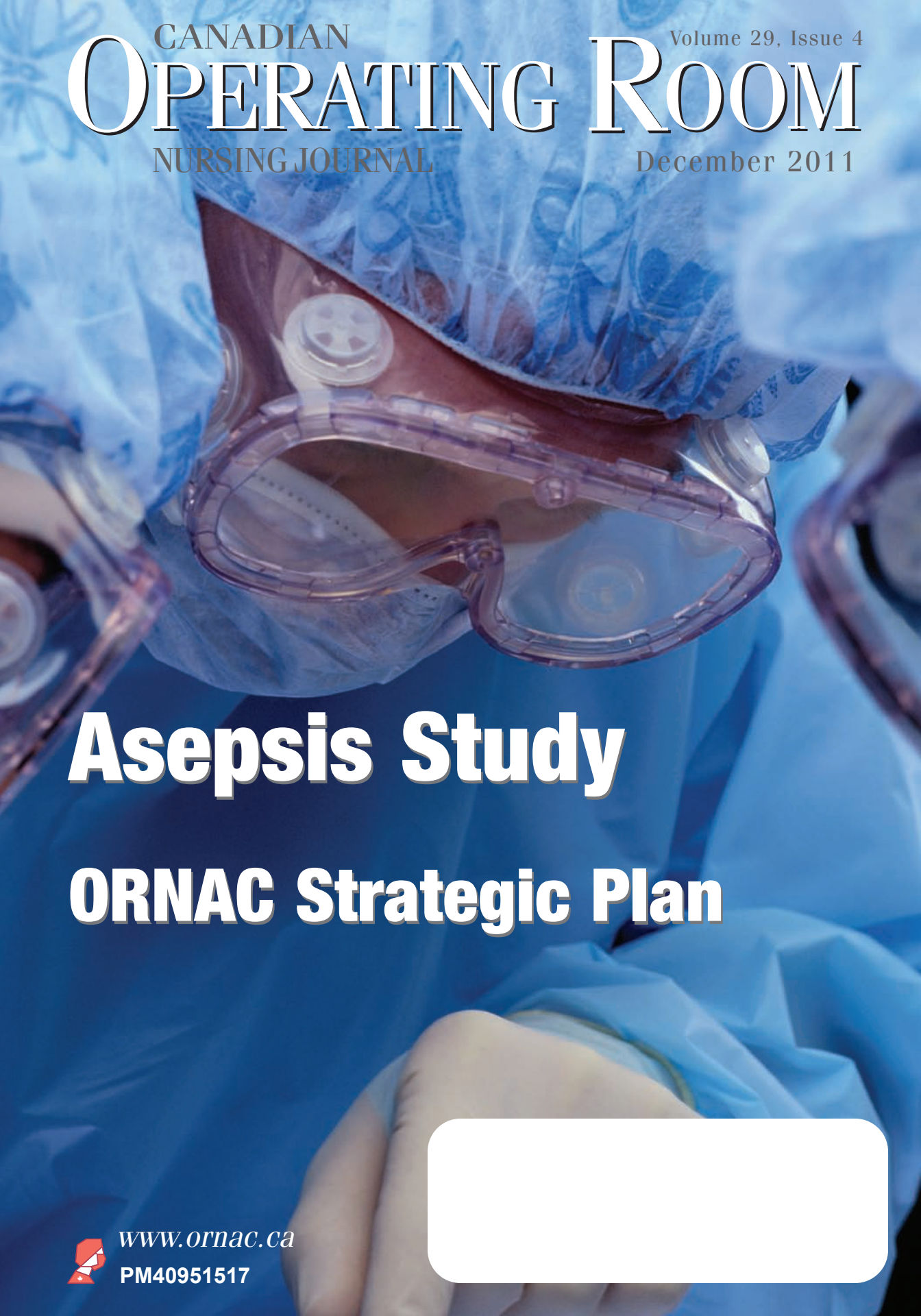
CANADIAN
OPERATING ROOM
NURSING JOURNAL

Volume 29, Issue 4
December 2011



Asepsis Study

ORNAC Strategic Plan

www.ornac.ca
PM40951517

The OR Goes Green

EcoDrape™

Medline's new patent-pending EcoDrape is the only eco-friendly surgical drape available today. Made of more than 96% wood pulp, EcoDrape will biodegrade in only two to five months in a landfill – polypropylene drapes take hundreds of years to break down. EcoDrape has all the same great features as other Medline drapes, including hook-and-loop line holders, large reinforcement zones, and premium tape and incise film flush to the fenestration.

Try the new EcoDrape and take your OR to the next level of green!

Composition Comparison

	EcoDrape	SMS
Fibers	More than 96% wood pulp	No wood pulp
Petrochemical ingredients (plastics)	0%	100% PP
Additives	Bio-based	Fluorine

To schedule a FREE demonstration of the EcoDrape contact your Medline representative, call 1-800-396-6996 or visit www.medline.com.

MEDLINE CANADA

President's Message

As 2011 draws to a close it is a time for forward thinking. A new year is on the horizon and with it comes new opportunity. Perioperative Registered Nurses must acknowledge that the work environment is evolving. Today's perioperative nurse works in a world of high technology and fiscal restraint. This is driven by both the present economic situation and governmental demands. We may work with colleagues who wish to return to the practices of the past but we must, instead, embrace our history and prepare for the future. The past has brought us to this place in time but it will not be able to sustain us as we meet the new demands of the future.

The same can be said for ORNAC. We are facing challenges and must set our path for the future. The approval of the ORNAC strategic plan was the first step in this process of change. Catherine Harley, the ORNAC Executive Director, provided strong guidance and leadership through the first step of implementing our strategic plan. The current Board governance structure requires strengthening in order to be consistent with the mission, vision, and values of ORNAC. The Board and Executive determined that there is a need for a strong national voice that will work to advance perioperative practice; a vigorous process for the validation of ORNAC Standards; and an evolving organization with a foundation based on education and research.

As part of the new organizational structure there will be a decrease in the number of seats on the ORNAC Board while maintaining representation from each of the provincial groups. The Board will also evolve in to one with a governance structure driven by policy. Governance can be defined as "a combination of both overall processes and the structures that are used in directing and managing the organization's operations and activities."[1] Good governance is designed to minimize risk, identify and avoid potential risk, and address problems, when they arise, in a legal and ethical manner.

ORNAC's new structure will require the active involvement of perioperative Registered Nurses from across the country. The input of a vast number of experts will be a valued, and vital, part of the growth of perioperative nursing practice. This is a means to involve all levels of perioperative Registered Nurses – from the academic world to the grass roots of practice… and everyone in between. ORNAC can accomplish great things as a unified national body with a common vision and voice.

The perioperative Registered Nurse has the ability and the responsibility to identify patient safety issues within our realm of practice and to influence change. The role of the RN in the perioperative setting must be preserved. Each and every perioperative nurse in Canada must be able to clearly articulate their role. Our breadth and depth of knowledge sets us apart from all other healthcare providers and the art and science of perioperative nursing practice is uniquely ours!

I challenge you to become more involved. With the dawning of a new year take the time to reflect on the successes of 2011 and the opportunities for improvement in 2012. Become involved with your provincial perioperative association and ORNAC. Embrace the opportunity to grow both personally and professionally.

On behalf of the entire ORNAC Board and Executive I would like to wish you and yours a wonderful festive season and a happy and prosperous New Year!

References

1. Cooper, K.J., *Presentation to the Operating Room Nurses Association of Canada*. Ottawa, ON, September 7, 2011.

Karen Frenette, RN, BN, MN, CPN(C), 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.

Mot de la president

Alors que l'année 2011 tire à sa fin, il est temps de penser de façon prospective. Une nouvelle année se pointe à l'horizon et avec elle, se présentent de nouvelles opportunités. Les infirmières et les infirmiers autorisés en soins périopératoires doivent reconnaître que leur environnement de travail est en constante évolution. Les infirmières et les infirmiers en soins périopératoires d'aujourd'hui travaillent dans un monde où la technologie de pointe et les compressions budgétaires sont une réalité, à la fois en raison de la situation économique actuelle et des exigences gouvernementales. Il se peut que nous travaillions avec des collègues qui aimeraient revenir aux pratiques d'antan, mais nous devons plutôt profiter de notre historique et nous préparer à l'avenir. Le passé nous a amenés jusqu'ici, mais il ne pourra pas nous soutenir, alors que nous nous efforçons de satisfaire aux nouvelles exigences de l'avenir.

Ainsi en est-il de l'AIISOC. Nous faisons face à des défis et nous devons définir la voie à suivre à l'avenir. L'approbation du plan stratégique de l'AIISOC constituait la première étape de ce processus de changement. Catherine Harley, la directrice générale de l'AIISOC, a fourni de judicieux conseils et une direction efficace au cours de la première étape de la mise en œuvre de notre plan stratégique. La structure actuelle du conseil de gouvernance doit être renforcée afin d'être cohérente quant à la mission, la vision et les valeurs de l'AIISOC. Le conseil d'administration et la direction ont déterminé que l'AIISOC avait besoin d'une voix nationale forte qui travaillera à faire progresser la pratique des soins périopératoires; d'un processus rigoureux pour la validation des normes de l'AIISOC et d'un organisme dynamique, doté d'une base reposant sur l'éducation et la recherche.

Dans le cadre de la nouvelle structure organisationnelle, il y aura moins de sièges au conseil d'administration de l'AIISOC, mais le nombre de représentants pour chaque groupe provinciaux sera maintenu. Le conseil d'administration sera maintenant doté d'une structure de gouvernance axée sur les politiques. On peut définir la gouvernance comme « la combinaison des structures et des processus généraux utilisés pour diriger et gérer les opérations et les activités de l'organisme. » (Traduction libre de la traductrice) [1] Une bonne gouvernance vise à minimiser les risques, identifier et éviter les risques potentiels et traiter les problèmes d'ordre juridique et éthique lorsqu'ils surviennent.

La nouvelle structure de l'AIISOC nécessitera la participation active des infirmières et des infirmiers autorisés en soins périopératoires d'à travers le pays. La participation d'un grand nombre d'experts sera un précieux élément clé de la croissance de la pratique des soins périopératoires. C'est un moyen de faire participer les infirmières et les infirmiers autorisés en soins périopératoires de tous les niveaux, allant de la sphère académique à la pratique communautaire… en passant par toutes les autres personnes entre ces niveaux. L'AIISOC peut accomplir de grandes choses en tant qu'organisme national uni, doté d'une vision et d'une voix communes.

Les infirmières et les infirmiers autorisés en soins périopératoires ont la capacité et la responsabilité d'identifier les risques liés à la sécurité des patients dans le domaine de leur pratique et de provoquer le changement. Le rôle des infirmières et des infirmiers autorisés dans le milieu des soins périopératoires doit être protégé. Toutes les infirmières et tous les infirmiers en soins périopératoires du Canada doivent pouvoir clairement exprimer leur rôle. Nos connaissances approfondies et vastes nous distinguent de tous les autres fournisseurs de soins et l'art et la science de la pratique des soins périopératoires nous sont uniques!

Je vous mets au défi de participer davantage. À l'approche de la nouvelle année, prenez le temps de réfléchir aux succès obtenus en 2011 et aux occasions de s'améliorer en 2012. Impliquez-vous auprès de votre association provinciale en soins périopératoires et de l'AIISOC. Profitez de cette occasion pour vous développer à la fois sur le plan personnel et professionnel.

Au nom de tout le conseil d'administration et de la direction de l'AIISOC, j'aimerais vous souhaiter ainsi qu'à vos proches une joyeuse période des fêtes et une bonne et heureuse Nouvelle Année!

Références :
1. Cooper, K.J., *Presentation to the Operating Room Nurses Association of Canada*. Ottawa, ON, September 7, 2011.

Karen Frenette, IA, B.Sc.Inf., M.Sc.Inf., CSP/C, 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.

CANADIAN
OPERATING ROOM
NURSING JOURNAL

Published Quarterly ✦ Volume 29, Issue 4, December 2011

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

Editor: Deborah Murphy
Art Director: Sherri Keenan
Translation: Jocelyne Demers-Owoka

Canadian Operating Room Nursing Journal
c/o **Clockwork Communications Inc.**
P.O. Box 33145
Halifax, NS B3L 4T6
Tel: 902.442.3882
Fax: 1.888.330.2116
E-Mail: Contact@ClockworkCanada.com

Address Changes:

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

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

Non-Member Subscription Rates

Canada	$30 *plus GST/HST*
Outside Canada	$52
Single Copy Orders	$12 *+ tax in Canada*
	$20 *outside Canada*

GST/HST# 84200 7148 RT0001
I.S.S.N. No. 0712-6778

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

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

EDITORIAL CONTENTS

UNE ÉTUDE DESCRIPTIVE EXAMINANT LES PRINCIPES DES TECHNIQUES ASEPTIQUES AU SEIN DU PERSONNEL EN SOINS PÉRIOPÉRATOIRES LORS DE CHIRURGIES

Auteurs :

Jeanette S. Adams, IA, Ph. D., IA en PIA - BC, IA certifiée en perfusion, école des sciences infirmières et d'études sur la santé de l'Université de Miami, Coral Gables, FL, É.-U. Chercheuse en prévention des infections, Mme Adams a travaillé pour une courte période en salle d'opération au cours de sa carrière infirmière.

Denise M. Korniewicz, IA, Ph. D., FAAN, doyenne associée en chef de la recherche et professeure à l'école des sciences infirmières et d'études sur la santé de l'Université de Miami, Coral Gables, FL, É.-U. Mme Korniewicz possède cinq ans d'expérience à titre d'infirmière en salle d'opération et est chercheuse en prévention des infections depuis plus de trente ans.

Maher M. El-Masri, IA, Ph. D., professeur agrégé et coordonnateur de la recherche, faculté des sciences infirmières de l'Université de Windsor, ON, Canada. Il est également chercheur en prévention des infections.

RÉSUMÉ

Contexte : On s'attend à ce que les infirmières et les infirmiers en soins périopératoires démontrent une adhérence rigoureuse aux principes aseptiques afin de prévenir les infections de sites opératoires (ISO) étant donné qu'un manquement à ces principes présente un risque grave d'infection pour les opérés.

Méthodes : Une enquête descriptive a été menée à l'aide d'un échantillon de commodité de 87 membres du personnel en soins périopératoires pour décrire le respect déclaré par les intéressés aux principes aseptiques durant les chirurgies.

But : Le but de cette enquête était d'examiner les pratiques des instrumentistes en soins périopératoires en ce qui a trait à l'asepsie chirurgicale.

Résultats : Un pourcentage assez important de participants ont indiqué qu'ils n'observent jamais ou rarement de manquement dans le champ stérile lors de chirurgies, relativement aux systèmes de drainage ouvert par aspiration (46,6 %; n = 41), aux systèmes de drainage fermé par aspiration (46,6 %; n = 41), au matériel de suture (39,7 %; n = 35), à l'utilisation d'instruments chirurgicaux (37,5 %; n = 33) et aux implants prothétiques (56,8 %; n = 50). Les instrumentistes en soins périopératoires étaient moins susceptibles de porter des couvre-chaussures lors d'interventions chirurgicales que les techniciens en salle d'opération (M = 3,42 et 4,17; mdn = 3,00 et 5,00 respectivement; p = 0,026).

Conclusions : Les résultats ont indiqué des domaines d'observance et de non-observance aux principes aseptiques. En raison du fait que le rôle des infirmières et des infirmiers en soins périopératoires est primordial pour maintenir l'intégrité chirurgicale et améliorer les résultats positifs pour les patients, une adhérence rigoureuse aux principes d'asepsie chirurgicale est essentielle pour prévenir les ISO et autres complications.

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés (9e édition) de l'Association des infirmières et des infirmiers de salles d'opération du Canada (AIISOC) de juin 2009, section 2, p. 138 à 142, Normes 7.1 à 7.5.

A DESCRIPTIVE STUDY EXPLORING THE PRINCIPLES OF ASEPSIS TECHNIQUES AMONG PERIOPERATIVE PERSONNEL DURING SURGERY

Authors:

Jeanette S. Adams, RN, PhD, APRN-BC, CRNI, Faculty, University of Miami School of Nursing and Health Studies, Coral Gables, FL, USA. An Infection Control researcher who worked in the OR for a short time in her nursing career.

Denise M. Korniewicz, RN, PhD, RN, FAAN, Senior Associate Dean for Research and Professor, University of Miami School of Nursing and Health Studies, Coral Gables, FL, USA. She has five years experience as an OR nurse and has been an infection control researcher for over three decades.

Maher M. El-Masri, RN, PhD, Associate Professor and Research Coordinator, Faculty of Nursing, University of Windsor, ON, Canada. He is also an infection control researcher.

ABSTRACT:

Background: Perioperative nurses are expected to demonstrate strict adherence with asepsis principles to prevent surgical site infections (SSIs) as breaching of these principles poses a serious risk of infection to surgical patients.

Methods: A descriptive survey was conducted with a convenience sample of 87 perioperative personnel to describe self-reported compliance with the principles of asepsis during surgery.

Purpose: The purpose of this study was to examine the practices of perioperative scrub personnel with surgical asepsis.

Results: A sizable percentage of participants indicated that they never or rarely observe breaches in the sterile field during surgery with regards to open suction drain systems (46.6%; n = 41), closed suction drain systems (46.6%; n = 41), suture material (39.7%; n = 35), use of surgical instruments (37.5%; n = 33), and prosthetic implants (56.8%; n = 50). Perioperative scrub RNs were less likely to wear shoe covers during surgical procedures than ORTs (M = 3.42 and 4.17; mdn = 3.00 and 5.00 respectively; p = .026).

Conclusions: The findings showed areas of compliance and noncompliance with the principles of asepsis. Given that the role of the perioperative nurse is paramount in maintaining surgical integrity, and enhancing positive patient outcomes, strict adherence to surgical asepsis is vital to prevent SSIs and other complications.

BACKGROUND:

Principles of asepsis are the cornerstones of best practices and positive patient outcomes during surgical procedures. Beyea[1] argued that the recognition of breaks, or breaches, of aseptic technique is paramount to maintaining surgical asepsis, protecting surgical patients, and preventing surgical healthcare associated infections (HAIs). It is incumbent upon perioperative nurses to uphold these principles to ensure the safety of surgical patients. The National Patient Safety Goals of the Joint Commission on the Accreditation of Healthcare Organizations[2] consider HAIs to be sentinel events that must require root cause analysis by healthcare settings.

Surgical site infections (SSIs), a subset of HAIs, continue to be a serious complication of operative procedures,[3] accounting for 14 - 20% of all HAIs.[4,5] Normally, the skin is the first line of defense against infection that is usually breached during surgery, which opens the pathway for microorganism invasion.[6] Surgical asepsis is the primary intervention against the introduction of bacteria at the surgical site. This is a fundamental responsibility of perioperative nurses with regard to the prevention of SSIs.[7]

It is estimated that 2-5% of clean surgical cases, and up to 20% of abdominal surgical patients in the western world, including Canada, develop

SSIs.[8] In the first national point prevalence study in Canada, Gravel and colleagues (2007) suggested furthermore that the rate of SSIs among all Canadian patients was 2.5%. SSIs contribute significantly to increased treatment costs,[9,10] length of stay,[11] and increased mortality and morbidity of patients.[12,13] In the United States, the annual estimate of SSIs are 500,000 out of an approximately 27 million procedures, resulting in it being the third most commonly reported HAI[4,14] (after urinary catheter associated infections and pneumonia).[15] Although it is difficult to project the costs associated with SSIs, because each case varies depending upon the severity of the infection and the resilience of the patient, the aggregate annual cost, in the US, is estimated to run in the billions of dollars.[14,16] Cost implications related to SSIs have also impacted on insurance reimbursement policies in the US. As of October 2008 the Centers for Medicare and Medicaid Services (CMS) no longer reimburse hospitals for costs associated with HAIs.[17]

Several initiatives have been launched to combat the increasing risk of developing SSIs in hospitalized patients. The Institute for Healthcare Improvement (IHI) in the United States, for instance, started several initiatives including the *100,000 Lives, 5 Million Lives, the Surgical Infection Prevention Project* (SIPP), and the *Surgical Care Improvement Project* (SCIP). The SCIP project provides a list of preventive measures that the perioperative team can take to reduce SSI associated morbidity and mortality.[18] In Canada, the Canadian Patient Safety Institute, along with a number of provincial and national partnering organizations, launched the *Safer Healthcare Now!* initiative. This initiative was responsible for the development of the "SSIs getting started kit" for healthcare providers.[19] Despite these initiatives, and advancements in infection control and prevention strategies, SSIs continue to be a common problem in North American hospitals.[3,20,21]

Given that 40% to 60% of surgical site infections are preventable,[22] it is important that perioperative personnel exercise strict adherence to aseptic principles in order to minimize the rate of such infections. Gruendemann reported that 75% of perioperative practices are aimed at the prevention of infections. Prevention of SSIs should start at the operating suite, where scrub personnel assume the responsibility for managing the sterile field and surgical instruments while circulating nurses control the environment and coordinate the aseptic activities of the surgical team. Perioperative nurses are, therefore, in a good position to serve as the first line of defense against surgical site infections.[1] Despite this pivotal role of perioperative personnel, breaching of aseptic principles continues to be a common problem among surgical patients.[14] The purpose of this study was to document self-reported compliance, by perioperative personnel who function in a scrub role capacity, with the principles of asepsis during routine surgeries. The overall aim of the study was to determine if perioperative personnel routinely follow the standards associated with "best practices" of asepsis.

METHODS:

Design:

A cross-sectional, self-report descriptive survey was performed using a convenience sample of 87 perioperative personnel, who function in a scrub role capacity, in two operating suites of a large urban tertiary, teaching medical center. The two operating suites were located in different areas of the hospital. While one suite was designated for general surgery the other was specific to trauma surgeries. While the general surgery suite had 27 operating rooms the trauma surgery suite had 12 operating rooms. The rooms in the general surgery suite were dedicated primarily to a category of surgeries such as women's health, gastroenterology, orthopaedic, and cystoscopies. The rooms in the trauma suite were used for emergency surgeries, routine orthopaedics adjustments, and overflow of routine surgery. Most of the nursing staff members were dedicated to certain rooms and/or specific categories of surgical procedures. However, it was possible that a staff member would be assigned to other operating rooms

Continued on Page 14

NEW: ENSEAL® G2 Super Jaw

Seals large vessels up to 7mm in open procedures

- **Strong:** Seal strength that withstands up to **7** times normal systolic pressure[1] combined with temperature regulating PTC material designed to minimize sticking by **94%** when compared to LigaSure Impact™[2]
- **Complete:** Patented I-BLADE™ Technology delivers high uniform compression including more than **2.5** times the compression at the distal tip compared to Ligasure Impact™[3]
- **Contained:** Offset electrode configuration designed to minimize lateral thermal spread ~ **1mm** in order to protect vital structures

To experience the new ENSEAL® G2 Super Jaw, contact your Ethicon Endo-Surgery Sales Professional or visit us at ethiconendosurgery.com.

That's positive energy.

1. Tested in porcine carotid arteries. Normal systolic = 120 mm Hg. Date on file, Ethicon Endo-Surgery, Inc.
2. Based on bench top testing on procine carotid arteries (0.05 lb f, median force to ENSEAL®, vs. 0.56 lb f, median force to release LigaSure™, P=0.0000) Data on file, Ethicon Endo-Surgery, Inc.
3. Testing conducted on an inanimate model. Average compression values: 141 psi. Data on file.
LigaSure™ is a registered trademark of Covidien.

Ethicon Endo-Surgery | Enseal

ORNAC to Re-Launch Journal

ORNAC's peer-reviewed journal has undergone many changes since its inception in 1983 – the most recent of which was when ORNAC obtained ownership of the Journal in 2001. As part of ORNAC's ongoing Strategic Planning it was identified that, after 10 years of ownership, it was time for ORNAC to invest in updating the Journal format.

As a result the *Canadian Operating Room Nursing Journal* will be re-launched in 2012 as the *ORNAC Journal*. The Journal will have a new look, a larger page size, and will place added emphasis on ORNAC's five pillars of planning: National Conference Planning, Professional Practice, Advocacy, Research and Informatics, and Marketing.

With the new look comes the same commitment to quality content. The ORNAC Editorial Board will continue to support the inclusion of peer-reviewed articles and news pertinent to Canadian Perioperative Registered Nurses. ORNAC is also pleased to announce that Clockwork Communications Inc. will continue in its role as the Journal publisher (since 2002) and Deborah Murphy will remain the Editor of the new ORNAC Journal.

ORNAC continues to work to bring more value to its membership and is preparing for the first issue of the ORNAC Journal (March 2012) with great anticipation. Your feedback and input is always appreciated – if you have comments to share about the new Journal please direct them to catherine.harley@sympatico.ca.

Relancement de la revue de l'AIISOC

La revue à comité de lecture de l'AIISOC a subi de nombreux changements depuis ses débuts en 1983 – le plus récent étant lorsque l'AIISOC est devenue propriétaire de la revue en 2001. Dans le cadre de la planification stratégique en cours au sein de l'AIISOC, nous avons déterminé qu'après 10 ans à titre de propriétaire de la revue, il était temps que l'AIISOC investisse dans une présentation plus moderne de la revue.

Par conséquent, la *Revue de l'Association des infirmières et infirmiers de salles d'opération du Canada* sera relancée en 2012 sous le nom de *Revue de l'AIISOC*. Le nouveau look de la revue et ses pages plus grandes mettront l'accent sur les cinq piliers de la planification de l'AIISOC : la planification des conférences nationales, la pratique professionnelle, la défense des droits, la recherche et l'informatique et le marketing.

Ce nouveau look conserve tout de même le même engagement envers un contenu de qualité. Le comité de rédaction de l'AIISOC continuera de favoriser les articles et les nouvelles révisés par des pairs, qui sont pertinents aux infirmières et aux infirmiers autorisés en soins périopératoires du Canada. L'AIISOC est également heureuse de vous annoncer que l'agence Clockwork Communications Inc. continuera de publier la Revue comme elle le fait depuis dix ans et que Deborah Murphy demeurera l'éditrice en chef de la nouvelle revue de l'AIISOC.

L'AIISOC poursuit son travail pour que son adhésion offre encore plus d'avantages et se prépare avec impatience au lancement du premier numéro de la Revue de l'AIISOC (en mars 2012). Nous apprécions toujours de recevoir vos commentaires, si vous en avez au sujet de la nouvelle revue, veuillez les envoyer à catherine.harley@sympatico.ca.

Call for Abstracts

ORNAC & IFPN

2013 INTERNATIONAL CONFERENCE

OTTAWA, ON • APRIL 21 - 25, 2013

Share your accomplishments in the field of perioperative clinical practice, education, professional development, research and administration!

The 2013 Conference Program Committee is accepting submissions of abstracts for paper or poster presentation at our 2013 ORNAC/IFPN International Conference. The theme of the conference is:

"International Alliance for Perioperative Best Practices"

Abstracts will be considered for presentation in one of the following forums:
Poster: A visual display. Posters will be displayed at the conference.
Paper: a 15 minute presentation by the author(s) plus 5 minutes for question and answers.

Posters will be selected based on relevance and implications for perioperative nursing and those in keeping with our theme. Criteria are available at **www.ORNAC.ca**

The deadline for submission is February 15, 2012. Submission details are available on the website.

"You are a vital part of patient safety"

Vous trouverez les directives en français pour la soumission d'articles à **www.AIISOC.ca**

IFPN
International Federation of Perioperative Nurses

I knew I would enjoy Vancouver, but I didn't really know that I would love it this much. My friends and I explore downtown together, bike the seawall around Stanley Park and enjoy getting out on the water. There are so many new things to do and to try.

Karen Aguana
Registered Nurse

ENRICH YOUR CAREER. ENHANCE YOUR QUALITY OF LIFE.

Join the hundreds of registered nurses who have moved to British Columbia to enjoy a quality of life that is envied around the world. Find out how our nurse services team can assist you in matching your lifestyle interests with exciting career opportunities. **Register online today!**

PHYSICIANS | NURSES | ALLIED HEALTH

healthmatchbc.org

FIND A JOB IN BC

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

health match bc

TEL: 604.736.5920 • TOLL-FREE: 1.877.867.3061 • EMAIL: welcome@healthmatchbc.org

ORNAC Executive

PRESIDENT
Karen Frenette
Bathurst, NB

PRESIDENT ELECT
Rupinder Khotar
North Vancouver, BC

PAST PRESIDENT
Bonnie McLeod
Maple Ridge, BC

SECRETARY
Sue Styles
Seba Beach, AB

EXECUTIVE DIRECTOR
Catherine Harley
Ottawa, ON

TREASURER
Alaine Young
Hamilton, ON

ORNAC Board Members

BRITISH COLUMBIA
Rupinder Khotar
Loraine Best

ALBERTA
Barbara Mushayandebvu
Colleen Marcotte

SASKATCHEWAN
Candace Franke

MANITOBA
Leah Restall

ONTARIO
Anita Esson
Debra Bastone

QUEBEC
Mireille Bélanger
Philippe Willame

NEW BRUNSWICK
Charlotte Roach
Linda Cormier

NOVA SCOTIA
Cathy Timmons
Cathy Ferguson

PRINCE EDWARD ISLAND
Katherine Wood
Cathy Doucette

LABRADOR
Margot Walsh
Debbie Keough

For full details visit **www.ORNAC.ca** and choose ***Corporate***

Affiliate Members

Pat Pocock
Canadian Operating Room Leaders (CORL)

Christine Bilopavlovic
RN First Assistant Network of Canada (RNFANC)

Tracie Scott
Perioperative Nurse Educators of Canada (PNEC)

Editorial Review Panel

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

Barbara Bolding, RN, BSN, MBA, Clinical Education Consultant, Advanced Sterilization Products, Johnson & Johnson Medical Companies, Burnaby, BC.

Deana Bueley, RN BScN CPN(C), Acting Unit Manager, DTC-OR, Royal Alexandra Hospital, Edmonton, AB

Dorothy Dewar, RN, BScN CPN(C), Staff RN, OR, Charlottetown, PE.

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

Marla Ewen, RN, BSN, RNFA, CTBS, CEBT, CPN(C), Tissue Donor Coordinator, Saskatchewan Transplant Program, Saskatoon, SK.

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

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

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

Diana Mabbett, RN, CPN(C), Manager CSR, Peace Country Health Alberta Health Services.

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

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

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

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

Marlene Weeks, RN, BScN, MHS, CPN(C), RNFA, Perioperative Staff Nurse, Royal Jubilee Hospital, Victoria, BC.

Lesia Yasinski, RN, BN, MSA, OR Program Team Manager, St. Boniface General Hospital, Winnipeg, MB.

If you're interested in joining the CORNJ review panel, e-mail **journal@ornac.ca** for more information.

and/or suites when it was deemed necessary. The inclusion criterion for participation required that a participant be a registered nurse (RN) or technician (ORT) practicing in the scrub role during sterile surgical procedures as part of their job description. Although there were approximately 250 full time equivalent (FTE) employees among the surgical healthcare workers, only 128 were eligible for inclusion of this study. A power analysis for .80, alpha of 0.05, and a medium effect size required a minimum sample of 64 participants to compare RNs and ORTs on specific asepsis principles (as outlined in Table 3). Of the 128 FTE eligible for participation in this study, 87 volunteered to participate for a response rate of 68%.

Data Collection and Instrumentation:
Upon ethical clearance from the Western Institutional Review Board® (Olympia, WA, USA), permission was granted by the Surgical Department Chairs and the Director of Perioperative Nursing to survey the participating nursing staff in the operating suites. The research team, consisting of three people (the lead primary investigator and two research assistants), attended a staff meeting during which the principal investigator described the study and invited all staff members who met the inclusion criteria to participate. A research team member provided those who opted to participate with a written informed consent form and an oral explanation about the study and the nature of their participation. Those who signed the informed consent were given two questionnaires to complete:

(1) a demographic data sheet; and

(2) the "Aseptic Technique Surveillance in Perioperative Procedures Survey", which was specifically developed for the purpose of this study.

The demographic data sheet solicited information about the age of the participant, gender, number of years working in the operating room, number of hours worked per shift per day, average number of hours worked per week, education level, basic nursing education, and job position category.

The "Aseptic Technique Surveillance in Perioperative Procedures Survey" was developed to rank best practices of asepsis among perioperative personnel. The survey was developed using the Centers for Disease Prevention and Control Guidelines for Prevention of Surgical Site Infection and the Association of periOperative Registered Nurses (AORN) standards of practice.[23] Standards and guidelines related to best practices of asepsis were extrapolated from the aforementioned documents and used as items in the survey. The survey comprised 47 items in which the participant rated the frequency of compliance with each item using a 5-point Likert scale (i.e., always, most of the time, some of the time, rarely and never). The content of the survey was examined by three infection control professionals who judged the relevance and clarity of each of the 47 items. This process resulted in no revisions being made to the survey. As the intent was not to treat the survey as a psychometric measure of an overall concept, no validity and reliability testing was necessary. Individual items in the survey were, instead, treated as independent units of analysis (i.e. stand-alone variables) in order to provide OR nurses and administrators with specific areas through which they could assess and evaluate their practice. This goal would not have been attainable if data on survey were analyzed within the context of one overall score.

A member of the research team provided each participant with a copy of the survey and allowed them to complete the survey form in private. A member of the research team was, however, present in the OR to answer any questions or concerns that the participant may have had. Completion of the survey was not based on a single procedure observation. Each participant was, instead, instructed to complete the survey considering their overall practice in the OR. Completion of the survey was estimated to take between 10 and 15 minutes. Upon completion the participant placed the survey into a sealed envelope and handed to the research team member. The research team member delivered the sealed envelopes to the research office on a daily basis where they were stored in a locked filing cabinet by the principal investigator (PI). Data

were then entered into a password protected computer by a nursing research assistant. To ensure confidentiality of responses, all data entries were coded so that no personal identifiers were disclosed or used.

Data Analysis:
The Statistical Package for Social Science computer program (version 15; SPSS Inc., Chicago) was used to analyze the data. Descriptive statistics were used to describe the characteristics of the study participants. Data from the Aseptic Technique Surveillance in Perioperative Procedures Survey were analyzed using frequencies, mean, and median descriptive statistics. Given that aseptic practices were measured at an ordinal scale (i.e. 5-point likert scale), comparisons in the scrub role between RNs and ORTs were analyzed using the Mann-Whitney U test.[24] Significant differences between RNs and ORTs were established using an alpha of .05, power of .80 and a moderate effect size.

RESULTS:

Sample Characteristics
Table 1 displays the characteristics of the perioperative personnel in the sample and shows that the majority of participants were female (82.8%; n = 72). It also shows that the sample comprised 74.7% (n = 65) RNs and 25.3% (n = 22) ORTs. The majority of participants were between 30 and 59 years old (85.1%), while a lesser percentage (11.5%) were between 21 and 29 years old. The most frequent range of years cited for experience in the operating room was 12 years or greater (56.3%; n = 49). Forty nine (56.3%) participants had at least a baccalaureate degree, while 35.6% (n = 31) had an associate degree, and 8% (n = 7) had only a high school diploma.

Adherence to Aseptic Techniques:
Table 2 shows that a sizable percentage of participants indicated that they never or rarely observe breaches in the sterile field with regards to open suction drain system in which wound drainage is open to air (46.6%; n = 41) or closed suction drain system whereby vacuum or plastic conduits are used to drain fluids away from the wound by negative pressure (46.6%; n = 41). It also suggests that a sizable proportion either never or rarely observe breaches in the sterile field related to suture material (39.7%; n = 35), use of surgical instruments (37.5%; n = 33), prosthetic implants (56.8%; n = 50), and the practices of other scrub personnel (34.1%; n = 30). Table 3 demonstrates that perioperative scrub RNs were less likely to wear shoe covers during surgical procedures than ORTs (M = 3.42 and 4.17; mdn = 3.00 and 5.00

Table 1. Descriptive statistics of the characteristics of perioperative personnel who practice in the scrub role in the operating room

Variable	N (%)	Variable	N (%)
Age		**Number of years working in the operating room**	
21 – 29	10(11.5)	0 – 3	14(16.1)
30 – 39	20(23.0)	4 – 7	14 (16.1)
40 – 49	32(36.8)	8 – 11	10(11.5)
50 – 59	22(25.3)	12 +	49(56.3)
60 – 69	3(3.4)		
Gender		**Number of hours worked per shift per day**	
Female	72(82.8)	8	71(81.6)
Male	15(17.2)	12 or more	16(18.4)
Position category		**Average number of hours worked per week**	
Technician	22(25.3)	8 – 40	9 (10.3)
Nurse	65(74.7)	41 or more	78 (89.7)
Education level		**Basic Nursing Education**	
High School	7(8.0)	Not applicable	13(14.9)
Associate	31(35.6)	Associate Degree	25(28.7)
Baccalaureate	49(56.3)	Diploma in nursing	11(12.6)
		Baccalaureate	27(31.0)
		Masters	4(4.6)
		Other	7(8.0)

respectively; p = .026). However, there were no significant differences between the two groups in the remaining items of the questionnaire.

DISCUSSION:

The Aseptic Technique Surveillance in Perioperative Procedures Survey was a descriptive self-report survey to determine if perioperative personnel routinely follow the standards for best practices of asepsis. The findings suggested that a high proportion of participating scrub personnel never or rarely observed breaches of asepsis in the sterile field during surgery with regard to the use of products such as suction, sutures, instruments, and implants. The results also suggested that a high proportion of participants never or rarely observed breaches of asepsis committed by other individuals in the operating rooms.

Although scrub nurse personnel are not solely responsible for maintaining the sterile integrity of the products during use, they are responsible for observing and reporting any breaches in the sterile field during surgery. It is the ethical duty and professional responsibility of the scrub personnel to draw attention to or identify the occurrence of a break in sterile asepsis. Although the fulfillment of this responsibility may be uncomfortable and unpopular it is pivotal to preventing SSIs and other complications and thus should be enforced to maintain the integrity of surgical procedures and enhance positive outcomes. Surgical conscience is of utmost importance to ensure patient safety and compliance with standards of care.[25]

The findings showed that RNs and ORTs reported a high frequency of maintaining the principles of asepsis with regard to activities that directly related to them such as wearing gowns, using surgical head cover, performing hand scrub before surgery, and cleaning under the finger nails during scrubbing. These findings, suggest that OR personnel try to adhere to the standards of asepsis during surgery when it comes to activities and standards that directly affect them.

Our findings also showed that RNs and ORTs were not different in their practice with regard to observing and performing most activities pertaining to protecting asepsis during surgery except for wearing shoe covers. The results suggested that RNs were less likely to wear shoe covers than ORTs. This finding is concerning in light of the fact that standards of care for intra-operative attire include wearing shoe covers when exposure to blood or potentially infectious materials is anticipated.[26,27] Although shoe covers are not mandated in all situations, they are part of the operating room attire to prevent microorganism transmission through blood and body fluids. Splatters may occur and fall on the operating attire. In the absence of shoe covers, such splatter may carry a risk to the healthcare provider and present a potential for contamination. Previous research has, in fact, shown that, even after routine cleaning procedures, 63% of the reusable surgical boots have a presence of blood and contamination and that the majority of those boots had significant numbers of bacteria.[25]

CONCLUSION:

The Aseptic Technique Surveillance in Perioperative Procedures Survey findings suggest that RNs and ORTs were similar in their self-reported practices of asepsis while performing in the scrub role. Given that the data suggest that a number of participants do not observe for breaches to asepsis standards as often as one expects, it is important that perioperative personnel strictly adhere to these standards for both their personal safety and the safety of their patients. Challenges for the perioperative team continue to rise as our patient population increases in acuity and microorganism resistance. SSIs must be kept at bay and the number one defensive strategy should be vigilance and assertiveness when enforcing the principles of asepsis in the operating room.

The process of completing the survey was beneficial to raising awareness of asepsis practices. Even though this study was conducted in a large facility, the researchers recommend that it be replicated in a multisite study. The survey tool can be utilized in a variety of ways including self-assessment and peer review. Self-

Continued on Page 21

3M™ Avagard™ CHG

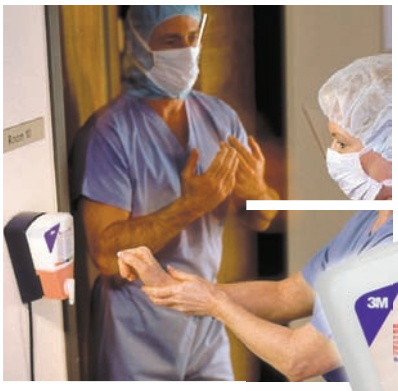
Surgical and Healthcare Personnel Hand Antiseptic with Moisturizers

(Chlorhexidine Gluconate 1% Solution and Ethyl Alcohol 61% w/w)

DIN 02246888

Yes, our competitors dry faster

Just ask your skin.



3M™ Avagard™ CHG

3M™ Avagard™ CHG Surgical Scrub's patented emollient system moisturizes skin and maintains skin integrity.

Destroys Bacteria. Not your Skin.*

3M Canada Company
P.O. Box 5757
London, Ontario N6A 4T1
Canada
1 800-364-3577
www.3m.com

 *Data on file

3M

ORNAC Strategic Plan in Action

Board Governance Initiative

Board Governance Working Group

ORNAC recently completed a five year (2011-2015) strategic plan that was approved by the ORNAC Board in May 2011. A key part of the strategic plan was to focus on strengthening the Board Governance of ORNAC in order to effectively implement the mission, vision and values of the organization. It was determined that there is a need for a strong national voice to advance perioperative care, that there must be rigorous validation of ORNAC National Standards, and that there needs to be access to ORNAC driven education and research. It was also determined that there is a need for ORNAC to have a strong Board with an effective decision-making process and a new board membership structure that meet the needs of perioperative nurses and associates nationally.

The ORNAC Board decided to hold a Board Governance weekend on September 9 to 11, 2011. This meeting involved representatives from each Province as well as from the three affiliate groups. The meeting focus was to address the current issues of declining provincial membership numbers, the need to attract the new generation of perioperative nurses to ORNAC, and ways to address the change in the Canadian Act for not-for-profit associations as ORNAC's current Board structure does not conform to this act (failure to conform can result in the association being dissolved by Industry Canada).

The ORNAC Board Governance meeting participants worked through a change management process where they analyzed, discussed, debated and made recommendations for an ORNAC Board structure change. Karen Cooper, an Ottawa based lawyer in not-for-profit law, presented on Board Governance Essentials and the new Canadian Act for not-for-Profit Associations in order to support the process.

The group then developed two potential scenarios for a new ORNAC Board structure in order to meet the future needs of ORNAC, to increase Board effectiveness, and to change the membership process in order to address the declining Provincial OR Nurses membership. The group also worked on setting clear priorities for all ORNAC value added initiatives organized under the previously identified 5 pillars of National Conference Planning, Professional Practice, Advocacy, Research and Informatics, and Marketing.

Two scenarios for the new ORNAC Organizational structure as well as the recommended Chairs and priorities for the ORNAC Pillars were presented to the ORNAC Board in October 2011 and were further discussed at the November ORNAC Board meeting. All feedback will be combined and a report will be sent to the Provincial board members in order to obtain feedback from each Provincial board. ORNAC would like to acknowledge the hard work and dedication of the Board Governance meeting participants. ORNAC has a promising and dynamic future thanks to its revised Board structure and strong strategic direction.❖

Le plan stratégique de l'AIISOC en action

Initiative du conseil de gouvernance

Tout récemment, l'AIISOC a mené à bien l'élaboration de son plan stratégique de cinq ans (2011-2015), et ce dernier a été approuvé par le conseil de l'AIISOC en mai 2011. Une tâche importante du plan stratégique visait à renforcer la gouvernance du conseil de l'AIISOC afin de mettre en œuvre de manière efficace la mission, la vision et les valeurs de notre organisme. Il a été déterminé que l'AIISOC avait besoin d'une voix nationale forte afin de faire progresser les soins périopératoires, que les normes nationales de l'AIISOC devaient faire l'objet d'une validation rigoureuse et que l'accès aux programmes de l'AIISOC axés sur l'éducation et la recherche devait être amélioré. En outre, l'AIISOC doit être mené par un conseil d'administration solide, capable de mettre en place un processus efficace de prise de décisions et possédant une structure d'adhésion des membres pouvant combler les besoins des infirmiers et des infirmières en soins périopératoires et des associés à l'échelle nationale.

Le conseil de l'AIISOC a pris la décision de tenir une fin de semaine de gouvernance du conseil qui a eu lieu du 9 au 11 septembre 2011. Cette réunion rassemblait les représentants de chaque province ainsi que ceux des trois groupes affiliés afin d'aborder les questions actuelles relatives à la baisse des adhésions provinciales des infirmiers et des infirmières de salles d'opération et au besoin d'attirer la nouvelle génération d'infirmiers et d'infirmières en soins périopératoires. De plus, le groupe s'est penché sur les changements apportés à la loi canadienne concernant les associations à but non lucratif et avec lesquels le processus actuel pour la nomination du conseil d'administration de l'AIISOC n'est pas conforme. (Si l'AIISOC ne s'y conforme pas, l'organisme pourrait être dissout par Industrie Canada.

Les participants à la gouvernance du conseil de l'AIISOC ont travaillé à l'aide d'une méthode de gestion du changement grâce à laquelle ils ont analysé, discuté, débattu et sont parvenus à faire des recommandations pour un changement de structure du conseil de l'AIISOC. Karen Cooper, une avocate d'Ottawa se spécialisant en droit à but non lucratif, a présenté un document sur les éléments essentiels de la gouvernance du conseil et les nouvelles lois canadiennes concernant les organismes à but non lucratif afin d'appuyer le processus.

Le groupe a ensuite élaboré deux scénarios possibles pour la nouvelle structure du conseil de l'AIISOC conçus pour combler les besoins futurs de l'AIISOC tout améliorant l'efficacité du conseil et en abordant la question de la baisse des adhésions provinciales des infirmiers et des infirmières de salles d'opération. Le groupe a également travaillé pour établir des priorités claires pour toutes les initiatives de l'AIISOC organisées sous les cinq piliers : Planification de la conférence nationale, Pratique professionnelle, Défense des droits, Recherche et Informatique et Marketing, tels qu'identifiés auparavant dans notre plan stratégique.

Deux scénarios de la nouvelle structure organisationnelle de l'AIISOC ainsi que les présidents et priorités recommandés pour les piliers de l'AIISOC ont été présentés au conseil de l'AIISOC au cours du mois d'octobre 2011 et ont été discutés plus en profondeur lors de la réunion du conseil de l'AIISOC du mois de novembre. Toutes les rétroactions seront recueillies et un rapport sera envoyé aux membres provinciaux qui pourront le réviser et le commenter avec leurs conseils provinciaux. Nous aimerions souligner les efforts et le dévouement des participants à la réunion de la gouvernance du conseil de l'AIISOC. L'AIISOC a devant elle un avenir prometteur et dynamique grâce à sa structure de conseil révisée et sa solide orientation stratégique. ❖

Groupe de travail du conseil de gouvernance

UPCOMING EVENTS / PROCHAINS ÉVÉNEMENTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

Manitoba		March 2012 Workshop
British Columbia	Nanaimo, BC	April 25 - 28, 2012
New Brunswick	Fredericton, NB	April 27 & 28, 2012
Nova Scotia	Antigonish, NS	June 1 & 2, 2012
Ontario	Toronto, ON	June 16 - 20, 2012
25th Atlantic Conference	Charlottetown, PEI	September 26 - 28, 2012
Alberta	Red Deer, AB	October 24 - 27, 2012
Quebec	Quebec City, QC	Oct 31 - Nov 2, 2012
Newfoundland	St. John's, NL	2012

ORNAC CONFERENCES www.ORNAC.ca

23rd ORNAC National & IFPN Conference	Ottawa, ON	April 21 - 25, 2013

INTERNATIONAL CONFERENCES

AORN (www.AORN.org)	New Orleans, LA	March 24 - 29, 2012
EORNA (www.eorna.eu)	Lisboa, Portugal	April 26 - 29, 2012
AfPP (www.afpp.org.uk)	Birmingham, UK	October 17 - 19, 2012

RELATED PROFESSIONS

CORL	Toronto, ON	May 6 - 8, 2012
CAS (www.cas.ca)	Quebec City, QC	June 15 - 19, 2012

Table 2. Frequency of perioperative personnel responses in survey instrument

Variable	Never N(%)	Rarely N(%)	Some of the time N(%)	Most of the time N(%)	Always N(%)
Observe a breach in asepsis during surgery related to open suction drains	11(12.5)	30(34.1)	12(13.6)	2(2.3)	33(37.5)
Observe a breach in asepsis during surgery related to closed suction drains	12(13.6)	29(33.0)	11(12.5)	3(3.4)	33(37.5)
Observe a breach in asepsis during surgery related to suture materials	4(4.5)	31(35.2)	15(17)	4(4.5)	34(38.6)
Observe a breach in asepsis during surgery related to use of surgical instruments	5(5.7)	28(31.8)	20(22.7)	2(2.3)	33(37.5)
Observe a breach in asepsis during surgery related to prosthetic implants	23(26.1)	27(30.7)	4(4.5)	1(1.1)	33(37.5)
Observe breaks in the field by scrub personnel	2(2.3)	28(31.8)	15(17)	4(4.5)	39(44.3)
Keeps hands up and away from body	1(1.1)	0(0)	0(0)	6(6.8)	81(92.0)
Uses sterile towel to dry hands and forearms prior to donning gloves	1(1.1)	0(0)	0(0)	2(2.3)	85(96.6)
Water drips from tips of fingers toward elbow	3(3.4)	1(1.1)	1(1.1)	8(9.1)	75(85.2)
Wears sterile gloves	0(0)	0(0)	3(3.4)	15(17.0)	70(79.5)
Checks integrity of glove for holes/deformities	1(1.1)	1(1.1)	5(5.7)	8(9.1)	73(83.0)
Checks room for proper air exchange/pressures	12(13.6)	6(6.8)	12(13.6)	18(20.5)	40(45.5)
Cleans under fingernails without brush/with brush if first scrub	3(3.4)	1(1.1)	4(4.5)	16(18.2)	64(72.7)
Keeps OR room doors closed during the procedure	0(0)	0(0)	4(4.5)	13(14.8)	71(80.7)
Performs hand/forearm scrub and at least two minutes	1(1.1)	0(0)	7(8.0)	17(19.3)	63(71.6)
Uses surgical head cover	1(1.1)	0(0)	1(1.1)	2(2.3)	84(95.5)
Wears sterile gown	2(2.3)	1(1.1)	1(1.1)	11(12.5)	73(83.0)

Table 3. Mann Whitney comparison of Registered Nurses and Operating Room Technicians survey results

Variable*	M ± SD	Median	Z	P*
Observe a breach in asepsis during surgery related to open suction drains			-.972	.331
RN	3.08 ± 1.503	3.00		
ORT	3.48 ± 1.620	4.00		
Observe a breach in asepsis during surgery related to closed suction drains			-.972	.342
RN	3.08± 1.514	2.00		
ORT	3.48 ± 1.648	4.00		
Observe a breach in asepsis during surgery related to suture materials			-1.201	.230
RN	3.26± 1.406	3.00		
ORT	3.70± 1.428	4.00		
Observe a breach in asepsis during surgery related to use of surgical instruments			-.515	.607
RN	3.28 ± 1.386	3.00		
ORT	3.52 ± 1.473	4.00		
Observe a breach in asepsis during surgery related to prosthetic implants			-1.306	.192
RN	2.78 ±1.682	2.00		
ORT	3.35 ± 1.722	4.00		
Observe breaks in the field by scrub personnel			-.609	.543
RN	3.51± 1.404	3.00		
ORT	3.74 ± 1.356	4.00		
Keeps hands up and away from body			-1.630	.103
RN	4.85 ± .565	5.00		
ORT	5.00 ± .000	5.00		
Uses sterile towel to dry hands and forearms prior to donning gloves			-.272	.786
RN	4.92 ± .510	5.00		
ORT	4.96 ± .209	5.00		
Water drips from tips of fingers toward elbow			-.524	.601
RN	4.77 ± .745	5.00		
ORT	4.57 ± 1.080	5.00		
Uses sterile gloves			-.772	.440
RN	4.78 ± .484	5.00		
ORT	4.70 ± .559	5.00		
Checks integrity of glove for holes/deformities			-.588	.557
RN	4.71 ± .678	5.00		
ORT	4.74 ± .864	5.00		
Checks room for proper air exchange/pressures			-.674	.501
RN	3.82 ± 1.457	4.00		
ORT	3.65 ± 1.402	4.00		
Cleans under fingernails without brush/with brush if first scrub			-.712	.477
RN	4.57 ± .918	5.00		
ORT	4.52 ± .898	5.00		
Keeps OR room doors closed during the procedure			-1.542	.123
RN	4.71 ± .579	5.00		
ORT	4.91 ± .288	5.00		
Performs hand/forearm scrub and at least two minutes			-.246	.806
RN	4.63 ± .651	5.00		
ORT	4.52 ± .947	5.00		
Uses surgical head cover			-1.210	.226
RN	4.58 ± .573	5.00		
ORT	5.00 ± .000	5.00		
Wears sterile gown			-.545	.586
RN	4.71 ± .843	5.00		
ORT	4.78 ± .422	5.00		
Wears shoe covers*			-2.230	.026
RN	3.42 ± 1.488	3.00		
ORT	4.17 ± 1.267	5.00		

Indicates statistical significance at an alpha of .05

reported behaviour calls attention to practice and follow up studies could be designed for actual practice behaviours. That is, future research may be conducted whereby members of the perioperative team could be visually observed during surgical procedures for their behavior toward aseptic techniques.

Given the descriptive self-reporting nature of this study, the researchers recognize that it is not without limitations. Although all perioperative nursing staff were invited to participate in the study, the potential for selection bias could not be eliminated because individual participants were able to self-select. In addition, the self-reporting nature of the study carries a potential for response bias and subjectivity on the part of the individual respondents. Despite these potential limitations, our findings shed light on the issue of breaching of the principles and standards of asepsis during surgery.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009). *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (9th edition). Section 2, pp 128 -132, Standards 7.1 - 7.5.

REFERENCES:

1 Beyea SC. Keeping patients safe from infection. Aorn J 2003; 78: 133-4, 7.

2 The Joint Commission of Accreditation of Healthcare Organizations. Sentinel event alert, Issue 28: Infection control related sentinel events. In, Vol. 2008: The Joint Commission of Accreditation of Healthcare Organizations, 2004.

3 Owens CD, Stoessel K. Surgical site infections: epidemiology, microbiology and prevention. J Hosp Infect 2008; 70 Suppl 2: 3-10.

4 Mangram AJ, Horan TC, Pearson ML et al. Guideline for prevention of surgical site infection, 1999. Hospital Infection Control Practices Advisory Committee. Infect Control Hosp Epidemiol 1999; 20: 250-78; quiz 79-80.

5 Klevens RM, Edwards JR, Richards CL, Jr. et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Rep 2007; 122: 160-6.

6 Fry DE, Fry RV. Surgical site infection: the host factor. Aorn J 2007; 86: 801-10; quiz 11-4.

7 Hopper WR, Moss R. Common breaks in sterile technique: clinical perspectives and perioperative implications. Aorn J; 91: 350-64; quiz 65-7.

8 Auerbach A. Prevention of surgical site infections. In: Making Health Care Safer: A critical Analysis of Patient Safety Practices Evidence (Shojania K, Duncan B, McDonnald K et al., eds). Rockville, MD.: Agency for Healthcare Research and Quality, 2001: 221-44.

9 Alfonso JL, Pereperez SB, Canoves JM et al. Are we really seeing the total costs of surgical site infections? A Spanish study. Wound Repair Regen 2007; 15: 474-81.

10 Sparling KW, Ryckman FC, Schoettker PJ et al. Financial impact of failing to prevent surgical site infections. Qual Manag Health Care 2007; 16: 219-25.

11 Monge Jodra V, Sainz de Los Terreros Soler L, Diaz-Agero Perez C et al. Excess length of stay attributable to surgical site infection following hip replacement: a nested case-control study. Infect Control Hosp Epidemiol 2006; 27: 1299-303.

12 Bratzler DW. The Surgical Infection Prevention and Surgical Care Improvement Projects: promises and pitfalls. Am Surg 2006; 72: 1010-6; discussion 21-30, 133-48.

13 Merrer J, Girou E, Lortat-Jacob A et al. Surgical site infection after surgery to repair femoral neck fracture: a French multicenter retrospective study. Infect Control Hosp Epidemiol 2007; 28: 1169-74.

14 Barnett TE. The not-so-hidden costs of surgical site infections. Aorn J 2007; 86: 249-58.

15 Roberts RR, Scott RD, 2nd, Cordell R et al. The use of economic modeling to determine the hospital costs associated with nosocomial infections. Clin Infect Dis 2003; 36: 1424-32.

16 Fitzgerald J, Kanter G, Trelease R et al.

Reducing surgical complications. Nurs Manage 2007; 38: 35-9.

17 Anderson D, Sexton D. Infection control and hospital epidemiology: a growth opportunity in medicine. Infect Dis Clin Prac 2007: 113-5.

18 Brendle TA. Surgical Care Improvement Project and the perioperative nurse's role. AORN J 2007; 86: 94-101.

19 Safer Healthcare Now. Prevent surgical site infections:Getting started kit. In, Vol. 2011: Canadian Patient Safety Institute, 2010.

20 Anderson DJ, Sexton DJ, Kanafani ZA et al. Severe surgical site infection in community hospitals: epidemiology, key procedures, and the changing prevalence of methicillin-resistant Staphylococcus aureus. Infect Control Hosp Epidemiol 2007; 28: 1047-53.

21 Griffin F. Reducing surgical complications. In: Joint Commission journal on quality and patient safety / Joint Commission Resources, 2007: 660-5.

22 Blanchard J. Leech storage, surgical site infection study; national patient safety goals; eating on instrument prep tables; razor shaving. AORN J 2004: 405-6;8-10.

23 AORN. Recommended practices for surgical attire. AORN J 2005: 413-6.

24 Pett M. Nonparametric statistics for health care research: Statistics for small samples and unusual distributions. Thousand Oaks:: Sage Publications, 1997.

25 Girard NJ. Surgical conscience: still pertinent. AORN J 2007; 86: 13-4.

26 AORN. Perioperative Standards and Recommended Practices 2011: AORN, 2011.

27 ORNAC. (2009). Standards, guidelines, and position statements for perioperative registered nursing practice. ❖

Introduction to CHICA-Canada

Author: *Donna Wiens, RN, BN, CIC is President, CHICA-Canada*

The Community and Hospital Infection Control Association (CHICA) – Canada is a national, multi-disciplinary, voluntary association uniting those with an interest in infection prevention in Canada. CHICA-Canada has over 1700 individual, institutional or corporate members in 22 chapters across the country, dedicated to the health of Canadians by promoting excellence in the practice of infection prevention and control.

The provision of infection prevention and control services is, amid the increasing demand for scarce health care resources, rapidly evolving. Challenges to practice include decreased numbers of acute care inpatient beds and an increased demand for long-term care beds; expansion of home care services; increased patient acuity; and increased numbers of ambulatory procedures, same day surgeries and advanced diagnostic procedures. Protection of clients and employees has been impacted by global travel, bloodborne pathogens, the resurgence of tuberculosis, and the explosive increase in antimicrobial resistant organisms.

CHICA members work in a variety of healthcare settings including acute, long term, home care, public health, physician or dental offices, corrections facilities, and emergency services. CHICA and its local chapters provide support to its members in many ways:

- Initiating and developing effective communication between professionals (website, member & source guide, e-newsletters, chapter web pages, and special interest groups);
- Supporting the development of effective and rational practice (position statements, collaboration on national guidelines/standards);
- Encouraging standardization and critical evaluation of practice (audit toolkit, professional and practice standards, e-learning modules);
- Promoting research in practices and procedures (publisher of *Canadian Journal of Infection Control*);
- Promoting and facilitating education (national and chapter education conferences/ road-shows, endorsement & provision of basic infection prevention and control courses); and
- Promoting consumer awareness within the community (collaboration on national and global awareness campaigns).

CHICA collaborates with many national agencies on infection prevention initiatives such as STOP - Clean Your Hands Day, World Health Day and the Global Hand Hygiene Campaign. CHICA-Canada works closely with its corporate sponsors who provide support to members through scholarships and awards as well as directly supporting education events and the audit toolkit. CHICA works internationally with partner associations to support collaborative education efforts during International Infection Prevention Week and promotes the international advancement of infection prevention and control professionals through recognition and certification.

This year CHICA-Canada and ORNAC are forging a stronger relationship. Both organizations are patient safety proponents and the two groups have much to share at conferences, in journals and at the point of care.

For more information about CHICA-Canada visit **www.CHICA.org**.

CHICA-CANADA

Introduction à CHICA-Canada

Auteure : *Donna Wiens, IA, B.S.Inf., certifiée en prévention et contrôle des infections est présidente de CHICA-Canada*

L'Association pour la prévention des infections à l'hôpital et dans la communauté – Canada (CHICA) est une association nationale, multidisciplinaire et bénévole unissant tous les professionnels s'intéressant à la prévention des infections au Canada. CHICA-Canada possède plus de 1 700 membres, soit à titre personnel, institutionnel ou collectif dans 22 sections régionales à travers le Canada et qui sont engagés à l'amélioration de la santé des Canadiens en favorisant l'excellence dans la pratique de la prévention et du contrôle des infections.

Dans un contexte où la demande pour des ressources de soins de santé rares est toujours plus grande, la distribution de services de prévention et de contrôle des infections est, quant à elle, en plein essor. Parmi les défis auxquels la pratique fait face, notons un nombre décroissant de lits pour malades hospitalisés en soins actifs et une demande accrue pour des lits de soins de longue durée; l'expansion des services de soins à domicile; une augmentation de l'acuité des besoins du patient; et un nombre accru de procédures ambulatoires, de chirurgies ambulatoires et de procédures de diagnostic de deuxième niveau. La protection des clients et des employés a été touchée par les voyages internationaux, les pathogènes à diffusion hématogène, la résurgence de la tuberculose et l'augmentation vertigineuse des organismes résistant aux antimicrobiens.

Les membres de CHICA travaillent dans différents milieux du domaine des soins de la santé, notamment les soins actifs, de longue durée, à domicile, dans le domaine de la santé publique, dans des bureaux de médecins ou de dentistes, dans des établissements correctionnels et les services d'urgence. CHICA et ses sections régionales offrent du soutien à ses membres de plusieurs façons :

- Établir et favoriser une communication efficace entre les professionnels (site Web, membres & guide de sources, bulletins d'information électroniques, pages Web des sections régionales et groupes d'intérêt particulier);
- Soutenir le développement d'une pratique efficace et rationnelle (énoncés de position, collaboration quant aux lignes directrices/normes nationales);
- Encourager la normalisation et l'évaluation critique de la pratique (trousse d'audit, normes professionnelles et de la pratique, modules d'apprentissage en ligne);
- Promouvoir la recherche au sein des pratiques et des procédures (éditeur du Canadian Journal of Infection Control);
- Promouvoir et favoriser l'éducation (conférences/tournées de présentation éducatives nationales et par secteur régional, promotion & distribution de cours fondamentaux sur la prévention et le contrôle des infections); et
- Promouvoir la sensibilisation des consommateurs au sein de la communauté (collaboration à des campagnes de sensibilisation nationales et mondiales).

CHICA collabore avec de nombreux organismes nationaux à des initiatives de prévention des infections, telles la Journée ARRÊT! Nettoyez-vous les mains, la Journée mondiale de la santé et la Campagne mondiale d'hygiène des mains. CHICA-Canada travaille en étroite collaboration avec ses sociétés commanditaires qui fournissent aux membres du soutien par le biais de bourses et de prix tout en appuyant directement des événements éducatifs et la trousse d'audit. CHICA œuvre à l'échelle internationale grâce à des partenariats afin de soutenir les efforts collectifs déployés pour l'éducation lors de la Semaine internationale de la prévention des infections et fait la promotion de l'avancement à l'échelle internationale des professionnels en matière de prévention et de contrôle des infections grâce à la reconnaissance et la certification.

Cette année, CHICA-Canada et l'AIISOC forgent des liens encore plus solides. Tous deux promoteurs de la sécurité des patients, les deux organismes ont beaucoup d'éléments à partager lors des conférences, dans les articles de revues et lieux de soins.

Pour de plus amples renseignements sur CHICA-Canada, visitez **www.CHICA.org**.

CHICA-CANADA

Proof is in the Pack

Chloraprep® preoperative skin preparation: Unmatched clinical evidence in every applicator.

Now **combined** with the convenience of Cardinal Health Canada's **Custom Sterile Packs**. Creating a safer more efficient O.R.

ChloraPrep®. The proven way to prep™.

REFERENCES:

- Darouiche R, Wall M Jr, Itani M, et al. Chlorhexidine-alcohol versus povidone-iodine for surgical-site antisepsis. N Engl J Med . 2010;362:18-26.
- Saltzman MD, Nuber GW, Gryzlo SM, Marecek GS, Koh JL. Efficacy of surgical preparation solutions in shoulder surgery. J Bone Joint Surg Am. 2009;91 A(8):1949–1953.

CardinalHealthCanada

CareFusion

For further information, please contact us at 1.888.291.5033.

There's never a good time for a POUR outcome.

Know the Math Before You Cath.™

Anesthesia, as well as post-op sedation and analgesia, directly affect the incidence of postoperative urinary retention (POUR) in the PACU. [1]

A recent approach to managing POUR suggests that in-out catheterization, monitored by ultrasound bladder volume measurement, may be adequate following many surgical procedures.[1]

BladderScan ultrasound bladder volume instruments help diagnose and monitor urinary retention.

BladderScan® instruments are noninvasive, accurate, and reliable. They are quick and easy to use. And they can help manage POUR and improve patient outcomes by reducing the duration of urinary catheterization or avoiding it altogether.

The new BVI 9600 features
bladder volume mode
+
AortaScan mode

AortaScan®

Contact us for a personal consultation:
1.800.331.2313
canadasales@verathon.com

BladderScan®
Bladder Volume Instruments

Noninvasive, Accurate, Reliable, Easy to Use

References: 1. Baldini G, Bagry H, Aprikian A, Carli F. Postoperative urinary retention: anesthetic and perioperative considerations. *Anesthesiology*. 2009;110(5):1139-1157.