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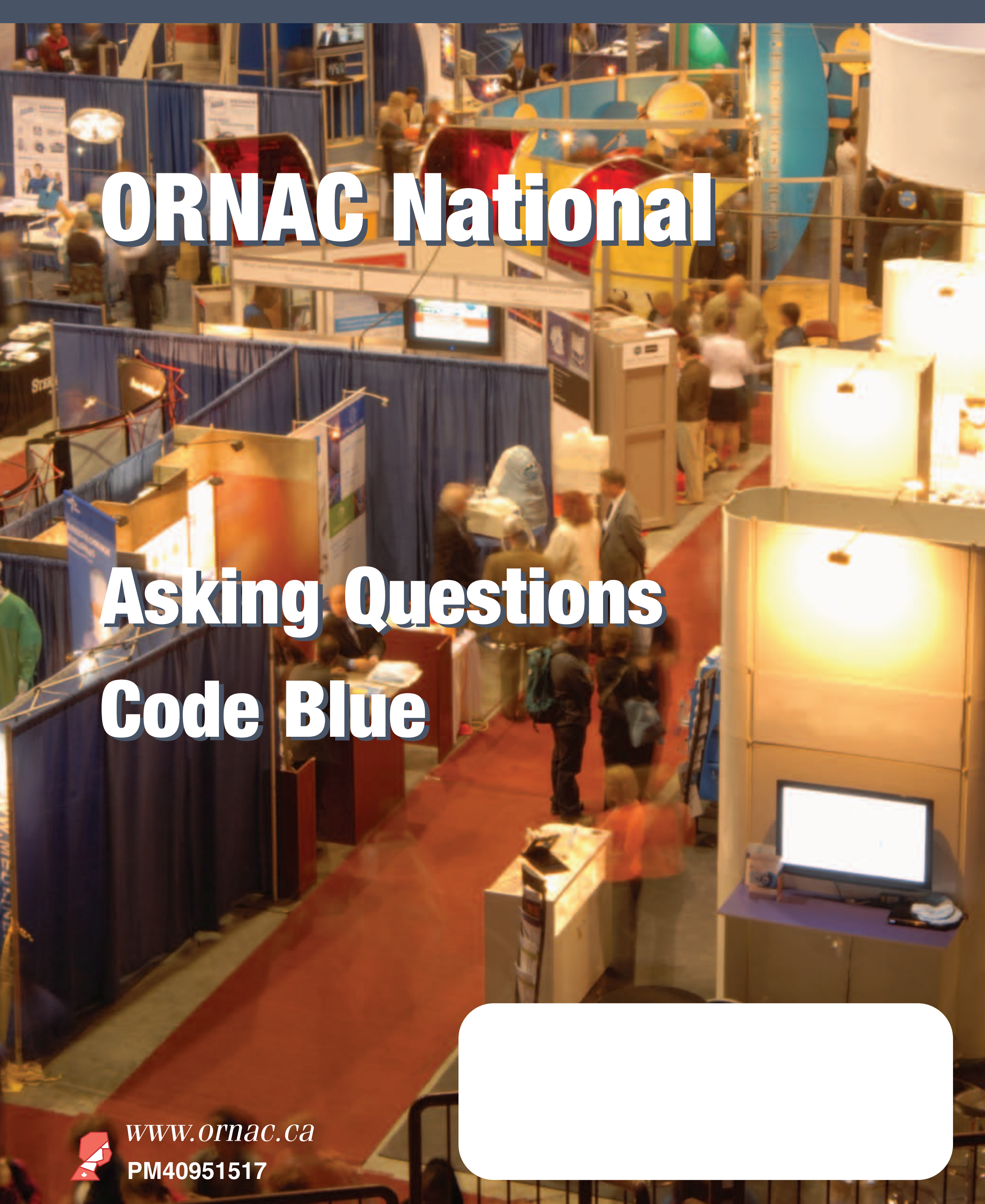

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President's Message

We are more than half of what we are by imitation.

The great point is to choose good models, and study them with care.

Lord Chesterfield

As I write my first message, as ORNAC President, I am cognizant of the past efforts of many perioperative nurses that have guided ORNAC toward today's successful association. In the second edition of the Canadian Operating Room Nursing Journal (June 1983) Val Shirreff's message as the first ORNAC President outlined the responsibilities of the membership:

> "The creation of this association, however, is only a beginning, albeit, an historical and propitious one. Now, it must be nurtured through its formative stages, sustained, and nourished until it has a strong and vibrant past on which to grow upon. In other words, as operating room nurses, it is yours and my task, together and as members of a professional fraternity, to guide it to maturity."[1]

Val's closing statement in the president's message also confirmed the importance of each member to ORNAC's actual existence, "ORNAC is your association. It needs the support of every member, every region and every province ... not just to make it work, but to make it work successfully".[1] This request is as important today as it was 26 years ago. Each of you, as a member of ORNAC, is the strength and vitality that guides and supports the accomplishments of the association.

This vital relationship was evident throughout the national conference in St. John's as 800+ delegates enjoyed a superb week of excellent education sessions, social events that truly showcased the east coast way to have fun, combined with the warmth of Newfoundland/Labrador hospitality that has left a lasting impression. Kudos to the 21st National Conference Planning Committee for a job well done!

I have had the good fortune to observe, and learn from, some superb role models that have represented ORNAC over the years. From the founding members (Gloria Stephens and Muriel Shewchuk) to the recent Past Presidents (Margaret Farley, Marcy McKay, and Linda Socha) I have had the best of the best to imitate. The ORNAC accomplishments during the past two years, under Linda's leadership, include the 9th edition of the *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice*; Incorporation of the Association; and the revision of the ORNAC web site. Each accomplishment is a milestone for the association.

ORNAC's motto "Promoting Excellence" describes the commitment of the organization to meeting the needs of the members and society. As we continue to work together, ORNAC can maintain this legacy and respond to the demands of the health care environment for our members and, ultimately, our patients.

I look forward to the next two years as your president. I welcome your comments and ideas and can be reached at president@ornac.ca. Have a safe and prosperous autumn.

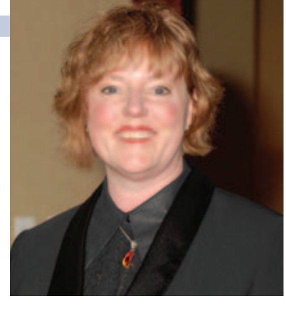
Bonnie W. McLeod

Reference

1. Val Shirreff "President's Message" *Canadian Operating Room Nursing Journal*. 1.3 (1983): 10.

Bonnie W. McLeod, RN, BScN, 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



We are more than half of what we are by imitation. The great point is to choose good models, and study them with care.
Lord Chesterfield

En rédigeant mon premier message comme présidente de l'AIISOC, je suis très consciente du travail du grand nombre d'infirmières et infirmiers périopératoires qui ont guidé l'AIISOC vers son succès actuel. Entre les pages du second numéro du journal de l'AIISOC, le Canadian Operating Room Nursing Journal (juin 1983), le message de Val Shirreff, première présidente de l'AIISOC, décrit les responsabilités de tout membre :

> « La création de cette association, toutefois, n'est que le début, bien qu'il soit un début historique et favorable. Il faut maintenant nourrir l'association lorsqu'elle traverse ses étapes déterminantes, l'entretenir et en prendre soin jusqu'à ce qu'elle porte avec elle un bien-fondé solide et une histoire brillante. En d'autres mots, la guider jusqu'à sa maturité relève de notre responsabilité collective, moi et vous et toute infirmière de salle d'opération qui travaillons ensemble comme membres d'une même fraternité professionnelle. » [1]

À la fin de son message Val confirme également l'importance de chaque membre de l'AIISOC : « L'AIISOC est votre association. Elle a besoin de l'appui de tout membre, toute région et toute province […] non seulement pour qu'elle puisse fonctionner, mais pour qu'elle connaisse le succès. »[1] Cette demande est aussi critique aujourd'hui qu'elle l'était il y a 26 ans. Chacune et chacun d'entre vous, dans votre rôle de membre de l'AIISOC, contribue à la force et la vitalité guidant et appuyant les réussites de l'association.

Ce lien critique était en évidence tout au cours de la conférence nationale à St John's où plus de 800 participants ont profité d'une incroyable semaine de sessions de formation et activités sociales qui ont vraiment su mettre en vedette la manière dont les Terre-neuviens et Labradoriens aiment s'amuser. Tout cela, sans oublier l'accueil chaleureux des gens de la place, laisse une impression durable. Félicitations au comité de planification de la 21e Conférence nationale!

Au cours des années, j'ai eu la bonne fortune d'observer, et apprendre, de superbes modèles de rôle au service de l'AIISOC. Des membres fondateurs (Gloria Stephens et Muriel Shewchuk) jusqu'aux plus récentes présidentes sortantes (Margaret Farley, Marcy McKay et Linda Socha), je n'ai que les meilleures sur lesquelles me modeler. Sous la direction de Linda Socha, les deux dernières années ont vu plusieurs réussites importantes. Parmi celles-ci, notons la publication de la neuvième édition des *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires*, la constitution en personne morale de l'association et la mise à jour du site de l'AIISOC. Chacune de ces réussites est un jalon pour l'association.

La devise de l'AIISOC, « Promouvoir l'excellence », capte bien l'engagement de l'association envers la satisfaction des besoins de ses membres et de la société. En poursuivant se travail collaboratif, l'AIISOC assure son mandat de répondre aux exigences du milieu de soins de santé pour le bien de nos membres et de nos patients.

C'est avec plaisir que je pense aux deux années que je passerai comme présidente de votre association. N'hésitez pas de m'envoyer vos commentaires et idées, vous pouvez me rejoindre à president@ornac.ca. Je vous souhaite toutes et tous un automne prospère et sécuritaire.

Bonnie W. McLeod

1. Val Shirreff "President's Message" *Canadian Operating Room Nursing Journal*. 1.3 (1983): 10.

Bonnie W. McLeod, infirmière autorisée, BScN, 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.

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POSER DES QUESTIONS – AMÉLIORER LA PRATIQUE

Auteures :
Susan Knoll, infirmière autorisée, maîtrise en sciences infirmières, CPN(C), est consultante en soins infirmières et en formation. Au moment de la présentation de cet article à la réunion semestrielle de BCORNG, Sue était membre de la faculté de soins périopératoires à la BC Institute of Technology. Elle est membre du BCORNG, occupant actuellement le poste d'historienne.

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RÉSUMÉ

Éprouvez-vous de la difficulté à incorporer les recherches existantes dans votre pratique périopératoire ou avez-vous encore des questions relatives aux soins périopératoires? Le cadre de Chulay offre aux infirmières et infirmiers sans expérience de recherche une structure détaillée mais compréhensible pour questionner, et donc influencer, les soins périopératoires des patients.

Note de l'auteur : Les deux articles par Rycroft-Malone et al. (2004) et Chulay (2006) offrent d'excellentes explications pour les personnes qui préfèrent les présentations visuelles et les listes de contrôle. Nous vous conseillons fortement les ressources suivantes également.

Les normes de l'AIISOC relatives à cet article se trouvent dans les *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires (8e édition)* de l'Association des infirmières et infirmiers de salle d'opération du Canada (AIISOC) (2007), module 1, page 35, normes 8 à 8.4

La Subvention de recherche Cardinal Health offerte par l'AIISOC offre une subvention de jusqu'à 5 000 $ pour le financement de recherches en soins périopératoires. Pour plus de détails et les critères d'admission, veuillez visiter www.ORNAC.ca.

ASKING QUESTIONS – IMPROVING PRACTICE

Authors:
***Susan Knoll, RN, MSN, CPN(C)** is a Nursing & Education Consultant. At the time of the presentation of this information at the BCORNG biennial meeting Sue was a member of the Perioperative Nursing Faculty at the BC Institute of Technology. She is an active member of BCORNG and currently holds the position of Historian.*

***Genelle Leifso, RN, MSN, CPN(C)** is perioperative faculty in the BCIT Specialty Nursing Program as well as a staff nurse at Vancouver General Hospital, Vancouver, BC. She is a member of BCORNG, the BC History of Nursing Group, and Sigma Theta Tau, an international Nursing Honor Society.*

ABSTRACT

Are you translating existing research into your perioperative practice or finding that you have unanswered questions related to perioperative patient care? Chulay's framework offers a detailed and understandable method for perioperative nurses without a research background to become involved in questioning, and thereby influencing, perioperative patient care.

Are you an expert perioperative nurse or are you just beginning the exciting journey in to perioperative nursing? Have you ever wondered whether your perioperative nursing practices are supported by "evidence"? Experienced perioperative nurses may gain confidence in their practices simply because they have been following them for so long. Novice nurses can gain this same confidence by observing and following their more experienced colleagues. But there is another objective option for evaluating perioperative nursing practice.

"Evidence based practice" is grounded in research and can be used by perioperative nurses to support and challenge their current practices. As an answer is really only as good as the question being asked, it is important to begin the process with a clear question in order to increase the chances of a reasoned and logical answer. As Claude Levi-Strauss, a French anthropologist, said, "the wise man doesn't give the right answers, he poses the right questions".[1]

What Is Evidence-Based Practice?

In an AORN Journal editorial, Nancy Girard suggested that when perioperative nurses began to question the profession's "sacred cows", evidence-based practice began to appear in the perioperative setting.[2] Evidence based practice has its roots in the work of the British epidemiologist, Archie Cochrane, whose 1972 publication *Effectiveness and Efficiency: Random reflections on Health Services*3 later led to the creation of the Cochrane Collaboration and Library. His ideas were considered very innovative at the time as they pulled together research done in particular areas of medical care, synthesized it, and then made it available in order to help guide clinical practice. The goal was to improve health care decision making. While Cochrane's work was primarily directed toward medical education and practice, his philosophy transcends professional boundaries.

Perioperative nursing, however, is about caring as well as care. And so, "relying only on evidence about the effects of health care alone can be inappropriate. Care and compassion are vital".[4] The evaluation of "evidence" can help determine how to provide the best possible care to perioperative patients but this evidence must still be interpreted, and used with caution.[2]

Have you considered how much of perioperative practice is actually built on a foundation of nursing research? Nurses, in fact, frequently adopt and apply research findings from other disciplines. While there is nothing wrong with utilizing research from other disciplines, we need to also ensure that **our** questions are being asked… and answered. If they aren't, perioperative nurses must get involved and ensure that this changes!

Getting Involved with Research

There are two key ways in which perioperative practitioners can be actively involved in research so that patients receive the highest quality care. One of these ways is by translating existing research data into practice.[5]

Critical thinking which incorporates the steps in the nursing process can offer an organized and grounded way of integrating research into practice. A large part of this activity involves asking the important questions related to current practice, the evidence and the outcomes of the implementation. There are a number of examples available in the literature on how to integrate research findings.[6,7] The second approach is by actually carrying out research studies. This approach includes thinking about what counts as data when examining practice issues.

What Counts As Evidence?

Traditionally the term evidence has been considered to mean "research evidence" – data that is counted and quantified, using statistical methods, or obtained through the systematic review (meta-analysis) of published research.[8] But evidence incorporates more than just these important elements.

While research evidence is important in practice there is other key information that is inherent to the nurse-patient relationship. For example, both the context of that relationship and the unique attributes of the individuals involved are components that need to be considered. Rycroft-Malone et al. include professional "craft knowledge" – personal knowledge that is formed by one's life experiences – and the context in which care is provided as sources of influential evidence in evidence-based, patient-centred care.[8]

In perioperative nursing it is important that we pay attention to the craft knowledge that is gained from clinical experience. This knowledge is the practice knowledge that we learn from our colleagues and exercise daily at work. This craft knowledge can be considered as evidence if it is

critically described, reviewed, and evaluated. Such attention removes it from the realm of opinion or anecdote and confirms it as data or knowledge. For example, many of us remember the time when patients coming for gynaecologic procedures that involved being positioned in lithotomy were given warmed leggings pre-operatively. As novice perioperative nurses, we were told that this was “nice for the patients”. Decades later, we now know the important role they play in maintaining patient normothermia. The initial practice was based on opinion; the current practice is based on evidence.

Evidence-based knowledge also encompasses the information gained from our sometimes unpredictable experiences with patients and their families. There is a dearth of research data related to this knowledge category and the literature supports this scarcity of knowledge.[7] While it is important, perioperative nurses are not yet bothering to study it. Most healthcare settings acknowledge the importance of delivering patient/family-centred care and there is documented evidence of the value of parental presence during induction. How can perioperative nurses work to provide evidence on whether efforts in family-centred care are making a difference with adult perioperative patients in order to help improve this aspect of care?

Additional knowledge is gained through the evaluation of the context in which care is provided. Rycroft-Malone et al. refers to this as “local data”. Aspects to consider include whether a nursing care audit is part of the healthcare facility’s perioperative nursing practice. If so this audit could form part of the contextual knowledge. The process for collecting and melding such information is complicated but not impossible to understand! The only thing required in order to begin is a question. If a question is developed in a thoughtful manner then many obstacles to the success of any research project can be avoided.[8]

Roadblocks to Research

It will save angst if, when approaching any research topic, some of the common roadblocks to success are first acknowledged. Chulay identifies and discusses them and suggests that the following points will likely need to be considered.[9]

- A perceived lack of time for research. Because we are so busy doing the “real” work of caring for patients in the operating room, it is hard to even contemplate activities that would result in more work! We often believe we don’t have the time, that our energies are better directed toward patient care, and that research is something to be conducted by academics;
- Inexperience in conducting clinical research or lack of expertise in the content area being explored. Who will review the literature, write the research proposal, and obtain ethics approval? Perioperative nurses often lack an understanding of how to analyze the validity and reliability of research studies.[2] Research language seems foreign to those in the “trenches”;
- Challenges surrounding data collection. If a study involves patients, will the researchers be able to gather enough subjects (and data) in a reasonable period of time? This is an important aspect of keeping those collecting the data interested in the project;
- Covering associated costs. Are there costs related to the planned research? Will the study be conducted as part of the researcher’s regular workload? If not, who is going to pay for the study? Recognize that there are costs associated with any study (i.e. paper, audio taping, transcription services, and personnel);
- Lack of support for the research project. Lack of managerial support for a study can present challenges. Who are the champions of this venture? Do you have sufficient administrative support? Lack of administrative support can defeat good work.
- Lack of relevance of the research to practice. When contemplating research it is necessary to ensure that the research is seen to address real-time, real-life clinical issues that are being dealt with on an ongoing basis in the operating room. If those in the profession can’t see the relevance of the project they will wonder what the point is which will undermine the credibility, and usefulness of the study.

Continued on Page 33

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ORNAC National 2009

Greetings from the most easterly point in North America where the sun always shines. St. John's, NL was the site of the 21st National ORNAC Conference and it was a pleasure and privilege to provide everyone the opportunity to share the true meaning of networking with our colleagues while experiencing a program that strengthened our educational knowledge, a vendor community committed to excellence and social activities with a down east flavour.

The conference week kicked off with a Welcome Reception "Half an Hour Later in Newfoundland" where traditional Newfoundland flavour was displayed with pewter smithing and quilt making in addition to the music of Gordon Quinton on guitar.

Monday's Opening Ceremonies included an impressive presentation of ORNAC Board and Executive with their respective Provincial Flags as well as the Provincial Planning Committee's entrance to Marconi Hall escorted by our own Fife and Drum quartet in full uniform representing our Signal Hill Tattoo followed by our very own Newfoundland Dog and Labrador Retriever.

The Val Shirreff Memorial Lecture, was presented by Mr. Rex Murphy, Rhodes Scholar, CBC Journalist, writer, teacher and Political Commentator. A lesson in Newfoundland culture and the role of its health care system over the years was very well received by all. Mr. Murphy brought the audience to its feet as he finished off his paperless presentation of satirical wit, energy and first hand health care knowledge.

By/par Dan Maher

Exhibitor Floor at ORNAC National 2009

By/par Dan Maher

Scoff, A Scuff and A Swalley – NL Kitchen Party

The response to the call for papers resulted in a total of 44 presentations with 77 speakers from Canada, the USA, and Australia. Topics included "Safe Surgery Checklist-Supporting Implementation" by Dr. Bryce Taylor and Dr. Chris Hayes; Mock Discovery – a new reality format to reflecting the legal side of nursing; Robotics-increased awareness of where surgery is headed; development of a Colorectal Cancer Biobank; OR Military Nursing; Operation Smile; Going Green; Implementing the CNA Code of Ethics; New Information on Sterilization Standards. A first for our ORNAC Conference was a Webinar, sponsored by J&J Medical Products – Working Towards Zero Surgical Site Infections. Twenty seven poster presentations were also displayed. Congratulations to Carol Adderson, winner of the People's Choice Award for her poster "Not Just A Nurse".

Tuesday saw the opening of the Exhibit Hall where 366 Exhibitors manned 139 booths. Of these booths 70 companies were represented.

Our social events represented true Newfoundland and Labrador hospitality. Delegates received a copy of the official conference limited edition print commissioned by Susan Parsons at the popular Print Presentation on Monday evening.

Continued on Page 14

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ORNAC National 2009 (cont.)

Following this delegates visited The Rooms, home to our Provincial Archives and Art Museum and Gallery to experience firsthand the special Afghanistan Exhibit and learn more of our provincial heritage and culture. What a beautiful evening to see St. John's scenic view both in the daylight and through the evening skyline as well as savour some of our famous delicacies.

Tuesday evening's dinner "A Scoff, A Scuff and A Swalley" was set to a Newfoundland kitchen party theme. Many delegates were dressed in their best kitchen garb and entertained by the talented Bernie Stapleton who regaled us with stories of OR nursing stories that had us laughing uncontrollably. Then we were surprised with a visit from the Newfoundland and Labrador Mummers who escorted us to our kitchen party with traditional Newfoundland and Labrador music by Siochana.

Thursday night proved to be a favourite with all, as "Rally in the Alley" completed the trip to St. John's with a visit to George Street. What a vision it was, 878 delegates and exhibitors wearing brightly colored bandanas, led by fiddlers, bagpipers, drummers and other musical instruments of pied pipers weaving their way to numerous pubs throughout George Street, while experiencing a traditional meal of fish and chips with song and dance and finally a "screech in" to officially make everyone an honorary Newfoundlander!

Carol Taylor, one of our final speakers presented "Navigating Icebergs: Leadership Skills for All Professional Nurses". Her energetic and inspiring presentation showed that leadership is about influencing others in the pursuit of valued goals. It demands clear thinking about goals that matter in our practice environments and the people skills to coordinate group action to secure these goals.

By/par Dan Maher

A Scoff A Scuff and A Swalley - The Mummers

By/par Dan Maher

The 21st National ORNAC Provincial Planning Committee

The conference closed with keynote speaker TA Loeffler. TA is an expeditionist whose work and adventures have taken her to 35 different countries and five different continents. She is attempting to complete "The Seven Summits", the highest peak on all seven continents. TA's presentation "From Deep Valleys to High Peaks: Lessons from an Amazing Journey" taught us about nurturing big dreams while learning from one's journey. She shared with us the reality of life's lessons as we accept our own "Everests". What a way to finish off a powerful week!

From our committee we hope that everyone has experienced a better understanding of "What Lies Beneath", and are now filled with new energy in promoting "The Depth of Perioperative Nursing".

Delegates were then introduced to the ORNAC Executive for 2009-2011. Incoming President Bonnie McLeod closed the conference and wished the delegates a safe journey home. The next ORNAC National will take place MAY 8-13, 2011, in Regina Saskatchewan where we once again will experience the friendship and networking of colleagues and industry partners. See you there!!!!

Conférence nationale de l'AIISOC 2009

Bonjour de la ville le plus à l'est en Amérique du Nord, où le soleil brille tous les jours. C'était bien St. John's, Terre-Neuve, où s'est tenue la 21e Conférence nationale de l'AIISOC, une merveilleuse occasion pour apprendre l'incroyable valeur du réseautage avec nos collègues tout en profitant d'un programme conçu pour approfondir nos connaissances en formation, nous familiariser avec nos fournisseurs voués à l'excellence et nous permettre de nous amuser un peu grâce aux activités de saveur maritime.

La conférence a commence avec une réception d'accueil, « Une demi-heure plus tard à Terre-Neuve », où ont été mise en vedette les traditions d'orfèvrerie d'étain et de courtepointe, sans oublier la belle musique de guitare de Gordon Quinton.

Lundi, les cérémonies d'ouverture à Marconi Hall étaient embellies d'une présentation impressionnante de drapeaux provinciaux portés par les membres des conseils exécutif et administratif et du comité de planification provincial, le tout accompagné par notre propre quatuor de fifres et tambours, le Signal Hill Tattoo et notre propre chien de Terre-Neuve et retriever du Labrador.

Rex Murphy, boursier de la fondation Cecil Rhodes, journaliste de CBC, écrivain, enseignant et commentateur politique, a présenté le discours commémoratif Val Shirreff. Sa leçon sur la culture terre-neuvienne et l'historique du rôle de son système de santé était très bien reçu par toute la foule. En terminant son discours, sans notes, M. Murphy a mérité une ovation grâce à son intelligence, énergie et grande expérience en soins de santé.

By/par Dan Maher

Val Shirreff Memorial Lecture Speaker - Mr. Rex Murphy

By/par Dan Maher

Ribbon Cutting Ceremony L to R: Rick Webber (industry liaison for exhibits), Dorothy Budgell (chair exhibits), Lenore Beyer (President, NEAC), Linda Socha- ORNAC President, Margot Walsh - Conference Co chair, Laura Ellsworth, Conference Co-Chair.

L'appel de présentations a eu comme résultat 44 présentations et 77 conférenciers de Terre-Neuve, le Canada, les États-Unis et l'Australie. Parmi les sujets traités, notons *Safe Surgery Checklist - Supporting Implementation* par Dr Bryce Taylor et Dr Chris Hayes; *Mock Discovery – a new reality format to reflecting the legal side of nursing*; *Robotics-increased awareness of where surgery is headed*; le développement d'une biobanque pour le cancer colono-rectal; les soins infirmiers périopératoires dans les forces armées; *Operation Smile*; *Going Green*; *Implementing the CNA Code of Ethics*; *New Information on Sterilization Standards*. Il y a aussi eu une première pour la Conférence nationale de l'AIISOC, un webinaire commandité par J&J Medical Products – *Working Towards Zero Surgical Site Infections*. De plus, 27 affiches étaient en exposition. Félicitations à Carol Adderson, gagnante du Prix du choix populaire pour son affiche *Not Just A Nurse*.

Continued on Page 37

A Memoir of an OR Nurse

The following essay won First Prize in the ORNAC Writing Contest

Author: *Dawn Affleck RN, BScN., Program Educator, Surgical Suite, Brandon Regional Health Center.*

Envision an OR nurse benevolently waving her arm whilst opening the big blue door with a red sign stating "No Admittance by Unauthorized Personnel" in a Nightingale ambiance… Ahhhh sounds lovely doesn't it? The woman behind the mask is motioning me to come closer and as she motions, she utters, "come…come to the OR". Perhaps this account may be a little too dramatic for how I actually came to be a perioperative nurse. Perhaps a more realistic account would stand more like this. In all fairness, I believe perioperative nursing chose me, as you shall read.

I was a fresh Registered Nurse with a little acute care experience under my nurse's hat and looking to continue my education while enhancing my professional practice. In the beginning, my thoughts leaned towards a career in critical care. The impetus for this professional desire had occurred during a brief clinical placement in ICU during my diploma program. I quickly gained respect and admiration for the ICU nurse caring for her patient and her abundance of knowledge wrapped up in a whole bunch of compassion.

As destiny began to unfold, my path crossed with an incredible, magnetic woman at a local nurses' union meeting. She sat at the back of the room and with a loud booming voice, proclaimed to all members how "wonderful it was to work in the OR". In any case, there was something about this woman and how she spoke about the OR that intrigued me. After this brief encounter, I enrolled and completed a certified perioperative nursing program and began my career in the OR in July 1997. This woman would come to be not only my preceptor and mentor for 10 weeks of clinical, but also my friend and confidant, all in one package. It became quite apparent that she was a passionate, boisterous spirit in the OR. Life in the OR was always about the patient for her and this very philosophy has guided my practice since and to her, I am eternally grateful. As I write this memoir, I wish to pay tribute to my friend and colleague, who continues to embody the art and science of nursing.

My passion grew rapidly over the next few years as I skied up and down the learning curve of perioperative nursing. However it was about at year 5 where I felt a little "professionally lost". As many of you may identify with, the politics and personalities within the perioperative setting can be quite intense and challenging. I was feeling rather "stuck in muck". I seemed to be struggling over having lost my clinical skills and competencies, which I had obtained in my general nursing practice area. Of more concern, I felt I was not growing in my role as perioperative nurse. It was only later that I would discover that this feeling was of my own doing. I was responsible for being stuck. I was not creating my own experience but rather waiting for an experience to create me.

So, a change was in order. I worked full time and juggled my family life while returning to university to complete my degree in nursing. As I was finishing my degree in May of 2005, I confidently proclaimed to my OR colleagues that I was going to venture out into the world of public health, where health promotion and disease prevention was "where it's at". This almost became a reality. I was mere weeks away from commencing a term position in public health.

But then, as fate would have it, I became "the patient". My world changed forever in August of 2005. After experiencing vague symptoms over a six month period, a colonoscopy by a surgeon colleague found a small tumor in my terminal ileum. I was 33 at the time. I could tell by the look on my surgeon that I was not the only one who was surprised by the result. Tests, scans, and more tests and I was quickly booked for a laparoscopic possible open right hemicolectomy. I must tell you, I was so scared. It brought me to my knees with fear.

How could this be? I began to think about my life very differently from that point on. Almost immediately, I spoke with my OR manager prior to my surgery and asked to rescind my intent to transfer to public health. Instantly, I couldn't bear to leave the OR.

I became the OR patient. My colleagues met me with warm smiles and a few misty eyes. The compassion was as palpable as my pulse. I was well aware that my colleagues cared but more importantly, I knew I was about to receive the best care in the country.

Enter my dear friend and colleague who came out to fetch me, as I lay waiting on the stretcher in the holding area. As she steered my stretcher whilst trying to hold my hand, I was overcome with emotion. I was so glad she was there with me. As we manoeuvred our way together down the corridor to Theatre 3, I thought of the many times she and I had walked down the hallway together to get ready for the next case. Only this time, I was the next case.

I experienced firsthand the vulnerability that all of our patients feel as they lay on their backs on a stretcher, feeling the temperature slowly diminish as they enter the OR. As we entered the theatre, my fear melted away as I looked around the room at the capable professionals about to care for me. I know you must be thinking my thoughts were the effects of the Versed. I was Versed free at this point. I knew I was in good hands.

I must tell you, I was never so proud to say I was an OR nurse then I was at that exact moment. I was absolutely blessed with the women and men that were in the theatre on that day. They were the wind beneath my wings and I will never forget their professionalism and kindness.

Simply put, I chose to be a perioperative nurse to enhance my nursing career. However, more importantly, I have stayed a perioperative nurse because it is a dynamic and challenging clinical area in which to practice. Even on a bad day, I am proud to say I am an OR nurse.

You see, it is all about those early influences that help shape us and inspire us to grow. It's the people we meet along the journey that in turn serve as catalyst for our professional careers. The patient and their families, our mentors and/or preceptors, or perhaps a surgeon and or anaesthetist who takes the time to teach and empower us in our practice can have a life long effect on our profession.

I am now in the role of clinical educator in the OR and I have found that implementing best practice and maintaining standards within a team continues to be a very challenging undertaking. I know first hand how challenging it is to maintain standards within an interdisciplinary team however, I feel very fortunate to have a national set of perioperative standards, which are current and best practice at my fingertips. Thank you ORNAC.

In closing this memoir, I wish to express my sincere gratitude towards the women and men who went before me. To the OR nurses who endured the laborious equipment and instrumentations and processes, which were arduous undertakings, thank you. To the OR nurses who traversed the clinical setting to develop and maintain the standards of perioperative nursing care whilst practicing as an integral member of the OR team, thank you. To my colleagues in Brandon, Manitoba, thank you for all that you do each and everyday.

Author's Note:

The incredible, magnetic OR nurse who became my preceptor, mentor colleague and friend is Judi Bailey, RN. Judi has worked as a perioperative nurse at the Brandon Regional Health Center since 1976. Judi has touched the lives of many patients and colleagues and continues to do so. Judi is treasured by many and is respected by all.

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Alberta	Red Deer	October 21-24, 2009
British Columbia	Penticton	April 28-May 1, 2010
Manitoba	Winnipeg	March 2010
New Brunswick	Bathurst	May 2010
Nova Scotia	New Glasgow	June 2010
Ontario	Niagara Falls	April 25-28, 2010
PEI	Charlottetown	September 26, 2009
Saskatchewan	Saskatoon	September 26, 2009

ORNAC CONFERENCES www.ornac.ca

22nd National	Regina, SK	May 8-13, 2011
23rd National	Edmonton, AB	May 5-10, 2013

INTERNATIONAL CONFERENCES

ACORN (www.acorn.org.au)	Adelaide, AUS	September 22-25, 2009
AFPP (www.afpp.org.uk)	Harrogate, UK	October 12-15, 2009
AORN	Denver, Colarado, US	March 14-18, 2010

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The ACART Presidential Endowment is awarded to the ORNAC President at the beginning of her/his term of office. The endowment is used to support the President's travel to international perioperative events and conferences. In this way the ACART Presidential Endowment helps promote and enhance ORNAC's profile and engagement within the international perioperative nursing community and increases the Canadian voice in the growth and development of global perioperative practice.

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CODE BLEU : QUE FAIRE?

Par : Joan Porteous, infirmière autorisée, baccalauréat en sciences infirmières, CPN(C), infirmière enseignante, Health Sciences Centre, salle d'opération adulte

RÉSUMÉ

L'arrêt cardiaque peut survenir à tout moment d'une cirurgie. L'objectif de cet article est de permettre au lecteur de reconnaître et participer à la gestion d'un arrêt cardiaque peropératoire. Les patients à risque d'arrêt cardiaque peropératoire et plusieurs différents types d'arythmie sans pouls sont identifiés. Les rôles que peuvent assumer le personnel périopératoire ainsi que la démarche pour noter l'événement sont également traités.

Les normes de l'AIISOC relatives à cet article se trouvent dans les *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires (8e édition)* de l'Association des infirmières et infirmiers de salle d'opération du Canada (AIISOC) (2007), module 4, page 41, norme 8.3.

CODE BLUE: WHAT TO DO?

By: Joan Porteous, RN, BN, CPN(C), Nursing Educator, Health Sciences Centre Adult OR

ABSTRACT

Cardiac arrest may occur intraoperatively at any time. The purpose of this article is to help the reader recognize and assist in the management of an intraoperative cardiac arrest. Patients who are at risk for cardiac arrest in the OR are identified and different types of pulseless arrythmias are identified. Roles of perioperative personnel are suggested and documentation during the code is discussed.

Introduction:

Cardiac arrest may occur in the OR at any time. Many intraoperative situations put the patient at an increased risk for cardiopulmonary arrest. Occurrences such as vagal stimulation, hypoxia, anaphylaxis, and hypovolemia all place the patient at a higher risk for a cardiac event. In the OR, patients undergo many procedures including placement of invasive monitoring lines, endotracheal intubation, tissue manipulation, and sometimes prolonged hypothermia. Patients are, understandably, afraid of and apprehensive about their surgery. This anxiety also contributes to their risk for cardiac arrest. Many patients arrive in the OR with pre-existing risk factors such as cardiac disease, hypertension, coronary artery disease, congestive heart failure, arrhythmias or a history of angina. Risk of an intraoperative cardiac arrest is even greater for patients with these pre-existing factors.

In smaller health care facilities the perioperative role is to manage the cardiac arrest until a resuscitation team arrives. In larger facilities the resuscitation team often compromises personnel in the surgical suite. In both types of facilities perioperative personnel need to recognize and manage a code blue at its onset. The purpose of this paper is to help the reader recognize, and assist in the management of, an intraoperative cardiac arrest at its onset.

Defibrillation is discussed in association with a manually operated defibrillator and not an automatic external defibrillator (AED).

Recognizing Cardiac Arrhythmias:

The electrocardiogram (EKG) is used to monitor the precise sequence of electrical events in the cardiac cycle. The EKG monitor provides continuous information about the heart's *electrical activity* only. In order to determine if the heart is actually beating in response to this electrical activity, the patient's pulse needs to be monitored. In a code situation, the best way to ensure the heart is actually beating in response to its electrical activity is to *palpate for a pulse.*

There are several arrythmias which indicate a cardiac arrest:

1. Asystole refers to the total absence of ventricular activity. Some activity may be

occurring in the atria, but there are no electrical impulses conducted to the ventricles, and as a result there is no cardiac output. The EKG waveform is almost a flat line. Asystole is associated with a low rate of survival unless the cause is reversed immediately.[1]

2. Ventricular Fibrillation (VF) is a chaotic pattern of electrical activity in the ventricles. Electrical impulses may arise from many different foci. The ventricles quiver and produce no effective ventricular contraction and no cardiac output. Ventricular fibrillation is a very treatable rhythm when treated immediately with defibrillation.[2]

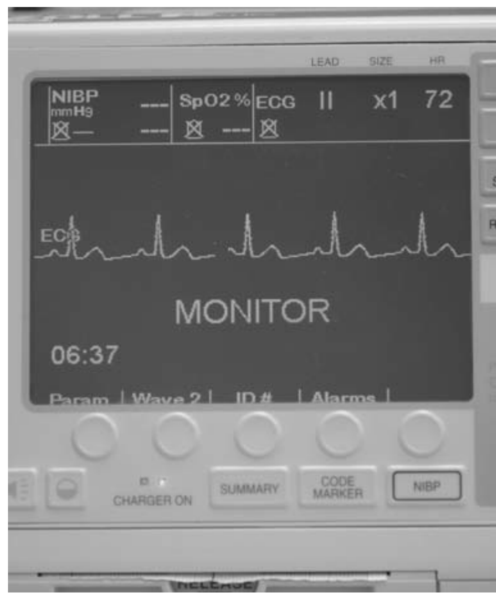
3. Pulseless Ventricular Tachycardia (VT) is a rapid tachycardia (160-250 beats/minute) where the ventricles are contracting too rapidly to allow blood to enter from the atrium. As a result, blood is not circulated. VT can be monomorphic, where the electrical impulse arises from the same origin, or polymorphic, where the sites of impulse origin changes. Pulseless VT is also a very treatable rhythm, and is managed in the same manner as VF.[1]

4. Pulseless Electrical Activity (PEA) is isolated electrical activity in the heart which occurs sporadically. The ventricles do not contract in response. The EKG monitor will show electrical activity, but the patient's heart is not beating. PEA is commonly caused by clinical conditions that can be reversed if quickly identified.[1]

All Cardiac Arrest Situations:

The anesthetist may choose to verify the rhythm in another lead along with checking lead and cable connections. No matter what rhythm is displayed on the EKG monitor, the presence of cardiac arrest is confirmed with a pulse check. In any cardiac arrest situation the following activities take place in the following order:

1. Call the code. In all intraoperative cardiac arrest situations, the very first thing to do is to *call the code*. This will ensure that help and the defibrillator arrive as quickly as possible. Effective time management is critical.



By/par J. Porteous

PEA (pulseless electrical activity) may appear in any form, even normal sinus rhythm

2. **Begin CPR.** If the patient has no pulse, *begin CPR*. Effective and timely CPR improves survival rates. Consider ABCD, which represents airway, breathing and circulation, and defibrillation.[4]

A: In most intraoperative cardiac arrest situations the patient is intubated and on a ventilator, but this is not always the case. It may be necessary for the patient to be ventilated using a bag-valve-mask until an endotracheal tube or a laryngeal mask airway is inserted.

B: When breaths are given by bag-valve-mask, the rate is 2 breaths for every 30 chest compressions. Once an endotracheal tube or a laryngeal mask (advanced airway) is in place, breaths are given independently from compressions at a rate of one breath every 6 to 8 seconds.

C: In order to perform effective compressions, the patient must be in a supine position. There will be some situations where the patient will need to be re-positioned.

Many mattresses on OR beds will compress to allow effective cardiac compressions. In some situations, if the mattress is very thick, a cardiac

board will need to be positioned under the patient first.

The compressor needs to be positioned directly over the patient's chest in order to give effective compressions.[2] With the OR bed at its lowest, and with an adult patient lying on top of it, most compressors will need to climb on a standing platform to get the height required above the patient. Only deep compressions with full chest recoil will physically force blood out of the ventricles, and recoil creates the vacuum in the heart which will pull more blood in. Effective compressions ensure that oxygenated blood is circulated to the brain and that the coronary arteries continue to perfuse the heart muscle to keep it viable until other treatment can commence.

D: Defibrillation, when warranted, is initiated as soon as the defibrillator arrives. The earlier defibrillation begins, the greater the patient's chances of survival. The heart's electrical activity is transmitted to the defibrillator either via its own cardiac leads or via a synchronizing cable from the anesthetic machine's EKG system.

Treatment:

1. Asystole is easily recognizable on the EKG screen as a flat line. Because a flat line can also be observed if EKG leads become displaced, it is important to rule out equipment malfunction. One quick and effective way to do this is to *palpate for a pulse*.

Once asystole is confirmed, call the code and begin CPR. If your role is to assist the anesthetist with medications, draw up epinephrine, vasopressin and atropine.[4] Epinepherine and vasopressin will induce vasoconstriction and facilitate blood flow to the coronary and cerebral circulation during CPR. Atropine, among other effects, increases SA node automaticity.

Nursing staff often assist the anesthetist with medication administration. This is performed under the direct supervision of the anesthetist, or other physician, and is acceptable practice, in a cardiac arrest situation, in most facilities.

Transcutaneous or transvenous pacing may also be considered if drug therapy is not effective.

2. Ventricular Fibrillation (VF) is also an easily recognized rhythm on the EKG monitor because it has no pattern or regularity. The ventricles are quivering. Coarse fibrillation waves indicate more electrical energy in the ventricles than fine fibrillation waves. If VF continues it will eventually lead to ventricular asystole. The greater the amount of electrical energy in the ventricles, the greater the chance of successful defibrillation. Rule out equipment malfunction or artefact by *palpating for a pulse*. The anesthetist may also verify the rhythm in another lead.

Once VF is confirmed call the code and begin CPR. The only effective treatment for VF is early defibrillation. Shocks are followed by administration of epinephrine and/or vasopressin and antiarrhythmic drugs such as amiodarone or lidocaine, or magnesium sulfate early in the code.[5] After each shock *palpate for a pulse*.

3. Pulseless Ventricular Tachycardia (VT) demonstrates a regular and rapid ventricular rhythm. Monomorphic VT is more common than polymorphic VT. The atrial rhythm is unmeasurable in both the monomorphic and the polymorphic VT. Because of the short ventricular filling time, cardiac output is decreased and the patient has no pulse. Confirm pulseless VT by *palpating for a pulse*.

Treatment for pulseless VT is the same as it is for VF. Call the code, begin CPR and assist with defibrillation as soon as possible. Prepare epinephrine, vasopressin amiodarone and possibly lidocaine for administration early in the code.[5]

4. Pulseless Electrical Activity (PEA) will appear differently on the EKG monitor for each patient. The monitor will show some type of electrical

Continued on Page 26

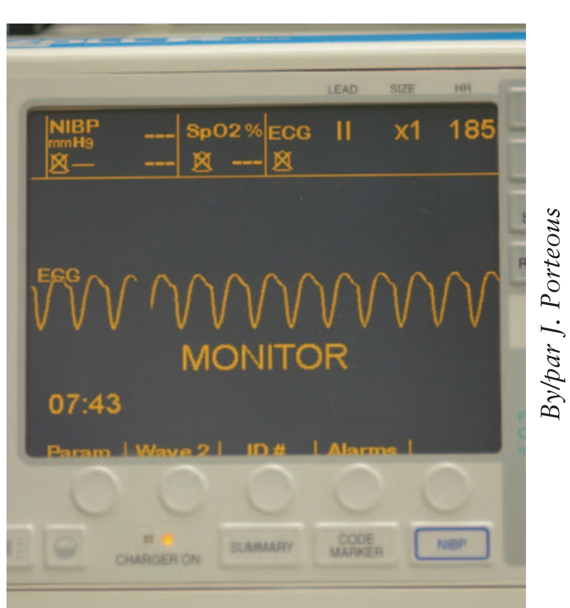
activity, other than VF or VT, but *the patient will have no pulse*. The first priority of treatment is to determine the underlying cause and to treat it quickly. Hypovolemia is the most common cause of PEA. Other causes include hypoxia, hypothermia, hyperkalemia, drug overdoses, tension pneumothorax, and acidosis.

When a cardiac arrest is confirmed, call the code and begin CPR. Prepare drugs such as epinephrine, vasopressin and atropine for administration at the beginning of the code.[9] Other medications will be required depending on the cause of the PEA arrest. Assist the anesthetist in treating the cause and continue to *palpate for a pulse* every couple of minutes.

PEA is the most common rhythm following defibrillation.[5]

Routes of Access for Drugs:

Drugs are often given intraoperatively via the intravenous (IV) or endotracheal (ET) route. New research has reprioritized these access routes.[5] ET absorption of drugs is inefficient and optimal drug dosage, if administered via this route, is not known. When IV access is unavailable, the intraosseous (IO) route is recommended.[5] Prioritization of drug administration routes are now IV first, then IO and, lastly, the ET route.



By/par J. Porteous

Ventricular tachycardia appears as a regular and rapid ventricular rhythm

A peripheral IV is preferred for drug and fluid administration during a code blue situation. Attempting to insert a central line while performing effective CPR is very difficult and the risk of complications is high.

If a drug is given by the peripheral venous route it is usually done so via bolus injection and followed by a 20mL bolus of IV fluid. Elevation of the extremity for 10-20 seconds facilitates circulation of the drug.

Intraosseous cannulation provides safe and rapid access to a non-collapsible route for drugs, blood, etc. The technique utilizes a rigid needle, preferably one designed specifically for intraosseous access, which is loaded onto an insertion device.

The endotracheal route is the least preferable route for drug administration because optimal drug dosages are not known and typical doses are 2 to 2.5 times the IV dosage. Epinepherine, vasopressin, atropine and lidocaine may be given via the ET route. The drug is diluted in 10ml of water or saline and injected directly into the trachea.

Roles of Theatre Personnel:

During a code blue, team members must act quickly and efficiently. One option for role assignment of theatre personnel at the beginning of a code is as follows:[3]

1. Director of the Code: Often the anesthetist will direct the intraoperative code.
- a. Confirm the code;
- b. Direct interventions such as medication administration and defibrillation; and
- c. Initiate the insertion of monitoring lines and IV access, if not already available.

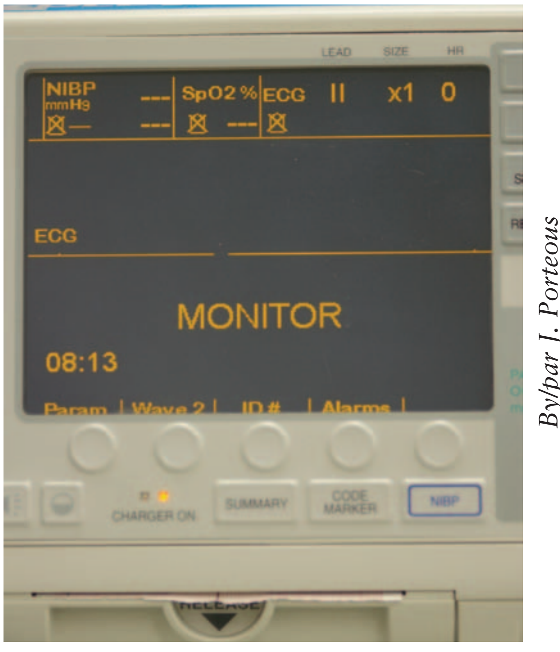
2. Circulating Nurse #1:
- a. Initiate the code;
- b. Activat the code alarm system which will call for cardiac arrest supplies;

- c. Help to reposition the patient if required;
- d. Ensure CPR is initiated and find the compressor a platform on which to stand. This helps to assure forceful downward compressions;
- e. Ensure a clear entry route for the code supply cart;
- f. Connect the defibrillator either to the anesthetic machine with a synchronizing cable or to the patient with cardiac leads;
- g. Prepare necessary equipment;
- h. Control traffic;
- i. Give the scrub team supplies as needed; and
- j. Maintain counts, blood loss measurements, documentation of personnel involved, etc .

3. Circulating Nurse #2:
- a. Assist the anesthetist;
- b. Prepares and assists with medication administration as required;
- c. Assist with intravascular line insertions; and
- d. Document medications and procedures performed. In an ideal situation a third circulating Nurse would be available to handle only the documentation, but if not this task would fall to Circulating Nurse #2.

4. Scrub Nurse:
- a. Protect the integrity of the sterile field;
- b. If the patient needs to be re-positioned for CPR the Scrub Nurse would cover the incision with a sterile drape;
- c. Keep track of all counted items;
- d. Keep all unnecessary instruments off the sterile field;
- e. Attend to the needs of the surgical team; and
- f. Perform closing counts as required.

5. Surgeon:
- a. Treat the cause of the arrest as required;
- b. Control bleeding, reduce vagal stimulation if caused by retractors, etc;
- c. Perform chest compressions on the sterile field; and
- d. Perform internal defibrillation if necessary.



By/par J. Porteous

Pattern for asystole shows a total absence of ventricular activity

6. Charge Nurse:
- a. Support the team as required;
- b. Assist and assign personnel to assist when necessary; and
- c. Alert other disciplines, such as radiology, as needed.

Documentation:

ORNAC's guidelines for documentation during a Code Blue situation include the following:
- Time of arrest;
- Time the code was called;
- Time of arrival of code members;
- Time CPR was initiated and by whom;
- Times of medication administration and dosages;
- Names of individuals administering medications;
- Times and types of Infusions and Transfusions; and
- Patient outcome.[6]

One should also document the times, power settings (joules) and outcomes of all defibrillation attempts. An Occurrence Report should also be completed for any cardiac arrest.

After the Code:

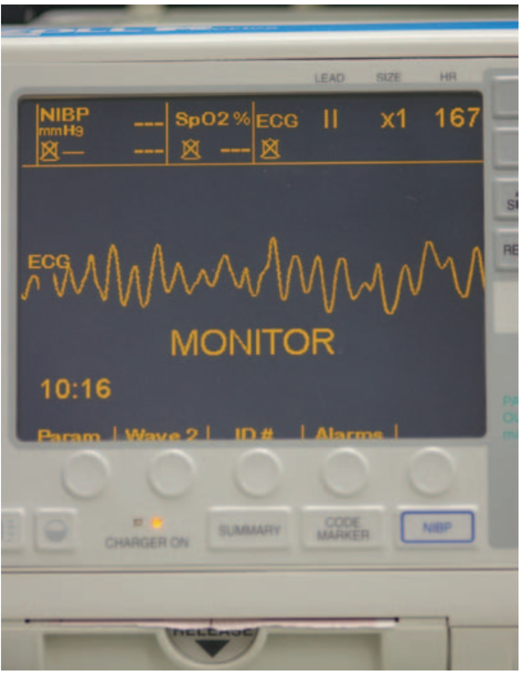
If the patient's condition becomes stable, he or she is then transferred to a critical care unit, and care is administered depending on the cause and duration of the arrest. In other situations resuscitation attempts may be discontinued depending on cerebral and cardiovascular status. The patient's family are notified of the patient's condition and the plan for postoperative care by the surgeon. If the patient did not survive the code, the surgeon will meet with the family. The nursing and anaesthesia members of the code team also often assist and support family members of the deceased patient in the immediate postoperative period. Clergy and supervisory/administrative personnel may also become involved.

Following a code, it is important to acknowledge the efforts of team members and to immediately re-stock supplies and re-test defibrillators. Some OR departments organize a cardiac arrest process review involving the anesthetist, nurses and surgeon. The experiences and documentation are reviewed and discussed to identify what worked well, any processes requiring improvement, and needs for future education.

Conclusion:

As with everything, practice makes perfect. Mock intraoperative codes provide excellent learning opportunities for OR personnel. A formal debriefing process, following each code, allows for the discussion of events and the opportunity to improve practice. The efficiency of the chain of events that occur during an intraoperative cardiac arrest plays a crucial role in patient survival. The importance of recognizing preoperative risks, being familiar with basic drug therapies and the operation of defibrillators cannot be overemphasized. In the event of a cardiac arrest, **everyone should know what to do**.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (2007) (ORNAC). *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (8th edition). In Module 4, p. 41, Standard 8.3.



By/par J. Porteous

Ventricular fibrillation rhythm has no pattern or regularity

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2009 Award Recipients / Récipiendaires des prix 2009

Cardinal Health Research Grant – L to R: Marlene Weeks, ORNAC Awards Chair; Margaret Farley, SK; Carol Bentley, VP & General Manager, Cardinal Health

Gloria Stephens Award for Excellence as an Educator in Perioperative Nursing – L to R: Gloria Stephens; Merritt Burstein, ON; Marlene Weeks, ORNAC Awards Chair

Isabelle Adams Award for Excellence in Perioperative Nursing
L to R: Marlene Weeks, ORNAC Awards Chair; Karen Frenette, NB.

Medline Mentorship Award
L to R: Ray Larkins, MB; Zach Pocklington, Executive Vice President, Medline Canada; Marlene Weeks, ORNAC Awards Chair; Tina Kennah, NB; Tyler Schueler, President, Medline Canada; Heather Rossi, ON; Absent: Gita Purkis, ON

Medline Mentorship Award
Award Presentation to Gita Purkis at Southlake Regional Health Centre, Newmarket, ON. Gita is shown with her work colleagues. Front – left to right, Tracey Elliott, Gita Purkis, Terri Ward, Christine Madill. Back – left to right, Derek Moynan, Lou Ceccarelli, Kathy Morrison, Stacy Adamczyk, Michelle Palmieri, Tammie Chuang.

Muriel Shewchuk Leadership Award:
L to R: Marlene Weeks, ORNAC Awards Chair; Karen Frenette, NB; Muriel Shewchuk.

ORNAC Writing Contest
L to R: Agata Repec, ON, 2nd Place Winner; Jessica Gerritts, NS, 3rd Place Winner; Marlene Weeks, ORNAC Awards Chair; Dawn Affleck, MB, 1st Place Winner

All photos courtesy D. Maher

Asking Questions (cont.)

Each of these potential road blocks can also be used as the criteria to evaluate research questions in order to help assess which questions are more likely to result in a successful research study (see Step 3 later in this article).

Guidelines for Choosing a Research Question

As previously mentioned, one of the big reasons to consider conducting "in the trenches" research, with a clinical focus, is to discover what, exactly, contributes to positive patient outcomes. While knowledge gained from personal practice experience is valuable, conclusions drawn from them about the care provided to patients may reflect personal biases. Chulay not only identifies the roadblocks to clinically focused research but also uses these parameters to identify the types of clinical questions most likely to result in the successful completion of research projects.[9] The researcher can, as a result, avoid many potential 'potholes'. Chulay's guidelines are invaluable to perioperative nurses who are eager to begin exploring their clinical practice. Chulay makes the following recommendations:

- A successful study will be applicable to a large number of patients being treated in the department as this provides a greater potential pool of subjects for the study. This means that the collection of data using the eligible patients (potential research subjects) can likely take place during OR time. This will also increase the chance that data collection will be completed within a reasonable time frame which increases the consistency of the data and reduces the chance of loss of staff interest. A large number of patients also increases the perception of the importance and accuracy of the study;
- Have a study sample of less than 75 subjects so that the actual study sample is limited to a manageable number. This criterion is also key to ensuring the data collection is completed in a timely fashion. While it is essential to calculate the number of participants required to make the study valid and reliable it is also important to recognise that the larger the sample the greater the data collection time. To reiterate, the larger the number of participants, the longer data collection will take and the greater the likelihood that interest in the study will wane;
- Focus the study on something important to patient outcomes. Following this advice will maximize the chances that the research will receive the recognition and support of others. It is likely that a study that not only improves patient outcomes but also has potential cost savings will be easier to propose to the perioperative managers, thus increasing the likelihood of receiving strong administrative support;
- Determine if additional funds will be needed. Exploring a research topic that allows you to use existing equipment and measurement tools is ideal. There are research grants available but the time required to develop a grant application can sometimes be daunting;
- Assess whether or not a tried and tested research measurement tool is available. This is fundamental as the development of such items can be costly in terms of both time and money. Without it the study may actually involve **two** research studies: one to test the new measurement tool and the second to conduct the actual study;
- An ideal research topic allows for data collection to be easily accomplished during the normal course of regular patient care. If the study, for example, is investigating an issue related to patient hypothermia in the OR, the patients' temperature throughout the perioperative period could easily be monitored and recorded and may already be available in their charts;
- Consider working with others. Sharing the project, and the workload, among a group of peers makes it more likely to succeed. As perioperative nurses we have the advantage of knowing the benefits of team work;
- Choose a topic that interests the entire group. Given the year that it will likely take to complete a research study, having an topic that is of interest to everyone involved will be key to success and to maintaining enthusiasm for the project.[9]

But what if attempting research is a new and

somewhat intimidating venture for those involved? Chulay offers these considerations for novice researchers:

- Consider a replication study. Following the map laid out in a previous study saves time and angst while still providing important and informative data. Even if the study is, for example, studying the population at a different clinical site or in a different age group of patients, the researcher is able to ask the same question and apply the methodology used in the original study, rather than having to spend time developing a new question and finding a suitable methodology;
- Don't make life any more difficult than necessary. If there is heated debate in your hospital surrounding a particular topic or practice then it is best to avoid such research ideas until you have some experience in the area;
- It is important, as a novice, to build on personal clinical expertise. Without having worked with paediatric patients, as an example, there would be little point in taking on a study relating to paediatric issues. Doing so would create a need to spend time learning about paediatric patients before the study can commence;
- Selecting a topic that is within the scope and control of nursing avoids the need to convince other disciplines of the importance of the study.[9]

Inquiring Minds at Work

During the 2008 BC Operating Room Nurses Group conference, this article's authors presented Chulay's material and her 4-step process for selecting a research topic. The perioperative nurse delegates at the conference then formed a focus group and brainstormed in order to identify high-volume patient care situations about which they had questions. Chulay recommends this process (Step 1) for discovering questions that may have the potential to meet the criteria of an ideal research question.[9] The questions generated by this group included:

- Surgical masks – Are they needed by anaesthesia and circulating nurses and, specifically, for MIS cases?
- Which pre-op surgical skin prepping practices are best?
- Post Anesthetic Room (PAR) – Is Tylenol #3 appropriate for pain management/control during the first 24 hours post-op?
- What intraoperative arm positioning contributes to neuropathy?
- What distraction techniques work for children requiring IV starts?
- Is Maruka honey an effective treatment for sinus fungal disease?
- What is the most effective surgical skin prep and urinary catheterization procedure prior to abdominal hysterectomy?
- If there is parental presence during induction do the parents need to wear cover-gowns and hats?
- What is the impact of staff arriving late for work?
- How do extended stay and long surgeries impact pressure sore risk?
- Does all body jewellery need to be removed from the patient prior to surgery?
- What about artificial nails worn by hand surgery patients?
- How does personnel hygiene (i.e. showering, bathing) affect a patient's post-op infections?
- What changeover efficiencies might be possible?
- How can patients be moved safely from the OR table?

There are many other possible questions, which Chulay suggests can be grouped according to patient populations, diagnosis or age (i.e. bariatric patients, elderly patients, day care patients), patient needs or problems (i.e. deep vein thrombosis (DVT) maintenance of skin integrity), common symptoms managed by nurses (i.e. anxiety, mobility challenges, pain), frequent nursing interventions (i.e. pre-operative patient education, hypothermia), commonly used medical equipment or technologies (i.e. Electro-surgical units (ESU), forced air warmers).[9] There might also be questions relating to important patient outcomes relating to perioperative nursing interventions (i.e. freedom from infection, freedom from injury). Or perhaps it is

important to address issues surrounding the "greening" of perioperative nursing practice given the current interest in the environment and the atmosphere of cost-containment. There are many potential topics on which perioperative nurses can provide credible evidence.

Refine Your Ideas… Ask More Questions!

Step 2 involves reviewing the list of questions generated by the focus group and revising it based on completeness. For example, does the group identify additional or related questions associated with the high-volume patient care situations previously brain-stormed? Further questioning can lead to an even more thoughtful, well conceived research question. At this point, it is also important to ensure the inclusion of only those patient care situations that are experienced in significant volume.[9] To evaluate the potential research question, Chulay suggests asking more questions, such as:

- What other questions do you have about these high volume care circumstances?
- Are there other ways to provide care or implement this practice? Which approach might work best? Do we know? What are other centers doing?
- Do you have ideas for more efficient ways to provide care?
- What is the best way to apply/use medical devices for the benefit of patient comfort and equipment operation?

Step 3 involves narrowing the list that has been produced based on the criteria of an ideal research project.[9] While there are a variety of ways to do this, a first step might be to set up a scoring or voting system to remove those research topics in which the OR staff will have little interest. But some topics may be important even if they are not popular. Look at the potential sample size and identify those questions that require less than 75 participants in order to further narrow potential research topics. Questions requiring more than 75 participants can then be eliminated and the remaining questions rated using Chulay's criteria for ideal research questions.

The remaining criteria that Chulay suggests are based on ensuring the question will avoid most, if not all, of the road blocks previously identified.[9] These criteria are, among other things, that the research question builds on the staff's clinical expertise, that it is important to clinical practice, and that it involves an area that will improve patient outcomes. The question also needs to be within the scope of nursing and to allow for easy data collection. The topic needs to be of interest to staff and have methods available to measure the variables. Finally, determine whether the research question avoids politically charged areas of practice, can be done as a replication study, or requires additional funding.[9] For all potential research questions the criterion should each be ranked to determine whether it is a bit present, a lot present, or not there at all. In this way the potential research questions with the highest scores can be identified.

Step 4, the final step in the selection of the research topic, can occur via a group vote. Alternately the group members can read relative research articles on the remaining topics, to gain an appreciation of what will be involved in conducting research on each of the remaining questions, and thus inform their decision-making before discussing the subjects as a group and selecting the final topic.

Just Do it!

While the Canadian perioperative research environment is somewhat barren it is not totally devoid of life. Canadian perioperative educators are initiating research related to perioperative education. ORNAC and regional perioperative conferences feature poster presentations – some of which describe research topics. And the ORNAC website offers further information on the projects of recipients of the *Cardinal Health Research Grant*.[10]

On reviewing the post-presentation evaluation forms submitted by delegates who attended the authors' presentation at the 2008 BCORNG Conference, it was noted that some of the nurses in the focus group expressed disappointment that answers to all the

questions posed were not made available during the presentation. Unfortunately not all the answers are available – yet more proof that perioperative nursing needs to be asking questions!

Perioperative nurses must never underestimate the importance of asking "Why?"[11] Are we doing what is best for our patients or most convenient for ourselves? It is vitally important that perioperative nurses develop a spirit of inquiry and ask questions about practice issues that can improve the outcomes for perioperative patients.

In the search for funding be sure to research all possibilities. There is ORNAC funding available, for nurses interested in doing perioperative research, in the form of the *Cardinal Health Research Grant*. Additional funding may also be available through Foundations and Provincial Ministries of Health.

Perhaps the answers to some perioperative patient care questions aren't readily available. Chulay's framework offers a detailed and easy to understand method that allows perioperative nurses without research backgrounds to become involved in questioning, and influencing, perioperative patient care.

Authors Note: *Both the Rycroft-Malone et al. (2004) and Chulay (2006) articles offer excellent schematics for readers who like visual presentations and checklists. We urge you to review these resources as well.*

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (2007) (ORNAC). *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (8th edition). In Module 1, p. 35, Standard 8 to 8.4

The ORNAC Cardinal Health Research Grant provides funding of up to $5,000 to assist with perioperative nursing research activities. For details and criteria visit www.ORNAC.ca.

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Mardi, Exhibit Hall a ouvert ses portes aux 366 exposants dans 139 kiosques où 70 entreprises étaient représentées.

Grâce aux activités sociales, nous avons pu jouir de l'hospitalité pour laquelle sont connus Terre-Neuve et Labrador. Tout délégué a reçu, lors de la présentation des tirages lundi soir, un tirage officiel de la conférence en édition limitée commandité par Susan Parsons. Ensuite, les délégués ont visité *The Rooms*, où se trouvent les archives provinciales ainsi que le Musée des beaux-arts, pour voir l'exposition spéciale sur l'Afghanistan et apprendre davantage sur l'héritage et la culture de la région. Ce fut vraiment une soirée extraordinaire, car nous avons pu réjouir de l'incroyable vue le jour comme la nuit et nous régaler de plusieurs des fameuses délices de l'Atlantique.

Le thème du souper mardi soir, « *A Scoff, A Scuff and A Swalley* », était la soirée traditionnelle à Terre-Neuve, la « kitchen party ». Plusieurs délégués étaient parés de leurs meilleurs costumes de cuisine et tout le monde était mort de rire en écoutant les histoires de salle d'opération hilarantes de Bernie Stapleton. Nous avons même été surpris par des Mummers qui nous ont accompagnés à la soirée où la musique traditionnelle de Terre-Neuve et Labrador était fournie par Siochana.

Le programme du jeudi soir était un vrai coup de cœur, car le « *Rally in the Alley* » s'est terminé nulle part ailleurs que dans George Street. Imaginez 878 délégués et exposants portant des écharpes vivement colorées précédés par violons, cornemuses, tambours et autres instruments se promenant de bar et bar, sans oublier les chansons, les danses, le poisson et frites, et enfin le « *screech in* » pour que tout le monde soit un Terre-neuvien honoraire!

Carol Taylor, une de nos dernières conférencières, a présenté « *Navigating Icebergs: Leadership Skills for All Professional Nurses* ». Sa présentation inspirante et pleine d'énergie nous a montré que l'essentiel du leadership, c'est influencer les autres lors de la

By/par Dan Maher

Exhibitor Floor at ORNAC National 2009

poursuite de leurs objectifs. Une pensée claire sur les objectifs pertinents dans notre milieu de pratique et les compétences interpersonnelles requises pour l'animation de groupe sont essentielles pour atteindre ces objectifs.

Pour clore la conférence, la conférencière principale TA Loeffler, une aventurière qui a visité 35 pays et cinq continents. Elle essaye d'escalader « les sept sommets », les cimes les plus hautes sur tous les sept continents. Sa présentation, « *From Deep Valleys to High Peaks: Lessons from an Amazing Journey* » a parlé de comment nourrir ses rêves et apprendre tout au cours du trajet de sa vie. Elle a parlé de la réalité des leçons de la vie et de comment accepter ses propres Everest. Que de mieux pour terminer la semaine!

Tout membre du comité souhaite sincèrement que tout délégué a pu approfondir ses connaissances sur ce qui se cache en dessous et déborde maintenant d'énergie pour faire la promotion des soins périopératoires.

Enfin, le nouveau conseil exécutif de l'AIISOC 2009-2011 a été présenté aux participants. La présidente entrante Bonnie McLeod a fermé la conférence et a souhaité à tout le monde un bon retour. La prochaine conférence nationale de l'AIISOC aura lieu le 8 au 13 mai à Regina (Saskatchewan), où, encore une fois, nous profiterons de cette merveilleuse occasion de connaître ses collègues et ses partenaires dans l'industrie des soins de santé. À bientôt!

ORNAC IN A NUTSHELL — SPRING 2009

By: Dorothy Dewar, ORNAC Secretary

The ORNAC Executive & Board met for its biannual meeting in St John's Newfoundland on June 6th and 7th 2009.

- ORNAC President Linda Socha welcomed the Board and Executive to the meeting prior to ORNAC's 21st National Conference.
- She also welcomed new board member Line Boucher from Quebec.
- Farewell and thank you was expressed to the following Board members leaving the Board after this meeting: Alicia Oucharek Mattheis SK, Joanna Schubert ON, Kim Reese NB, Pam Railton RNFA, Muriel Shewchuk CORL, Thelma Floyd NS and Catherine MacAulay PEI.
- Each member was presented with a Past Board member pin during Sundays meeting.
- Executive Board member Marcy McKay Past President, was presented with a Past President's Pin during the closing ceremonies of the ORNAC Conference.
- Dorothy Dewar was presented with a Past Secretary pin during the week of the conference.
- Linda Socha thanked all the above people for all their hard work over the past few years on behalf of ORNAC.

ORNAC Standards:

- The 9th edition of the ORNAC Standards was unveiled at this Conference. It is available for sale through the Canadian Standards Association (CSA). Please check out the web site to order.
- The Standards Committee has worked very hard over the past 2 years to produce this document and Linda Socha thanked them all for their hard work and dedication.
- She also thanked all the validators from across the country who have assisted with the work on this document.

By/par Dan Maher

2009 ORNAC Board & Executive

ORNAC Incorporation:

- ORNAC is officially incorporated and all assets will be transferred on July 1, 2009 with Industry Canada.

Other News:

- ORNAC is investigating the option of developing a Perioperative course. One Board member completed a preliminary investigation and presented to the ORNAC Board on Saturday. It was identified that further investigation is required and thus the work begins. Keep an eye on this space for further developments.
- ORNAC continues to work on projects with the Canadian Nurses Association (CNA). Most recently we have participated on an Environment Committee. CNA has opened up membership of this group to all interested nurses. Check out their web site for more information.
- ORNAC also continues to be involved with the Canadian Patient Safety Institute. ORNAC was also one of the Canadian groups that endorsed the World Health Organisation's Surgical Safety Checklist and has since participated as a working member of the CPSI working group to further refine the Surgical Safety Checklist to the Canadian context. If your institution is seeking help with instituting this check list the CPSI has an implementation kit and assistance on its website. ✦

L'AIISOC EN BREF– PRINTEMPS 2009

Par : Dorothy Dewar, secrétaire de l'AIISOC

Les conseils exécutif et administratif se sont assemblés à St. John's (Terre-Neuve) le 6 et 7 juin 2009 pour la réunion semestrielle de l'AIISOC.

- La présidente de l'AIISOC, Linda Socha, a accueilli les membres des conseils avant le début de la 21e Conférence nationale de l'AIISOC
- Elle a également accueilli une nouvelle membre, Line Boucher, du Québec.
- De grands remerciements ont été offerts aux membres suivantes qui quittent le conseil après cette réunion : Alicia Oucharek Mattheis (SK), Joanna Schubert (ON), Kim Reese (N-B), Pam Railton RNFA, Muriel Shewchuk CORL, Thelma Floyd (N-É) et Catherine MacAulay (I-P-É).
- Chaque membre a reçu pendant la réunion de dimanche une épingle commémorative.
- Marcy McKay, membre du conseil exécutif et ancienne présidente, a reçu une épingle commémorative pendant les cérémonies de fermeture de la conférence de l'AIISOC.
- Dorothy Dewar, secrétaire sortante, a reçu une épingle pendant la conférence.
- Linda Socha a remercié toutes les personnes mentionnées pour tout le travail qu'elles ont fait pour l'AIISOC pendant les deux années précédentes.

By/par Dan Maher

L to R: ORNAC President Bonnie McLeod & ORNAC Past-President Linda Socha

- La neuvième édition des normes de l'AIISOC ont été dévoilées pendant la Conférence. Elles sont en vente par l'Association canadienne de normalisation (CSA). Pour commander, veuillez visiter le site Web.
- Depuis deux ans, le comité des normes travaille assidûment pour produire ce document. Linda Socha a offert à tout le monde impliqué ses plus sincères remerciements pour leur dévouement et tout leur travail.
- Elle a également reconnu les vérificateurs à travers le pays qui ont participé au développement du document.
- L'AIISOC est officiellement personne morale, et tout son actif a été transféré auprès d'Industrie Canada le 1er juillet 2009.
- L'AIISOC explore actuellement la possibilité de créer un cours de formation périopératoire. Samedi, un membre du conseil a présenté les résultats de son enquête préliminaire au conseil, qui a décidé de poursuivre l'enquête. Et voilà que le travail commence. Restez à l'écoute pour de plus amples renseignements.
- Le travaille se poursuit sur les projets entrepris en partenariat avec l'Association des infirmières et infirmiers du Canada (AIIC). Parmi les projets récents, signalons le comité sur l'environnement. L'AIIC permet maintenant à tout/e infirmier/ère intéressé/e de s'abonner. Pour plus de détails, veuillez visiter le site Web de l'AIIC.
- Le partenariat entre l'AIISOC et l'Institut canadien pour la sécurité des patients se poursuit également. L'AIISOC était un des groupes canadiens ayant appuyé la liste de contrôle OMS pour la sécurité chirurgicale, et depuis, elle participe au groupe de travail de l'ICSP dont l'objectif est d'adapter la liste de contrôle au contexte canadien. Si votre institution aimerait des conseils sur l'institution de la liste de contrôle, l'ICSP offre sur son site Web un guide et d'autres outils de mise en œuvre. ✦

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References

1 The Joint Commission. The Statistics page. Available at: http://www.joint-commission.org/NR/rdonlyres/D7836542-A372-4F93-8BD7-DDD11D43E484/0/SE_Stats_12_07.pdf. Accessed March 13, 2008.

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