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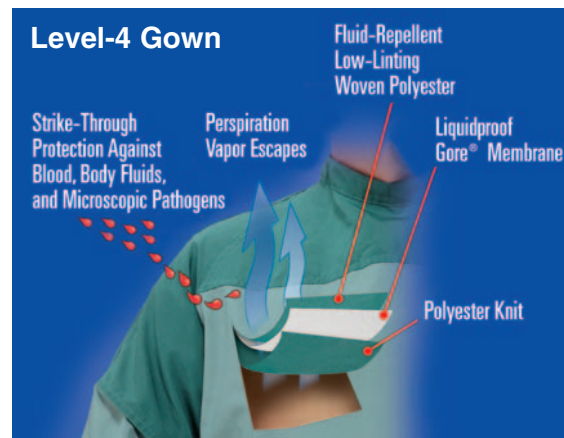
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President's Message

In a previous President's Message I discussed the subject of patient safety and the fact that creating a culture of safety is every health care provider's responsibility. ORNAC continues to be actively involved in several patient safety initiatives of which the most recent and far-reaching is the World Health Organization's (WHO) *Safe Surgery Saves Lives Challenge*.

As the volume of surgery continues to experience worldwide growth at unprecedented rates, and because surgery is an integral part of health care, the WHO launched a campaign to specifically address patient safety in surgical care. By taking the step to recognize surgery as a major public health issue and by defining a core set of minimum standards that can be universally applied regardless of borders and settings, we can create an environment of safety that will help improve both the access and the level of care available to surgical patients.

In February of 2008, a Surgical Safety Checklist was proposed by WHO. It has been designed to be easy to understand and widely applicable in order to help reinforce established safety practices. While many of these practices are already common in Canada, they are not always so in many other parts of the world.

The goal of the *Safe Surgery Saves Lives Challenge* is to create safety norms and to ensure they are positioned in the forefront of every surgical provider's mind. There has been an immense global endorsement of the campaign and the checklist – ORNAC has collaborated with several other Canadian organizations in a joint endorsement of both. The ORNAC vision has always focused on enhancing patient perioperative experiences by promoting best practices. To successfully achieve our vision we must put patients at the very heart of our care and build a culture of safety within operating rooms and surgical facilities across Canada.

Since the official launch of the WHO campaign and the Surgical Safety Checklist, the Canadian Patient Safety Institute (CPSI) has organized a working group of representatives from several disciplines and organizations across Canada.

This working group is further defining the checklist and adapting it to the Canadian environment while identifying other issues related to safe surgery. ORNAC is honoured to be involved. By the time this issue of CORNJ is published you may already be hearing about some of the work this group has accomplished!



In order to meet the demands of an ever-changing healthcare environment, ORNAC will continue to be proactive in working for change in the future. It will continue to stand by its mandate of focusing on the promotion and advancement of excellence in the provision of safe patient care in the perioperative environment and on the professional growth of perioperative nurses. Creating a culture of safety in healthcare should be everyone's mission. Our patients deserve it!

On another note, don't forget to register for the upcoming ORNAC National Conference to be held in St. John's, NL, in June 2009. It promises to be an event not to be missed! More information can be obtained at our website www.ornac.ca – hope to see you there! 🍁

Wishing you and your family a happy and peaceful holiday season....

Linda Socha

Linda M. Socha, RN, BSN, RNFA, CPN(C), CEBT, CTBS, is President of the Operating Room Nurses Association of Canada. She is Clinical Nurse Educator for the OR at Saskatoon City Hospital and Casual Tissue Donor Coordinator for the Saskatchewan Transplant Program. She is also the past Chair of the ORNAC Editorial Committee.

President's Message

Dans une de mes dernières communications, j'ai parlé de la sécurité des patients ainsi que du fait que la création d'une culture de sécurité relève de la responsabilité de tout professionnel de soins de santé. L'AIISOC poursuit ses efforts dans ce domaine en participant à plusieurs initiatives, la plus récente et la plus vaste étant celle de l'Organisation mondiale de la Santé, le *Safe Surgery Saves Lives Challenge*.

À l'échelle mondiale, le nombre de chirurgies ne cesse d'augmenter plus rapidement que jamais. Étant donné que la chirurgie fait partie intégrante des soins de santé, l'OMS a lancé une campagne ciblant la sécurité des patients subissant une procédure chirurgicale. En identifiant la chirurgie comme dossier important pour la santé publique et en définissant un ensemble de normes de base à respecter dans tout pays et dans toute circonstance, il est possible de créer un milieu sécuritaire au sein duquel sont améliorés l'accès et le niveau de soins disponibles aux patients subissant des interventions chirurgicales.

Cette année, en février, une liste de vérification relative à la sécurité chirurgicale a été proposée par l'OMS. Dans le but de renforcer les normes de sécurité déjà établies, la conception de la liste vise une simplicité de compréhension et une polyvalence importante quant aux circonstances traitées. Bien que bon nombre de ces pratiques soient bien connues au Canada, ce n'est pas toujours le cas dans d'autres parties du monde.

L'objectif du programme *Safe Surgery Saves Lives Challenge* est d'établir des normes de sécurité et d'assurer que les professionnels chirurgicaux ne les perdent jamais de vue. Notons que la campagne et la liste connaissent un énorme appui international et que l'AIISOC, en association avec plusieurs autres organismes canadiens, offre également son appui. La vision de l'AIISOC a toujours visé l'amélioration de l'expérience périopérative des patients grâce au partage des meilleures pratiques. Il s'ensuit donc que la réussite de notre vision repose sur le placement des patients au cœur de notre pratique dans les salles d'opération et les services périopératoires partout au Canada.

Suivant le lancement de la campagne de l'OMS et sa liste de vérification de la sécurité chirurgicale,

L'Institut canadien pour la sécurité des patients (ICSP) a établi un groupe de travail rassemblant des membres de plusieurs disciplines et organismes à travers le Canada. L'objectif de ce groupe de travail est de raffiner la liste et de l'adapter au milieu canadien tout en identifiant d'autres circonstances pouvant avoir un impact sur la sécurité d'une chirurgie. L'AIISOC a l'honneur de participer à ce projet. Au moment de la publication de ce numéro de la revue de l'AIISOC, il se peut que vous ayez déjà entendu parler des premiers succès de ce groupe!

Afin de pouvoir demeurer au courant face au changement continu dans le domaine des soins de santé, l'AIISOC ne laissera pas tomber son approche proactive pour promouvoir le changement positif. Elle demeurera fidèle à son mandat citant la promotion de soins périopératoires de qualité supérieure et le développement professionnel du personnel infirmier de salle d'opération. La création d'une culture de sécurité en soins de santé doit être la mission de chacun d'entre nous. Nos patients le méritent!

Je change brièvement de sujet pour vous rappeler de vous inscrire à la Conférence nationale de l'AIISOC qui aura lieu en juin 2009 à St. John's à Terre-Neuve. Il s'agit là d'un événement à ne pas manquer! Pour plus de renseignements, veuillez visiter notre site Web à www.ornac.ca. Au plaisir de vous voir en juin!

Je souhaite à chacune et chacun une saison des Fêtes pleine de joie et de paix... Linda Socha ❁



Linda M. Socha, infirmière autorisée, baccalauréat en sciences infirmières, RNFA, CPN(C), CEBT, CTBS, est la présidente de l'Association des infirmières et infirmiers de salle d'opération du Canada. Elle est infirmière clinicienne enseignante de salle d'opération au Saskatoon City Hospital et coordonnatrice occasionnelle des dons de tissus pour le Saskatchewan Transplant Program. Elle est également la présidente sortante du comité de rédaction de l'AIISOC.



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EDITORIAL CONTENTS

6 THE IMPACT OF THE SURGICAL LIAISON NURSE ON PATIENT SATISFACTION IN THE PERIOPERATIVE SETTING
By: KIM STEPHENS-WOODS, RN, BScN, MN



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18 A SUCCESSION PLAN IS NEEDED FOR OPERATING ROOM NURSES
By: GYSLAINE DESROSIERS, OIIQ

22 UN PLAN DE RELEVÉ S'IMPOSE AU BLOC OPÉRATOIRE
Par: GYSLAINE DESROSIERS, OIIQ

25 ORNAC STANDARDS QUESTION & ANSWER

INDUSTRY HAPPENINGS

16 ORNAC INTRODUCES THE RMAC PATIENT SAFETY AWARD

26 ORNAC NATIONAL 2009

28 UPCOMING EVENTS

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L'IMPACT DE L'INFIRMIERE/INFIRMIER DE LIAISON SUR LA SATISFACTION DU PATIENT QUANT AUX SOINS PERIOPERATOIRES

Auteure : Kim Stephens-Woods, infirmière autorisée, baccalauréat en sciences infirmières, maîtrise en soins infirmiers, est la directrice des services chirurgicaux à l'hôpital St Joseph's à Hamilton (Ontario). Elle travaille dans les soins infirmiers et la gestion depuis 28 ans, et détient un baccalauréat en soins infirmiers et une maîtrise en sciences en soins infirmiers communautaires. Elle est également membre de la Registered Nursing Association of Ontario (RNAO) et du Canadian OR Leaders (CORL).

RESUME

Améliorer la satisfaction, maintenir la communication et réduire l'anxiété des patients est un élément important des soins périopératoires. L'introduction d'infirmières et d'infirmiers de liaison en soins périopératoires aura un impact important. Grâce à la capacité de ces professionnels de se concentrer sur le patient et de l'aider à naviguer les différentes étapes de son expérience chirurgicale, les soins qui en résultent seront moins fragmentés et l'amélioration sera manifeste.

La déclaration de l'AISOC intitulée *The Perioperative Nurses' Role in Primary Health Care* (Le rôle de l'infirmier(ère) périopératoire en soins de santé primaires) traite de ce sujet important. Reportez-vous au module 1 de l'Association des infirmières et infirmiers en salle d'opération du Canada (AISOC). *ORNAC Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice* (8^e édition).

THE IMPACT OF THE SURGICAL LIAISON NURSE ON PATIENT SATISFACTION IN THE PERIOPERATIVE SETTING

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ABSTRACT

Improving patient satisfaction, communication, and the reduction of anxiety, is an important factor in perioperative care. The introduction of a surgical liaison nurse (SLN) will have significant impact. Through the SLN's ability to focus on the patient and to transition with the patient through all areas of the surgical experience, the resulting care will be less fragmented and the improvement will be evident.

The majority of health care organizations are targeting the key concepts of escalating patient satisfaction, improving the process of communication, and reducing the perception around levels of anxiety in all areas. The concern in these areas as it relates to surgical patient is no exception. Millions of patients, and their family members, come into contact with surgeons, anesthesiologists, nurses, and other perioperative health care professionals on a daily basis as a result of any number of surgical procedures.

Who prepares these patients or their family members for the anxiety and fear that they face while they wait, often hours at a time, to be informed about the condition of their loved ones? As noted by Cooke, Chaboyer, Schluter and Hiratos the long waits throughout the

perioperative experience may enhance the perceptions of anxiety,

"Waiting time, with its opportunity for brooding, thinking, worrying and fearing the forthcoming surgery may also exacerbate perceptions of anxiety".¹

The perioperative environment is often seen as impersonal and unfriendly. Patients arrive, are relieved of their belongings, families are asked to wait, often in a remote waiting area. These waiting areas are often congested with a high level of noise and a lot of movement of patients and staff.² How do patients or family members know what to expect?

Patients and their family members often note, throughout the perioperative phase of hospitalization, a fragmentation of the communication process. This fragmentation may add to heightened levels of stress and anxiety. Dunne articulates the importance of good communication,

"Communication is an essential part of good practice in nursing and is the basis for building a trusting relationship that will greatly improve care and help to reduce anxiety and stress for patients and clients, their families and their carer".³

Not only can ineffective communication be linked to higher levels of stress and anxiety, a lack of communication can also result in an overall feeling of dissatisfaction with hospital care.⁴ Nurses, the main service providers within most health care settings, are most often responsible for having the greatest influence on overall patient satisfaction levels.⁵

In September 2005 the surgical liaison nurse (SLN) role was introduced at Trillium Health Centre (THC) in an effort to improve the process of communication and the level of patient and family satisfaction as well as to reduce the feelings of anxiety felt by many patients and their family members, throughout the peri-operative phase of hospitalization. THC is a large community hospital located in Mississauga, ON, that

provides surgical services to approximately 30,000 patients per year.

The SLN is dedicated to ensuring patients and families are kept informed throughout the surgical care process. Patients and family members are greeted by the SLN after the registration process is complete. During this initial introduction, the SLN explains the sequence of events that are likely to occur during the perioperative period. If it is known that the patient will be admitted to the hospital for an overnight stay the SLN provides information about room numbers, visiting hours and other hospital information. The SLN answers any questions or concerns that are raised by the patients and their family members. The SLN does not provide medical information or medical care to the patient or family. The SLN will, however, seek out the physician or primary nurse if this type of information or care is required. While the patient is in the operating room, a connection is maintained between the SLN and the waiting family members through the sharing of information about the progress of the procedure, the location of the patient and when they will be able to have contact with their loved ones. Once the patient has arrived in the recovery room, the SLN makes contact with the nurse who is providing medical care and determines an appropriate time for a family member to visit with the patient. They may, if required, accompany the physician when he/she speaks with the family member about the procedure, diagnosis or outcome of the surgery. When possible, the SLN will visit with admitted patients on the following day.

MacDonald and Latimer, note that there have been limited studies in relationship to the SLN however, literature is very supportive of the face to face communication facilitated by this role and the resulting reduction in the level of anxiety when the communication is enhanced.⁶

The introduction of the SLN role at THC was based on a current literature review with a focus on increasing patient and family satisfaction, communication and the ability to reduce the feelings of anxiety felt by patients and their families throughout the perioperative period.

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IMPACT OF THE SURGICAL LIAISON NURSE (cont.)

This review was conducted by the Surgical Health System nursing administration and educators. Research into the impact of these elements on patient satisfaction in the perioperative setting has been carried out, albeit on a much smaller scale than the studies relating to inpatient satisfaction. As noted by Gardner, Nnadozie, Davis and Kirk,

*"Although considerable research has been conducted in regard to patients' assessments of services rendered in the inpatient setting, minimal research has been conducted in the outpatient setting."*⁷

A current review of the literature specifically related to the peri-operative area, has outlined 97 research reports dealing with issues in the peri-operative care area.⁸ Much of this research focused on the process of communication, improvements to overall patient satisfaction & quality of care, and the reduction of anxiety.

The relationship between patient satisfaction and improvements in the process of communication is of considerable importance within the perioperative setting. It is noted that communication in the perioperative setting tends to be fragmented due to the very nature of the area.⁹ Improvements in the area of communication have been shown to have a positive impact on the level of patient and family satisfaction in the perioperative setting. This improvement also results in a reduction in the level of anxiety and fear that patients experience as they wait for their surgical procedure. A reduction in this level of anxiety has been shown to have a positive influence on medical outcomes.¹⁰

An improvement in patient satisfaction scores will result from a focus on improvements to the process of communication along with the development of a true therapeutic relationship with the patients and families.¹¹ Mahon notes,

*"Apart from producing emotional upset ranging from discomfort to debilitating panic and avoidance, anxiety may also adversely affect such patient outcomes as recovery/recuperation and understanding of postdischarge care."*¹²

The measurement of patient satisfaction is not a new phenomenon. Most health care organizations have, historically, measured and monitored patient satisfaction on a regular basis. Current literature, however, supports a belief in the resurgence and mounting interest in the area of patient satisfaction. It is important to understand and monitor the patients' perspective, as it relates to the provision of quality care, as well as to document required improvements in specific areas.¹³

Of note, the World Health Organization (WHO), as cited in De Silva¹⁴, speaks to a new framework for measuring overall health system performance. This framework consists of the following: health, responsiveness, and fairness of financing. More importantly, there is significant attention paid to focusing on the:

*"...responsiveness to individuals' legitimate expectations regarding the non-health enhancing aspects of the health system..."*¹⁵

This responsiveness can be linked to patient and family satisfaction as well as to effective communication. The involvement of WHO, and other international agencies, leverages the significance of measuring the expectations of the patients through patient satisfaction indicators.

It has been noted that technical care versus holistic care is emerging as a central theme in today's health care society. This is of significant importance for the perioperative area. Typically, patients are satisfied with the technical quality and outcomes of the care they receive, however, growing concern and emphasis is being placed on the ability of the system to meet the emotional and other psychosocial needs of the patients and their families.¹⁶ These may be described as communication enhancements as well as improving the relationship between the provider and the patient.

It is this change in the landscape of health care, along with the thousands of surgical procedures that are being performed across the country on a daily basis, which provides the reasoning associated with improving the process of communication in order to enhance patient

IMPACT OF THE SURGICAL LIAISON NURSE (cont.)

satisfaction and reduce anxiety in the perioperative setting.

Since the introduction at THC of the SLN role, there has been an increase in overall patient and family satisfaction within the perioperative setting. Much of the information around satisfaction rates is anecdotal. Family members often call with compliments about the SLN and the service that is provided. Letters have also been received about the impact of this role. Surgeons and nursing staff have embraced the role and now depend upon the services of the SLN to enhance the experience of the patients and families within the perioperative area.

Several other hospitals (Halifax, Hamilton, and Kingston) have since implemented a comparable role within their perioperative areas. There is however some controversy over who should be hired to perform this role. Many of the organizations surveyed have operating room nurses in this role. At THC, however, the position is held by a recovery room nurse. Several applicants were interviewed for this role and the decision was difficult however, communication skill and the ability to liaise with all team members was evident in the person chosen. There is no minimum level of experience or educational preparation required for the SLN role. A good understanding and knowledge of the surgical procedures as well as the ability to communicate are, however, paramount for success. With an emphasis on communication as well as an increase in patient and family satisfaction, the ideal SLN is capable of, and proficient in, building relationships in addition to being very knowledgeable about the perioperative area. An understanding of the roles of the professionals that work in this area is also an asset.

From an in-patient perspective there is strong support for the benefits of enhanced patient and family satisfaction, improved communication, and a reduction in the perception of anxiety. There appears, however, to be limited research around, or appreciation for, the magnitude of these benefits in the perioperative setting.

Further research in this area is warranted. Thousands of surgical patients and families throughout the world wait anxiously, on a daily basis, in perioperative settings. If we are able to improve communication and, ultimately, patient and family satisfaction the potential benefits are endless.

The ORNAC Position Statement entitled The Perioperative Nurses' Role in Primary Health Care speaks to this important subject. Refer to Module 1 of the Operating Room Nurses Association of Canada (ORNAC) (2007). *ORNAC Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice* (8th ed).

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A SUCCESSION PLAN IS NEEDED FOR OPERATING ROOM NURSES

Author: Gyslaine Desrosiers, President of the Order of Nurses of Quebec.

Following her Bachelor of Science in Nursing, Gyslaine Desrosiers completed a Masters of Business Administration (MBA) at l'École des Hautes Études Commerciales de l'Université de Montréal. She has been President of the Order of Nurses of Quebec since 1992.

Mrs. Desrosiers is also President of the Fondation de recherche en sciences infirmières du Québec (FRESIQ) and President of the Secrétariat international des infirmières et infirmiers de l'espace francophone (SIDIIEF).

This editorial first appeared in the November/December 2007 issue of the OIIQ Journal *Perspective Infirmière* (page 10-11). While it was written with a provincial focus it provides a perspective that is of immense interest to perioperative registered nurses across Canada.

It is reprinted with permission of the author Gyslaine Desrosiers, President of the Ordre des infirmières et infirmiers du Québec (OIIQ) (Order of Nurses of Quebec).

Nothing appeals to people's imaginations quite as much as the mysterious goings-on in an operating room—that place where consciousness fades, where the heart stops beating, where blood is shunted through a pump as bones are sawed and nailed back together and the brain is laid bare. Where the soul waits to flow back into a damaged body filled with new hope.

We've all seen the images in TV hospital shows: a stretcher being wheeled away down a long corridor, loved ones clasping the patient's hands, and the anxious faces waiting outside the swinging doors. The doctors and nurses, caps and masks hiding all but their eyes, exchanging meaningful glances expressing wordless concern. And all the time we hear the beep-beep of the heart monitor

and the whooshing of the mechanical ventilator, as gloved hands push aside the organs, cauterize and suture incisions. *Grey's Anatomy* and *House* are two series that take viewers straight into operating rooms these days and leave us all admiring the miracles of modern medicine.

Who are operating room nurses?

There are about 2,500 operating room nurses in Quebec, and 46 nurse first surgical assistants (NFSAs). They are grouped into two dynamic associations: the Corporation of Operating Room Nurses of Quebec (CORNQ) and the Registered Nurse First Surgical Assistant Association (RIPAC). There is considerable concern at the moment about what will become of them, for 41.6% of them are age 50 or older. Will they have time to pass along their unique knowledge and expertise before they retire?

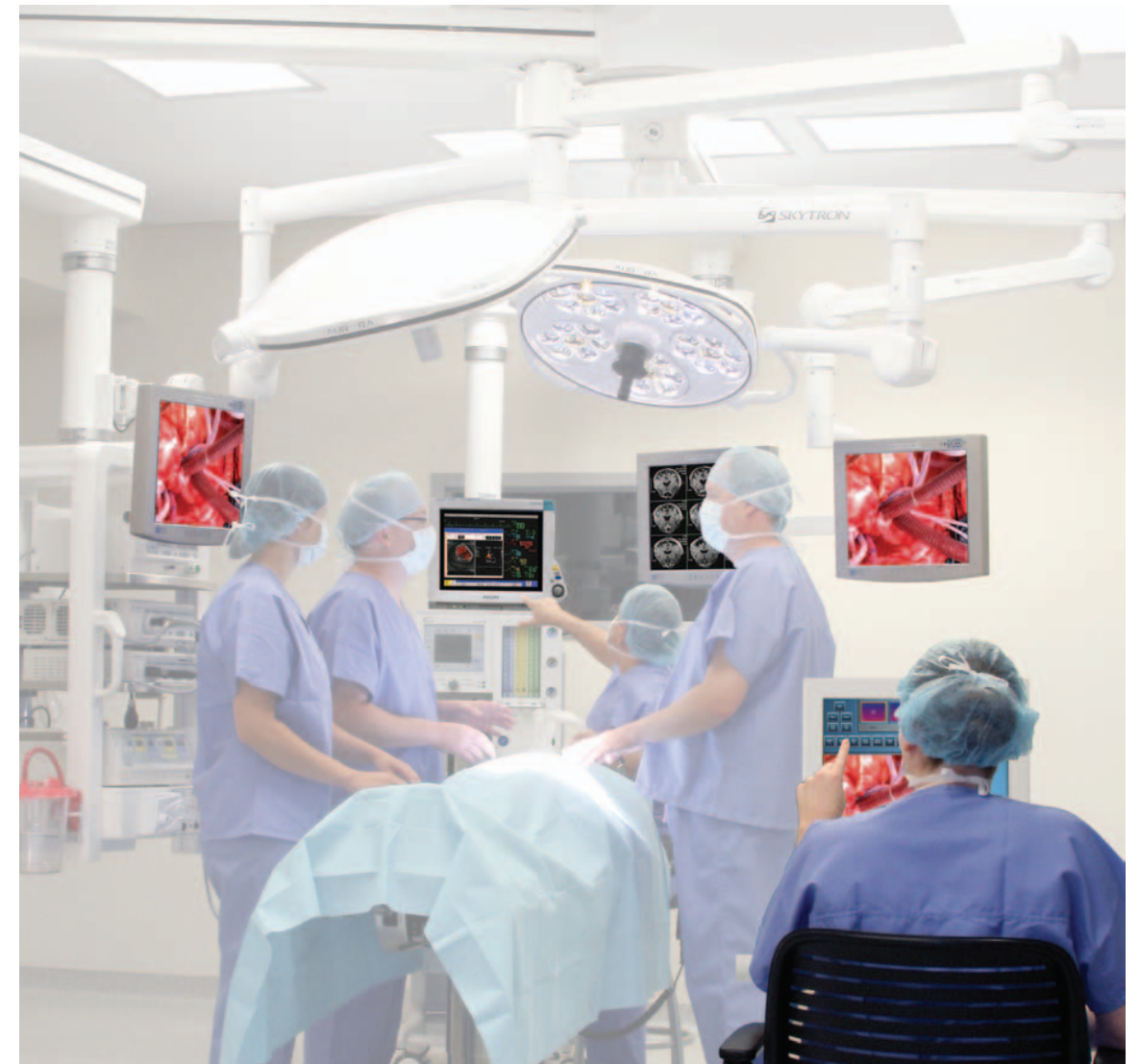
Clearly, a succession plan is needed.

It wasn't so long ago that all nurses received an introduction to internal and external operating room services. But as the profession evolved and hospital nursing schools closed, the college-level nursing program kept only a few hours of observation in an operating room. When the program was revised, training in this area disappeared completely from the basic nursing curriculum. The length of the training and its specific nature made it difficult to include it in the DEC-BAC program, as well. This means that in Quebec, each hospital offers its own theory and practical training lasting six to nine months, and covered by no outside certification. To guarantee the skills required to work in an operating room, many countries demand that candidates wishing to practise in this setting have a degree on top of their basic training, or special certification. In France, operating room nurses with state diplomas (IBODE) are very highly regarded.

An operating room, it must be remembered, is a place where the risk factors for patients are high: 51.4% of adverse events in hospitals are related to surgical care, mainly in perioperating

Continued on Page 21

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SUCCESSION PLAN (cont.)

room settings, and it is estimated that 37% of these events are avoidable.¹ Nurses working there must master a wide range of knowledge and skills required for the different kinds of surgery, asepsis control, infection prevention, compliance with environmental standards, the safe use of a huge variety of devices, operating room and recovery room pharmacology and clinical monitoring during the immediate postoperative phase.

In 2000, Quebec led the way among Canadian provinces by adopting a regulation recognizing the delegation of medical acts to NFSAs, in keeping with North American trends. This role goes beyond internal service, allowing such nurses to perform clinical and technical activities, i.e. using surgical instruments during the operation; exposing the surgical site; handling tissues safely; performing hemostasis; dissecting tissues and helping to close incisions. This regulated role requires at least three years' operating room experience and a baccalaureate including a 30-credit certificate offered only at the Université du Québec à Trois-Rivières. It should be noted that at the time, it was assumed that these nurses' role would evolve into that of specialized nurse practitioners. However, perioperating room functions were not included in the role of nurse practitioners specializing in cardiology.

A study² done by the Order in winter 2006 showed that administrative, budgetary and other constraints related to the requirement for this baccalaureate and insufficient access to training have delayed the deployment of NFSAs. Yet 92% of hospitals estimate that they are needed for certain operations. In addition, 48% of hospital centres feel that nurses in internal service exceed their roles by providing first assistance, in violation of the regulation in effect.

What does the future hold?

Given the widespread nursing shortage, the Federation of Medical Specialists of Québec (FMSQ) has suggested that a new category of operating room personnel be introduced in Quebec: instrumentalists. Heart surgeons and orthopedists continue to call for NFSAs,

however. In short, the situation is becoming confused, and all the more worrisome in that there is considerable pressure on operating rooms with the aim of reducing waiting times, shortages of nurses (and doctors) appear to be here to stay, and hundreds of young nurses will have to be trained to work in operating rooms. Not to mention the opening of private clinics, where the current regulation concerning NFSAs would not apply...

The Order wishes to propose, in conjunction with the CORNQ and the RIPAC, a succession plan³ for operating room nurses and an approach to enhancing their role, based on the following principles:

- Focus on attracting and retaining operating room nurses. This will mean setting up mandatory province-wide training for operating room nurses through a 30-credit post-DEC alternating work/study program and recognizing operating room nurses by means of a permit attesting to their competency.
- Reorganize operating room work. This will mean increasing nurses' versatility by enhancing their skills so that all of them are capable of providing surgical assistance in both public and private settings, thanks to a specific permit for perioperative care and first assistance. Nursing assistants will also have to be trained for internal service in large surgeries.
- Ensure operating room safety by identifying which operations require surgical assistance, obliging all new nurses working in this field to have the specific permit, and providing appropriate professional training for nursing assistants in internal service and nurse first assistants.

I am convinced that by reorienting and enhancing the role of operating room nurses so that they can act as nurse surgical assistants, the versatility gained would help ensure public safety. Moreover, creating a specific permit could help attract competent newcomers to the field.

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3. Brief being prepared at the time this editorial was written. ❁

UN PLAN DE RELEVÉ S'IMPOSE AU BLOC OPÉRATOIRE

Auteur : Gyslaine Desrosiers, Présidente, Ordre des infirmières et infirmiers du Québec Titulaire d'un baccalauréat en sciences infirmières de l'Université de Montréal, Gyslaine Desrosiers a complété également une maîtrise en administration des affaires (MBA) à l'École des Hautes Études Commerciales de l'Université de Montréal. Elle préside l'Ordre des infirmières et infirmiers du Québec depuis 1992.

Madame Desrosiers est également présidente de la Fondation de recherche en sciences infirmières du Québec (FRESIQ), et présidente du Secrétariat international des infirmières et infirmiers de l'espace francophone (SIDIEF).

Cet éditorial a premièrement été publié dans le numéro de novembre/décembre 2007 du périodique *Perspective infirmière* de l'Ordre des infirmières et infirmiers du Québec (pages 10 à 11). Bien que sa perspective soit provinciale, il fournit un point de vue d'un grand intérêt aux infirmier(ère)s autorisé(e)s de salle d'opération à travers le Canada.

Cet article est réimprimé avec l'autorisation de l'auteure Gyslaine Desrosiers, présidente de l'Ordre des infirmières et infirmiers du Québec (OIIQ).

Rien ne nourrit mieux l'imaginaire collectif que le mystère qui plane sur les salles d'opération. Ce lieu où la conscience s'engourdit, où le cœur cesse de battre, où le sang est dérivé vers une pompe, où les os sont sciés et cloués, où le cerveau est mis à nu. Ce lieu où l'âme espère réintégrer ce corps usé mais plein d'espérance.

Quelle télésérie médicale ne montre pas le corridor dans lequel s'engouffre la civière, les mains qui serrent celles du patient et les visages anxieux des proches qui restent derrière les portes battantes ? Puis, les médecins et les infirmières, bonnet et masque couvrant presque tout le visage, échangent des regards complices et lourds de préoccupation. Avec pour seul fond sonore le bip-bip du moniteur cardiaque et le chuintement du ventilateur mécanique, les mains gantées sanguinolentes écartent des viscères, cautérisent, suturent. *D^{re} Grey*, *leçons d'anatomie* et *D^r House* sont deux téléséries qui, par les temps qui courent, nous en mettent plein la vue et nous laissent admiratifs devant les miracles de la médecine moderne.

Qui sont les infirmières de salle d'opération ?

Au Québec, il y a environ 2 500 infirmières de salle d'opération et 46 infirmières premières assistantes en chirurgie. Elles sont regroupées dans des associations dynamiques : la Corporation des infirmières et infirmiers de salle d'opération du Québec (CIISOQ) et le Regroupement des infirmières premières assistantes en chirurgie (RIPAC). Aujourd'hui, l'inquiétude règne sur leur devenir. En effet, 41,6 % ont 50 ans et plus. Partiront-elles sans avoir transmis leur savoir et leur expertise uniques ?

De toute évidence, un plan de relève s'impose. Il n'y a pas si longtemps encore toutes les infirmières étaient initiées aux services interne et externe de salle d'opération. Mais l'évolution de la profession a fait en sorte qu'à la fermeture des écoles d'infirmières des hôpitaux, le programme collégial de soins infirmiers n'a conservé que quelques heures d'observation en salle d'opération et, lors d'une révision du programme, la formation relative à ce domaine a complètement disparu de la formation initiale. La longueur de cette formation et son caractère particulier ne permettent pas davantage de l'intégrer au

programme DEC-BAC. Ainsi, au Québec, chaque hôpital offre sa propre formation pratique et théorique d'une durée de six à neuf mois qui ne fait l'objet d'aucun agrément externe. Afin de garantir les compétences requises pour travailler en salle d'opération, plusieurs pays exigent des candidates désirant exercer dans ce domaine un diplôme postérieur à la formation initiale ou une certification particulière. En France, les infirmières de bloc opératoire diplômées d'État (IBODE) jouissent d'une réputation enviable.

Il faut souligner que le bloc opératoire est un lieu où les facteurs de risque pour les patients sont élevés : 51,4 % des incidents indésirables en milieu hospitalier sont reliés aux soins chirurgicaux, principalement en peropératoire, et on estime que 37 % des incidents pourraient être évités.¹ Les infirmières doivent y maîtriser un large éventail de connaissances et d'habiletés reliées aux activités infirmières requises pour les différents types de chirurgies, le contrôle de l'asepsie, la prévention des infections, le respect des normes environnementales, l'utilisation sécuritaire d'appareils très divers, la pharmacologie utilisée en salle d'opération et salle de réveil ainsi que celle nécessaire à la surveillance clinique durant la phase postopératoire immédiate.

En 2000, le Québec a innové par rapport aux autres provinces canadiennes en reconnaissant dans un règlement de délégation d'actes médicaux la fonction d'infirmière première assistante en chirurgie (IPAC), et ce, conformément à la tendance nord-américaine. Cette fonction qui va au-delà du service interne permet d'exercer les activités cliniques et techniques qui consistent à utiliser des instruments chirurgicaux en cours d'opération ; exposer le champ opératoire ; manipuler les tissus de façon sécuritaire ; procéder à l'hémostase ; disséquer les tissus et assister pour la fermeture de la plaie. Cette fonction réglementée exige au minimum trois années d'expérience au bloc opératoire et un baccalauréat comportant un certificat de 30 crédits offert uniquement à l'Université du Québec à Trois-Rivières. Il faut mentionner qu'à l'époque, on avait prévu que les IPAC verraient leur rôle évoluer vers celui d'infirmière praticienne spécialisée (IPS). Or, le

peropératoire a été exclu du rôle de l'IPS spécialisée en cardiologie.

De plus, une enquête² effectuée par l'Ordre à l'hiver 2006 a démontré que des difficultés administratives, budgétaires et d'autres liées à l'exigence du baccalauréat et au manque d'accès à la formation ont freiné le déploiement des IPAC. Pourtant, on estime dans 92 % des hôpitaux que certaines opérations nécessitent la présence d'une première assistante. De plus, on est d'avis dans 48 % des centres hospitaliers que les infirmières en service interne vont au-delà de leur rôle et font de la première assistance, et ce, en contrevenant au règlement en vigueur.

Quel avenir devons-nous aménager ?

Devant la pénurie généralisée d'infirmières, la Fédération des médecins spécialistes du Québec (FMSQ) a proposé d'introduire dans les salles d'opération du Québec une nouvelle classe de personnel, à savoir les instrumentistes. Par ailleurs, les chirurgiens cardiaques et les orthopédistes continuent d'exiger des IPAC. Bref, la situation devient confuse et d'autant plus préoccupante que la pression exercée sur les blocs opératoires en vue de réduire les listes d'attente est grande, que la pénurie d'infirmières (et de médecins) s'annonce permanente et que des centaines de jeunes infirmières devraient être formées pour intégrer les blocs opératoires. Sans oublier l'ouverture de cliniques privées où le règlement actuel visant les IPAC ne s'appliquerait pas...

Conjointement avec la CIISOQ et le RIPAC, l'OIIQ propose un Plan de relève³ des infirmières de salle d'opération et de mise en valeur de leur rôle basé sur les orientations suivantes :

- Assurer l'attraction et la rétention des infirmières de salle d'opération. À cet effet, il faut uniformiser sur le plan provincial une formation obligatoire pour l'exercice infirmier en salle d'opération dans un programme de 30 crédits post-DEC de type alternance études/travail et reconnaître les infirmières de salle d'opération au moyen d'un permis qui garantit leur compétence.
- Réorganiser le travail en salle d'opération. Pour ce faire, il faut améliorer la

SUCCESSION PLAN (cont.)

polyvalence des infirmières en rehaussant leurs compétences pour permettre à toutes de faire de l'assistance chirurgicale dans le milieu public comme dans le milieu privé grâce à un permis particulier en soins périopératoires et première assistance. Il faut aussi former des infirmières auxiliaires pour le service interne dans les blocs opératoires à grand volume.

- Assurer la sécurité dans les blocs opératoires en déterminant les opérations qui requièrent une assistance chirurgicale, en obligeant toutes les nouvelles infirmières travaillant dans ce domaine à posséder le permis particulier et en offrant un encadrement professionnel approprié aux infirmières auxiliaires en service interne ainsi qu'aux infirmières qui assurent la première assistance.

Je suis convaincue qu'en recadrant et en rehaussant le rôle des infirmières de salle

d'opération pour qu'elles puissent faire de l'assistance chirurgicale, la polyvalence acquise serait une garantie pour la sécurité du public. De plus, la création d'un permis particulier pourrait devenir une force d'attraction pour une relève compétente dans ce domaine.

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3. Mémoire en cours d'élaboration au moment d'écrire l'éditorial. 🍁

L'AISOC PRESENTE LE PRIX DE SECURITE DES PATIENTS RMAC!

L'AISOC et RMAC reconnaissent l'importance de la sécurité en soins de santé, en particulier pour les patients périopératoires. À cette fin, un nouveau prix sera décerné pour la première fois à la conférence nationale 2009 de l'AISOC : le **Prix de sécurité des patients RMAC**. Ce prix a été conçu par Ron MacLeod, infirmier autorisé et président de RMAC Surgical Inc.

Ce prix reconnaît les leaders en soins infirmiers faisant preuve d'innovation dans le domaine de la sécurité des patients, c'est-à-dire des personnes ayant développé ou décrit des stratégies de sécurité des patients pertinentes et pratiques.

Ce prix sera décerné à un(e) infirmier(ère) autorisé(e) périopératoire ayant présenté un discours exceptionnel au sujet de la problématique de la sécurité des patients dans un des formats suivants :

- Article dans la revue de l'AISOC, *Canadian Operating Room Nursing Journal* (publié dans les deux ans précédant l'année de la conférence nationale)
- Affiche présentée lors de la conférence nationale de l'AISOC
- Discours présenté lors de la conférence nationale de l'AISOC

Les sujets traités peuvent inclure les innovations touchant aux systèmes, à la formation, à la communication, à la revendication ou à la recherche dans le domaine de la sécurité des patients.

Le prix de 1 000 \$, accompagné d'un certificat et d'une épingle, sera présenté lors de chaque conférence nationale de l'AISOC. Pour de plus amples renseignements, veuillez visiter www.ornac.ca, cliquez sur *Education* et ensuite sur *Awards*.



QUESTION:

My question is regarding flipping of scrub nurses gloves on a sterilegloving stand. I understand that the standards are against flipping of any materials, but why are we not allowed to flip gloves on the gowning stand, which is separate from the main sterile table?

ANSWER:

You are correct that ORNAC's **Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (8th edition)** states "items shall not be flipped". The rationale for this standard includes:

- ❖ A sterile item may become contaminated as it shifts from the sterile inner package, across the peel package edges and onto the sterile table.
- ❖ Flipping requires reaching over the sterile field, which is not an acceptable practice.
- ❖ Air currents can be created when flipping which can cause movement of microorganisms in the operating room leading to contamination.
- ❖ Flipped items may also miss their intended mark and land on an unsterile space.

In addition:

- ❖ There is a risk of cutting the table drape when flipping larger items, which may not be immediately noticed.
- ❖ Mechanical items may be damaged if flipped.
- ❖ Flipping creates a risk of contamination which saves minimal time. Patients deserve best practice.



QUESTION :

Ma question concerne déposer ses gants stériles sur un guéridon stérile réservé à cette fin en renversant l'emballage.

Je comprends que les normes interdisent cette procédure pour tout matériel, mais pourquoi pas laisser tomber ses gants sur un champ stérile autre que la table stérile principale?

REPOSE :

Vous avez raison, les **Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (8^e édition)** de l'AISOC interdisent ce procédé. Le raisonnement derrière cette interdiction est la suivante :

- ❖ En sortant de l'emballage stérile intérieur pour tomber sur le champ stérile, l'article stérile peut être contaminé par les bords de l'emballage extérieur.
- ❖ Déposer un article directement sur le champ stérile exige placer ses mains au-dessus de ce champ, ce qui constitue une pratique inacceptable.
- ❖ Les courants d'air créés en laissant tomber l'article peuvent déplacer des microorganismes dans la salle d'opération, ce qui peut contaminer le champ stérile.
- ❖ Un article ainsi déposé peut finir ailleurs que prévu, même sur une surface non stérile.

De plus,

- ❖ En suivant ce procédé pour ouvrir l'emballage d'articles plus grands, vous courez le risque de couper ou déchirer le champ stérile, ce qui pourrait passer inaperçu.
- ❖ Les articles mécaniques peuvent être endommagés en tombant sur le champ stérile.
- ❖ Laisser tomber un article sur le champ stérile court le risque de contamination et n'économise que très peu de temps. Nos patients méritent les meilleures pratiques.



VISIT www.ORNAC.ca FOR EXHIBIT FLOOR TIMES

www.ORNAC.ca FOR REGISTRATION PRICES AND TIMES

MONDAY, JUNE 8

0800 – 1000 Opening Ceremonies

0930 – 1000 Coffee Break

1030 – 1145 Key Note Address - Rex Murphy, CBC Journalist

1145 – 1300 Lunch

1300 – 1400 Evidence Based Practice: Adding to the depth of Perioperative Nursing - Dr. Hugh McKenna

1400 – 1600 A Mock Discovery Dan Boone, Lynn Anderson & Tina Parrill

TUESDAY, JUNE 9

0830 – 0930

- A) Perioperative Nursing Research Karen Frenette CORL
- B) Working toward Zero SSI—Maureen Spencer
- C) Oral Abstract presentations x 3

0930 – 1000 Coffee Break

1000 – 1100

- A) Smoke Exposure: Can Clean Air Be a Reality? - Kay Ball
- B) RNFA Session- Grace Groetzsch
- C) Competency Development & Advanced Practice - Dr. Lois Hamlin

1100 – 1500 Exhibits/ Posters/ Lunch

1500 – 1600

- A) High Performance in Perioperative Leadership & Opportunities for High Performing Perioperative Leaders — Muriel Shewchuck/ Charlie Byers (CORL)
- B) Evaluation of Skin Preparation Marion Yetman /Glenda Tapp/ Donna Moralejo
- C) Oral Abstract presentations x 3

WEDNESDAY, JUNE 10

0830 – 0930

- A) Operation Smile - Dr. David Jewer
- B) CORL—Carol Kirkwood
- C) Oral Abstract presentations x 3

0930 – 1000 Coffee Break

1000 – 1100

- A) Pathology Research - Dr. Betty Dicks (RN)
- B) Sterilization Standards - Colleen Landers
- C) Oral Abstract presentations x 3

1100 – 1500 Exhibits/ Posters/ Lunch

1500 – 1600

- A) The Perioperative Adventure! Coping in Challenging Seas - Lynn Walters CORL
- B) Military Nursing-- Nathalie Auger & Peter Hennecke
- C) Pediatric Pt with Osteogenic Sarcoma - Debbie Jaraway

THURSDAY, JUNE 11

0830 – 0930

- A) Innovation and Leadership in Perioperative Nursing: P. Elliott & J. Koekebakker (CORL)
- B) Code of Ethics- Panel discussion with Margot McNamee/ Rick Singleton/ Margaret Farley
- C) Organ Retrieval- DCD

0930-1000 Coffee Break

1000 – 1100

- A) Robotics in the OR —Dr. Anavari
- B) Oral Abstract presentations x 3
- C) Safer HealthCare Now-- Theresa Fillatre & Dannie Carrie

1100 – 1500 Exhibits/ Posters/ Lunch

1500 – 1600

- A) Perioperative Benchmarking - Contributions to Best Practice Tina Foster & Randy Heiser CORL
- B) Oral Abstract presentations x 3
- C) A Greener O. R. Lyndsay Downes & Lucia Pfeuti

FRIDAY, JUNE 12

1000 – 1015 Break

1015 – 1145 T.A. Loeffler

1145 – 1200 Break

1200 – 1245 Closing Ceremonies

SOCIAL EVENTS

SUNDAY

- Welcoming Reception – “Half Hour Later In Newfoundland”

MONDAY

- J&J Medical Products Print Reception
- An Evening at “the Rooms”

TUESDAY

“A Scoff, A Scuff and a Swalley”

WEDNESDAY

A free evening to explore the City of St. John’s

THURSDAY

“Rally in Alley”

Please note the above schedule is subject to change



Keynote Speakers:

Rex Murphy

T.A. Loeffler

Registration will be online January 2009.

WATCH FOR DETAILS!

Visit www.ORNAC.ca for more information

Please check the website for information on Hotel Accommodations

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Apply to – www.capitalhealth.ca/Careers/CareerOpportunities/HR-EmploymentCategory.asp

UPCOMING EVENTS / EVENEMENTS SUIVANTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

Alberta	Red Deer	October 21-24, 2009
British Columbia	Penticton	April 28 - May 1, 2010
Manitoba	Winnipeg	March 2009
Newfoundland & Labrador	St. John's	June 10, 2009
PEI	Charlottetown	September 2009
Nova Scotia	Halifax	May 23, 2009
New Brunswick	Woodstock	April 17 & 18 2009

ORNAC CONFERENCES www.ornac.ca

21st National	St. John's, NL	June 7-12, 2009
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
AORN (www.afpp.org.uk)	Chicago, USA	March 15-19, 2009
EORNA (www.afpp.org.uk)	Copenhagen, Denmark	April 17-19, 2009

RELATED PROFESSIONS

CAS (www.CAS.ca)	Vancouver, BC	June 26-30, 2009
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ISABELLE ADAMS AWARD FOR EXCELLENCE IN PERIOPERATIVE NURSING

This award is presented at the National Conference, if there is a suitable candidate, to an outstanding nurse who through major commitment has made a significant contribution to perioperative nursing in Canada. The Award winner will reflect the practice and ideals of Mrs. Isabelle Adams of Montreal. The Award was established on the initiative of the Operating Room nurses of Quebec in 1987 and is one of a high-profile recognition with no monetary award.

More details can be found at www.ORNAC.ca.
Nomination deadline is January 15th.



LE PRIX D'EXCELLENCE EN SOINS PERIOPERATOIRES ISABELLE ADAMS

Ce prix est décerné lors de la Conférence nationale de l'AIISOC à un candidat qualifié qui s'est distingué par son engagement et par sa contribution significative au domaine des soins périopératoires au Canada. Le récipiendaire sera une infirmière ou infirmier de salle d'opération dont la pratique professionnelle suit les principes de Mme Adams de Montréal. Ce prix hautement reconnu, mais ne comportant aucune récompense monétaire, fut créé en 1987 par l'Association des infirmières de salle d'opération du Québec.

Veillez visiter le site Web de l'AIISOC (www.ornac.ca) pour plus de détails.
La date limite des soumissions est le 15 Janvier.

SOLUMED AWARD for best scientific presentation

SOLUMED sponsors this award in appreciation of the integral role that perioperative nurses play in the advancement of perioperative practice.

Present your research at any ORNAC National Conference and you could win a \$1,000!

Complete award details are available at www.ORNAC.ca (click on [Education](#) then [Awards](#))

PRIX SOLUMED pour la meilleure présentation scientifique

Ce prix, commandité par SOLUMED, reconnaît le rôle critique que jouent les infirmières et infirmiers de salle d'opération dans l'évolution de la pratique périopératoire. Il est présenté lors de la Conférence nationale.

Présentez vos recherches en soins périopératoires lors d'une Conférence nationale et vous pourriez recevoir 1 000 \$!

Veillez visiter www.ORNAC.ca pour connaître tous les détails. (Cliquez sur [Education](#), puis sur [Awards](#). Disponible en anglais seulement.)

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