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President's Message

This evening, as I sit here writing my first solo president's message, I am reflecting on what a busy year 2007 has already been. The 20th National ORNAC Conference, held in Victoria in April, was amazingly successful in many ways. The event had fantastic delegate turnout, including the largest international delegate turnout in ORNAC's history, offered a comprehensive array of plenary sessions, and featured an impressive industry representation.

The conference's success truly demonstrated that perioperative nurses are committed to learning, improving our practice, and ensuring the provision of safe patient care. Talk about a dynamic group! The energy and enthusiasm was palpable and inspiring. I would like to, on behalf of the ORNAC Board, congratulate and thank everyone involved with the BCORNG planning committee for their tireless efforts in hosting a brilliant conference.

At the ORNAC Information Session (presented just after the Opening Ceremonies) the 5 year future direction for the association was outlined. Seeking a bold tomorrow is important, but our plans must proceed in a rational fashion. To ensure both were possible, ORNAC retained the services of a business consultant services to aid in the development of a strategic plan. The analysis developed for our new strategic plan highlighted many opportunities/areas where it is important to focus our attention. Given, however, ORNAC's current volunteer-based structure, it was necessary to refine the list and prioritize to suit our available resources. The key priorities include:

1. Improving the development and revision process for our *Recommended Standards, Guidelines and Position Statements for Perioperative Nursing Practice*;
2. Increasing and improving our communication platform (CORNJ and the website) as well as investigating other opportunities for communication with members; and
3. Refining and standardizing the structure of the National Conference Planning Committee.

Other items on ORNAC's current agenda include completing the process to incorporate ORNAC, creating a national database of ORNAC members by January 2008, and investigating opportunities for members to obtain continuing education credits on-line. In order to meet the demands of an ever-changing healthcare environment, ORNAC must continue to be proactive towards change in the future. We will continue to stand by our mandate to focus on the promotion and advancement of excellence in the provision of perioperative care to our patients and the professional growth and personal enhancement of perioperative Registered Nurses.

ORNAC has changed significantly during its 24 years as an association. It has created a forward-thinking, progressive organization that is built on solid traditions and the hard work of the many who served ORNAC before us.

It is an exciting time for ORNAC and I encourage you to take a closer look by exploring the web site, submitting an article to the Journal or volunteering with our editorial review or standards of practice committee.

The future depends on what we do in the present.
- Mahatma Gandhi

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, Manager of the Saskatchewan Transplant Program, and the past Chair of the ORNAC Editorial Committee.

President's Message

Ce soir, en écrivant mon premier mot du président à moi toute seule, je réfléchis sur la période très chargée qu'a déjà été l'année 2007. La 20e Conférence nationale de l'AIISOC, qui a eu lieu à Victoria en avril, a connu un énorme succès à plusieurs niveaux. Un très grand nombre de délégués y a participé, y compris le plus grand nombre de délégués internationaux de toute l'histoire de l'AIISOC. Les nombreuses sessions plénières étaient exhaustives et témoins d'une forte représentation de l'industrie.

Le succès de la conférence fait preuve de l'engagement du personnel infirmier périopératoire envers la formation, le perfectionnement de notre pratique et un service de soins sécuritaire pour tous nos patients. Quel groupe passionné! Son énergie et son enthousiasme inspirants se sentaient dans l'air. Au nom du conseil de l'AIISOC, j'aimerais féliciter et remercier tout membre du comité de planification BCORNG pour ses efforts inlassables dans le but d'organiser une conférence aussi brillante.

Pendant la session d'information de l'AIISOC ayant eu lieu immédiatement après les cérémonies d'ouverture, l'esquisse du plan décrivant les cinq prochaines années a été présentée. Viser un avenir avec une certaine audace est importante, mais nos plans doivent également faire preuve de logique. Afin d'assurer ce mariage, l'AIISOC a retenu les services d'un expert-conseil en affaires lors de l'élaboration de son plan stratégique. L'analyse ainsi développée a souligné plusieurs points sur lesquels nous devons concentrer nos efforts. Par conséquent, le fait que l'AIISOC soit un organisme bénévole nous a obligé à peaufiner la liste et identifier les priorités selon les ressources qui nous sont disponibles. Parmi les priorités figurent les suivantes :

1. Améliorer le processus de rédaction et de mise à jour des Normes, directives et exposés de fonctions recommandés pour la pratique des soins périopératoires (*Recommended Standards, Guidelines and Position Statements for Perioperative Nursing Practice*);
2. Épanouir et améliorer nos méthodes de communication (le journal de l'AIISOC et le site Web) ainsi qu'étudier de nouvelles voies de communication avec nos membres;
3. Perfectionner et normaliser la structure du comité de planification de la Conférence nationale.

Aussi à l'ordre du jour sont les dernières étapes à franchir pour incorporer l'AIISOC, la création d'une banque de données nationale de membres de l'AIISOC avant janvier 2008 et l'exploration de la possibilité de recevoir des crédits de formation professionnelle en ligne. Afin de satisfaire aux besoins toujours changeants du domaine de soins de la santé, l'AIISOC doit adopter une attitude proactive envers le changement futur. Ce qui ne change pas, c'est notre engagement au progrès et à la promotion de l'excellence dans le domaine des soins périopératoires ainsi qu'au perfectionnement professionnel et au développement personnel des infirmières autorisées et infirmiers autorisés en soins périopératoires.

En 24 ans, l'AIISOC a beaucoup changée. Elle est devenue un organisme progressiste tourné vers l'avenir prenant racine dans les traditions respectées et le travail assidu des membres antérieurs de l'AIISOC.

Il y a beaucoup qui se passe chez l'AIISOC ces jours-ci, et je vous encourage à en apprendre davantage en explorant le site Web, en soumettant un article au journal ou en offrant vos services au comité de rédaction et de révision ou de normes de pratique.

L'avenir dépend de ce que nous faisons dans le présent.
- Mahatma Gandhi

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 clinique enseignante pour la salle d'opération de Saskatoon City Hospital, gérante du programme de greffe de la Saskatchewan et présidente sortante du comité de rédaction de l'AIISOC.

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Editorial Contents

ORNAC National 2007

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COMPTER, C'EST SOIGNER

Auteure : *Chris Downey, infirmière autorisée, baccalauréat en sciences infirmières, CPN(C), maîtrise en sciences, infirmière autorisée première assistante, est leader en pratique clinique (série périopératoire) et infirmière autorisée première assistante au Kingston General Hospital ainsi qu'à l'Hotel Dieu Hospital à Kingston en Ontario. Elle est ancienne présidente de la periOperative Registered Nurses Association of Ontario (ORNAO).*

RESUME :

Les infirmières et infirmiers périopératoires ont développé des pratiques en soins infirmiers de pointe très spécifiques. La pratique de compter tous les instruments et matériaux en est une découlant directement du principe directeur des soins périopératoires de ne jamais faire de tort. Cet article s'agit d'une analyse rétrospective de cette pratique et des influences l'ayant changée de la première moitié du 19e siècle jusqu'aux années 60.

COUNTING AS CARING

Author: *Chris Downey, R.N., B.ScN., CPN(C), M.Sc., RNFA, is the Clinical Practice Leader (Perioperative Services), and practicing as an RNFA, at both Kingston General Hospital and Hotel Dieu Hospital, in Kingston, Ontario. She is the Past President of the periOperative Registered Nurses Association of Ontario (ORNAO).*

ABSTRACT:

Perioperative nurses have developed specific expert nursing care practices. "Counting as caring" is certainly an approach in keeping with the perioperative nurse's guiding principle of beneficence (to do no harm). This article takes a retrospective look, from the first half of the last century through into the late 1960s, at the practice of counting and the influences that have changed it.

INTRODUCTION

Perioperative nursing is a specialty devoted to the ethical principle of beneficence (to do no harm). In order to maintain the safety of a patient undergoing surgical intervention perioperative nurses have developed expert nursing care practices regarding aseptic technique, patient positioning, and counting of sponges and instruments. This article takes a retrospective look, from the first half of last century through to the late 1960s, at the practice of counting and the influences that have changed it.

The operating room has traditionally been the domain of surgeons. Perioperative nurses took direction, regarding patient care, from the surgeon.[1] Like their sisters on the wards, however, these nurses took these directions, turned them in to rituals, and made them their own:

> "…the specific rituals of their practice empowered nurses to define for themselves what constituted good nursing."[2]

The practice of counting was, and is, one such ritual. This practice has evolved from counting only sponges (1900 through the 1950s), to counting sponges and all of the instruments (by the 1960s).

A review of the literature proves challenging as there are large gaps in the body of historical evidence regarding perioperative nursing. Some of the secondary sources used in this article are based on actions and happenings in the United States. These sources are felt to be valid, and their use to be justified, as the medical changes in the United States very often set the precedents for what happens in Canada.

COUNTING IN THE OPERATING ROOM

Perioperative nurses have counted surgical sponges since the early 1900s when sea sponges began to be used to clear blood from the surgical site.[3] Counting was of utmost importance to surgeons who also practiced the principle of beneficence and therefore did not wish to leave any sponges in the wound. Surgeons and nurses alike were well versed in the complications, such as pain and infection, associated with retained sponges.

By the post World War II era counting had become part of the perioperative nurse's surgical repertoire. The ritual itself, was taught by the demonstration and return demonstration method as described in the following,

> "It wasn't a written procedure but I was taught by the nurse who taught me that the scrub nurse was the person who must count the sponges with another Registered Nurse, and she was the person who would count the sponges and relay the final count to the surgeon…"[4]

Counting was done at the beginning of the case, before a cavity was opened, again when layers, such as the peritoneum, were closed, and finally when the skin was closed. The most important aspect of an uneventful surgical intervention remained the sponge count. As a perioperative nurse in 1953, OR/Perioperative Consultant Teresa Rodgers, RN, pointed out,

> "…when you would give them [surgeons] their count they would stop talking and listen very carefully to what you had to say."[5]

COUNTING IN THE 1950s

By 1957, Canada had moved to insurance-based payment for hospitalization. The availability of these programmes made medical and nursing services affordable to a greater segment of the public and, thereby, increased the demand.[6] Third party payments also meant that the insurance companies could dictate terms regarding practices to both doctors and hospitals. This was seen to be a shift in power as the public began to recognize the authority of the insurance company. The insurance company could pick and choose physicians and hospitals depending on whether or not they conformed to accepted practices. The practice of counting was outlined, by such a company, in 1956:

> "to ensure the patient's safety in the operating room, the Insurance Council of the California Hospital Association strongly recommends the use of sponges containing radio-opaque materials, and an accurate sponge count. The council's research indicates that three sponge counts are being taken routinely in most of the hospitals studied…"[7]

The insurance companies now became involved in setting hospital policy and nurses were required to follow these policies in order to ensure patient safety and fiscal responsibility on the public's behalf.

Despite this redistribution of power among doctors and insurance companies, the OR, as far as the courts were concerned, remained a surgeon's domain. Surgeons were responsible for everything that went on and lawsuits during this period of time were low,

> "…the operating surgeon must take legal notice of the fact that in the O.R., he is the master and has control over, and is responsible for, the acts of orderlies, nurses and his associates."[8]

During this time nursing schools began to separate students from the regular hospital workforce. Training was becoming more theoretical and students were being taught the rationales for nursing practice.[9] Better education for nurses came after 1945 as a result of the fact that perioperative nurses had shown, during World War II, that they could be educated to do some jobs previously assigned only to surgeons. These jobs were most commonly the role of surgeon's scrub nurse and first assistant. These nurses learned to assess, or triage, surgical patients, to suture, to ensure hemostasis, and, many times, to open and close the incision itself,

> "In this role, nurses opened and closed wounds; the surgeon performed the internal interventions. Tying and clamping of bleeders was a routine nursing function. Nursing experience with abdominal and chest surgery was increasing, and nurses sometimes performed procedures such as tracheostomy and chest tube insertion."[10]

Counting As Caring (cont.)

This specialized education of perioperative nurses, outside the schools of nursing, also increased their personal awareness of their role as patient advocate and of their responsibilities to patients, staff, and students. It allowed them, through their professional organizations, to question the status quo and to become more self-directed:

> "The first national conference of AORN [Association of Operating Room Nurses] was held in February 1954, with the major topic 'Where Do We Belong?'. Through this peer support, operating room nurses began to identify themselves as leaders, supervisors and teachers."[11]

This was seen to be a shift in power for nurses as their authority regarding perioperative nursing was being clearly identified, their education and abilities to perform what had been traditional surgeon's work increased, and nurses began to feel able to pass judgement on a surgeon's abilities.

Advancements in technology, during the late '50s and early '60s, would greatly impact on the practice of surgery. Technologies such as the cardiopulmonary bypass machine (allowing surgeons to perform open heart surgery), blood transfusion equipment (allowing for emergency surgery of unstable patients), and ventilators for anaesthetized patient (allowing for an increase in the duration of surgical procedures), dramatically changed surgery. The formulation of antibiotics also reduced risk of postoperative infection and sepsis.[12]

These advancements influenced the practice of counting. First, increased numbers of instruments were now required for more specialized interventions such as cardiac, thoracic and vascular surgery, and second, the size of the instruments varied from large to very small. Nurses knew what basic instruments were required, what specialized instruments were required, how to clean, sterilize, and maintain them for optimal use. Perioperative nurses not only cared for their patients- they also "cared" for the instruments. The more instruments and the smaller the instruments the higher the risk of leaving them in the patient.

COUNTING IN THE 1960s

The greatest change in the practice of counting came during this decade. Nurses were dealing with an increasing numbers of instruments, per case, on their back tables and many of these instruments were much smaller in size than ever before. The literature, for the first time, made reference to both the sponge count and the "lap" count (which included instruments):

> "Any similar omissions as failure to use a sponge stick for sponges, or a ring on a lap or failure to ask the nurse if she has verified the lap count or failure upon the part of the surgeon to check the sponge count would be sufficient to be circumstantial evidence of neglect."[14]

By the 1960s hospitals, instead of the home, were the primary site of health care delivery, and the only site for surgical interventions. Medical services were now being subsidized by the federal and provincial governments as outlined by the Hall Commission in 1964[15] and enacted by the Medical Care Bill in 1966.[16] Insurance companies and/or patients no longer paid the doctor's services. The government now paid and it demanded fiscal accountability. Insurance-based programmes were still available to those wishing to purchase "extras" such as private rooms and special private-duty nurses.

In hospitals, patients were now seen to cost money. Hospital administrators depended on nurse managers to implement rationalization methods in order to improve hospital efficiencies and reduce expenditures. These rationalization methods, which "served to standardize the amount of time nurses spend on particular tasks…"[17], had on effect on how counting was done. Perioperative nurses increased their expert power, acquired through knowledge of surgical interventions and instrument usage, in order to devise the fastest and most efficient way to count both sponges and instruments. This included a standard way of setting up or placing the instruments on the

table that coincided with the order of the instruments on the count sheet. Two nurses could then *run* through the count, in the order expected, in a shorter period of time, while ensuring the process was accurate. This increased the efficiency of the OR, minimized the time required by the surgeon, maintained patient safety. The lessons, provided by their predecessors, regarding scientific management[18] were well used.

In addition, under the new socialized system the purchase of expensive surgical instruments would have to be justified. Counting them allowed the hospital administration to keep track of how many instruments were needed and were used for each intervention.

By the mid 1960s, cardiac, thoracic, and neurological surgeries were part of the services expected by the general public in most hospitals. As Teresa Rodgers describes,

> "…surgery was pretty routine until we got a new chief of surgery… and then we seemed to embark on different procedures…I can recall…a couple of new procedures that we did would be a thoracotomy, the other one is a cardiovascular surgery like mitral commissurotomies and neurosurgery. Those were some of the things that came in, in the sixties."[19]

The 1960s saw changes in the public's expectation surrounding health, medicine, and the law as they were portrayed through the medium of television. This was the time of well known television "physicians" such as *Dr. Ben Casey*, and *Dr. Kildare*, as well as an interest in the courtroom activities of Perry Mason. This decade witnessed extreme changes in the actions of the public from Woodstock and love-ins, to increased recreational drug use and the Vietnam war. These turbulent times also saw dramatic increases in technology including the ability to put a man on the moon. In this decade people questioned the establishment, denied authority, and prioritized the rights of individuals:

> "There was a time when it was a generally accepted principle that every citizen owed something to his country in the way of service, and to his fellow citizens in the matter of fair play. The new political philosophy has taught people that they owe nothing to anyone but themselves."[20]

A change in the public's expectations of nurses was seen in the increasing number of references, in the nursing literature, to legal issues. An article in the *Canadian Nurse*, in December 1964, is cited,

> "In the performance of her duties, the nurse is subject to the common regulations of law. This means that when she is proven to be at fault, she incurs responsibility according to the foregoing criterion based on the concept of the ideal citizen…"[21]

Attitudes of the general public, reflecting an increase in the public's legal power, were summed up in 1968,

> "It is sad to relate that malpractice actions and claims are on the rise. The reasons for this are not too difficult to explain when one realizes that we are living in an era in which the general public is law suit conscious."[22]

This change in attitudes was reported in a U.S. *Department of Health, Education and Welfare* study issued in 1973,

> "In the Commission's study of legal doctrines, it was reported that *res ipsa loquitor {the thing speaks for itself}* [13] has been an issue in an increasing percentage of appellate decisions in the past 20 years. It was considered in 13.4% of the cases decided in the period 1961-1970, as compared to only 6.3% of the cases prior to 1950."[23]

Throughout the 1960s medical technology continued to expand and to refine previous developments. The invention of equipment such as the operating microscope allowed surgeons to perform more invasive microsurgery that resulted in the creation of even smaller instruments and the need for even more intensive instrument "care".

CONCLUSIONS

This ritualized practice of counting remained unchanged during the first half of the last century until the 1960s when it was influenced by shifts in power within the health care system.

Power shifted from away from doctors and administrators and toward governments who now took on managing the fiscal side of health care. The result was an increase in the public accountability and responsibility of institutions and individuals. Counting offered a way to prevent the re-admission of patients, due to complications resulting from retained objects, and ensured proper inventory of instruments.

Additional power shifted away from doctors, and on to administrators and nurse managers, in response to increased patient workloads due to increasing public demand for services. The ritual of counting was rationalized to be an efficient and accurate way to maintain safety while ensuring best use of the surgeon's time.

In another form, power shifted from doctors to the general public as legal actions for untoward events due to perceptions of practice, as portrayed in the media, were successful.

Medical advancements, resulting in more and smaller instruments, also increased nurses' expert power and placed a greater importance on counting. Counts ensured the safety of the public and maintained the reputation of the surgeons and the nurses by guarding against the possibility of litigation.

By the 1960s, counting had changed. Today, new innovations such as laparoscopic, or "keyhole", surgery offer OR nurses the opportunity to reassess counting practices and to determine whether more changes are necessary in order to best serve both our patients and our institutions.

Whatever form counting takes in the future, it will undoubtedly continue to be an important part of the perioperative nurse's role in the caring, and curing, of surgical patients.

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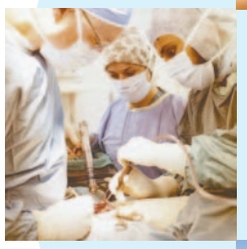

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2007 Cardinal Health Research Grants

2007 Cardinal Health Research Grant

Project Title:
What is the experience of parents of children with cancer in viewing their child's amputated leg before the child wakes from anaesthesia?

Recipients: Deborah Jaraway, Shirley Perry, Marjorie Phillips, Patricia Wade, and Peggy Ziegler – Stollery Children's Hospital, Edmonton, AB.

Research Project Summary:

This research project, led by Patricia Wade and Shirley Perry, will be a retrospective study, covering the period from 1996 to 2006, of parents whose children have undergone the *Van Ness procedure* at the University Hospital (Edmonton) and the Stollery Children's Hospital.

Children with Osteogenic Sarcoma and other forms of lower leg bone cancer can benefit from a procedure named the Van Ness. The tibia, foot and ankle are preserved and fixed to the remaining femur with the foot facing backward.

It can be traumatic for a family to see the child's foot rotated 180 degrees and the leg shortened. To help the family cope with this change in their child's body Image the perioperative team at the Stollery Children's Hospital has been taking families into the operating theatre to view the results of the procedure before the anaesthetic is reversed.

The study will examine the hypothesis *that allowing families to express their grief and shock, while the child is anaesthetised, helps the families better support their child in adapting to the change in body image.*

2007 Cardinal Health Research Grant

Project Title:
An Examination of Learning Styles in a Multigenerational Environment

Recipient: Patricia Cuddy – Victoria General Hospital, Winnipeg, MB.

Research Project Summary:

OR nurses work in a fast-paced, and highly technical, environment with new procedures and new equipment being introduced regularly. Lectures, videos, and demonstrations are some of the methods employed to teach nurses about these procedures and products. Today an educator assists with these, and other, learning experiences in the OR. 35 years ago, however, the position of 'educator' did not exist.

InterZone Photography

Cardinal Health Research Grant 2007 recipients. *L to R: Karen Frenette, Research Chair, with Marjorie Phillips, AB, (accepting on behalf of team from Stollery Children's Hospital), Patricia Cuddy, MB, (accepting on behalf of Victoria General Hospital, MB), and Carol Bentley (Cardinal Health).*

The Manitoba Operating Room Nurses Association (MORNA) was established in the 1970s under the name of the Manitoba Operating Room Nurses Study Group, by OR nurses concerned about their education. MORNA continues to ensure operating room nurses keep current by offering a forum to learn through communication, meetings, presentations, workshops, and conferences. Many of the founding members still participate along with many new OR nurses. The result is a very diverse group. How do they all manage to learn given this diversity?

The purpose of this study is to determine the different learning styles of the multigenerational environment by examining the operating room nurses who are members of MORNA.

2007 Cardinal Health Research Grants

Titre du projet de la Subvention de recherches Cardinal Health Research Grant 2007

Quelle est l'expérience de parents d'enfants atteints du cancer ayant observé la jambe amputée avant que l'enfant ne se réveille de l'anesthésie?

Récipiendaires : Deborah Jaraway, Shirley Perry, Marjorie Phillips, Patricia Wade, and Peggy Ziegler – Stollery Children's Hospital, Edmonton (AB).

Résumé du projet de recherche :
Ce projet, mené par Patricia Wade et Shirley Perry, est une étude rétrospective des réactions de parents d'enfants ayant subi la procédure *Van Nes* à l'University Hospital (Edmonton) et au Stollery Children's Hospital entre 1996 et 2006.

Certains enfants souffrant de sarcome ostéogène et d'autres formes de cancer des os de la jambe inférieure peuvent profiter d'une procédure nommée *Van Nes*. Le tibia, le pied et la cheville sont gardés et fixés à ce qui reste du fémur, le pied orienté vers l'arrière.

Le raccourcissement de la jambe et la rotation à 180° du pied de l'enfant peuvent être traumatisants pour les parents. Afin d'aider les parents à faire face à ce changement important dans le corps de leur enfant, l'équipe périopératoire du Stollery Children's Hospital permet aux parents d'entrer dans salle d'opération pour qu'ils puissent voir le résultat de la procédure avant que l'enfant ne se réveille de l'anesthésique.

L'étude examinera l'hypothèse suggérant que *permettre aux familles d'exprimer leur chagrin pendant que l'enfant est encore sous l'effet de l'anesthésie les aide à mieux appuyer l'enfant lorsqu'il s'adapte à sa nouvelle image corporelle.*

Titre du projet de la Subvention de recherches Cardinal Health Research Grant 2007

Une analyse de styles d'apprentissage dans un environnement multigénérationnel

Récipiendaire: Patricia Cuddy – Victoria General Hospital, Winnipeg (MB).

Résumé du projet de recherche :
Le personnel infirmier en salle d'opération travaille dans un milieu hautement technique où les choses se déroulent à un rythme rapide et de nouvelles procédures et de nouveaux outils sont régulièrement intégrés. Les sessions d'information, les vidéos et les démonstrations sont tous utilisées pour présenter ces nouvelles procédures et ces nouveaux produits. Aujourd'hui, un formateur facilite les expériences d'apprentissage dans la salle d'opération. Il y a 35 ans, le poste de « formateur » n'existait pas.

Quand la *Manitoba Operating Room Nurses Association* (*MORNA*) a été fondée dans les années 70 par un groupe d'infirmières de salle d'opération voulant prendre en main leur formation, elle se nommait le *Manitoba Operating Room Nurses Study Group*. Aujourd'hui la *MORNA* continue à répondre aux besoins du personnel infirmier périopératoire en offrant un forum d'apprentissage sous forme de communication, réunions, présentations, ateliers et conférences. Plusieurs membres fondateurs y participent encore aux côtés des nouveaux infirmières et infirmiers de salle d'opération, ce qui en fait un groupe très hétérogène. Comment arrivent-ils à apprendre au sein d'un groupe si varié?

L'objectif de cette étude est d'identifier les différents styles d'apprentissage dans un groupe multigénérationnel en examinant les infirmières et infirmiers de salle d'opération membres de la MORNA.

InterZone Photography

***Récipiendaires de la Subvention de recherches Cardinal Health Research Grant 2007**, gauche à droite : Karen Frenette, chaire de recherche, avec Marjorie Phillips (AB) (au nom de l'équipe du Stollery Children's Hospital), Patricia Cuddy (MB) (au nom du Victoria General Hospital [MB]) et Carol Bentley (Cardinal Health)*

ORNAC in a Nutshell — Spring 2007

Author: *Lynn Anderson, ORNAC Secretary 2002-2007*

The ORNAC Executive and Board met in Victoria April 19 & 20 and 21 & 22 prior to the 2007 National Conference. The Standards Committee also met for two days, prior to the Board meetings.

- ORNAC President, Marcy McKay, expressed farewell and thank you to departing Executive members Margaret Farley, Past President, and Lynn Anderson, Secretary and to departing Board members Chris Downey, ON; Karen Frenette, NB; Alicia Oucharek Mattheis, SK; and Audrey Hiebert, MB. Marcy thanked each for their contributions and their dedication to ORNAC.

- Observers at the Board meeting were: Ray Larkins, Past Treasurer; Bonnie McLeod, BC; Vanna Wasson, NB; Gayle Ritchie, BC; Candace Franke, SK; Ronn Ginther, SK; and Barb Mushayandebvu, AB.

- The 2007 National Conference in Victoria was a huge success. The attendance and presentations by the International Federation of Perioperative Nurses (IFPN) added a first time international dimension. The conference saw the largest international representation ever at an ORNAC conference, including delegates from Australia, New Zealand, Korea, the United Kingdom, Papua New Guinea and the Unites States. The National Planning Committee and the host provincial group, BCORNG, are to be commended for organizing such a fabulous conference.

- Elections were held and Bonnie McLeod was elected as the incoming President Elect and Dorothy Dewar was elected to the office of Secretary.

- There were numerous awards presented at Opening Ceremonies of the National Conference and a full write up can be **found on page 36 in this** Journal.

- Several new awards are `in the process of being developed. See www.ORNAC.ca.

- In order to help standardize the development of criteria, reduce duplication, and improve effeciency, the Board has voted to combine the Awards Committee and Research Committee in to the Awards & Research Committee.

- Plans are well under way for the next National Conference in St John's, NL, June 7 to 12, 2009. Watch the website for more details.

- Thank You to Marge Ensminger, who is retiring as the ORNAC Historian & Photographer, for her many years of support to ORNAC. All ORNAC files and photos will now be housed in Saskatoon. In order to continue to capture the history of ORNAC Margaret Farley will be compiling a History Corner for the Website. Also, in an effort to maintain consistency Ray Larkins will continue as ORNAC Webmaster for an additional year.

- The Strategic Plan was reviewed in its entirety and ORNAC will be prioritizing its goals for the next 5 years. Of note, the CORNJ Contract with Clockwork Communications Inc. has been renewed for 5 years.

- The Standards Committee has recently reviewed Module 1 and the Standards review process is ongoing. We encourage members to send us suggestions of items to add or delete and any comments related to the review process. We have many experts in various areas and the Standards Committee, as are all ORNAC committees, is composed entirely of volunteers. We would like to see more perioperative nurses become involved in the review of YOUR standards of practice.

This is my last Nutshell and I would like to thank all the people that have assisted me in the role of ORNAC Secretary during the past 5 years. I wish my successor, Dorothy Dewar, every success as she assumes the role of Secretary.

L'AIISOC en bref Printemps 2007

Auteure : *Lynn Anderson, secrétaire de l'AIISOC, 2002-2007*

Les conseils exécutifs et administratifs se sont réunis à Victoria du 19 au 22 avril (avant la Conférence nationale 2007). Le comité des normes s'est également réuni pendant deux jours avant les réunions du conseil administratif.

- La présidente de l'AIISOC, Marcy McKay, a dit adieu et a remercié les anciens membres du conseil exécutif : Margaret Farley, présidente sortante, et Lynn Anderson, secrétaire, ainsi qu'aux anciens membres du conseil administratif : Chris Downey, ON; Karen Frenette, NB; Alicia Oucharek Mattheis, SK; et Audrey Hiebert, MB. Marcy a remercié chacun d'entre eux pour leurs contributions et leur dévouement à l'AIISOC

- Ray Larkins, trésorier sortant; Bonnie McLeod, BC; Vanna Wasson, NB; Gayle Ritchie, BC; Candace Franke, SK; Ronn Ginther, SK; et Barb Mushayandebvu, AB, ont observé la réunion du conseil administratif.

- Des élections ont été tenues et Bonnie McLeod fut élue présidente désignée et Dorothy Dewar fut choisie secrétaire.

- Plusieurs prix ont été décernés pendant les cérémonies d'ouverture de la Conférence nationale. Pour tous les détails, veuillez consulter la page 36 de ce journal.

InterZone Photography

Incoming Executive. L to R, Bonnie McLeod, President Elect; Dottie Dewar, Secretary; Linda Socha, President; Alaine Young, Treasurer; and Marcy McKay, Past-President.

- Plusieurs nouveaux prix sont en cours de développement. Veuillez vous renseigner à www.ORNAC.ca.

- Afin de faciliter la normalisation de l 'élaboration de critères, de réduire le travail inutile et de créer un processus plus efficace, le conseil a décidé de combiner le comité des prix et le comité de recherche pour en faire le comité des prix et de recherche.

- L'organisation de la prochaine Conférence nationale à St John's Terre-Neuve du 7 au 12 juin 2009 est déjà bien commencée. Surveillez le site Web pour plus de détails.

- Nous tenons à remercier Marge Ensminger, historienne et photographe de l'AIISOC, pour son appui pendant de si nombreuses années. Désormais, tous les fichiers et les photos de l'AIISOC seront entreposés à Saskatoon. Afin de conserver l'histoire de l'AIISOC, Margaret Farley créera un coin historique sur le site Web. De plus, dans le but de maintenir une certaine uniformité, Ray Larkins demeurera responsable du site Web jusqu'à la fin de 2008.

Continued on Page 42

Module 1 of ORNAC's ***Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice*** was revised in June 2007and is now available from CSA at www.CSA.ca.

Since the introduction of the modular format, in 2003, ORNAC has revised Modules 1, 2 and 3. In order to ensure you have the most current version of each module, visit www.CSA.ca today.

Individual modules are $18.75 and the complete ***Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice*** is $75. Applicable taxes and shipping are extra.

For more information on the Standards process contact standards@ORNAC.ca.

Translation of Modules 1 & 2 sponsored by 3M *Canada Company*

Traduction du module 1 & 2 est commanditée par la 3M *compagnie Canada*

UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

British Columbia	Whistler	May 2008
Alberta	Red Deer	October 24-27, 2007
Saskatchewan	Moose Jaw	Fall 2007
Ontario	Toronto	June 2008
Quebec	Quebec City	October 28-30, 2008
Newfoundland & Labrador	Corner Brook	October 11-13, 2007
Affiliate: CORL	Toronto, ON	May 5-6, 2008

ORNAC CONFERENCES

www.ornac.ca

21st National	St. John's, NL	June 7-12, 2009
22nd National	Regina, SK	May 8-13, 2011

INTERNATIONAL CONFERENCES

ACORN (www.acorn.org.au)	Surfer's Paradise, AUS	May 21-24, 2008
AFPP (www.afpp.org.uk)	Harrogate, UK	October 9-11, 2007
World Conference on Surgical Patient Care	Seoul, S. Korea	October 1-2, 2007

November 11-17 is National Perioperative Nurses' Week

ORNAC National 2007

Author: Marcy McKay, RN, CPN(C), was the Co-Chair of the 2007 National Conference Planning Committee and is the current Past-President of ORNAC.

Victoria was the site of the 20th National ORNAC conference. Almost 950 nurses, from eight countries, gathered to network and learn from a variety of presentaters. Nurses from New Zealand, Australia, New Guinea, England, Wales, United States, Korea and, of course, Canada met for the week of April 22 to 27, 2007.

The International Federation of Perioperative Nurses (IFPN) participated fully in the conference, sponsoring five speakers from around the world. It was the first time that IFPN has been fully integrated in to an association's conference, rather than participating as observers. It was certainly a first for ORNAC and, interestingly, it caused IFPN to re-think the way they get involved and to decide that this fully integrated format is the one they will propose to other associations that request their involvement.

InterZone Photography

Caption: Our UK Colleagues. L to R Melanie van Limborgh (UK), Claire Campbell (UK) , Lesley Fudge (UK), Jane Reid (UK), Diane Gilmore (UK)

On the Saturday evening, prior to the start of the conference, ORNAC hosted a reception to honour its industry partners that sponsor grants, bursaries, awards and special projects. The partners honoured were 3M Canada, Cardinal Health Canada, Johnson & Johnson Medical Products, Medline Canada, RMAC Surgical, and Solumed Inc.

Sunday saw the delegates arrive and attend the Welcome Reception in the Crystal Ballroom of the Fairmont Empress Hotel.

Monday's Opening Ceremonies, and first full day of the conference, took place at the Royal Theatre in Victoria. An impressive show included the piping in of the flags, the ORNAC Board, and ORNAC Executive. The master of ceremonies, Dr. David Naysmith, wowed the audience and his Top Ten Things to know if you want to be a Perioperative Nurse, was a complete hit with the audience. Dr. Naysmith said he enjoyed himself and that it was fun to present to 1,000 nurses who could turn on him at any moment!

The Val Sherrif Memorial Lecture, sponsored by J&J Medical Products, was presented by Carol Taylor, the Director of Bioethics at Georgetown University in Washington, DC. It was great to once again see this long time friend of ORNAC!

There were a wide variety of topics presented at this conference. While there were some presentations from physicians, the Planning Committee made a conscious decision to increase the number of Call for Abstract presentations in order to ensure there was additional opportunity for delegates to hear from their fellow nurses.

InterZone Photography

Opening Ceremonies - Piping in of The Board

Canadian Operating Room Leadership (CORL) Network participated in the conference and sponsored a total of 7.5 hours of educational sessions. The Registered Nurse First Assistant Network of Canada (RNFANC) also provided educational content.

Social events were as varied and vibrant as you would expect at an ORNAC conference. Johnson & Johnson Medical Products sponsored their ever popular *Print Reception*, where each delegate picked up a copy of the limited edition conference print. An evening at the Royal BC Museum and the Titanic exhibit provided the delegates with the opportunity to visit a world-class museum, enjoy some delicious food and enjoy a range of music being played among the exhibits. The ice sculpture of the acronym "ORNAC" provided a great background for many photographs.

Tuesday night's entertainment went off in a completely different direction as delegates boarded buses and travelled to the *ORNAC Pep Rally*. Many delegates appeared in costume and some even participated in the cheering contest. The *TimeBenders* provided musical entertainment at this fun event and the bar was staffed by industry representatives. Everyone had a great time!

InterZone Photography

This Is Your Life Marcy McKay.

InterZone Photography

Caption: Presidential Pose Jennifer Rabach, President. Australia College of Operating Room Nurses (ACORN), and Marcy McKay, President, ORNAC)

Thursday night at the Strathcona Pub was eye-opening for many, as *Rock Paper Scissors*, a nationally known improvisational group, entertained the delegates with 'This is Your Life, Marcy McKay'.

One of our final speakers, Tim Porter O'Grady (sponsored by CORL), was thought provoking in his presentation on *Leadership*. Mr. O'Grady has presented to ORNAC delegates at past conferences and his presentations have always been well received.

The conference closed with a keynote presentation from Olympian Mark Tewksbury, sponsored by Tyco Healthcare. His presentation, '*Leadership Traits of Legacy Leavers*', was the perfect ending to a great week.

Delegates were then introduced to the ORNAC executive for 2007-2009. New President Linda Socha closed the conference and wished the delegates a safe journey home. The next ORNAC National will take place June 7 to 12, 2009, in St. John's Newfoundland in June 2009. Plans are well underway – see you there!

Continued on Page 30

UN HERITAGE D'EXCELLENCE EN SOINS PERIOPERATOIRES

Presente a la Conference nationale de l'AIISOC 2007, commandite par Tyco Healthcare

Auteur : *Mark Tewksbury est un nageur olympien canadien qui, au moment de sa retraite, avait gagné des médailles d'or, d'argent et de bronze. À l'extérieur de la piscine il est devenu un grand activiste pour les droits de la personne, était président des premiers Outgames et a animé des émissions de télévision telles How It's Made de Discovery Channel. Un conteur énergique et charmant, Mark se sert de ses expériences personnelles pour illustrer ses points lors de ses discours stimulants.*

Le 27 avril 2007, Mark Tewksbury a présenté un discours liminaire aux délégués de la 20e Conférence nationale de l'AIISOC à Victoria en Colombie-Britannique. Ce résumé fait l'esquisse est points saillants du discours.

LEAVING A LEGACY OF PERIOPERATIVE EXCELLENCE

Presented at ORNAC National 2007, sponsored by Tyco Healthcare

Author: *Mark Tewksbury is a Canadian Olympian swimmer who retired with gold, silver and bronze medals. Outside the pool he has become one of North America's great performers, was President of the 1st World Outgames, is a human rights advocate and spokesperson, and hosted TV shows including Discovery Channel's 'How It's Made'. An energetic and engaging storyteller, Mark's rousing presentations use personal anecdotes to illustrate lessons learned in his own life.*

On April 27, 2007, Mark Tewksbury provided a keynote address to delegates at ORNAC's 20th National Conference in Victoria, BC. In an energetic, humorous and highly inspirational presentation, he connected his Olympic experience and personal values with the essence of perioperative nursing. This summary features takeaway points from this presentation.

National Speakers Bureau

Mark Tewksbury

Trait 1: Embody Values

Your values, and how you embody them, are the foundation of your legacy. ORNAC values knowledge (a commitment to education and research), collaboration (with nurses in specialty, organizational agencies and other disciplines that affect your practice), respect (recognizing the worth, quality, diversity and importance of each other and the patients you care for), professionalism (work together to promote and advance your specialty), and continuous learning (striving to achieve excellence in perioperative practice). Coming together in Victoria, and on other occasions, will reconnect many of you to these values. How can you bring these values to life in your daily practice?

Trait 2: Challenge Convention

It is important to understand the potentially limiting nature of the status quo. Collective group think doesn't necessarily make something right, or the truth – it simply makes it popular. Conventional wisdom might have said that health care is focused on just caring for the sick, but that has been challenged to include pre-emptive concern for the healthy as well.

Conventional wisdom might have members thinking that you have to be in management to be a 'leader' in operating room nursing and perioperative care. "I haven't been doing it long enough." Challenging convention means that leadership starts at the bedside, at point of service. Patients and families look to you for that.

Trait 3: Influence Wisely

Just like we all leave a legacy, whether we realize it or not, we also all have a greater scale of influence than we may know. The challenge is to use it wisely for the benefit of others. Influencing doesn't have to be 'kumbaya'. It can sometimes take the form of tough love, especially peer to peer, as long as it creates a win/win situation. Imagine the three OR nurses, Isabelle Adams, Victoire Audit and Mary Taylor, organizing for the first time in 1958. In 1965 they met with representatives from Ontario, BC, Alberta, Manitoba, Quebec and New Brunswick. A group of all volunteers, it took patience, determination and years before ORNAC was formed, but these women came together and used their influence for the common good.

On a personal level, your impact ripples further than you can imagine. How many patients and health care professionals do you meet? What kind of influence are you having?

Trait 4: Have Purpose

When we have a compelling vision and understand our role in making it happen, we can lead ourselves and others to remarkable results. As OR nurses, purpose is primarily patient safety. It is the cornerstone of what you do – providing the highest standards of health care to the patient. You literally wrote the book on this – writing the standards for operating room nursing practice in Canada. Have a clear purpose and understand your role in making that come to life every day in the operating room.

Trait 5: Show Conviction

No matter how hard times get, it is the leader's ability to show conviction and to believe in both themselves and others that gets them through. Sister Carol Taylor opened the conference with the topic: *Rethinking what it means to be a good OR nurse, and why this matters.* So why does it matter to you? What is it that fuels your belief in what you are doing? Why are you doing it? When you connect to that you connect to an unwavering resolve that will get you through those inevitable tough times.

Trait 6: Embrace Contradictions

Life is filled with paradoxes. Sometimes ideas that seem like extreme opposites work well together. Plan Meticulously/Go With the Flow; Use Logic/Follow your Gut; Work Hard/Have Fun are just three examples. The point is that life is not black or white; it is black and white – and everything in between. Use your experience, knowledge and skills to find what works. The OR environment is supposed to be organized and calm, but at times it is the exact opposite. Find what works best in any given situation, knowing the one thing that you never contradict is your values.

Trait 7: Continually Evolve

What happens if you don't? ORNAC promotes excellence in perioperative nursing through various educational opportunities. A huge part of evolution is about creating the environment for people to learn. This is where growth comes from. It helps keep us from getting complacent and ensures we are able to serve the mandate of excellence in patient safety. What have you learned recently that led to personal growth and progress? In what areas do you have room to improve?

Trait 8: Make It Possible

This was the whole point of the conference, as well as this presentation: to make it possible for you to lead yourself, your colleagues and your patients and to leave a lasting impact along the way. All of us are asked to do more with less. Our jobs ask us to be innovative and sometimes expand our perspective to remember how good we have it in Canada. A fundamental part of our system is that we make it possible for people to receive care regardless of their financial situation. I wish you success in applying the knowledge of the week, turning ideas into excellence that raises the standard for patients.

If you don't do it, who will? If not you, then who?

Conference nationale de l'AIISOC 2007

__Auteure :__ Marcy McKay, infirmière autorisée, CPN(C), était la co-présidente du comité de planification de la Conférence nationale 2007 et est aussi la présidente sortante de l'AIISOC.

La 20e Conférence nationale de l'AIISOC a eu lieu à Victoria en Colombie-Britannique. Près de 950 infirmières et infirmiers de huit pays se sont réunis pour créer des liens et apprendre d'une variété de conférenciers. Des infirmières et infirmiers de la Nouvelle-Zélande, de l'Australie, de la Nouvelle-Guinée, de l'Angleterre, de Galles, des États-Unis, de la Corée et, bien sûr, du Canada, se sont rassemblés pendant la semaine du 22 au 27 avril 2007.

La *International Federation of Perioperative Nurses* (*IFPN*) a beaucoup participé à la conférence, parrainant cinq conférenciers venant des quatre coins de la planète. Cette conférence a marqué la première fois que la *IFPN* s'était complètement intégrée dans la conférence d'une autre association au lieu d'observer tout simplement. Ce fut certainement une première pour l'AIISOC, et, chose intéressante, cette expérience a incité une réflexion de la part de l'*IFPN*, qui va maintenant suggérer aux autres associations qui demandent leur participation si un format complètement intégré sera possible.

Samedi soir, avant le début de la conférence, l'AIISOC a organisé une réception à l'honneur de ses partenaires dans l'industrie qui parrainent les subventions, les bourses, les prix et les projets spéciaux. Les partenaires ainsi reconnus sont 3M Canada, Cardinal Health Canada, Johnson & Johnson Medical Products, Medline Canada, RMAC Surgical, et Solumed Inc.

Dimanche, les délégués sont arrives et ont assisté à la réception dans la Crystal Ballroom du Fairmont Empress Hotel.

Lundi, les cérémonies d'ouverture et les activités de la première journée complète de la conférence ont eu lieu dans le Royal Theatre à Victoria. La magnifique présentation comprenait l'entrée,

InterZone Photography

ORNAC National Conference Planning Committee with ORNAC ice sculpture. L to R. Back row: Marcy McKay, Bianca Christians, Gayle Ritchie, Joanne Thackray, Sandra Stewart, Marian Sanderson. Middle row: Marlene Weeks, Mona Bastell, Cheryl Hosie, Cathy Rees. Front row: Nick Fitterer, Donna Gramigna, Kathy Morris. Absent: Dilys McGibbon

accompagnée de cornemuses, des drapeaux, du conseil d'administration et du conseil exécutif de l'AIISOC. Le maître des cérémonies, Dr David Naysmith, a emballé la foule avec ses dix choses à savoir avant de devenir une infirmière périopératoire. Le Dr Naysmith a dit qu'il s'est bien amusé et qu'il a apprécié le défi de faire un discours devant 1 000 infirmières qui pourraient décider à tout moment qu'elles ne l'aimaient plus!

InterZone Photography

Conference Planning Committee showing their provincial spirit at the ORNAC Pep Rally.

La conférence Val Sherrif Memorial Lecture, parrainée par J&J Medical Products, était présentée par Carol Taylor, la directrice de la bioéthique à la Georgetown University à Washington (DC). Ça nous a chauffé le coeur de voir cette amie fidèle de l'AIISOC!

Les sujets présentés lors de la conférence étaient d'une grande variété. Bien que certains discours aient été présentés par des médecins, le comité de planification a fait un grand effort pour hausser le nombre de sessions tirées de demandes soumises suite à l'appel de présentations afin qu'il existe une plus grande occasion d'entendre parler ses collègues en soins périopératoires.

Le réseau *Canadian Operating Room Leadership* (*CORL*) a participé à la conférence et a parrainé un total de 7,5 heures de sessions informationnelles. Le *Registered Nurse First Assistant Network of Canada* (*RNFANC*) a également fournit du contenu informationnel.

Les événements sociaux étaient très variés et enthousiastes, tout comme on pourrait s'y attendre à une conférence de l'AIISOC. Johnson & Johnson Medical Products a commandité le toujours populaire *Print Reception*, où chaque délégué obtient une reproduction de l'affiche de la conférence. Une soirée au Royal BC Museum et l'exposition sur le Titanic a fourni aux délégués l'occasion de visiter un musée de première classe, de déguster des plats délicieux et d'entendre une variété de musique. La sculpture de glace en forme des lettres ORNAC a servi d'arrière-plan de bon nombre de photos.

Mardi soir, le divertissement était de toute autre sorte. Les délégués se sont rendus en autobus au *Pep Rally* (rassemblement) de l'AIISOC. Plusieurs délégués y sont arrivés en costume et certains ont même participé au concours de hourras. Le groupe musical *TimeBenders* ont joué et le personnel du bar était des représentants de l'industrie. Tout le monde s'est très bien amusé!

Jeudi soir, au Strathcona Pub, le groupe

InterZone Photography

IFPN (L to R) Marg Farley (Canada, Board Member), Kim Hepper (Australia, Newsletter Editor), James Harrison (Australia, President), Marcy McKay (Canada, Representative), Sheila Allen (USA, Secretary), Leslie Fudge (UK, Treasurer of IFPN)

d'improvisation connu à l'échelle du pays, *Rock Paper Scissors*, a emballé les délégués avec une présentation intitulée « This is your life, Marcy McKay » (*Quelle vie, Marcy McKay*).

Un de nos derniers conférenciers, Tim Porter O'Grady (parrainé par le *CORL*), a présenté un discours inspirant sur le leadership. M. O'Grady a déjà présenté aux délégués de l'AIISOC et a toujours été très bien reçu.

La conférence a terminé avec un discours liminaire présenté par l'olympien Mark Tewksbury, commandité par Tyco Healthcare. Son disours, *« Leadership Traits of Legacy Leavers »* (*les qualités de leadership de ceux qui laissent des traces*) finissait parfaitement une semaine extraordinaire.

Et, finalement, les membres du conseil exécutif de l'AIISOC pour 2007 à 2009 ont été présentés. La nouvelle présidente Linda Socha a clos la conférence et a souhaité a dit au revoir au groupe. La prochaine conférence nationale de l'AIISOC aura lieu le 7 au 12 juin 2009 à St. John's à Terre-Neuve. Nous planifions déjà! Venez vous joindre à nous!

ORNAC Executive

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

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GESTION PERIOPERATOIRE DU PATIENT AINE

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RESUME

Afin de fournir une sécurité et des soins optimaux, les infirmières et infirmiers périopératoires doivent demeurer conscients des caractéristiques particulières aux différentes populations qui se présentent en salle d'opération. Les patients aînés risquent davantage de comorbidité et d'autres conditions liées à l'âge telles une santé cardiovasculaire plus fragile, l'isolation sociale et une capacité sensorielle amoindrie. Une connaissance spécifique aux soins des personnes aînées est le sujet de cet article.

PERIOPERATIVE NURSING MANAGEMENT OF THE ELDERLY PATIENT

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ABSTRACT

In order to provide optimum care and safety perioperative nurses must be aware of the unique characteristics of the populations encountered in the operating room. Older patients are more likely to experience comorbidities and age related health changes such as decreased cardiovascular reserves, social isolation, and sensory deficits. Specific knowledge of the elderly population is the focus of this paper.

Introduction

In order to provide optimum care and safety, perioperative nurses must be aware of the unique characteristics of the populations encountered in the operating room. The elderly are one such population that will be the focus of this paper. Since Canada's population is continuing to age[1], the perioperative nurse is increasingly likely to be caring for older individuals. Therefore, the nurse requires the skills and knowledge necessary to properly assess older patients in order to take appropriate precautions and plan nursing interventions as well as to avoid complications during the pre-operative, intra-operative, and post-operative phases. For example, the existence of comorbidities (such as additional health issues experienced by a patient other than the primary reason for his/her current hospitalization) is the leading cause of death amongst elderly surgical patients, and necessitates a thorough assessment and complex plan of care.[2] Accordingly, it is suggested that planning for potential problems associated with comorbidity is as important as identifying actual problems.[2] In this paper the author will outline important assessment criteria for elderly patients, nursing interventions and precautions to be observed during the pre, intra, and post-operative phases.

Important Assessment Criteria for Elderly Patients

Functional and physical status:

The preoperative interview is an excellent opportunity to assess the elderly patient's baseline functional status. During this time the nurse can determine if the patient suffers from any preexisting functional limitations or impairments by asking focused questions, such as those related to the ability to complete activities of daily living (ADLs). However, Jackson[3] reports that this population may be reluctant to answer questions truthfully for fear of losing independence and autonomy, and may attribute their symptoms to the aging process. To counteract this behaviour, Jackson[3] suggests that the nurse discourage family members from answering for the patient and encourage the patient to answer for him or her self and to raise any concerns with the health care team.

Due to the preexisting physical limitations that are common among this population group, there is a higher likelihood that the patient may temporarily experience a period of helplessness during hospitalization.[2] Furthermore, older patients frequently have limited social support.[4] The nurse can facilitate the patient's return to the preoperative state by determining a functional baseline and stressing the temporary nature of postoperative recovery, through proper pain control, and by encouraging early resumption of physical activity as tolerated and ordered.[2] Stress can tax an elderly patient's normal physiological reserves, creating an increased vulnerability to complications associated with the perioperative experience. This leads to an increase in the potential for negative outcomes as compared to younger patients.[5] Polypharmacy is also common among the elderly due to the presence of multiple chronic conditions and should be given consideration during the preoperative interview.[4]

Psychosocial status:

As mentioned previously, a high percentage of elderly patients lack adequate social support. As a result as many as 65% of elderly patients undergoing surgery experience post-operative depression and alterations in self-image.[2] It is noted that this tendency is often accompanied by rapid physical decline and therefore it is important to ensure that depressed patients receive additional emotional support, throughout the surgical experience, from family members and the perioperative team.[2] In addition to assessing the patient's psychological well-being, the nurse must assess the patient's perception of aging in order to plan appropriate nursing interventions.[2] During the assessment, the nurse's own subjective views and feelings towards aging should not interfere or introduce bias.[2] Other factors to take into consideration during the psychosocial assessment include the patient's own subjective feelings towards wellness and illness, culture of origin, and the influence of the place of residence.[2]

Preoperative Precautions and Nursing Interventions

It is clear from the information presented above that elderly patients' unique needs require thoughtful, individualized nursing interventions in order to ensure optimum care and safety are

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Donna Gramigna (Conference Program Chair) presents to **Janice Koekebakker and Pat Elliott (People's Choice Award for Best Poster** titled *Innovation and Leadership in Perioperative Nursing: A Vision for Change)*.
Donna Gramigna (chaire du programme de la conférence) décerne à **Janice Koekebakker** et **Pat Elliott** le **Prix pour la meilleure affiche** (*Innovation and Leadership in Perioperative Nursing: A Vision for Change* [Innovation et leadership en soins périopératoires : Une vision de changement])

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Photos non disponibles : **Christine Bilopavlovic** (ON) récipiendaire de la **Subvention de soins infirmiers ORNAC / J&J Nursing Bursary** **Neretta Cummings** (AB) récipiendaire du **Prix de leadership Muriel Shewchuk Leadership Award**
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Perioperative Nursing Management (cont.)

provided during the perioperative process. The pre-operative period is a critical time for the nurse to plan and implement nursing interventions for the elderly patient. Factors such as a potential for a high level of historical health factors, polypharmacy related to comorbidities, and an increased need for social, physical and emotional support can all play a role in recovery. It is noted that the elderly have a decreased ability to recover from physical and emotional stress thus increasing the importance of the circulating nurse's role in helping the patient through the stressful surgical experience.[1] The following section will expand on factors and interventions specific to elderly patients.

The hospital, in general, and the operating room environment, in particular, can create a confusing experience for even the most cognizant minds. When additional factors, common to the elderly, are also involved (such as chronic pain, social isolation, and poor overall health status) the entire surgical encounter can be frightening. The nurse is in an ideal position to alleviate the resulting anxiety.

Before beginning the interview, the nurse should become familiar with the patient's condition by reviewing the chart, including the medical history and physical examination report provided by the physician, and reviewing laboratory reports to discern the medical diagnoses.[2] To ease a timid or frightened patient, the nurse should approach the patient in their direct line of sight (to allow for the possibility of limited peripheral vision)[1], greet and introduce him or herself to the patient in a calm and friendly manner, and provide the patient with some orientation to the environment. In order to demonstrate respect, the nurse should ask the patient how he or she would like to be addressed. Since hearing and vision loss can contribute to confusion, anxiety, and misunderstanding[6] patients should be allowed to wear glasses and/or hearing aids into the OR in order to increase comfort and facilitate conversation.[1] Since, with age, there is a decrease in the number and complexity of stimuli that can be simultaneously processed the nurse should speak clearly, present one idea at a time, and allow the patient adequate time to respond.[1] A sensory assessment, including visual, auditory, and tactile senses, may be performed in order to accurately determine pre-existing sensory deficits. Any significant findings should be documented and incorporated into the plan of care.[2]

Similarly, cognitive status should be assessed in order to determine the patient's ability to perform a behaviour that is essential to the procedure. The nurse should be aware of any inconsistencies in the health history information as reported by the patient. Conducting a psychosocial assessment during the preoperative interview may identify those at risk of inadequate social support. The nurse can then assist the patient to identify strengths to help him/her achieve optimal independence, maintain dignity, and promote autonomy despite any physical, social, and psychological losses.[7] Performing a nutritional assessment is also important as poor eating habits may lead to risk factors such as dehydration, delayed wound healing, increased risk of infection, and osteoporosis.[1] Again, all significant findings should be reported to the surgeon and anaesthetist.

The use of medication, that may alter laboratory and physical findings, should also be assessed including vitamins, topical ointments, over the counter medications, and recreational drugs.[2] Fluid status too may be affected by certain medications. Chronic dehydration may be present due to diuretics being used to treat medical conditions such as hypertension.[8] Orthostatic hypotension during ambulation and hypotension during anaesthesia induction are risks to consider in the event of mild dehydration. If dehydration is suspected, the patient should be closely monitored during position changes, and anaesthesia induction and emergence. Similarly, alterations in renal function may result in prolonged medication effects and dysrhythmias. Urine output and laboratory values should be closely monitored.[8] As careful regulation of blood pressure, arrhythmias, angina, and cardiac failure will reduce perioperative mortality and morbidity in older patients, cardiac medications should be continued until the morning of surgery unless contraindicated.[4]

As the patient's posture, mobility, gait, dexterity, body height and weight may impact the method of transfer they should be assessed prior to bringing the patient into the theatre.[2] More time may be required to transfer an elderly patient from the stretcher to the OR bed. To promote the patient's feelings of independence, the patient should, if able, be allowed to walk into the theatre or move independently from stretcher to the OR table.[2] When the patient arrives in the theatre, the staff should introduce themselves and encourage the patient to do the same and to state what surgery they are having done. Any significant information gained during the preoperative assessment should be shared with the health care team such as allergies, asthma, previous anaesthesia problems experienced by the patient or family members, abnormal laboratory data, and physical limitations that may affect airway management or positioning.[8] While the patient is still conscious in the theatre, loud noises, such as from instrument setup, should be avoided as this may lead to disorientation and agitation.[9]

Ensuring proper positioning and preparing of the patient's body for surgery also requires special attention. The elderly have fragile skin, with a thin dermis layer, low elasticity, less collagen, muscle and adipose tissue, thus creating a high potential for bruising, skin tears, infection, pressure ulcers, impaired thermoregulation, and delayed wound healing.[6] Shearing forces and use of heavy adhesive tape should be avoided. Extra padding may be necessary over bony prominences and support devices and joints should be placed in a neutral position, with proper alignment consistent with age-related musculoskeletal changes, to minimize stress and pressure.[6] The popliteal space and heels are especially vulnerable areas where extra pillows and padding are necessary.[10] Thermoregulation may be compromised during surgery so warm blankets or forced warm air blankets can be used to provide comfort and protect against heat loss during extended surgical procedures.[1] Sequential compression devices (SCDs) placed on the lower extremities are also important to reduce the incidence of deep vein thrombosis (DVT).[1] Being of age 40 or older is a risk factor for the development of DVT. Other factors raising the risk of DVT include the administration of general anaesthesia, surgery lasting longer than 2 hours, obesity, varicose veins, cancer, prolonged immobility or bed rest, and smoking. Many elderly patients would have one or more of these other predisposing factors.[6] Extra caution should be used when determining placement of the electrosurgical unit (ESU) disbursement pad since reduced muscle mass may, in some areas, provide inadequate vascularity for the prevention of electrical burns.[1]

Intraoperative Complications and Nursing Interventions

Once the elderly patient is properly prepared and positioned for the surgical procedure there are many other potential risks that require astute monitoring and possible intervention by the nurse. During the operative period the patient relies heavily on the nurse to act as an advocate while they are anaesthetized and cannot speak. For example, information gained during the preoperative assessment, such as hydration status, should be used to carefully monitor levels and ensure any abnormal findings are reported to the surgical team.

There are, of course, many other factors to be monitored during the operative period. For instance the patient's response to anaesthesia should be closely observed as an elderly patient will be more sensitive to alterations in blood pressure, oxygenation, blood volume, and body temperature.[1] Anaesthetic agents can cause significant physiologic responses including fluctuations in blood pressure and pulse rate, and stress on the cardiopulmonary system. Therefore slow titration of anaesthetics, and adjunctive drugs such as analgesics and neuromuscular blockers, is recommended for the elderly whose reduced baroreceptor reflexes and increased vascular wall rigidity can interfere with compensatory mechanisms and result in sharp drops in blood pressure. Additionally, the transition from spontaneous to controlled ventilation can lead to a significant drop in cardiac output.[11]

Prolonged surgical procedures can lead to hypothermia. Geriatric patients are at risk

when their core body temperature falls below 36°C.[2] Shivering can cause tissue oxygen requirements to increase between 200% and 500%, thereby increasing the risk of myocardial infarction. Nursing interventions to prevent patient harm include covering the patient with forced-air blankets, or blankets from a warmer, infusing warm fluids and blood, and the use of an intravenous fluid warming device and heated, humidified inspired gases.[11] Wet linens should be removed before transporting the patient to the recovery unit.[10] Respiratory complications account for 40% of all surgical complications and 20% of all surgery-related deaths. The elderly are particularly vulnerable to respiratory complications, such as pneumonia, COPD, and emphysema, because of the age-associated decline in pulmonary function.[6]

Since general anaesthesia presents several risk factors as mentioned above, other techniques may be considered. For example, regional methods, such as spinal or epidural anaesthesia or peripheral nerve blocks, may be useful alternatives for patients with cardiopulmonary disease.[11] Regional, spinal, epidural, and nerve block procedures are associated with less myocardial depression and postoperative disorientation.[11] The anaesthesia provider may, however, have difficulty performing these techniques due to spinal deformities from arthritis or degenerative disk disease. Hypotension is a potential complication of spinal and epidural anaesthesia and can, until the effects of the block wear off, expose the patient to a greater risk of postoperative myocardial infarction, worsening heart failure, and urinary retention.[11] Conscious sedation is yet another anaesthesia option that poses fewer cardiovascular risks, and has several potential advantages over regional techniques. Medications used for sedation generally have a shorter duration and half-life, offer the option of using reversal agents (such as flumazenil and naloxone) in the event of adverse reactions, and do not affect postoperative motor function.[11] Sedating agents should be carefully chosen to avoid potential interactions with medications the patient may already be taking to manage chronic conditions.

A further nursing intervention that can help provide safe care to the elderly is the monitoring of fluid balance during the operative procedure. As renal function decreases with age both intake and output of fluids should be closely monitored and recorded.[6] A distinction should be made between blood versus irrigation fluid amounts collected in the suction bottle. The urine drainage bag should be easily visualized by both the nurse and the anaesthesia provider. The nurse may also be required to assist the anaesthesia provider by providing new IV solution bags and assisting with initiating fluid therapy measures such as IV, central line, or arterial line insertion.

Postoperative Implications and Nursing Interventions

At the conclusion of surgery, care must still be taken to protect the vulnerable elderly patient. Hopefully the vigilance used during the preoperative interview and the use, by the nurse, of appropriate precautions and interventions during the operation, have resulted in a safe patient outcome.

During emergence from anaesthesia, the nurse should remain at the patient's side and monitor for complications, such as vomiting and laryngospasm, and be ready to assist with anaesthesia emergence. Respiratory distress in the elderly is primarily the result of small airway closure due to excessive sedation, analgesic use, and pain. While the patient is waking up, the nurse can explain to the patient that the surgery is complete, that they are waking up from anaesthesia, and that they will soon be transferred to the recovery room.

Just as caution was required to bring the patient into the theatre, the transfer out of the OR also requires additional precautions. For example, care should be taken not to damage the fragile skin of the elderly when removing ESU pads, ECG leads and tape.[1] The skin should be examined for any signs of injury, with special attention paid to bony prominences and the area under the ESU pad.[10] Any alterations should be documented and reported to the surgeon. Wound dressings should be carefully

chosen to maximize wound protection, while being minimally irritating to the skin, (i.e. an ABD pad with paper tape rather than a elasticized pressure dressing) in order to reduce the risk of infection.[10]

When in the recovery room, the patient should be introduced to the nurse who will be providing care and told what to expect in the recovery unit.[10] A thorough report on significant findings from the pre-operative interview and surgical events should be given to the recovery room nurse.

Once again there are many assessments that should be completed to ensure the patient's safety and comfort at the conclusion of surgery. For example, several risk factors for postoperative pulmonary complications exist. They include chronic pulmonary diseases, smoking, obesity, anaesthesia lasting longer than 3 hours, high abdominal or thoracic incisions, and multiple surgeries within one year. Pneumonia, the most lethal postoperative infection with a mortality rate of 27% among elderly patients, can also result.[12] Nursing interventions to prevent pneumonia include maintaining sterility with respiratory equipment, hand hygiene, and encouraging the patient to perform breathing exercises with the use of an incentive spirometer. For patients who smoke the nurse should stress the benefits of quitting before and after surgery.[11] Older patients are increasingly susceptible to respiratory complications due to an age related decline in pulmonary function including reduced chest wall elasticity resulting in decreased vital capacity and tidal volume, and increased residual volume. Effects can include hypoxemia, increased risk of respiratory failure under anaesthesia, aspiration, and pulmonary infection.[11]

Urinary tract infections (UTIs) are the most common post-operative infection. In order to reduce risk, care should be taken to avoid unnecessary catheterization, to remove necessary catheters as soon as possible, and to maintain strict aseptic technique with a closed one way drainage system.[12] Wound infection is the second most common nosocomial infection and can be avoided by using aseptic technique.

CONCLUSION

It is clear from the information presented above that the elderly surgical patient requires special attention from the perioperative nurse. Jarvis[13] reminds us that "older adults should be seen not as a homogeneous group with predictable reactions but as individuals with specific needs and widely divergent responses" (p. 32). Further, "illness affects aging people more than those in other age groups. After an acute illness an aging person does not recover as quickly or as completely as younger person" (p. 33).[13]

In order to provide optimum care during each phase of the operative process there are several interventions the perioperative nurse can take into consideration. For example, older patients are more likely to suffer comorbidities creating an increased risk of complications. A thorough preoperative interview is an excellent opportunity for the nurse to plan individualized care and interventions based on the information provided by the patient and his/her history. This information is then communicated to the other members of the health care team. Care is taken to maintain the older patient's dignity and promote their autonomy through interventions such as allowing the patient to ambulate into the theatre and provide an introduction to the team. While positioning the patient, extra padding is placed at pressure points to reduce the risk of pressure sores, and ESU pad placement is selected to minimize skin trauma and burn risk.

In the postoperative period, the nurse remains at the patient's side during anaesthesia emergence to provide assistance with associated complications. Reorientation, including introduction to the recovery room nurse, is provided to the awakening patient. By following the recommendations provided in this paper, the perioperative nurse can ensure that elderly patients under their care receive appropriate interventions to minimize the potential risks posed by surgery.

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RNFANC Report From The National Conference

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Registered Nurse First Assistant Network of Canada (RNFANC) would like to take this opportunity to congratulate Marcy and the conference planning committee for an incredible job. Attending ORNAC 2007 was a truly revitalizing experience, both personally and professionally. The RNFANC held an information meeting that was well attended by delegates looking to meet colleagues from across the country. We shared ideas and searched for solutions to some common issues. There were also a number of people in attendance who were seeking information about the role and its requirements.

RNFANC presented a panel discussion on the evolution of the role of the RNFA in Canada. It began with a brief history of the role, followed by presentations from five of RNFANC's provincial representatives who provided an update on the progress being made at a local level. It concluded with an open forum that generated some interesting debate.

There were a number of surgical assistants in attendance from the US, Australia and the UK. It was interesting to learn that we shared many of the same challenges and successes.

For more information about RNFANC visit www.ORNAC.ca and access the **RNFANC link** on the home page.

L'AIISOC en bref Printemps 2007

- Le plan stratégique a été examiné en détail et l'AIISOC établira la liste de ses priorités pour les cinq prochaines années. Notons que le Journal de l'AIISOC a renouvelé son contrat avec Clockwork Communications Inc. pour les cinq prochaines années.

- Le comité des normes a récemment révisé le premier module; la révision de toutes les normes continue. Nous encourageons nos membres à ajouter ou supprimer tout commentaire lié à la révision. Nous avons à notre disposition bon nombre d'experts et le comité des normes, comme tout comité de l'AIISOC, est composé de bénévoles. Nous aimerions voir plus d'infirmières et d'infirmiers périopératoires s'impliquer dans la révision de VOS normes de pratique.

InterZone Photography

Outgoing ORNAC Executive. L to R, Alaine Young, Margaret Farley, Marcy McKay, Linda Socha, and Lynn Anderson.

Il s'agit ici de mon dernier article « L'AIISOC en bref » et j'aimerais remercier toutes les personnes qui m'ont aidé dans mon rôle de secrétaire de l'AIISOC pendant les cinq ernières années. Je souhaite à mon successeur, Dorothy Dewar, un énorme succès dans son nouveau rôle de secrétaire.

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