 2000 it was evident that the nursing shortage was not going to diminish. In 2002 the CNA predicted a shortage of 78,000 RNs by 2011 and 113,000 RNs by 2013.[14]

Another trend that developed during this period was that of the extended practice. The Registered Nurse First Assistant (RNFA) evolved in the United States and was formally recognized in 1984. Because of differences in health care funding and practices, however, Canada had no formal history of RNFA prior to the 1990s.[15] ORNAC supported the development, in 1994, of the RNFA and ratified a definition of the role that recognized the increasing complexity of surgery and its requirement for a higher level of expertise than the scrub nurse.[15] As a result of intense lobbying, by provincial perioperative nursing associations, RNFA programs were developed, over the next decade, in many Canadian provinces including Quebec (1994), Newfoundland & Labrador (1996) and Alberta (1997).[16] As of 2000, ORNAC reported that all Canadian provinces acknowledged that the role of the RNFA fell within the scope of practice of perioperative nurses.

2000-2010: The Continued Decline of the Specialty

In the early 21st century it became apparent that the specialty was facing major recruitment and retention issues. Perioperative nursing was at a crossroads. A growing body of literature called for changes in the education of perioperative nurses,[17] a return of the operating room rotation to the undergraduate educational curriculum,[18] and greater support for the expansion of the perioperative nursing practice.[19] At this time the specialty was being influenced by the same factors as previous generations but at an increased pace. Willemsen-McBride[12] reported a 55% turnover rate in Canadian nursing and an average training cost between US$50,000 and US$59,000 for perioperative nurses.

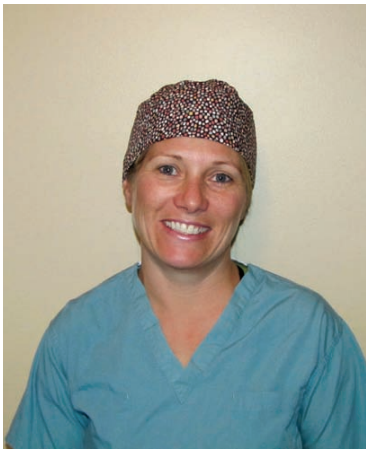
Unsuccessful preceptorship programs are expensive for institutions and result in a low level of retention. Willemsen-McBride stated "Current nursing shortages and unsuccessful nursing orientation programs have been major concerns for the past decades because they result in poor retention, reduced quality of patient care, decreased job satisfaction, and high financial costs to healthcare organizations."(p.10)[12] With additional influencing factors, such as the nursing shortage and the increased pressure to meet surgical wait time benchmarks, today's perioperative nursing specialty follows the general nursing trend toward increased sick time and higher job dissatisfaction rates.[20] This situation creates particular challenges for the preceptoring programs on which specialty training, such as perioperative nursing, depends. As discussed by Young,[21] today's perioperative nurses are struggling with heavy workloads, high patient acuity, various instrument processing issues, low morale, and staffing shortages. These factors create particular challenges for both preceptors and preceptees. With all these issues contributing to low staff morale, and the increase in work-related stress, the increased demand on experienced nurses to preceptor new nurses can become overwhelming.

HISTORICAL TRENDS cont. on page 32

SPOTLIGHT ON ORNAC MEMBERS

AN INTERVIEW WITH KIMBERLY LONG, RN, RNFA, CPN(C)

By: *Catherine Harley, RN, eMBA, Executive Director of ORNAC*



Kimberly Long is a Perioperative Registered Nurse who recently completed the RNFA Program and is a resource nurse for the Urology service at the North Bay Regional Health Center (NBRHC) in North Bay, ON. Kim works as an RNFA/RN in a composite position that is approximately a half and half split and carries an expectation of both call and evening shifts.

Question: Can you tell us a bit about yourself?

I am a Perioperative Registered Nurse, who graduated from the nursing program at Canadore College, located in North Bay, in 1995. I have worked as a perioperative nurse for the past twelve years, have been a resource nurse for the Urology service, and recently became an RNFA. I am married to a Detective Constable and have two young children. I enjoy the outdoors and look forward to getting my kayak out as the summer approaches.

Question: You say that you recently became an RNFA – can you explain what role you play within the perioperative setting?

As an RNFA my role in the operating theatre has changed. I am, however, first and foremost a registered nurse member of the perioperative team.

As a perioperative Registered Nurse First Assistant I practice in an expanded role. I provide assistance to the surgeon to help ensure the best possible outcomes for patients undergoing surgery. I practice in collaboration with the surgeon under his/her direction. The role of RNFA ideally encompasses the preoperative, intraoperative, and postoperative phases of the surgical experience.

I interview and assess the patient preoperatively, and of course, assist the surgeon intra-operatively. I have, however, little to no follow up with the patient post-operatively. This is for a variety of reasons including the fact that I am needed to help turn the room over for the next cases. My work day is, overall, very busy. The RNFA role has not evolved to its fullest potential in many hospitals including the NBRHC. In the post-operative phase we should, ideally, do rounds on our patients, do dressing changes, provide patient education, and do wound surveillance. Working in a composite role I am, however, not able to leave my team, to check in on patients, as I am needed in the room as a registered nurse on the days when I am not working in the role of a RNFA.

Question: When did you become interested in pursuing the RNFA Program?

My interest in becoming a RNFA developed over several years. It first started while I was on maternity leave with my son seven years ago. I was approached by my manager who encouraged me to take the RNFA program at the British Columbia Institute of Technology (BCIT) in order to further develop my knowledge and skills. There was an on-site component to the program so, while it looked really interesting, I was faced with making a hard choice between being home with my newborn son or pursuing the RNFA program. After careful consideration I decided that I really wanted to be home devoting my time to my newborn son and that meant I would have to wait to take the RNFA program. The idea of becoming a RNFA never left me but the timing had to be better.

SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH KIMBERLY LONG, RN, RNFA, CPN(C)

There is so much that an RNFA can do and the list grows as you acquire more education!

While home on my second maternity leave with my daughter a co-worker informed me that she, and one other nurse, had signed up for the government funded RNFA program at Mohawk College. I was very discouraged that I had missed this opportunity and asked my manager to keep me in mind if the opportunity presented itself again. It did, thankfully, in 2010.

Question: Can you describe the RNFA Program that you took?

I took the one year program offered through Mohawk college/McMaster University, in Hamilton. There were many online modules, followed by a one week on-site lab component, and then a move into clinical hours. I was very fortunate in that my employer values the RNFA role, and allowed me to be removed from the regular schedule and to complete my program hours with pay. Many in my class did not have that level of support from their institutions and were doing it all on their own. Obtaining 50 hours of non-OR time, and 175 hours of OR time (which has to involve everything from cut to close), mainly with a surgeon who agreed to mentor me, was no easy task even without a full work week! I completed my internship hours in February 2012.

Question: How has taking the RNFA Program helped enhance your career?

It is quite exciting to go to work every day! I love the role. I enjoy using the surgical instruments, handling tissue, providing exposure, using electrocautery, knot tying, and suturing. It is so exhilarating and still a bit overwhelming. I often find myself having to review the surgeries, anatomy, and background information prior to scrubbing in for a case. My favourite gift at Christmas was my Netters Text of Human Anatomy!

I am one of two RNFAs employed in my hospital with two more coming in the near future. The surgeons all seem to enjoy working with us. We are working really hard to prove that we are a valuable asset. The amount that we are booked indicates that we are succeeding. They are realizing that the extra pair of nursing hands in the room is beneficial to them. I have always loved working in the OR and becoming an RNFA has given me a new perspective.

Question: What role do you see yourself playing on the perioperative team?

I am a Registered Nurse first. My role is to help ensure the best patient outcome. I believe that, in order to do this, I need to spend time with the patient preoperatively and help ensure that the OR suite has the right equipment for each surgery by collaborating with the surgeon and other team members. I am knowledgeable and a good teacher to those who need guidance. I am a strong critical thinker and can react quickly to anything that may come up.

Question: Do you have any advice for perioperative RNs who are interested in taking the RNFA program?

The role of an RNFA is an important one. As the role is still not completely understood, by many, RNFAs have to continually prove themselves and promote their role. Anyone wanting to become an RNFA must be ready to do this.

An RNFA needs to have great communication and interpersonal skills, be a leader, and be committed to ongoing education.

Before considering becoming an RNFA be sure to do your homework. Find out if your hospital is interested in employing RNFAs and if they are applying for grant money to support this role.

Question: What is next in your career?

This opportunity has really given me a new thirst for knowledge. I plan to start working towards my Bachelor of Nursing this fall. There is so much that an RNFA can do and the list grows as you acquire more education! I want to open more doors for myself. Food for thought..... Advanced Practice Nurse (APN) RNFAs are involved in the full scope of practice including writing post operative orders, etc...

My dream is to complete my degree and obtain my Enterostomal Therapy Nursing certification (a nurse specialist in wound, ostomy and continence care). I believe the people of my community can only benefit from the care that I could provide with this combination of skills. Imagine if, as a patient, you can meet your RNFA in the pre-operative setting, then they are with you again for the intra-operative phase, and finally for post-operative follow-op. I think that for patients that are dealing with a diagnosis such as colon cancer, and the possibility of life-long ostomy, this continuity of care would be incredibly beneficial.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Be part of the $448 million Interior Heart and Surgical Centre (IHSC) Project happening at Kelowna General Hospital. The new Interior Health Regional Cardiac Revascularization Program will provide residents of the British Columbia Interior with the cardiac care they need, closer to home. We are building a team that ensures the highest standards of patient and family care for both critical care and cardiac services throughout our region. The first phase is now complete; the second phase is the introduction of open heart surgery by December 2012. We will have two operating rooms dedicated to cardiac surgery. Kelowna General Hospital currently has 19 ICU beds with six additional beds opening in the brand new Cardiac Surgery ICU in December 2012. Come join our team!
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For details visit www.ornac.ca

Perioperative Nurses Week is November 11-17, 2012

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Ontario	Toronto, ON	June 17 - 20, 2012
25th Atlantic Conference	Charlottetown, PEI	September 26 - 28, 2012
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23rd ORNAC National & IFPN Conference	Ottawa, ON	April 21 - 25, 2013
24th ORNAC National Conference	Edmonton, AB	May 2015

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GHOSTS OF VIOLENCE

Authors:

Anne Masters-Boyne, RN, MN, is a member of the Canadian Occupational Health Nurses Association (COHNA).

Vanna Wasson, RN, BN, CPN(C), is a member of the Operating Room Nurses Association of Canada (ORNAC).

Anne Masters-Boyne, *Canadian Occupational Health Nurses Association* (*COHNA*), and Vanna Wasson, *Operating Room Nurses Association of Canada* (*ORNAC*), were pleased to accept an invitation from the *Canadian Nurses Association* (*CNA*) to represent their associations at recent Fredericton, NB, performances of the *Atlantic Ballet Theatre of Canada's* "Ghosts of Violence". Both women were deeply moved by this beautifully choreographed ballet that puts the spotlight on the issue of domestic violence against women. Life stories, inspired by women who have died at the hands of a partner, are told through the creativity and athleticism of professional dancers. Anne and Vanna were amazed by the numbers of young men and women, as well as high school students, who attended the performances.

Photo Courtesy V. Wasson

Anne Masters-Boyne (*COHNA*) and Vanna Wasson (*ORNAC*) manning the *CNA* table at *the Atlantic Ballet Theatre of Canada's* performance of *Ghosts of Violence*, January 19, 2012

A statement in the event program, by Rachel Bard, CEO of the *Canadian Nurses Association*, noted that "half of all women age 16 or older in Canada have experienced at least one incident of physical or sexual violence. A primary goal of this performance is to act as a catalyst for community dialogue and action on domestic violence."[1]

Anne and Vanna were also privileged to meet with New Brunswick Premier David Alward and his wife, Rhonda, who toured the *CNA* booth. The Premier inquired about the *CNA*'s connection to domestic violence. Anne and Vanna were able to convey that nurses are often the front-line contact for abused women and children regardless of the type of nursing we are practicing. He was very attentive and appreciative of the pivotal role nurses play in domestic violence interventions and counseling.

The *Atlantic Ballet Theatre of Canada* conducted its first performances of "Ghosts of Violence" in February 2011. They have just concluded a cross-Canada 2011-2012 tour. *CNA* was a major sponsor of this tour in an effort to help break the cycle of violence. For more information about the event please visit www.AtlanticBallet.ca.

Reference:

1. Bard, Rachel. Letter from Rachel Bard, CEO of *CNA*, as published in the *Atlantic Ballet Theatre of Canada* event program "Ghosts of Violence: an emotionally charged choreographic landscape." 2011-2012 Season. Page 11.

Another factor that contributed to the decline of perioperative nursing is the lower than average educational level. Perioperative nurses demonstrate the lowest education levels of any specialty in Canadian nursing. Master's and Doctorate prepared perioperative nurses represent only 0.73% of the specialty's practitioners (compared to 3% of all Canadian nurses).[3] Perioperative nurses have the lowest average education level of Canadian nurses – Perioperative nurses with a college Diploma represent 76.41% of the practitioners compared with 62.2% of all Canadian nurses.[3] Today's preceptors, as a result, may not have the educational preparation required to teach the new generation of nursing graduates.

The specialty is also losing experienced nurses at a faster pace than that of the overall nursing profession. Perioperative nurses who were eligible for retirement, in 2008, represented 43.35% of the workforce compared to 39.4% in the general nursing population.[3]

The Canadian Health Act guarantees accessibility to health care for all and Canadians demand timely and fair access to health care services. Surgical wait times were addressed in the 2002 Romanov report on the Future of Health Care in Canada. When discussing these issues, Romanov mentioned that there may not be a sufficient supply of specialists, surgeons, operating room nurses, and technology to guarantee timely access to surgical care.[22] Recognizing the imminent shortage of health care professionals, including operating room nurses, this report proposed "Directions for change" that recommended that the government establish strategies for addressing the supply, distribution, education, training, and changing skills and patterns of practice for Canada's health workforce. This health care report wielded important political influence on the expansion of the perioperative nursing practice. Later reports, published by ORNAC and the CNA, further supported this expansion.[23]

By addressing the need to change the scopes and patterns of practice for health care workers, the 2002 Romanov report, along with others published by ORNAC and CNA, validated the need for the greater expansion of the RNFA role. In 2005, the CNA published a discussion paper on expanded roles for Registered nurses and supported the RNFA role. It stated, "Further development of the RNFA role has the potential to provide avenues for OR nurses to grow within their area of specialization into an expanded role by providing a different career path."[23] Political and fiscal constraints have, however, been major barriers to the development of the expanded role in all provinces.[19]

A final, and key, factor in the future of perioperative nursing is the decreased membership levels observed by professional associations. ORNAC reported, in 2010, a declining membership trend of 10% per year over the previous three years.[5] Murphy also reviewed the declining membership trends within AORN and predicted, "In 10 years, we can reasonably expect AORN membership (now about 40,000) to number about 20,000, of whom 7,000 will be younger than age 50."(p.132)[4] AORN has always had a strong influence on American health policies due to its strong lobbying and powerful membership numbers. Noting the decline in registration, and an increase of the median membership age, Murphy questions the future ability of AORN to influence health policies.[4] This current trend highlights a need for other associations, such as ORNAC, to evaluate current membership levels and the association's future if recruitment and retention strategies are not updated.

The Future of Perioperative Nursing

To avoid the further decline of the specialty, and reverse the current trend, perioperative nurses need to positively influence the educational, societal, and political factors that are shaping nursing and the perioperative specialty. Despite the historical decline of the perioperative nursing specialty there are also some positive changes on the horizon.

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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, 2013.

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 2013.

Professional organizations have risen to the challenge by promoting the integration of perioperative nursing in to the BN curriculum.

In an American study on the career preferences of undergraduate nursing students, Happell demonstrated that perioperative nursing was a popular career choice for students.[10] It was, in fact, the third most popular choice, at 16.8%, after Midwifery (26.2%) and Pediatric (22.9%). Capitalizing on this interest is crucial for perioperative nursing. Implementing a perioperative elective for undergraduate students is one method that can maintain student interest in the specialty. Christensen describes the successful introduction of the perioperative nursing program to 4th year undergraduate nurses at the Vancouver Island Health Authority.[9] After the first year there was a 50% retention rate of undergraduate students who stayed on to become OR staff nurses. Christensen further stated, in her conclusions, "The operating rooms are beginning to be staffed with a new generation of nurses that are well educated, specialized, dedicated, and eager to take on the future role of the registered nurse in the operating room."(p.11)[9]

With the continuation of the trend toward higher education in nursing,[24] it is important to emphasize the role of Baccalaureate nurses in the operating room. The operating room is a highly technological environment that presents many risks to patient safety. Breitz & Houck stated "Surgery departments desperately need Baccalaureate graduates to fill demanding contemporary nursing roles and to become perioperative nurse managers or clinical specialists in the reengineered health care system."(p.120)[13] Recruiting undergraduate nurses into the specialty is also justified by Christensen when she discusses the need for perioperative nurses to design, coordinate, evaluate, and deliver care to meet the identified needs of each patient during the preoperative, intraoperative, and postoperative phase of surgery.[9]

In 2008, there were 13,157 students admitted into nursing programs across Canada, representing a 2.2% increase over 2007. The 2007-2008 periods experienced an historical high in admission to Entry-to-Practice Nursing programs.[24] The healthcare system should, as these nurses graduate, experience an increase in staffing levels. The number of Canadian graduates from Master's nursing programs has also been steadily rising (from 427 Master's graduates in 2004 to 723 in 2008).[24] While Baccalaureate educated nurses only represented 22.86% of perioperative nurses in 2008[3] this was, in fact, an increase from the 19.5% represented three years earlier.[25] As more BN nurses enter the workforce this will elevate the educational level of perioperative nurses and should also demonstrate the benefits of higher education on the quality of patient care.

Professional organizations have risen to the challenge by promoting the integration of perioperative nursing in to the BN curriculum. ORNAC has, with its position statements and educational guidelines, been actively promoting the return of perioperative experience as part of basic nursing programs. ORNAC reinforced, in a position statement on perioperative nursing education, that perioperative experience is the primary means by which students obtain knowledge and skills in the management of care for the surgical patient. The association strongly recommends that the perioperative experience become a component of basic nursing programs.[26]

National strategies must be developed to promote and support the recruitment and training of RNFA. Desrosier, in her 2008 succession plan for Quebec's perioperative nurses, proposed reorganizing the operating room's nursing roles.[27] She suggested the enhancement of the scrubbing role, in both public and private settings, in order to include surgical assistance. Her proposal would have allowed all specialty nurses, with a specific permit for perioperative care, to act as assistants in internal service (formerly the scrub role) and as registered nurse first assistants (RNFA). In March 2010, however, she stated that the health regions, as well as nursing managers, had not supported this proposal and considered it too ambitious and costly.[28]

Other provinces have, however, proposed and implemented strategies to develop the RNFA role. In 2007-2008 the Ontario Ministry of Health and Long-Term Care, in an effort to decrease wait times for orthopaedic surgery, funded a program to educate and employ RNFA in a high volume orthopaedic center.[15] This was part of a national objective designed to decrease surgical wait times for joint replacements.[29]

Professional associations have also responded to the issues facing perioperative nursing by developing strategies to maintain and increase membership levels in order to maintain political influence in the area of perioperative nursing practice. AORN recognized "the need for more choices in avenue for participation (in association meetings) is most acute among nurses who have joined our profession since the technology revolution, the same group that is underrepresented and has the highest lapse rate now."(p.134)[4] In 2010 17% of AORN members belonged to the e-chapter when geographical meeting attendance was on average 10%-20%.[3] This indicates that members are following the technological trend and prefer the convenience of internet social networks, such as Facebook and Twitter, to exchange information and ideas with their nursing colleagues. Murphy suggests a more flexible approach to membership status.[4]

ORNAC recently released a Strategic Planning communiqué that emphasized the current challenges faced by the organization and a plan to address those issues at both on a provincial and a national level. It addressed the issues of increasing membership sustainability, the future of the perioperative nurse within the surgical team, the importance of patient safety, surgical wait times, perioperative nursing education, and the lack of representation in health care organizations as it impacts perioperative nursing.[5] ORNAC demonstrated its intention to improve the status of perioperative nursing care in Canada and positively affect the recruitment and retention of nurses in the specialty.

With the political influence of the Romanov report[22] and the importance of primary health care, ORNAC also supports a greater role for perioperative nurses in primary health care. Within this scope of practice, operating room nurses are able to perform direct patient care and to teach and educate patients, family, health care personnel and the community at large. ORNAC also states that Perioperative Registered Nurses should support and/or perform research as well as supervising and managing health care services.[26] Perioperative nurses are in a position to research and report on recurrent surgeries and to promote health by educating patients on ways to prevent the diseases that lead to surgery. By expanding the perioperative nursing practice into the community these nurses can contribute to the overall health of the Canadian population. Perioperative nurses can actively research infections rate and surgical complications by participating in the *Safer Health Care Now*! initiative.[30]

Lorne Flower Memorial Award

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, 2013.

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

Prix Commémoratif Lorne Flower

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 2013.

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

ORNAC / AIISOC

Editorial Review Panel

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Both American and Canadian perioperative nurses face the threat of extinction if the current trends are not reversed.

CONCLUSION:

Since the establishment of perioperative nursing as the first nursing specialty many political, educational, and societal factors have shaped the practice. Nurses must, in order to control the future of the specialty, understand these factors and take action to regain control of their practice and support recruitment and retention.

ORNAC, in collaboration with provincial operating room associations, must sustain its efforts to return the perioperative rotation to undergraduate nursing programs. Perioperative nurses must also get involved with their provincial associations to promote the development of the RNFA role, influence the development of perioperative nursing education, and improve preceptorship programs. The necessity of Baccalaureate educated nurses in the OR is also beginning to become evident. The focus on patient safety and the expansion of the perioperative nursing role further emphasizes the need for education.

Both American and Canadian perioperative nurses face the threat of extinction if the current trends are not reversed. Perioperative nurses must, in recognition of increased patient acuity and the increased knowledge and critical thinking skills that the specialty requires, stand together and save their specialty.

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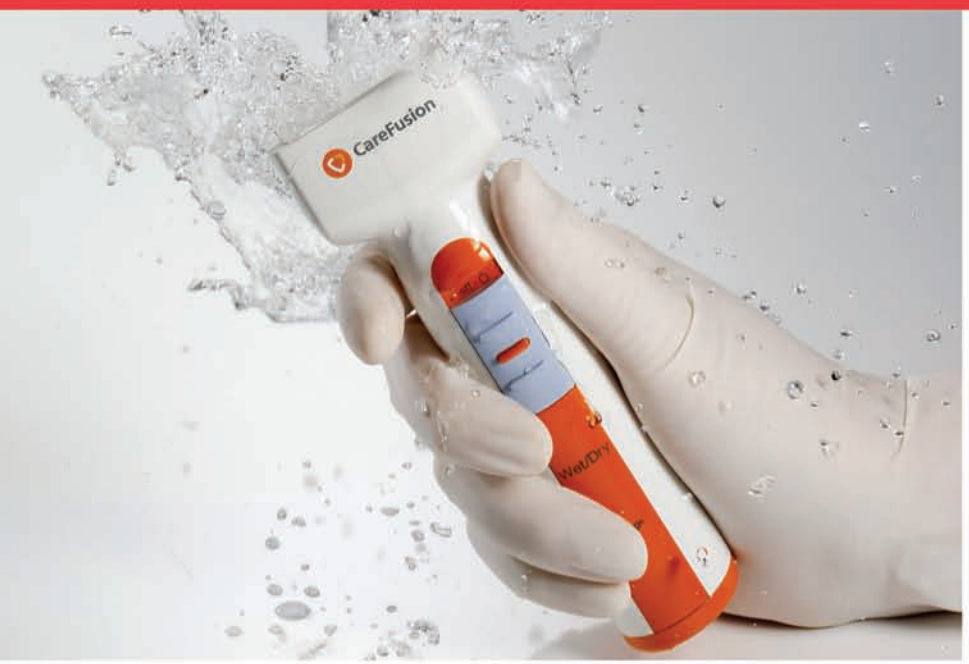

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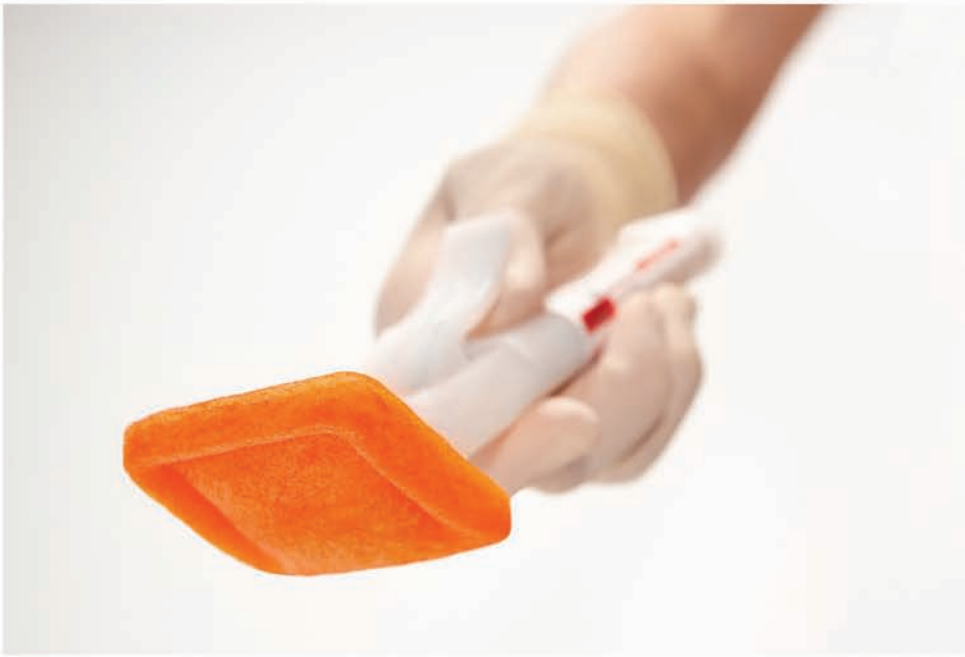

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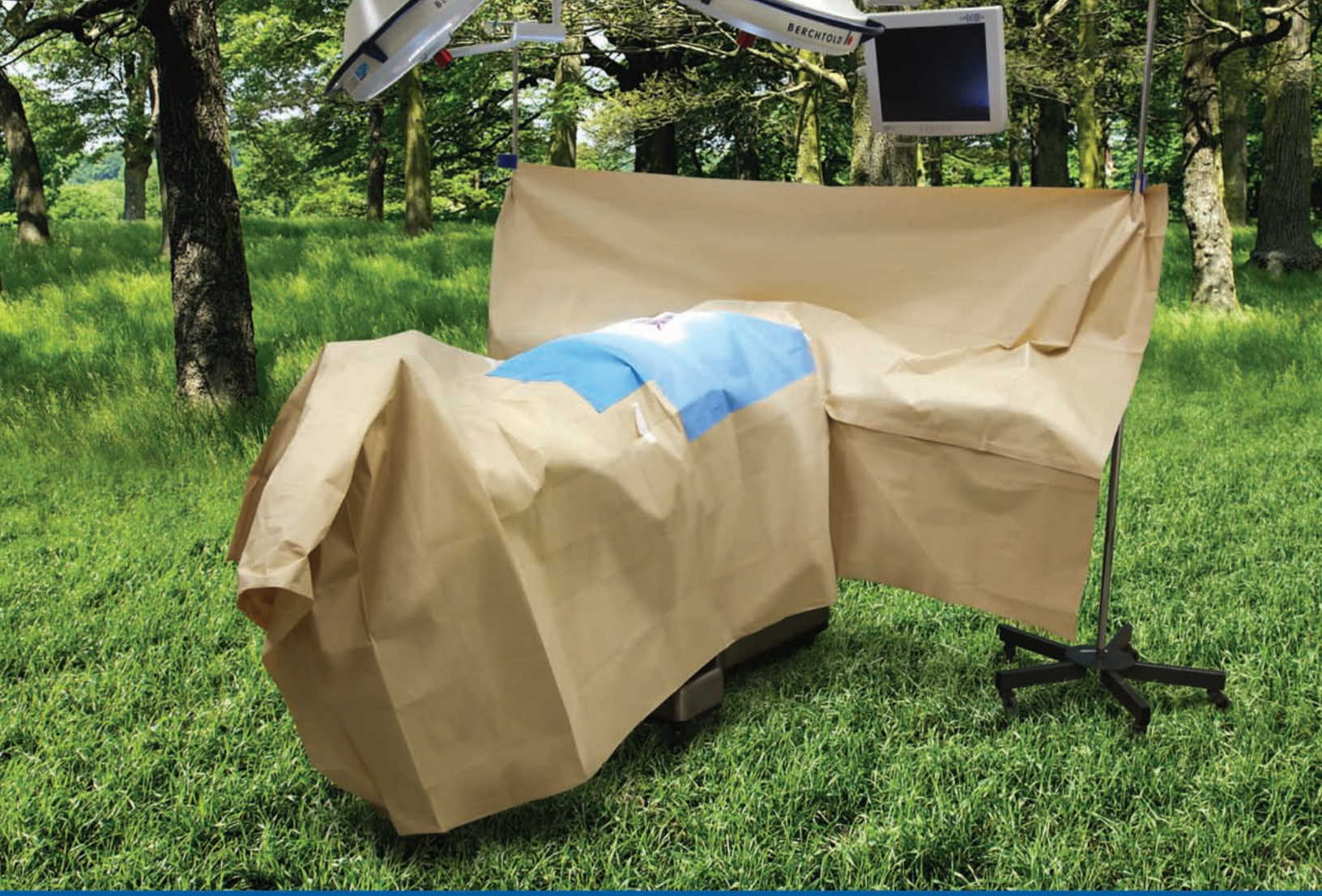

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