CANADIAN
OPERATING ROOM
NURSING JOURNAL

Volume 28, Issue 2
June 2010

Conflict Resolution

Call for Abstracts

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President's Message

"Medicine used to be simple and ineffective and relatively safe, but now it is complex, effective, and potentially dangerous"[1]

Chantler, cited by Baker, 2005

At the recent *Surgical Safety Saves Lives Workshop* in Vancouver, I had the privilege of representing perioperative nurses on an interdisciplinary panel. The participants included a Chief Executive Officer of an eastern hospital, two surgeons, an anesthesiologist, and a member of 'Patients for Patient Safety'. The discussion was structured by questions delivered by a facilitator: "(1) Why do you think the checklist has received so much attention; (2) Why might surgeons/anesthesiologists/nurses be opposed to using the checklist; and (3) How has using the checklist influenced or changed the way you practice?"

My response to the first question was short – "It is the right thing to do". There is strong evidence that checklists (and briefings) reduce adverse events and improve patient safety in the operating theatre.[2] The second question could be the focus of a full day conference, but in the essence of brevity I focused on the myths presented by members of the surgical team during checklist discussions within my health authority. Myth #1 "The checklist won't make a difference as we are already careful and we have never had a problem – it will just create extra work"; Myth # 2 "Staff introductions are a waste of time – we already know our team"; and Myth # 3 "We are experts – we do not need to critique our practice and we can ignore the checklist as it does not apply to us". In order to address these myths and to ensure effective implementation and sustained benefits, providing education to the surgical teams regarding the significance of the checklist is crucial.

The third question highlights the essence of the checklist beyond a piece of paper. I contend that the term "checklist" is inadequate as the importance of the usage extends beyond a document to a tool for improved team communication, collaboration, and caring. Instead, I suggest that we use the terminology "team connection".

Jane Reid, one of the seven nurses in Geneva for the initial development of the World Health Organization's Surgical Safety Checklist, coauthored a review of safer surgery progression and captured this issue under the heading "Promoting a safety culture":

> *"The real value of the checklist lies in its use as a tool, to focus everyone's attention on the critical safety points of a patient's surgery, and to create a forum for anyone in the room to question and challenge what is happening, needs to happen or to stop happening, regardless of their status or grade, thus flattening the hierarchy."*[3]

The checklist is about working differently – it will open up lines of communication between all staff present and will enhance teamwork, for the improvement of patient safety, clinical outcomes for patients, and cohesive work environments. Have a safe and happy summer!

Bonnie W. McLeod

References

1. Baker, R. (2005). Editorial. *Healthcare Quarterly*, 8, 2.

2. Haynes AB, Weiser TG, Berry, WR, et al (2009). A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine*, 360 (5), 491-497.

3. Reid, J., & Clarke, J., (2009). Progressing Safer Surgery. *Journal of Perioperative Practice*, 19 (10), p 340.

Bonnie W. McLeod, RN, BScN, MN, CPN(C), is Clinical Nurse Educator - Perioperative, Fraser Health Authority, Ridge Meadows Hospital site, the ORNAC representative on the Canadian Patient Safety Institute, and the past Chair of the ORNAC Standards committee.

Mot de la president

"Médicament utilisé pour être simple et inefficace et relativement sûre, mais maintenant il est complexe, efficace et potentiellement dangereuse"[1]

Chantler, cité par Baker, 2005

Lors de la récente *sécurité sauve des vies chirurgicale atelier* à Vancouver, j'ai eu le privilège de représenter les infirmières périopératoires sur un panel interdisciplinaire. Les participants ont inclus un chef de la direction d'un hôpital de l'Est, deux chirurgiens, un anesthésiste et un membre de «Les patients pour la sécurité des patients». La discussion a été structurée par des questions livrés par un animateur: (1) Pourquoi pensez-vous de la liste de contrôle a reçu autant d'attention; (2) Pourquoi les chirurgiens / anesthésistes et infirmières de s'opposer à l'utilisation de la liste de contrôle, et (3) Comment utiliser la liste de contrôle influencée ou modifiée de la façon dont vous la pratique? "

Ma réponse à la première question fut de courte - "C'est la bonne chose à faire". Il est manifeste que les listes de contrôle (et des séances d'information) réduire les événements indésirables et d'améliorer la sécurité des patients dans le fonctionnement theatre.[2] La deuxième question pourrait faire l'objet d'une conférence d'une journée complète, mais dans l'essence de brièveté je me suis concentré sur les mythes présentés par les membres de l'équipe chirurgicale au cours des discussions au sein de ma liste de contrôle des autorités sanitaires. Mythe # 1 "La liste de contrôle ne fera pas une différence en tant que nous sommes déjà attentive et nous n'avons jamais eu un problème - il suffit de créer un surcroît de travail»; Mythe # 2 introductions du personnel " sont une perte de temps - nous le savons déjà à notre équip ", et Mythe # 3" Nous sommes des experts - nous n'avons pas besoin de critiquer notre pratique et nous ne pouvons ignorer la liste car il ne s'applique pas à nous ". Afin de répondre à ces mythes et de veiller à la mise en œuvre efficace et soutenue des prestations, fournir une éducation aux équipes chirurgicales concernant l'importance de la liste de contrôle est crucial.

La troisième question met en lumière l'essence de la liste de contrôle au-delà d'un morceau de papier. Je soutiens que le terme «liste» est insuffisant que l'importance de l'utilisation s'étend au-delà d'un document à un outil de communication améliorée équipe, la collaboration et de soins. Au lieu de cela, je suggère que nous utilisons la terminologie de connexion d'équipe ».

Jane Reid, l'un des sept infirmières à Genève pour le développement initial de l'Organisation mondiale de la santé la sécurité chirurgicale liste de contrôle de la, co-écrit un examen de la chirurgie plus sûre et la progression capturé cette question sous la rubrique «Promouvoir une culture de sécurité»:

" La valeur réelle de la liste de contrôle réside dans son utilisation comme un outil, de se concentrer l'attention de tous sur les points critiques pour la sécurité du patient un cabinet, et de créer un forum pour toute personne dans la salle à la question et un défi à ce qui se passe, qui doit se passer ou d'arrêter de se produire, quelle que soit leur statut ou leur grade, ainsi aplatissement de la hiérarchie."[3]

La liste de contrôle est de travailler différemment - il va ouvrir des lignes de communication entre tous les membres du personnel présents et permettra d'améliorer le travail d'équipe, pour l'amélioration de la sécurité des patients, les résultats cliniques des patients, et des environnements de travail cohérent.

Bonnie W. McLeod

References

1. Baker, R. (2005). Editorial. *Healthcare Quarterly*, 8, 2.

2. Haynes AB, Weiser TG, Berry, WR, et al (2009). A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine*, 360 (5), 491-497.

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Bonnie W. McLeod, infirmière autorisée, BScN, MN, CPN(C), est infirmière clinicienne enseignante (périopératoire) à la Fraser Health Authority, Ridge Meadows Hospital, représentante de l'AIISOC auprès de l'Institut canadien pour la sécurité des patients et ancienne présidente du comité des normes de l'AIISOC.

CANADIAN OPERATING ROOM NURSING JOURNAL

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CALL FOR ABSTRACTS AND POSTERS

Operating Room Nurses Association of Canada

22ND NATIONAL CONFERENCE

Regina, Saskatchewan – May 8th-13th, 2011

SHARE YOUR ACCOMPLISHMENTS!

The 2011 Conference Program Committee is currently accepting submissions of abstracts for paper or poster presentations at the **22nd ORNAC National Conference**.

Submissions are welcome in the fields of perioperative clinical practice, education, professional development, research, and administration! The theme of the Conference is:

"Elevating the Field of Perioperative Nursing"

Abstracts will be considered for presentation in one of the following forums:

Poster: A visual display to be displayed at the conference.

Paper: A 25 minute presentation by the author(s) and 5 minutes for questions & answers.

Posters will be selected based on relevance and implications for perioperative nursing as well as conformity with the Conference theme.

Proposals are welcome for presentations in either English or French.
The deadline for submissions is September 30th, 2010.
Criteria, forms, and submission details are available via email at abstracts@ORNAC.ca.

Unsigned, incomplete, or late submissions will not be processed.

APPEL DE SOUMISSIONS

L'Association des infirmières et infirmiers de salle d'opération du Canada

22È CONFÉRENCE NATIONALE

Regina, Saskatchewan – du 8 au 13 mai 2011

APPEL DE SOUMISSIONS

Le Comité du Programme de la Conférence 2011 accepte maintenant la soumission de résumés de discours et de présentations visuelles (affiches) pour la **22e Conférence Nationale de l'AIISOC**.

Les soumissions sont bienvenues dans les domaines de la pratique clinique perioperative, de l'education, du développement professionnel, de la recherche, et de l'administration ! Le thème de la conférence est le suivant :

"Rehausser le champ des soins périopératoires"

Les résumés seront évalués pour présentation dans une des formes suivantes :

Poster: Une présentation visuelle. Les affiches seront exposées à la conférence.

Paper: Un discours de 25 minutes présenté par son auteur(e) ou auteurs (es) suivi d'une période de 5 minutes pour les questions.

Les affiches seront choisies selon leur pertinence et leur implication aux soins périopératoires tout en respectant le thème.

Nous vous invitons à soumettre vos résumés dans le langage de votre choix, soit en anglais ou en français.
La date limite pour les soumissions électroniques est le 30 septembre 2010.
Les critères détaillés pour les soumissions et les formulaires sont disponibles au courriel suivant : abstracts@ORNAC.ca.

Aucune soumission non-signée, incomplète ou en retard ne sera considérée.

CONFLITS DANS LA SALLE D'OPÉRATION : LUTTE ET FUITE OU CROISSANCE ET COMMUNICATION

Auteure : *Cheryl Stella C. Okoli, IA, B.Sc.Inf, M.Sc.Inf., réside à Calgary, en Alberta, et travaille comme infirmière autorisée de salle d'opération pour les chirurgies générales au Foothills Medical Centre. Elle est membre de l'ORNAA, elle assume le rôle d'infirmière responsable de la spécialisation sur le stimulateur cardiaque (Pacemaker) dans la même institution et elle agit à l'occasion comme préceptrice auprès du nouveau personnel en salle d'opération. Elle assume aussi les responsabilités d'infirmière de liaison en salle d'opération. Elle vient d'être acceptée au programme de pratique infirmière à l'université Athabasca. Elle a vécu en Afrique, en Asie et en Amérique du Nord et elle fait du bénévolat avec de jeunes délinquants et prévoit travailler et œuvrer comme bénévole auprès des Premières nations dans un avenir rapproché.*

RÉSUMÉ :

Le conflit n'est le domaine de personne en particulier. Il prend sa source chez un individu et se propage chez les autres par effet domino. Les conflits parmi le personnel infirmier autorisé et les techniciens en salle d'opération, et entre les infirmières et les infirmières, est courant dans les salles d'opération. Le milieu opératoire se compose de plusieurs personnalités, chacune préconisant des méthodes différentes pour offrir des soins aux patients. La communication efficace est essentielle pour prévenir et résoudre les situations de conflit.

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 infirmiers et infirmières de salle d'opération du Canada (AISSOC) de juin 2009, section 3, p.218, Normes 3.2.4.

CONFLICT IN THE OPERATING ROOM: FIGHT AND FLIGHT OR GROWTH AND COMMUNICATION

Author: *Cheryl Stella C. Okoli, RN, BN, MSN, lives in Calgary, AB and works as a General Surgery OR nurse at the Foothills Medical Centre. She is a member of ORNAA and serves as a resource nurse for the Pacemaker specialty at the same institution and occasionally preceptors new OR staff. She also serves as a surgical liaison nurse. She has currently been accepted into the nurse practitioner program through Athabasca. She has lived in Africa, Asia, and North America, and volunteers with Young Offenders and the First Nation population.*

ABSTRACT:

Conflict is partial to no one. It ranges from within an individual and spirals in a ripple effect to others. Conflict among Registered Nurses (RNs) and Operating Room Technicians (ORTs) and between fellow RNs is prevalent in the operation room. The OR environment is filled with a number of personalities, each possessing varying methods for the implementation of patient care. Effective communication is key to preventing, and resolving, conflict situations.

By/par J. Porteous

Dealing with Conflict in the Workplace

Conflict (cont.)

What is conflict? According to Cox, "there is no universally accepted definition of conflict."[1] Is it a bold statement to suggest that "conflict" is synonymous with fight, flight or even growth and communication? This question will be addressed in this article.

With the right approach, conflict can provide a channel for communication and growth. Kelly says that,

> "nursing requires a guiding definition of conflict that is positive and comprehensive so that conflict is embraced constructively"[2]

The benefits of conflict can be positive as Grossman and Valiga remind us when they say that some of the results of conflict are "growth, an ability to accept that what was can no longer be, and collaboration, which builds healthy relationships."[3] Cox also lists the positive benefits of conflict when she says "conflict is constructive when it improves the quality of decisions, stimulates creativity and innovation, encourages interest and curiosity among group members, provides the medium through which problems can be aired and tensions released, and fosters self-evaluation and change."[1]

Envision this… a Case Study:

Marcy is a twenty-five year old nurse. She has practiced as an operating room nurse for about three years. She is a keen learner, her key learning style is visual in nature, and she seeks rationales for certain tasks that need to be performed. She is vibrant and cheerful but, because of her inquisitive nature and tendency at times to question authority, some describe her as a non-team player.

Imagine being assigned to work with Marcy in the theatre for a day. The team has adequate staffing including two other staff members, one of whom is an ORT and one of whom is an RN, with over seven years experience, who is deemed to be the senior RN in the theatre.

In light of the information provided, what is the best way to plan the day in order to avoid negative conflict situations? What is the most effective way to address the following situations?

1) **Communication dealing with the division of labour.** Suppose a thoracotomy with lobectomy is scheduled for the first case of the day. Marcy loves scrubbing in for thoracotomies but has not done so for approximately 6 months. She would really like to scrub in on this particular case in order to maintain and boost her expertise in the procedure. The potential conflict situation is that, by default, an ORT usually scrubs in on the first case of the day, as scrubbing is an ORT's primary job. What factors should be taken into consideration and why (e.g. who does what and why)?

2) A **difference of opinion.** Imagine being the senior nurse who wants a task done a certain way despite the fact that it could be done in another manner. What is the reaction to Marcy asking why it can't be done in another manner – that is, why not do it her way?

3) **A miscommunication occurs during the day**. Which of the following is the best course of action and why?

a. Talk directly to the to the person it occurred with;
b. Talk to another staff member(s) about what happened; or
c. Go straight to the clinician or your manager?

The purpose of these questions is to help the reader problem solve and utilize critical thinking skills to analyze the case study. The answers will be provided at the end of the article.

Understanding and Resolving Conflict

The following theories/concepts can help shed light on understanding the people we work with: Parse's *Theory of Human Becoming* and the *Generation Gap Theory*. It is important to note that, for the purpose of this article, generalizations are being made and it is crucial to emphasize that each conflict situation will be unique.

Continued on Page 13

℞Precedex™
(Dexmedetomidine Hydrochloride for Injection)

Prescribing Summary

Patient Selection Criteria

THERAPEUTIC CLASSIFICATION: Alpha$_2$-adrenergic agonist
INDICATIONS AND CLINICAL USE:
Intensive Care Unit Sedation
Precedex™ is indicated for sedation of initially intubated and mechanically ventilated postsurgical patients during treatment in an intensive care setting by continuous intravenous infusion. The Precedex™ infusion must not exceed 24 hours.
Precedex™ has been continuously infused in mechanically ventilated patients prior to extubation, during extubation, and post-extubation. It is not necessary to discontinue Precedex™ prior to extubation. After extubation, the dose of Precedex™ should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.
Conscious Sedation
Precedex™ is indicated for sedation of non-intubated patients prior to and/or during surgical and other procedures by continuous intravenous infusion for the following procedures:
- Monitored Anesthesia Care (MAC) with an adequate nerve block and/or local infiltration; and
- Awake Fiberoptic Intubation (AFI) with adequate topical preparation of the upper airway with local lidocaine formulations.

Due to insufficient safety and efficacy data, Precedex™ is not recommended for use in procedures other than the two listed above.
CONTRAINDICATIONS
Patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the Dosage Forms, Composition and Packaging section of the product monograph.
SPECIAL POPULATIONS
Pregnant Women: There are no adequate and well-controlled studies in pregnant women. Precedex™ should be used during pregnancy only if the potential benefits justify the potential risk to the fetus.
Labor and Delivery: The safety of Precedex™ during labor and delivery has not been studied. Therefore, Precedex™ is not recommended during labor and delivery including cesarean section deliveries.
Nursing Women: It is not known whether Precedex™ is excreted in human milk. Radio-labeled Precedex™ administered subcutaneously to lactating female rats was excreted in milk. Because many drugs are excreted in human milk, caution should be exercised when Precedex™ is administered to a nursing woman.
Pediatrics: There have been no clinical studies to establish the safety and efficacy of Precedex™ in pediatric patients below 18 years of age. Therefore, Precedex™ should not be used in this population.
Geriatrics: Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection in elderly patients, and it may be useful to monitor renal function **(see Dosage and Administration).**

Safety Information

WARNINGS AND PRECAUTIONS
General
Precedex™ should be administered only by persons skilled in the management of patients in the intensive care or operating room setting. Due to the known pharmacological effects of Precedex™, patients should be continuously monitored while receiving Precedex™.
Cardiovascular
Hypotension, Bradycardia and Sinus arrest: Clinically significant episodes of bradycardia and sinus arrest have been reported with Precedex™ administration in young, healthy volunteers with high vagal tone or with different routes of administration including rapid intravenous or bolus administration.
Reports of hypotension and bradycardia have been associated with Precedex™ infusion. If medical intervention is required, treatment may include decreasing or stopping the infusion of Precedex™, increasing the rate of intravenous fluid administration, elevation of the lower extremities, and use of pressor agents. Because Precedex™ has the potential to augment bradycardia induced by vagal stimuli; clinicians should be prepared to intervene. The intravenous administration of anticholinergic agents (e.g., glycopyrrolate, atropine) should be considered to modify vagal tone. In clinical trials, glycopyrrolate or atropine were effective in the treatment of most episodes of Precedex™-induced bradycardia. However, in some patients with significant cardiovascular dysfunction, more advanced resuscitative measures were required.
Caution should be exercised when administering Precedex™ to patients with advanced heart block and/or severe ventricular dysfunction. Because Precedex™ decreases sympathetic nervous system activity, hypotension and/or bradycardia may be expected to be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension and in elderly patients. In situations where other vasodilators or negative chronotropic agents are administered, coadministration of Precedex™ could have an additive pharmacodynamic effect and should be administered with caution.
Transient Hypertension: Transient hypertension has been observed primarily during the loading dose in association with the initial peripheral vasoconstrictive effects of Precedex™.
Treatment of the transient hypertension has generally not been necessary, although reduction of the loading dose infusion rate may be desirable.
Dependence/Tolerance
Precedex™ is not a controlled substance. The dependence potential of Precedex™ has not been studied in humans.
Endocrine and Metabolism
The available evidence is inadequate to confirm if dexmedetomidine is associated with significant adrenocortical suppression. The adequacy of the adrenocortical function should be individually assessed and managed.
Hepatic/Biliary/Pancreatic
Since Precedex™ clearance decreases with severity of hepatic impairment, dose reduction should be considered in patients with impaired hepatic function.
Renal
Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. **(see Dosage and Administration)**
Peri-Operative Considerations
Arousability: Some patients receiving Precedex™ have been observed to be arousable and alert when stimulated. This alone should not be considered as evidence of lack of efficacy in the absence of other clinical signs and symptoms.
Withdrawal
Intensive Care Unit
Precedex™ is indicated only for sedation of initially intubated and mechanically ventilated postoperative patients recovering in a post-operative care unit or an intensive care unit. During the use of Precedex™ in an intensive care setting, the patients must be monitored continuously, particularly for their cardiovascular safety indicators.
If Precedex™ were to be administered for more than 24 hours and stopped abruptly, withdrawal symptoms similar to those reported for other alpha-2-adrenergic agents may result. These symptoms include nervousness, agitation, and headaches, accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma. Precedex™ infusion must not exceed 24 hours.
Conscious Sedation
Withdrawal symptoms were not seen after discontinuation of short term infusion of Precedex™.
Patient Counselling Information
Precedex™ is indicated for short-term intravenous sedation. Dosage must be individualized and titrated to the desired clinical effect. Blood pressure, heart rate and oxygen levels will be monitored both continuously during the infusion of Precedex™ and as clinically appropriate after discontinuation.
- When Precedex™ is infused for more than 6 hours, patients should be informed to report nervousness, agitation, and headaches that may occur for up to 48 hours.
- Additionally, patients should be informed to report symptoms that may occur within 48 hours after the administration of Precedex™ such as: weakness, confusion, excessive sweating, weight loss, abdominal pain, salt cravings, diarrhea, constipation, dizziness or lightheadedness.

Intensive Care Unit Sedation
A total of 849 patients in the clinical studies were 65 years of age and over. A total of 242 patients were 75 years of age and over. In patients greater than 65 years of age, a higher incidence of bradycardia and hypotension was observed following administration of Precedex™. Therefore a dose reduction should be considered in patients over 65 years of age **(see Dosage and Administration).**
Conscious Sedation
A total of 131 patients in the clinical studies were 65 years of age and over. A total of 47 patients were 75 years of age and over. Hypotension occurred in a higher incidence in Precedex™-treated patients 65 years or older (72%) and 75 years or older (74%) as compared to patients <65 years (47%). Pre-specified criteria for the vital signs to be reported as adverse reactions are footnoted below Table 2 **(see Adverse Reactions)**. A reduced loading dose of 0.5 mcg/kg given over 10 minutes is recommended and a reduction in the maintenance infusion should be considered for patients greater than 65 years of age **(see Dosage and Administration)**.
ADVERSE REACTIONS
Adverse Drug Reaction Overview
Use of Precedex™ has been associated with the following serious adverse reactions:
- Hypotension, bradycardia and sinus arrest **(see Warnings and Precautions)**,
- Transient hypertension **(see Warnings and Precautions)**.

Most common treatment-emergent adverse reactions, occurring in greater than 2% of patients in both Intensive Care Unit and conscious sedation studies include hypotension, bradycardia and dry mouth.
Intensive Care Unit Sedation
Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. Overall, the most frequently observed treatment-emergent adverse events included hypotension, hypertension, nausea, bradycardia, fever, vomiting, hypoxia, tachycardia and anemia **(see Table 1).**
Conscious Sedation
Adverse event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Treatment-emergent adverse events occurring at an incidence of >2% are provided in **Table 2**. The most frequent adverse events were hypotension, bradycardia, and dry mouth.
Post-Market Adverse Drug Reactions
Hypotension and bradycardia were the most common adverse reactions associated with the use of Precedex™ during post approval use of the drug.
DRUG INTERACTIONS
Drug-Drug Interactions
Anesthetics, sedatives, hypnotics, opioids
Co-administration of Precedex™ with anesthetics, sedatives, hypnotics, and opioids is likely to lead to an enhancement of effects. Specific studies have confirmed these effects with sevoflurane, isoflurane, propofol, alfentanil, and midazolam. No pharmacokinetic interactions between Precedex™ and isoflurane, propofol, alfentanil and midazolam have been demonstrated. However, due to possible pharmacodynamic interactions, when co-administered with Precedex™, a reduction in dosage of Precedex™ or the concomitant anesthetic, sedative, hypnotic or opioid may be required.
Neuromuscular Blockers
In one study of 10 healthy volunteers, administration of Precedex™ for 45 minutes at a plasma concentration of 1 (one) ng/mL resulted in no clinically meaningful increases in the magnitude of neuromuscular blockade associated with rocuronium administration.
Cytochrome P450
In vitro studies in human liver microsomes demonstrated no evidence of cytochrome P450 mediated drug interactions that are likely to be of clinical relevance.
REPORTING SUSPECTED SIDE EFFECTS
Toll-free telephone: 1-866-234-2345 • Toll-free fax: 1-866-678-6789
Online at: www.healthcanada.gc.ca/medeffect
Regular Mail: Canada Vigilance Program, Health Canada
Postal Locator 0701C, Ottawa, ON K1A 0K9

Administration

Dosing Considerations
- Precedex™ should be used in only facilities adequately staffed and equipped for anesthesia, resuscitation, and cardiovascular monitoring.
- Precedex™ dosing should be individualized and titrated to the desired clinical response.
- Precedex™ is not indicated for infusions lasting longer than 24 hours.
- Precedex™ should be administered using a controlled infusion device with adequate precision.

Recommended Dose and Dosage Adjustment
Intensive Care Unit Sedation
- Precedex™ is indicated for post-surgical patients in an intensive care setting, e.g. in Post Anesthesia Care Unit or Intensive Care Unit.
- An assessment of the level of sedation and the need for Precedex™ should precede the initiation of Precedex™.
- Another intravenous sedative (e.g. midazolam or propofol) may be added if Precedex™ provides inadequate sedation at the highest recommended dose level.
- The need for Precedex™ continuous infusion post-extubation must be assessed individually.

If the continuous infusion is needed post-extubation, the infusion speed should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.
- Precedex™ use should not exceed 24 hours in an ICU setting.

A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.
Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of up to one mcg/kg over 10 to 20 minutes, if needed. For patients being converted from alternate sedative therapy a loading dose may not be required.
Maintenance: Adult patients will generally require a maintenance infusion of 0.2 to 0.7 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the desired level of sedation.
Conscious Sedation
- Based on the Ramsay and Observer's Assessment of Alertness/Sedation Scales, the loading infusion provides clinically effective onset of sedation 10 to 15 minutes after start of infusion.
- For use in Monitored Anesthesia Care, an adequate nerve block and/or local infiltration should be used.
- For Awake Fiberoptic Intubation, the upper airway should be topicalized with proper lidocaine formulations.

Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of one mcg/kg over 10 minutes. For patients over 65 years of age or those undergoing less invasive procedures such as ophthalmic surgery, a loading infusion of 0.5 mcg/kg over 10 minutes may be suitable.
Maintenance: The maintenance infusion of Precedex™ is generally initiated at 0.6 mcg/kg/hr and titrated to achieve desired clinical effect with doses ranging from 0.2 to 1 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the targeted level of sedation. Following the load in awake fiberoptic intubation, a fixed maintenance dose of 0.7 mcg/kg/hr is recommended until the endotracheal tube is secured.
Dosage Adjustment: Due to possible pharmacodynamic interactions, a reduction in dosage of Precedex™ or other concomitant anesthetics, sedatives, hypnotics or opioids may be required when coadministered. A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.
Administration
Precedex™ must be diluted in 0.9% sodium chloride solution to achieve required concentration (4 mcg/mL) prior to administration. Preparation of solutions is the same, whether for the loading dose or maintenance infusion.
Strict aseptic technique must always be maintained during handling of Precedex™.
To prepare the infusion, withdraw 2 mL of Precedex™ and add to 48 mL of 0.9% sodium chloride injection to a total of 50 mL. Shake gently to mix well. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Study References

1. ℞PRECEDEX™ (Dexmedetomidine Hydrochloride for Injection) Product Monograph, December 8, 2009, Hospira Healthcare Corporation.

Supplemental Product Information

Clinical Trial Adverse Drug Reactions: *Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.* **Intensive Care Unit Sedation** Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. In these studies, the mean total dose was 7.06 mcg/kg (SD = 2.86), mean dose per hour was 0.51 mcg/kg/hr (SD = 0.39) and the mean duration of infusion of 15.6 hours (range: 0.17 to 29.08). Midazolam or propofol was used as the rescue medication for patients on Precedex™ or placebo. The population was between 19 to 83 years of age, 43% > 65 years of age, 73% male and 97% Caucasian. Treatment-emergent adverse events occurring at an incidence of >1% are provided in Table 1.

Table 1: Treatment-Emergent Adverse Events Occurring in >1% Of All Dexmedetomidine-Treated Patients in the Randomized Placebo-controlled Continuous Infusion Short-Term Intensive Care Unit Sedation Studies

Adverse Event	Randomized Dexmedetomidine*	Placebo with Midazolam Rescue	Placebo with Propofol Rescue
	(N=387)	(N=181)	(N=198)
Hypotension	28%	15%	10%
Hypertension	16%	13%	23%
Nausea	11%	9%	10%
Bradycardia	7%	3%	2%
Fever	5%	6%	4%
Vomiting	4%	6%	6%
Atrial Fibrillation	4%	4%	3%
Hypoxia	4%	5%	3%
Tachycardia	3%	7%	3%
Hemorrhage	3%	6%	4%
Anemia	3%	4%	1%
Dry Mouth	3%	2%	<1%
Rigors	2%	3%	4%
Agitation	2%	3%	3%
Hyperpyrexia	2%	3%	2%
Pain	2%	3%	1%
Hyperglycemia	2%	3%	1%
Acidosis	2%	<1%	3%
Pleural Effusion	2%	<1%	2%
Oliguria	2%	1%	<1%
Thirst	2%	<1%	<1%

*Data combined from studies conducted in post-surgical patients recovering in an ICU setting.

Conscious Sedation event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Midazolam was used as the rescue medication for patients on Precedex™ or placebo. The mean total dose was 1.6 mcg/kg (range: 0.5 to 6.7), mean dose per hour was 1.3 mcg/kg/hr (range: 0.3 to 6.1) and the mean duration of infusion of 1.5 hours (range: 0.1 to 6.2). The population was between 18 to 93 years of age, 30% > 65 years of age, 52% male and 61% Caucasian. Treatment-emergent adverse events occurring at an incidence of >2% are provided in Table 2. Pre-specified criteria for the vital signs to be reported as adverse reactions are footnoted below the table. The decrease in respiratory rate and hypoxia was similar between Precedex™ and comparator groups in both studies.

Table 2: Adverse Events with an Incidence >2% – Conscious Sedation Population

Body System/Adverse Event	Precedex™ N = 318 n (%)	Placebo N = 113 n (%)
Vascular disorders		
Hypotension[1]	173 (54%)	34 (30%)
Hypertension[2]	41 (13%)	27 (24%)
Respiratory, thoracic and mediastinal disorders		
Respiratory depression[5]	117 (37%)	36 (32%)
Hypoxia[6]	7 (2%)	3 (3%)
Bradypnea	5 (2%)	5 (4%)
Cardiac disorders		
Bradycardia[3]	45 (14%)	4 (4%)
Tachycardia[4]	17 (5%)	19 (17%)
Gastrointestinal disorders		
Nausea	10 (3%)	2 (2%)
Dry mouth	8 (3%)	1 (1%)

1 Hypotension was defined in absolute and relative terms as Systolic blood pressure of <80 mmHg or <30% lower than pre-study drug infusion value, or Diastolic blood pressure of <50 mmHg. **2** Hypertension was defined in absolute and relative terms as Systolic blood pressure >180 mmHg or >30% higher than pre-study drug infusion value or Diastolic blood pressure of >100 mmHg. **3** Bradycardia was defined in absolute and relative terms as <40 bpm or <30% lower than pre-study drug infusion value. **4** Tachycardia was defined in absolute and relative terms as >120 bpm or >30% greater than pre-study drug infusion value. **5** Respiratory Depression was defined in absolute and relative terms as respiratory rate (RR) <8 bpm or >25% decrease from baseline **6** Hypoxia was defined in absolute and relative terms as SpO_2 < 90% or 10% decrease from baseline

Post-Market Adverse Drug Reactions *The following adverse reactions have been identified during post approval use of Precedex™. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.*

Table 3: Adverse Events Experienced During Post approval Use of Precedex™

Body System	Preferred Term
Body as a Whole	Fever, hyperpyrexia, hypovolemia, light anesthesia, pain, rigors
Cardiovascular Disorders, General	Blood pressure fluctuation, heart disorder, hypertension, hypotension, myocardial infarction
Central and Peripheral Nervous System Disorders	Dizziness, headache, neuralgia, neuritis, speech disorder, convulsion
Gastrointestinal System Disorders	Abdominal pain, diarrhea, vomiting, nausea
Heart Rate and Rhythm Disorders	Arrhythmia, ventricular arrhythmia, bradycardia, hypoxia, atrioventricular block, cardiac arrest, extrasystoles, atrial fibrillation, heart block, t wave inversion, tachycardia, supraventricular tachycardia, ventricular tachycardia
Metabolic and Nutritional Disorders	Acidosis, respiratory acidosis, hyperkalemia, increased alkaline phosphatase, thirst, hypoglycemia
Psychiatric Disorders	Agitation, confusion, delirium, hallucination, illusion
Red Blood Cell Disorders	Anemia
Renal disorders	Blood urea nitrogen increased, oliguria
Respiratory System Disorders	Apnea, bronchospasm, dyspnea, hypercapnia, hypoventilation, hypoxia, pulmonary congestion
Skin and Appendages Disorders	Increased sweating
Vascular disorders	Hemorrhage
Vision Disorders	Photopsia, abnormal vision

Compatibility with Other Fluids Precedex™ has been shown to be compatible when administered with the following intravenous fluids: Lactated Ringers, 5% Glucose in Water, 0.9% Sodium Chloride in Water, 20% Mannitol in Water. Dexmedetomidine has been found to be compatible with water solutions of the following drugs when administered via Y-site injections: thiopental sodium, vecuronium bromide, pancuronium bromide, glycopyrrolate bromide, phenylephrine hydrochloride. **Compatibility with Natural Rubber** Compatibility studies have demonstrated the potential for absorption of Precedex™ to some types of natural rubber. Although Precedex™ is dosed to effect, it is advisable to use administration components made with synthetic or coated natural rubber gaskets.
Incompatibilities Precedex™ infusion should not be coadministered through the same IV catheter with blood, serum, or plasma because physical compatibility has not been established. Precedex™ has been shown to be incompatible when administered with the following drugs: amphotericin B, diazepam. **OVERDOSAGE**
The tolerability of Precedex™ was studied in one study in which healthy subjects were administered doses at and above the recommended dose of 0.2 to 0.7 mcg/kg/hr. The maximum blood concentration achieved in this study was approximately 13 times the upper boundary of the therapeutic range. The most notable effects observed in two subjects who achieved the highest doses were first degree atrioventricular block and second degree heart block. No hemodynamic compromise was noted with the atrioventricular block and the heart block resolved spontaneously within one minute. Five patients received an overdose of Precedex™ in the intensive care unit sedation studies. Two of these patients had no symptoms reported; one patient received a 2 mcg/kg loading dose over 10 minutes (twice the recommended loading dose) and one patient received a maintenance infusion of 0.8 mcg/kg/hr. Two other patients who received a 2 mcg/kg loading dose over 10 minutes, experienced bradycardia and/or hypotension. One patient who received a loading bolus dose of undiluted Precedex™ (19.4 mcg/kg), had cardiac arrest from which he was successfully resuscitated. **STORAGE AND STABILITY** Store at controlled room temperature, 25°C (77°F) with excursions allowed from 15 to 30°C (59 to 86°F). (See USP.) **DOSAGE FORMS, COMPOSITION AND PACKAGING** Precedex™ (dexmedetomidine hydrochloride for injection) is a sterile, nonpyrogenic solution suitable for intravenous infusion following dilution. Each 1 mL of Precedex™ contains 118 mcg of dexmedetomidine hydrochloride equivalent to 100 mcg dexmedetomidine and 9 mg of sodium chloride in water. The solution is preservative-free and contains no additives or chemical stabilizers. Precedex™ (Dexmedetomidine Hydrochloride for Injection), 100 mcg/mL as the base is available in 2 mL clear glass vials (200 mcg/2 mL). Vials are intended for single use only.

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Parse's Theory of Human Becoming

Parse's *Theory of Human Becoming* can be summarized as "the process of coming to know. It is an ongoing inquiry designed to discover and understand the meaning of lived experiences."[4] As this definition is analyzed, a few key words stand out. They are: 'process,' 'coming to know,' 'ongoing,' 'inquiry to understand,' and the 'meaning of lived experiences.' The author understands these terms as:

- A 'process' indicates a dynamic, and not a static, action;
- 'Coming to know' suggests a process of realization… an epiphany if you will;
- 'Ongoing,' again suggests a continuous motion, action, or process;
- 'Inquiry to understand' can be likened to the process of an investigator on a mission to find out the truth. The analogy of viewing an object through a magnifying glass comes to mind. The magnifying glass magnifies the object and helps it be seen in a better light or as it truly is. In the same way magnifying a conflict situation through inquiry, in an effort to resolve the conflict, will help everyone see it in its true light and not through the bias of assumptions or pre-conceived ideas; and
- 'Meaning of lived experiences,' suggests being interested enough in somebody else's life to ask questions in order to understand what an experience means to them. This helps create an understanding of their unique perspective of things. The old idiomatic phrase 'Don't judge a book by its cover' is a great description of this issue.

Application in the OR

How can this strategy be applied in the OR? As one example, imagine a novice operating room nurse, Brian, who is seen by his team members as not taking the initiative in helping the other circulating nurse, Agnes. While Agnes is positioning a patient, prior to surgery, Brian just watches. Agnes feels overwhelmed and silently 'stews' over the fact that she is doing all the work while Brian just 'stands there.' Once the case is in progress, Agnes feels the need to address the issue with Brian in an effort to prevent the festering of frustration and creation of grudges. Brian's response is 'I learn better by watching first and then doing.' Brian's learning style is one of 'reflective observation,' a style characterized by watching and listening.[5] Because Agnes took the time to inquire and seek Brian's unique perspective she has developed an understanding of his behaviour. She learned from her discussion with Brian that although she might have 'jumped in' and helped had she been in his position, not everyone is like her or learns in the same way as she does.

Generation Gap Theory

The commonly accepted theory of a generation gap refers to different people born at different points in history or eras. It classifies or categorizes individuals on the basis of the period of their birth. It is assumed, and expected, that when individuals from differing eras come together at work conflict will often arise due to different experiences and perspectives. It is important to reiterate the fact that generalizations are applied here and not every individual fits the norm for his or her respective era.

This theory is based on four main generational categories: the traditionalists; the baby boomers; the Xers generation; and the millennials.[7] Each is examined below:

a) Traditionalists (born before 1946)
These employees, also known as the Veterans generation, live out a work ethic that was influenced by the dark days of the Great Depression. Through hard work and a willingness to make personal sacrifices for the greater good of an organization, this generation fuelled the economic boom. Deeply patriotic, Traditionalists are characterized by fiscal restraint and a strong work ethic. They are also loyal and have faith in institutions.[6,7]

Dealing with Conflict with Traditionalists:
The notion "No news is good news" is

synonymous with the Traditionalist view.[8] When addressing conflict situations with this group of people it is most effective to present the change as an evolution, not a revolution.[7] In the health care arena, for example, the tendency is often to usher in the use of electronic patient records and gradually eliminate the art of paper charting. An example of such an update is the introduction of a computer based patient information entry system to operating rooms in Calgary, Alberta. Studies have shown that traditionalists struggle with computer skills and the new system caused much strife in some institutions. The purpose of the computerized system could be explained to this group as a means of keeping up with technology, and improving efficiency, and not as a means to weed them out in order to accelerate the retirement process!

b) Baby Boomers (1946 - 1964)
The succeeding generation has faith in its ability to change things for the better. And this group has had the sheer numbers to do it. As such, this generation is optimistic and idealistic. Baby Boomers are extremely competitive because they've had to be, due to their large numbers.[6,7]

Dealing with Conflict with Baby Boomers:
For this group of individuals present the issue as the glass being half-full and not half-empty.[7] For instance, borrowing the example of the electronic charting it might be deemed a hassle to input patient information into the computer and deal with technical difficulties that may result in information being lost. However, on further examination, the benefits, relating to speed, legibility, and accuracy, outweigh the risks.

The Baby Boomers prefer 'ceremony' such as the introduction of objective annual pay-for-performance appraisals, certificates and awards, and the use of medals and other insignia to symbolize superior performance.[8]

c) Generation Xers (1965-1981)
Gen Xers grew up seeing every major institution, from the stock market and big business to marriage, called into question. As a result, they learned to trust themselves rather than institutions. While they are a resourceful and independent generation that is comfortable with change their defining trait is skepticism.[6,7]

Dealing with Conflict with Gen Xers
This group puts more value on work/life balance than is the case with previous generations.[7] Transactional incentives, such as an RN agreeing to assume a colleague's on-call duty in exchange for a similar trade later on in the month in order to meet his/her own needs, or an ORT staying overtime to finish off a case in a theatre because the RN had previously allowed the ORT to go home early, help prevent animosity and foster harmony which leads to job satisfaction. The Generation X-ers are most likely to step into the Baby Boomers' positions when the boomers retire and wise managers are creative enough to cater to the negotiations of this group, especially when it comes to providing incentive in the form of flexible work schedules versus increase in pay. Gen Xers crave feedback and their best rewards are autonomy, freedom and meaningful work.[8]

d) Millennials (1982-2000)
The youngest generation currently in the workforce, this group (also known as Gen Y, Nexters, or Echo Boomers) has seen more at an earlier age than most of those in previous generations, thanks to the internet and 24 hour media.[6,7,8] Individuals from this group are go-getters. They require immediate feedback and want "structure, guidance, and extensive orientation."[9]

Dealing with Conflict with Millennials:
This group needs work to have meaning and to be able to contribute to the larger picture.[7] This group loves to rock the boat. Some jump out of the boat or some just remain in it and question the status quo. It is very important that they be heard and not just be seen. Their ideas must not be shrugged off as youthful exuberance. In the operating room an individual in this group who is always asking questions is not necessarily seeking to be rebellious and it is best to try to understand his/her rationale.

5A's of Conflict Resolution
The 5A's of conflict resolution (Assess, Approach, Analyze, Assert, and Agree to disagree), as developed by the author of this article, can provide a guide for any conflict situation (see figure 1). They are examined individually below:

Assess
In 'assessing' the conflict situation the following questions are asked: How important is this **situation and does it need addressing?** If yes, is this a good time to bring up the issue? If the answer to this last question is yes, then the next step (Approach) is taken. If the answer to the second question is no, then proceed to the next step when the time is right for the issue to be addressed. (See Figure 2)

Approach
It is best to 'approach' the person you have a conflict with privately and in a non-threatening manner or environment. If you do not feel comfortable approaching the person alone, take someone with you as an observer and, if need be, as a mediator. Be sure to explain to the other party that another person is coming along not as a means to gang up but rather as a means of support for both of you. If you feel threatened by or afraid of the individual be sure to tell them how they are making you feel, but be sure to do so politely.

Analyze
In 'analyzing' the conflict situation, look for ways in which things may have been misinterpreted or misconstrued. Ensure you hear each side of the story as there really are two sides to every story.

Assert
When 'asserting' do not be aggressive. Pelusi says "the golden mean of assertiveness resides between the extremes of passivity and aggression. Straightforward communication always beats cowering or commandeering."[10] Try not to use any words that could be construed as an attack on the other person's personality. Focus on the issue at hand, and the resulting feelings, without bringing up past problems or perceived personality flaws. For example don't say 'You belittled me when you took that instrument away from me to demonstrate" rather say "I felt belittled when the instrument was taken from my hand for the demonstration."

Agree to disagree
It has been popularly said that 'two heads are better than one' but then again it has also been said that 'too many cooks spoil the broth.' Which adage is correct? Both are, but it is all a matter of perspective. We sometimes won't see eye to eye in conflict situations and sometimes the wise thing to do is to agree to disagree for the sake of peace.

Case Study Answers

The following answers to the case study questions were developed based on the author's application of the theories mentioned above as well as from feedback provided by staff at the Foothills Medical Centre (FMC), Peter Lougheed Centre, Alberta Children's Hospital and the Canmore General Hospital, during presentations in the respective facilities, by the author, on conflict resolution.

1) **Communication dealing with the division of labour.** What factors would you take into

Figure 1.

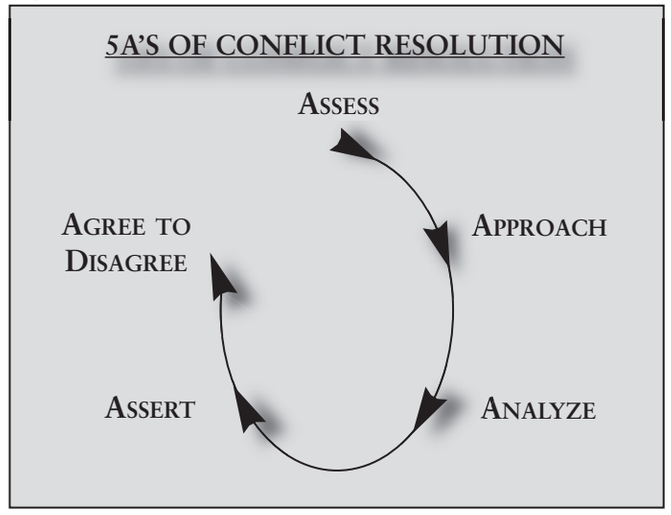
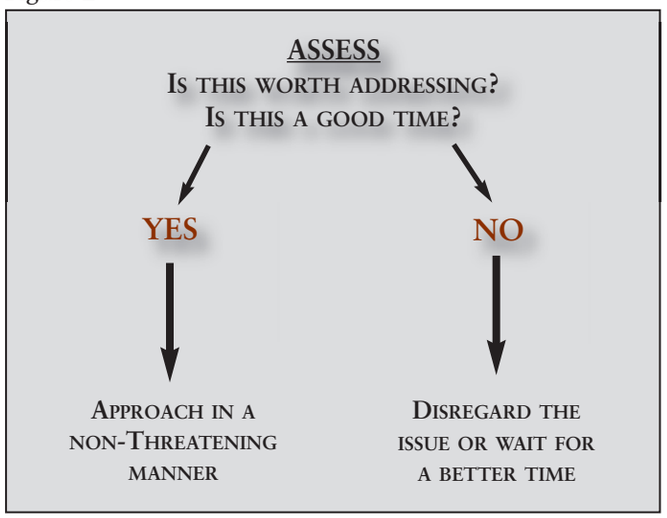


Figure 2



consideration and why? (e.g. who does what and why?)

Response: Effective communication is an, if not the strongest, asset, in the smooth operating of any theatre. It not only ensures the safety of the patient but facilitates the methods by which both inter and intra health care professionals provide such care. It is imperative that staff members decide at the beginning of the day who wants to do what.

Marcy explained her rationale for desiring to scrub in on the thoracotomy. It is up to the other members of the theatre to grant her request if possible.

Various factors such as the need for breaks, acuity of the patient, and learning needs of the staff play crucial roles in determining who gets to do what and in turn help prevent or diffuse a potential conflict situation. Not every ORT can circulate independently in all institutions. In a facility like the Foothills Medical Centre only an ORT with the designation of Licensed Practical Nurse (LPN) can circulate independently (with the exception of pacemaker cases). Since this particular staff member bears the title ORT and not ORT/LPN, it means that the second RN will have to sacrifice his or her coffee break to meet Marcy's request as the ORT cannot circulate independently. Secondly, the patient's safety is of paramount importance. Does the surgeon anticipate a difficult operation? If so, it may not be a good idea for Marcy to scrub in since her last thoracotomy was about 6 months ago. This decision adheres to the following competency for ORNAC's standard for providing physical patient care in the scrub role: the perioperative nurse "is vigilant, attentive, and responds appropriately to complications and unexpected events during the surgical procedure."[11]

After weighing the risk/benefit ratio of Marcy scrubbing in, with respect to the factors mentioned above, the best decision will be made and, with adequate rationales provided, no conflict situation should arise.

2) Suppose **a difference of opinion** exists, say the senior nurse wants a task done a certain way despite the fact that it could be done in another manner. What is the reaction to Marcy asking why it can't be done in another manner – that is, why not do it her way?

Patient safety should take precedence over all other options that might be considered. Critical thinking should be employed and should govern how the senior nurse responds to Marcy. It has been observed that the "important indicator of critical thinking is the ability to provide the rationale for one's judgment."[12] In addition to utilizing critical thinking, decisions must not breach the ORNAC standards and other legal and ethical regulating standards (CNA Code of Ethics for Registered Nurses).

As long as Marcy can provide a rationale for her choice, and this choice adheres to the above mentioned conditions, the senior nurse should be flexible and open to change. If the senior nurse is adamant that his or her way be adhered to this must be communicated in a mature and non-threatening manner.

Continued on Page 18

Marcy may also need to become more adept at the appropriate timing of her questions. She should not appear confrontational in spite of her inquisitive and keen nature.

3) **A miscommunication occurs during the day.** Which of the following is the best course of action and why?
   a. Talk directly to the to the person it occurred with;
   b. Talk to another staff member(s) about what happened; or
   c. Go straight to the clinician or your manager?

Answer
Talk first with the person directly involved in the miscommunication {Option (a)}. This mode is more respectful and honest. It gives the individual a chance to explain. In addition, it should be done quietly, privately and in a non-threatening environment. Talking to another staff member may be necessary as a means of venting (venting needs to be done in the right spirit and not as a means to gossip or backbite) and clarifying/validating the situation.

Conclusion
Effective communication has the tendency to diffuse conflict. Lyons and Block say that "effective communication involves being able to produce contextually appropriate language and understand the nuances of a given situation."[13] However, conflict may also arise despite the presence of effective communication. In such rare, and enigmatic, cases, the positive perspective should be adopted by considering the event as a vehicle for growth. Relaxing and embracing the conflict situation, rather than fighting against or fleeing it, will usher in an opportunity for growth and communication. This change in paradigm, with respect to conflict, will foster harmony in the operating room.

In Martin's words,
> "in this new workplace, no generation's needs or expectations have a monopoly. Everyone must be flexible, techno-savvy, and knowledgeable, focusing on getting great work done every day"[14]

What is the reality of the world today though? It is that of the Millennials or Gen Y's? Martin says that, "although Yers are high maintenance, they have the potential to become the highest-producing workforce in history."[14]

If Martin[14] is correct, all team members from all generations need to understand and work together in the operating room to not only foster harmony but most importantly to provide the best possible care to the patients. It will, therefore, be highly desirable in any conflict situation that the following mindset prevails in the minds of both parties, 'I reach out my hand to you, the onus is upon you to take it or not!'

The original version of this article, a comprehensive manual, with the title "Conflict Resolution in the Operation Room: Fight, Flight or Growth and Communication (A manual for new employees)", by this author, is available, according to the College & Association of Registered Nurses of Alberta (CARNA) librarian, at the CARNA library. The manual can be likened to a reference tool in which a coach mentors a student along the journey of conflict and includes a wide range of images to illustrate the various concepts of conflict prevention, management, and resolution.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009). *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (9th edition) in Section 3, page 218, Standard 3.2.4

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Continued on Page 26

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 inaugural award will be presented at the 2011 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.

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Correction:

In the March 2010 Journal "Ask a Question", a question was submitted regarding eating and drinking in the OR. In the 9th edition of *Standards, Guidelines and Position statements for Perioperative Registered Nursing Practice* (2009), there is no reference to this issue. The answer that was given came from the 8th edition of the Standards (2007). This issue of eating and drinking in the OR is being reviewed by the ORNAC standards committee.

Dans la Revue de 2010 mars "Posez une question" la question a été soumise quant à manger et boire dans le bloc opératoire. Dans la 9e édition de *Normes, lignes directrices et énoncés de positions pour la pratique infirmière en soins périopératoires* (2009), il n'y a pas de référence à ce problème. La réponse qui a été donnée est venue de l'huitième édition des Normes (2007). Ce problème de manger et boire dans le bloc opératoire est réexaminé par le comité de normes d'AIISOC.

In the March 2010 Journal, the question was submitted regarding wearing a surgical mask in the OR. The reference for the standard of practice was inadvertently omitted. The answer came from 9th Edition of the *Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice*, section 2, Infection Prevention and Control 5.3.13 page 122

Dans la Revue de 2010 mars, la question a été soumise quant à porter un masque chirurgical dans le bloc opératoire. La référence pour la norme de pratique a été omise par inadvertance. La réponse est venue de 9e edition *Normes, lignes directrices et énoncés de positions pour la pratique infirmière en soins périopératoires*, section 2, empêchement d'infection et le contrôle 5.3.13 p 122.

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