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the World**

**IFPN Special Edition**

**2007 ORNAC National**

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## President's Message



ORNAC is a founding member of the International Federation of Perioperative Nurses (IFPN). It is a great honour for me, and for the association, to share this issue of the journal with IFPN. Our membership and involvement in IFPN provides ORNAC with many opportunities for learning and growth.

IFPN meetings are held twice per year in conjunction with a Perioperative Nursing Conference. Many of you will recall that in 2003, Kate Woodhead, president of IFPN, spoke at the ORNAC National conference. She opened our eyes and hearts to those nurses working in countries where electricity and running water are luxuries.

ORNAC has recently sponsored the membership of Kenya in IFPN. It has also helped establish a library, in Nairobi, for perioperative nurses to use. A copy of the *Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing* sits on the shelves of that library. Some provinces have been active in sponsoring IFPN activities. Perhaps your own provincial association or regional group would like to raise funds for IFPN activities? Feel free to contact me at [president@ornac.ca](mailto:president@ornac.ca) and I will gladly get you started!

IFPN is providing speakers for our upcoming national conference. As a result, delegates will have the opportunity to learn from, and network with, perioperative nurses from around the globe. This first for ORNAC will turn our national conference in to an international forum. Don't miss this great opportunity! ✨

*Marcy McKay, RN CPN(C), is President of the Operating Room Nurses Association of Canada. She is a staff nurse at Victoria, General Hospital, Victoria BC, and is currently the webmaster for [www.ornac.ca](http://www.ornac.ca).*



This message is my first official duty as President of the International Federation of Perioperative Nurses (IFPN)! Firstly I need to say what an honour it is to have been elected to this position and to represent perioperative nurses in the international arena.

Secondly, may I add how special it is that my first official duty is associated with ORNAC. Your Association has been a strong supporter of IFPN since its inception and throughout its development. What has been even more pleasing is the way your provincial and regional groups have embraced the philosophy of assisting those in need. Your efforts have created a high level of support – particularly for our African colleagues.

Many of the issues addressed by IFPN are issues shared by nurses around the world. By discussing them in forums such as this, and at conferences such as the upcoming ORNAC National, we are all able to reflect on our practice and to learn new approaches to old problems. Combined with the support of Council of National Representatives (CNR) and committed individuals, such as members of ORNAC, IFPN is working to achieve its mission statement goal of *actively promoting perioperative nursing globally*. I, along with the IFPN Board, look forward to meeting many of you at the ORNAC National Conference in April 2007. ✨

*James Harrison RN, ICN, Foundation FACORN, AFAIM, MRCNA, has been President of IFPN since September 2006. Past involvements include Tasmanian Operating Room Nurses, Australian College of Operating Room Nurses, and Tasmanian Infection Control. He is currently the manager of Clinical Services for St. Luke's Health in Tasmania, Australia.*



L'AISOC est un des membres fondateurs de la *International Federation of Perioperative Nurses* (IFPN). Il est un honneur pour moi, comme pour notre association, de partager ce numéro du journal de l'AISOC avec la IFPN. LA relation entre l'AISOC et la IFPN nous fournit maintes occasions de développement et d'apprentissage.

Les réunions semi-annuelles de la IFPN correspondent avec les conférences sur les soins périopératifs. Plusieurs parmi vous savent sans doute déjà que Kate Woodhead, la présidente de la IFPN, a présenté un discours à la Conférence nationale de l'AISOC en 2003. Elle nous a ouvert les yeux sur les infirmières et infirmiers travaillant dans des pays où l'électricité et l'eau courante sont des luxes.

Dernièrement, l'AISOC a appuyé le Kenya dans sa demande de devenir membre de la IFPN. Nous avons aussi participé à la création, à Nairobi, d'une bibliothèque pour les infirmières et infirmiers périopératoires. Une copie des *Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing* se trouve sur ses rayons. Certaines provinces ont appuyé les travaux de la IFPN; votre association provinciale ou régionale serait-elle intéressée à recueillir des fonds pour les activités de la IFPN elle aussi? Si oui, contactez-moi à [president@ornac.ca](mailto:president@ornac.ca) et je me ferai un plaisir de vous aider!

Des conférenciers de la IFPN présenteront des discours à notre prochaine Conférence nationale, ce qui fournira à nos membres l'occasion de connaître des infirmières et infirmiers périopératoires de partout sur la planète et d'apprendre de leurs expériences. Avec la participation de la IFPN, la Conférence de l'AISOC sera un forum international. C'est une occasion à ne pas manquer! 🍀

*Marcia McKay, infirmière autorisée, CPN(C), est la présidente de l'Association des infirmières et infirmiers de salle d'opération du Canada. Elle est infirmière de soins généraux au Victoria General Hospital, Victoria, C.-B., et est actuellement webmestre du site [www.ornac.ca](http://www.ornac.ca).*

Ce message constitue mon tout premier acte officiel en tant que président de la *International Federation of Perioperative Nurses* (IFPN)! Premièrement, quelle honneur d'être élu à ce poste et de représenter sur la scène internationale les infirmiers et infirmières périopératoires. Deuxièmement, quel plaisir de communiquer avec l'AISOC comme premier acte officiel. Non seulement votre association nous appuie depuis la création de la IFPN, ses groupes provinciaux et régionaux ont vraiment pris à cœur la philosophie de l'aide des personnes dans le besoin. En raison de vos efforts, plusieurs de nos collègues, en particulier nos collègues africains, connaissent un niveau d'appui auparavant inconnu.

Bon nombre de sujets examinés par la IFPN préoccupent également les professionnels infirmiers d'un coin à l'autre de la planète. En les discutant au sein de forums tels que celui-ci et bientôt à la conférence nationale de l'AISOC, nous sommes tous en mesure d'examiner notre pratique et d'apprendre de nouvelles approches et de les appliquer à de vieux problèmes. Avec l'appui du Council of National Representatives (CNR) et d'individus engagés comme les membres de l'AISOC, la IFPN ne cesse de poursuivre l'objectif de son énoncé de mission, c'est-à-dire de *promouvoir activement les soins périopératoires à l'échelle mondiale*. J'espère, comme l'espère les membres du conseil de la IFPN, tous vous rencontrer à la conférence nationale de l'AISOC en avril 2007. 🍀

*James Harrison, infirmier autorisé, ICN, Foundation FACORN, AFAM, MRCNA, est le président de la IFPN depuis septembre 2006. Autrefois membre de plusieurs organismes tels le Tasmanian Operating Room Nurses, le Australian College of Operating Room Nurses et le Tasmanian Infection Control. Il est actuellement gérant des services cliniques à St. Luke's Health à Tasmanie en Australie.*



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*The list of successful CPN(C) candidates in the September 2006 Journal was incomplete. Due to Federal Privacy Regulations the CNA was only able to include the names of those who had given permission for their details to be shared with ORNAC. We apologize for any confusion caused and wish all candidates every success.*

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## THE INTERNATIONAL FEDERATION OF PERIOPERATIVE NURSES (IFPN)



International Federation of Perioperative Nurses

The International Federation of Perioperative Nurses (IFPN) is a relatively new organisation that was officially launched in Helsinki in 1999. It was formed as a result of interest, on the part of a number of countries, to provide formalised links between countries, support and infrastructure to developing nations, a focal point for representing perioperative nursing internationally, and a forum to discuss international issues.

A unique feature of the IFPN is its affiliate status with the International Council of Nurses (ICN). The ICN grants affiliate status to nursing special interest groups with a limit of one member per specialty group. The IFPN is the only perioperative nursing group affiliated with the ICN.

The mission goal of the IFPN is *actively promoting perioperative nursing globally*.<sup>1</sup> This mission is being realised on a daily basis through the work of individuals on the board, the efforts of member countries, and through the support of generous perioperative nurses around the world.

The IFPN will *support Perioperative Nurses to work towards globally improving patient care by promoting evidence based best practice standards, through research and education in collaboration with member organizations*.<sup>1</sup> This mission reflects the fact that the IFPN does not aim to do it all alone, or even to reinvent the wheel, but rather aims to use available resources and to pool the collective knowledge and experience of all its member countries. A much-used acronym is TEAM – *Together Everyone Achieves More* – as it sums up the belief of the IFPN.

The structure of the IFPN is continually evolving to meet the needs of the organisation and its member countries. For example, the IFPN recently created a president elect position to help ensure smooth transition and continuity. Currently the main structure is two layered; it consists of the Executive Board (EB) and the Council of National Representatives (CNR).

The EB is responsible for the day-to-day management of the IFPN and the development of guidelines, policies and position statements. The EB meets face to face twice a year and functions on a continual basis via electronic media.

The CNR consists of representatives from all the IFPN full member and pre-member countries. Full membership is available to the largest national perioperative nursing organisation within a country, or an equivalent perioperative nurses group affiliated to the official nursing organization. Pre-member status is available to countries that do not yet have, but are working toward the formation of, a recognised Perioperative nursing organisation. For a full listing of members and pre-members see **page 10** or visit [www.ifpn.org.uk/members.htm](http://www.ifpn.org.uk/members.htm).

The transition from pre-member to member involves a great deal of commitment. As an example, Papua New Guinea has recently formed its own new association, the Papua New Guinea Perioperative Nurses Association (PNGPNA) and developed a constitution. At a recent conference the President of the association, Ms. Edna John appealed to delegates to continue their work. During the opening ceremonies she stated "We must stand together as one body and one voice for our profession if we want to create a strong united voice for professionals and endeavour for better quality care for our patients." These are powerful words and encapsulate the ideals of the IFPN. ORNAC members should be proud that PNGPNA has been assisted financially by Canadian perioperative nurses.

Since its inception in 1999, the IFPN has grown from the seed of an idea in to a living and thriving organization. Like all new beings it requires support, nurturing and development in order to continue to grow. The IFPN has already received tremendous support from ORNAC and from individual Canadian nurses. With the ongoing support of yourselves, and nurses around the world, the IFPN will continue to grow strong and proud.

<sup>1</sup> IFPN Mission Statement 🍁

## Affiliate Members

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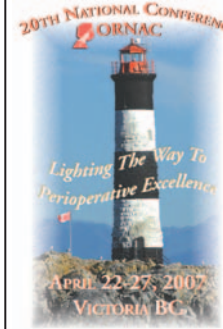
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see you in Victoria April 23 to 27, 2007.

## Operating Room Nurses Association of Canada (ORNAC) 20TH NATIONAL CONFERENCE Victoria, BC – April 22 to 27, 2007

CONFERENCE INFORMATION & REGISTRATION PACKAGES ARE NOW AVAILABLE

### CONFERENCE SCHEDULE



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Speakers from IFPN;  
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CORL Leadership Sessions;  
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#### SOCIAL EVENTS INCLUDE:

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**Tuesday:** The ORNAC Pep Rally!!!  
**Wednesday:** Free Night to explore Victoria  
**Thursday:** Comedy and Pub Night

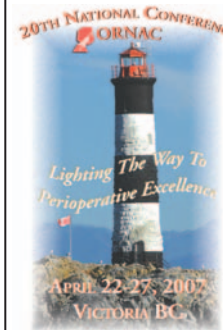
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## L'Association des infirmières et infirmiers de salle d'opération du Canada 20IÈME CONFÉRENCE NATIONALE Victoria (C-B) 22 au 27 avril 2007

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Leadership (CORL)  
RNFA  
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#### ÉVÉNEMENTS SOCIAUX :

**Dimanche :** Réception de bienvenue  
**Lundi :** Une soirée au Royal British Columbia Museum  
**Mardi :** Célébrons l'AISOC!  
**Mercredi :** Soirée libre pour visiter la ville de Victoria  
**Jeudi :** Soirée de comédie

Personnes-contact :

Marcy McKay, Co-présidente de la Conférence nationale, [NationalConference@ORNAC.ca](mailto:NationalConference@ORNAC.ca)

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# INTRODUCING IFPN

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Photo by/par M. McKay

*IFPN Executive Board (L to R) Back: Melanie van Limborgh, Lesley Fudge, Margaret Farley, Kim Hepper. Front: Betty Schultz, James Harrison, Sheila Allen.*

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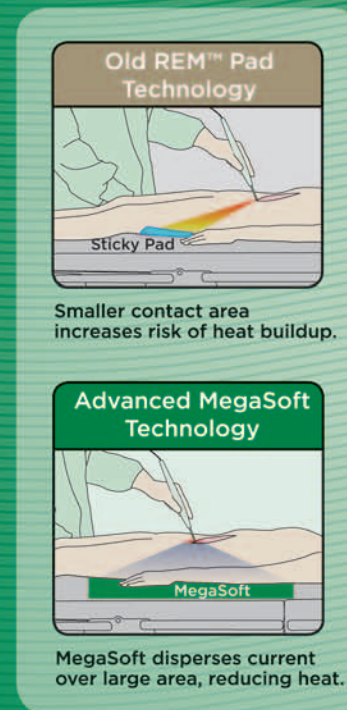
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### POURQUOI, ÉTANT DONNÉ QUE NOUS SOMMES DES SOIGNANTS PROFESSIONNELS, SOMMES- NOUS SI MÉCHANTS ENVERS NOS COLLÈGUES?

#### Violence horizontale et verticale en milieu de travail

*Auteure : Lesley Fudge, maîtrise en sciences, baccalauréat ès arts (avec distinction), RGN. Pendant sa carrière d'infirmière, Lesley a travaillé dans une variété d'environnements périopératoires et a accueilli des habiletés spécialisées en neurochirurgie et en chirurgie plastique reconstructive pour les brûlés. Elle a terminé sa carrière au National Health Service au Royaume-Uni en 2003 et gère maintenant son propre service de conseil en soins de la santé. Elle est la présidente-directrice générale des Friends of African Nursing (FoAN) et la trésorière et membre du conseil exécutif de la International Federation of Perioperative Nurses (IFPN). Lesley détient un baccalauréat ès arts en art, architecture et philosophie ainsi qu'une maîtrise en sciences en éthique biomédicale et en loi relative aux soins de la santé.*

#### RÉSUMÉ

L'auteure traite de la violence horizontale et verticale telle qu'elle existe en soins infirmiers depuis bien des années mais qui ne fait que débiter comme sujet de discussion.

Violence horizontale – entre pairs au même niveau hiérarchique  
Violence verticale – entre collègues de différents niveaux hiérarchiques (normalement du haut vers le bas, mais peut aussi être l'inverse)

Le présent article examinera ces questions en illustrant avec des exemples tirés de partout au monde l'impact de ce type de violence sur le personnel périopératoire.

### WHY, WHEN WE ARE DEEMED TO BE CARERS, ARE WE SO MEAN TO OUR COLLEAGUES?

#### Horizontal and vertical violence in the workplace

*Author: Lesley Fudge, MSc, BA (Hons), RGN. Lesley's nursing career involved work in a wide range of perioperative environments with specific skills in neurosurgery and burns reconstructive plastic surgery. She retired from the UK's*



Lesley Fudge

*National Health Service (NHS) in 2003 and now runs her own independent healthcare consultancy. She is Chief Executive Officer of Friends of African Nursing (FoAN) and is Treasurer and an Executive Board member of the International Federation of Perioperative Nurses (IFPN). Lesley has an honour's Bachelor's degree in art, architecture and philosophy and a Master of Science degree in biomedical ethics and health care law*

#### ABSTRACT

The author discusses horizontal and vertical violence as they have existed in nursing for many years but are only recently beginning to be discussed and dealt with.

*Horizontal violence – across peer groups and similar levels of staff*

*Vertical violence – from senior to junior colleagues usually downwards but possible upwards*

The article will consider some of the issues from examples around the world and how they impact on perioperative nurses.

### INTRODUCTION:

**Horizontal violence** in the workplace was a relatively unknown phrase around five years ago when Dr Lois Hamlin, a Senior Lecturer at Northern Sydney Health and University of Technology in Sydney Australia, presented a paper on the topic<sup>1</sup>. As she spoke, attendees were able to reflect on the many times the behaviours she described had been experienced, witnessed, or even conducted.

### THE EVIDENCE:

Lack of morale or positive attitudes to the working environment may have a negative impact on patient care because it leads to a loss of trust and a decrease in communication. It may also increase staff sickness rates<sup>2</sup>.

Hamlin described nurses as often functioning within a hierarchy where they are deemed to be second-class health care workers, or the “Cinderellas” of health care, and that, despite the changing role of women in society, nurses continue to be oppressed<sup>3</sup>. Certainly some things have changed as we now have Nurse Consultants in the United Kingdom with (in the OR) their own surgical caseload, taking referrals directly from family doctors in the community, and working under the indirect supervision of a Consultant Surgeon. Nurse Consultants also teach junior doctors so perhaps, at some levels, nurses are less subordinate than in the past. This change has empowered these nurses, placed them on a similar level with their doctor colleagues and removed the ‘hand-maiden’ perception of the past.

However, further change is required as staff are still experiencing horizontal and vertical violence. New staff and students entering the OR are less likely to remain in this specialty if their initial experience includes working with

inappropriate team members. With the world wide nursing shortage and an aging workforce, it is important that new recruits be treated well from day one. It is also crucial that we retain experienced team members by ensuring they are being treated well. During the author’s research a colleague shared the story of a young, new, enthusiastic staff nurse being brought to tears by an Health Care Assistant who had been in the department for years and wanted to make sure that the staff nurse understood who knew more about the job!

In order to understand violence toward staff it is necessary to understand the types of violence, how to recognise it, what causes it, and how it can be effectively addressed and eliminated.

### TYPES OF VIOLENCE:

**Horizontal and vertical violence** can be overt or covert, physical or psychological. They can take place from a senior to junior staff member or within peer groups. Hamlin and Gilmour<sup>3</sup> (2003) describe the work of Rene Michael<sup>4,5</sup>, who wrote two papers in 2001 entitled “Survive or Thrive? The Impact of workplace trauma on peri-operative nurses” and “When speciality becomes a nightmare.” Michael showed that perioperative workplace traumas included verbal abuse, sexual harassment, sexual intimidation and physical assault from peers and those in authority.

Overt violence is “in your face” and obvious for everyone else to see. It can be either physical or psychological.

Covert, or hidden, violence is mainly psychological and would range from unkind behaviour to extreme cruelty.

### How to Recognise It:

Overt violence can take many forms. Examples include a team member being constantly criticised in front of others. The critic may be doing so either through lack of consideration or in order to deliberately humiliate. Either way, this behaviour needs to be considered to be

entirely unacceptable. If not handled properly, overt violence might be driven underground and result in covert violence.

Covert violence can include abuse of power such as ensuring certain staff members always work with the unpleasant surgeon or receive the difficult, long operating list. Denial of requests for time off or providing preferential scheduling to other nurses can allow an abuser to take advantage of the ‘power of the rota’.

Michael’s studies<sup>4,5</sup> demonstrated that the majority of physical violence in the workplace involved doctors and these perpetrators are mainly, according to the author, surgeons and anaesthetists. Among the more worrying stories was one nurse relating her story that a surgeon stapled her shoulder with a used skin staple gun. The violence can also often be of a sexual nature.

During the author’s first week as a junior Sister in cardio-thoracic surgery she experienced two events that have remained strong in her memory.

During a cavity closure swab check it was discovered that a swab was missing and this fact was reported to the surgeon. Swabs were recounted and the circulator searched the theatre, bags, boots, under the table etc. It was reported back to the surgeon that the swab could not be located. The surgeon then opened his hand and said, “Is it this that you are looking for?”

The second formative event in the author’s memory was more of a physical nature. While leaning through a hatch in the OR, another member of the team soundly slapped the author across the backside. The reaction, while wrong, was instinctive and involved slapping the face of the perpetrator... who then had to spend the day explaining the handprint on his face. To this day the author wonders how the perpetrator might have behaved if they hadn’t been in a public place in front of colleagues.

Reporting bullying can have a positive impact for everyone in the workplace. While working

in Africa the author witnessed a surgeon behaving badly towards a nurse and reported the abuse. The nurse, who was very junior, was not being allowed to place her instrument trolley in the most sensible position for either a view of the operation or to hand and receive instruments easily. The surgeon threw bloodied swabs in the nurse’s direction and was abusive to both her and to the anaesthetist. After the report of abuse his contract was not renewed.

### WHAT CAUSES IT?

What causes this behaviour? It is not unusual for human beings to be threatened by new and keen to learn staff. Add in to it pressure from above and personal tension at work, or home, which can often create these types of hostile, and unsupportive behaviour. But a quote from IFPN research undertaken across New Zealand, Australia, the UK and the US shows how certain negative behaviours are pervasive and sometimes accepted “Nurses eat their young, they do it all the time”<sup>6</sup>.

Brewer’s<sup>7</sup> research survey of nurses working in the UK showed that nurses from ethnic minorities are more likely to report being bullied by a member of staff than are Caucasian nurses. There was no information as to the reasons for why this was so. Perhaps, it was because these nurses felt that they were subject to racial abuse or perhaps it was because the Caucasian nurses perceived the behaviours as part of normal working situations.

### ADDRESSING AND ELIMINATING BULLYING:

**So what are the mechanisms for dealing with bullying behaviours?**

Direct confrontation is not without risk, but should always be tackled with a witness present to ensure the safety of all individuals and to provide a third person record of what has taken place.

Healthcare employers in the UK generally recommend dealing with issues through formal

## WHY ARE WE SO MEAN TO OUR COLLEAGUES? (cont.)

channels. This ensures all issues are dealt with in a way that is in-line with policy and that follows structured and safe methodologies. While this route raises the profile of the issues and makes them more public, which can make some uncomfortable, it is also more likely to result in effective resolution. Documentation of incidents should be kept by anyone involved. If the situation becomes formalised they will need all documentation as evidence. These might include copies of off-duty or daily rosters, spiteful notes or similar communications. All should be kept and copied.

Informal methods of dealing with bullying are also often discussed and OR nurses often find their own ways of handling bullies. Nurses in the US have been calling a "Code Pink" when there is an event that needs handling in the OR. For example, if a doctor is shouting or being verbally abusive or throwing his (or her) instruments "Code Pink" is called and all colleagues who can be released from patient care, come into the room and stand, silently, staring at the abuser. This has been shown to be very effective<sup>8</sup>. Appropriate humour can also help diffuse situations, such as with the nurses seen to pretend to be plucking the air around them and when asked what they were doing responded with "Just un-ruffling your feathers". Another story was of a US nurse down on the floor looking for a tiny lost atraumatic needle and when an irritable co-worker asked what she was doing her response was "just looking for the glamour in my job."

While stress and difficulty can sometimes be turned in to fun, in the right situation, not all bullying can be diffused this way. Observers and victims need to make sure fear and self-pity do not stop them from acting against bullying. If no one acts it will never stop happening. Zero tolerance is the only policy that allows for change. Education will also help develop a collaborative environment equipped with knowledge of how to positively use change processes, conflict management, decision making skills, stress management and leadership with a focus on an outcome that suits the whole team, not just an individual.

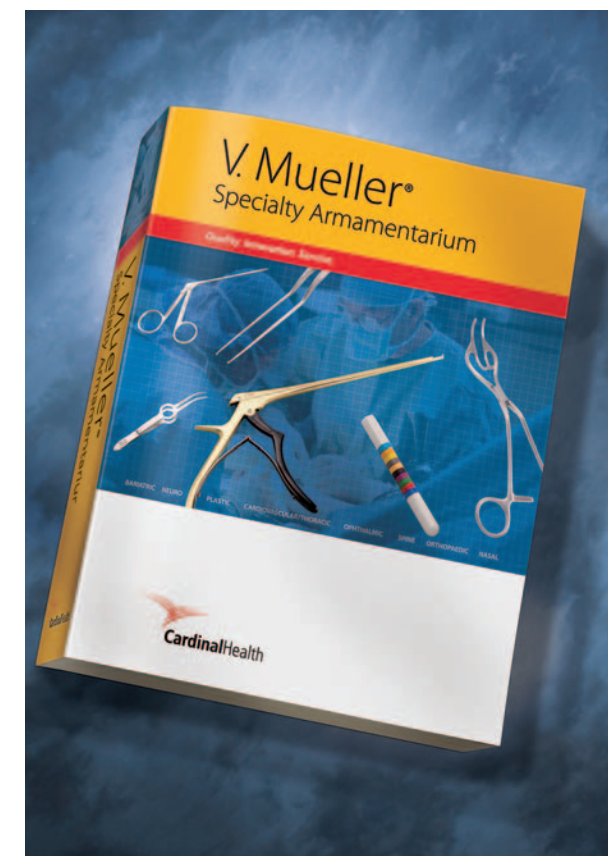
### CONCLUSION:

While in Africa with Kate Woodhead, President of the IFPN, the author witnessed much to demonstrate the strength of a good team. Nurses, with nearly no physical resources or staff and working under enormous pressure, were laughing, having fun, and caring for each other as they worked to achieve the best that could be achieved together. By creating a strong, supportive environment we make sure bullies do not have an opportunity to thrive and will eventually be able to stop these destructive behaviours.

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## ÉTABLISSEMENT D'UN NOUVEL ORGANISME PÉRIOPÉRATOIRE EN PAPOUASIE-NOUVELLE-GUINÉE

*Auteure : Kate Woodhead DMS, RGN, est la présidente de la International Federation of Perioperative Nurses (IFPN) et une experte-conseil indépendante sur les salles d'opération au Royaume-Uni.*

Suite à une demande d'un groupe d'infirmières périopératoires en Papouasie-Nouvelle-Guinée soumise à la *International Federation of Perioperative Nurses (IFPN)*, Kate Woodhead et Phyllis Davis ont offert une session à Port Moresby en Papouasie-Nouvelle-Guinée sur la création d'une association locale dont le but serait de fournir des conseils au gouvernement au sujet des politiques touchant à leurs services et de créer un lieu où seraient discutées la formation et la motivation des professionnels en soins périopératoires. L'article décrit le processus, l'enthousiasme rencontré et les techniques qui ont permis la création de la *Papua New Guinea Perioperative Nurses Association*.

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## DEVELOPING A NEW PERIOPERATIVE ORGANISATION IN PAPUA NEW GUINEA

*Author: Kate Woodhead DMS, RGN, is President, International Federation of Perioperative Nurses (IFPN) and an Independent Operating Theatre Consultant in the UK.*

A request to the International Federation of Perioperative Nurses (IFPN), by some nurses

in Papua New Guinea led to Kate Woodhead and Phyllis Davis running a workshop in Port Moresby, Papua New Guinea. They set out to help the perioperative nurses establish their own organisation to advise the government on policy which affected their service, and to serve as a forum for perioperative education and motivation. This article describes the process, the enthusiasm which greeted them and the mechanisms by which the Papua New Guinea Perioperative Nurses Association came into being.

### INTRODUCTION

One of the most pleasurable pieces of work which I have undertaken as president of the International Federation of Perioperative Nurses (IFPN) was to be involved in the start of a perioperative organisation for the islands of Papua New Guinea (PNG). The country lies north east of Australia, south of the equator and comprises a string of small islands with the main island being the eastern half of New Guinea Island. The country is dominated by a central spine of high mountains (<13,000ft) covered by tropical rainforests. There are over 750 languages spoken in PNG.

Fortunately for me English was spoken by all the nurses, although they spoke to each other in a language called Pidgin, which borrows words from a number of different languages, particularly German and English.

The Lonely Planet Guide (2006) did not give me much comfort when doing my homework before travel. It describes Papua New Guinea by warning of petty crime, banditry and isolated instances of violence, much of it concentrated in Port Moresby, the capital, where it was planned we would be staying.

### PROJECT PLANNING

The first approach from PNG to the IFPN for assistance was to my predecessor, Carolyn Webster, in 2001. This came by way of a letter, which was passed to me for exploration. A number of companies working in the Asia-Pacific Rim were approached to see if they would help IFPN with the project. Funding

was eventually identified during a visit to Australia in 2003. Johnson and Johnson Australia agreed to fund a colleague and I to run a workshop for the nurses. Following this offer, a formal proposal was developed and accepted by Johnson and Johnson. During the same conference that funding was offered, following some collaboration with the Australian College of Operating Room Nurses (ACORN), a great many colleagues approached me to share their knowledge of working in perioperative practice in PNG. This helped to understand the potential conditions that we would find there.

A colleague, Phyllis Davis, known to AfPP members for her excellent Daisy Ayris Memorial Lecture in 2002 (Davis 2003), was to travel with me, and coordinate the PNG Project. With hindsight, this was a wise decision as her enthusiasm for the task, as well as her ability to raise further funds linked into the region's medical device companies, has been invaluable. Together we developed a project plan by email as Phyllis lives in Sydney, Australia.

The first, vital element of this plan was to contact PNG's Ministry of Health, chief nursing officer (CNO) and other officials, in order to give the workshop credibility and enable nurses to be given study time to leave their posts for two days. By chance, during the International Council of Nurses Conference in Geneva in 2003, I met the CNO of Papua New Guinea and told her of the project plan. Soon, we were in regular email contact and she supplied many names and addresses for local hospitals and health officials. Letters were subsequently dispatched.

### FIRST IMPRESSIONS

Phyllis and I booked hotel rooms and a small conference room for the workshop online and made our own travel plans. We finally arrived and were met by the perioperative nurses that had written initially to Carolyn. They were excited that we had arrived, and had spent the morning picking Bougainvillea blossoms and sewing them into welcome garlands with black silk from theatres. After such an extended



Photo by/par K. Woodhead

*Imagine our surprise when 28 nurse showed up!*

planning phase, it was wonderful to finally arrive, in May 2004.

The enthusiasm from the nurses was evident when we asked to be shown their operating theatres in the main referral hospital in Port Moresby. Many colleagues approached me to share their knowledge of working in PNG.

The plan had identified that between five and eight local perioperative nurses would attend the two-day workshop to explore and set up, if possible, an organisation which they had expressed a desire to have in the country. Imagine our surprise when 28 nurses showed up! A bit of hasty re-organisation of the room and the catering arrangements had to be done, but otherwise, it was a case of 'the more the merrier!' We were amazed that the hospitals had allowed so many nurses to be present, and many had travelled for hours to get to the capital and attend the event. Indeed, many hospitals had funded their travel and accommodation too.

### IDENTIFYING GOALS

We spent the next two days brainstorming: working out the details of membership categories, structure of the organisation, the name and other vital minutiae. The majority of the work was done by small groups, who fed back to all and, with much debating, a consensus was gained. Phyllis and I facilitated

*Continued on Page 34*

## LA PRÉVENTION DES INFECTIONS

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### RÉSUMÉ

Cet article est basé sur un discours présenté par les auteurs au 42<sup>e</sup> congrès de la *Association for Perioperative Practice* (AfPP) en octobre 2006 au Royaume-Uni. Le thème du congrès était les Zones d'influence et la *International Federation of Perioperative Nurses* (IFPN) a animé une journée dont le thème était la sécurité.

L'article présente un bref résumé de l'influence des pratiques de prévention des infections sur la pratique périopératoire ainsi que sur les résultats chirurgicaux. Il offre également un résumé des principes de l'asepsie et des pratiques reconnues en prévention des infections.

De nos jours, la sécurité des patients est suivie de plus près que jamais – non seulement par les hôpitaux mais aussi par les consommateurs, le gouvernement, les patients et ceux qui appuient la réforme des soins de santé. L'Institut canadien d'information sur la santé (ICIS) démontre qu'un Canadien sur neuf contracte une infection hospitalière et qu'un canadien sur neuf reçoit un mauvais dosage ou une mauvaise médication. Le taux de mortalité des patients suivant une réaction indésirable est plus élevé que le taux de mortalité combiné de Canadiens morts d'accidents de voiture, du cancer du sein et du

VIH<sup>7</sup>. Tout praticien périopératoire doit utiliser toutes les ressources disponibles pour assurer la sécurité de tout individu impliqué dans une intervention chirurgicale.

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## INFECTION CONTROL CIRCLE OF SAFETY

### Authors:

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### ABSTRACT

This article is based on a presentation given by the authors at the 42<sup>nd</sup> Congress of the Association for Perioperative Practice (AfPP), October 2006, in the United Kingdom. The conference theme was *Circles of Influence* and the Congress also hosted an International Federation of Perioperative Nurses (IFPN) Study Day featuring a safety theme.

This article contains a brief review of the influence of infection control practices on perioperative practice and surgical outcome. It reviews the Principles of Asepsis and accepted infection control practices.

Patient safety is more closely monitored today than ever before – not only by hospitals but also by consumers, health care reformers, governments and patients. The Canadian Institute for Health Information, (CIHI) shows one in nine Canadian adults acquire a hospital

infection and that one in nine receives an incorrect medication or medication dosage. Our rates of patient deaths following an adverse event are higher than the combined death rates for Canadians involved in motor vehicle accidents, suffering from breast cancer, and HIV Positive.<sup>7</sup> Each perioperative practitioner must use all available resources to assist in the safety of everyone involved in surgical interventions.

Patient safety is a challenge. Infection Control is a challenge. The increased awareness surrounding patient safety issues in turn means more attention is being paid to all aspects of patient care. The spotlight is illuminating practices contributing to adverse events. Adverse events (AE) are defined as an unintended injury or complication that results in disability, death or prolonged hospital stay and that is caused by health care management rather than by a patient's underlying disease process.<sup>8</sup> Nosocomial or hospital acquired infections are considered one of the most common complication of hospitalized patients.<sup>11</sup> Surgical Site Infections, (SSI) are considered an AE under the heading of hospital acquired infections or nosocomial infection.<sup>8,11</sup> Surgical site infections should be considered a mortal enemy of perioperative practice and should also be considered a patient safety issue.

Every OR nurse can probably remember a time when she/he committed, or witnessed, a break in proper technique. While we hope it is not something that happens on a daily basis, it can be helpful to go back to basics and review the best practices and the reasons behind their development.

A 2002 submission to The Future of Health Care in Canada Commission included this quote from Donald M. Berwick, MD "We envision a system of care in which those who give care can boast about their work, and those who receive care can feel total trust and confidence in the care they are receiving."<sup>13</sup>

Surgical suites are dynamic environments that operate behind closed doors and are constantly undergoing change. The challenge for all perioperative practitioners is to be active in creating safe environments and to make use of

all tools available to our practice. The end result will be the creation of an Infection Control *Circle of Safety* for all patients and perioperative team members. Available tools include:

- Surgical asepsis;
- Standard infection control practices;
- Sterile Technique;
- Infection Prevention Strategies;
- Professional standards and best practices;
- Hospital guidelines, policies, procedures, and protocols; and
- An awareness and understanding of current research.

In order to ensure the Circle of Safety is not broken, it is important for all perioperative nurses to ask themselves, on a daily basis "do I follow these safe practices? Am I making use of all the tools available to me". Hospitals are, inadvertently, a source of harm. While it is not possible to entirely eliminate infection, and microorganisms, the perioperative team has an obligation to "do no harm" by making use of all tools and adhering to best practices and policies.

### SURGICAL ASEPSIS

Time, and the advancement of science, has not changed the basic principles of asepsis. Neither have they removed the need for adherence to basic infection prevention practices.

Our infection prevention foundation remains hand washing or hand cleansing. It is simple, cost effective, quickly and easily achieved, and, most importantly, it is proven to be successful! As far back as the 19<sup>th</sup> century perioperative practice included initiatives to prevent infection and ultimately death. Florence Nightingale led the way in nursing practice by instituting changes to infection control practices.<sup>1</sup> Dr. Semmelweis (1818-1865), a Hungarian physician, noted that the rate of infection, and death, decreased if he simply washed his hands after performing autopsies and prior to delivering babies or conducting patient examinations.<sup>2</sup>

Hand washing or hand cleansing is the basis on which today's practices of infection control, and the Principles of Asepsis, have been built. When these practices and principles are adhered to **without fail** there is a decrease in infection rates.

### NOW A BRIEF RE-CAP OF PRINCIPLES OF ASEPSIS:

1. All items within a sterile field must be sterile;
2. The edges of a container, bundle or wrapper are not considered sterile once open;
3. Gowns of scrub personnel are only sterile in front and on the sleeves to table level;
4. The sterile table is sterile only at table level.;
5. Sterile persons and items should only touch sterile persons or items;
6. Movement of people and items in and around the sterile field should be done in a manner that avoids contamination of the sterile field;
7. When a barrier is permeated or broken the area is considered contaminated. Recognize the break and rectify it; and
8. Last, and by far not the least, is the fact that any item of questionable sterility should **not** be used. "If in doubt, throw it out".<sup>2</sup>

### OTHER INFECTION CONTROL PRACTICES:

Patients may acquire new diseases, ones with which they did not arrive in hospital. In addition, patients may acquire a nosocomial infection, including Surgical Site Infections (SSI). In Canada this adverse event has an incident rate of 7.5%.<sup>8</sup> The perioperative team needs to be committed to the prevention of this all too common post-operative complication.

In our quest to follow and re-affirm infection prevention strategies in today's more complicated health care environment it is important to review accepted infection control practices:

1. Do No Harm;
2. Remove Contaminants or Organisms;
3. Destroy Harmful Organisms;
4. Shield and Separate; and
5. Proper Disposal of Contaminants<sup>3</sup>

### CHANGING OR ENVIRONMENTS:

Many surgical suites have de-canted procedures to other areas of the hospital, or to facilities such as ambulatory clinics, endoscopy units, angiography

suites, nuclear medicine departments, catheterization labs, free standing clinics, or mobile clinic. It is important to remember surgeries performed outside the primary operating theatres must also employ all infection prevention strategies.

Many Minimally Invasive Surgeries (MIS) are being performed, on a day surgery basis, with increasing frequency and for a wider variety of procedures. To some the threat may seem less imminent with these types of simpler, shorter procedures. The microorganisms, however, do not care – any incision, no matter how small, presents an opportunity for infection.

Many facilities are discharging patients earlier than in the past and making use of other areas of the hospital or other services, such as home care or ambulatory settings, for follow-up work such as suture removal, dressing changes, or drain removal. As a result, the perioperative team may see fewer, and hear less about, post-operative complications, infections and outcomes. In facilities that service a physically large geographic area (as is the case in many areas of Canada) many patients will find it more convenient to seek post-operative assistance with their family physician, or at a clinic near their home, rather than traveling to the hospital where the surgery was performed. As a result, the perception may be that rates of infection have decreased but in fact, we may simply be unable to track them. The fact that infection rates may be less obvious can cause some to wonder if the need for the Principles of Asepsis, and other infection prevention strategies, are diminished.

Is there a need to follow all the Principles of Asepsis in every instance? Perhaps we could reduce changeover time by only cleaning floors that are visibly dirty, or by only wiping the OR bed and not the tables? Remember, your patient could suffer the consequences.

When we cross the first line of defense, the skin, we afford microorganisms with a port of entry. Adherence to best practices regarding infection prevention would help fulfill the obligation of healthcare professionals and provide the safest possible environment with the optimal patient outcomes.

### CHALLENGING INFECTION CONTROL PRACTICES:

While certain infection control practices have been proven to be effective, that does not mean there is not room to challenge existing practices and determine more effective methods. Practices should be based on effectiveness, and research, not habit. The use of lab coats, for example, used to be considered necessary when leaving a surgical suite. This practice has been challenged and research has shown that it does not necessarily prevent surgical site infections. We do know, however, that leaving an unwashed lab coat hanging in a locker or on a hanger may cause cross contamination to scrub attire or to personal attire.<sup>5</sup>

By contrast, shoe covers have been proven to prevent infection. If used properly, and changed frequently, on footwear that is in clean and in good repair these covers can be effective.<sup>6</sup>

The Principles of Asepsis have stood the test of time. Research shows that hand washing compliance and cleansing practices help reduce the spread of antibiotic resistant organisms (ARO) such as MRSA.<sup>3</sup>

The ritualistic type behaviour that helped create an awareness of sterile and unsterile environments also helps maintain aseptic behaviour. Learning, practicing and teaching behaviours such as closing the theatre doors, never putting a hand or arm over a sterile field, and separating sterile and unsterile equipment, help to enforce sterile technique.

In today's fast paced perioperative setting it may be a challenge to not alter your circle of safety regarding infection control practices. The perioperative environment is also under the pressure of limited resources, limited time, and the urge to do things more quickly. It is important to remember that maintaining high standards, and consistent behaviour, sets boundaries and limits for the entire perioperative team. There is less pressure to take short cuts **if no one is doing it**. It also helps new team members define and reinforce their recently learned behaviours.

### INFECTION CONTROL RESEARCH AND INFORMATION:

Research shows that we are not able to discard

these practices. More information is now available about emerging diseases and adverse events, (surgical errors, and post-operative complications) than ever before. New technology allows for the tracking of numbers, and types, of infections, treatment cures, and results and to show us room for more improvement.

The push is on at a local, national, and global level for everyone to improve surgical outcomes. Recommendations have been laid out by Health Canada, the Canadian Patient Safety Institute (CPSI), Community and Hospital Infection Control Association (CHICA), the Canadian Council on Health Services Accreditation (CCHSA), the Institute for Safer Medication Practices (ISMP) Canada, and many others. Health care facilities and organizations also consult agencies such as the World Health Organization (WHO), the US Centers for Disease Control & Prevention (CDC), and the United Kingdom's National Health Service (NHS). Technology has allowed for an almost instant global sharing of resources regarding diseases, practices, and success rates.

There has been a profound impact on the Canadian government, health care providers, and the public since the publication of the Canadian Adverse Events Study by Baker et al released in 2004.<sup>8</sup> Table 1 outlines some study results relating to A/Es/SSIs. The study forced everyone involved in healthcare to face the facts and to begin to work to improve upon the statistics.

Today's public is full of well informed health care consumers. They are demanding better health care and a better performance from healthcare providers. The Canadian Institute for Health Information, (CIHI) shows one in nine Canadian adults acquire a hospital infection and that one in nine receives an incorrect medication or medication dosage. Canada's rate of patient deaths following an adverse event is higher than the combined death rates of Canadians involved in motor vehicle accidents, suffering from breast cancer, and who were HIV Positive. The study reported that hospitalization came with a higher risk of death than driving a car, working as a coal miner, doing construction work, being a truck driver, or working on an off-shore rig!<sup>7</sup>

## INFECTION CONTROL (cont.)

The Canadian Adverse Event Study used data retrieved from charts retro speculatively from the year 2000.<sup>8</sup> The data showed the rate of incidence of adverse events, including nosocomial infections and SSIs, in Canadian hospitals as 7.5%. In actual numbers that is approximately 70,000 preventable adverse events experienced by patients in 2000. The study also determined that in the year 2000 there were between 9,000 and 24,000 deaths, in Canada that might have been attributable to preventable adverse event deaths. Scary and significant numbers to mull over – and a sign that there is definitely room for improvement.

In 2002 the Canadian government invested fifty million dollars in the creation of the Canadian Patient Safety Institute (CPSI). The CPSI has identified the need for six targeted interventions, in 2005/2006, in its *Safer Healthcare Now!* initiative. Among the six is a strategy to reduce Surgical Site Infections (SSI) as outlined at [www.saferhealthcarenow.ca](http://www.saferhealthcarenow.ca).<sup>7</sup> Canadian healthcare organizations are taking up the call – the Fall 2006 *Safer Healthcare Now!* Newsletter (Volume 2, issue 3) lists approximately 470 teams with 160 healthcare organizations enrolled in the CPSI initiative.<sup>7</sup> As a result of this level of activity, the initiative will continue through 2007.

Infection Control and Patient Safety are two terms that are more closely linked, and being more carefully scrutinized, than ever before. Healthcare consumers are better informed about, and interested in, more aspects of healthcare and healthcare professionals are being held accountable for their actions. Our processes and outcomes are under scrutiny by the media, healthcare facilities, patients, and regulatory bodies. In the 2003 SARS outbreak the disease spread quickly and severely. Much post-SARS criticism was leveled at insufficient hospital infection control practices. As a result, a class action suit was filed on behalf of patients who contracted SARS whilst in hospital.<sup>10</sup>

The release of the Canadian Adverse Events Study<sup>8</sup>, coupled with happenings during the SARS outbreak, has created public angst about our healthcare system and hospital safety. The healthcare system and healthcare professionals

have an obligation to work diligently to improve our practices and patient care, reduce infection rates, increase safety and patient care, and thereby alleviate public fears and concerns.

### WORKING FOR CHANGE:

Many perioperative nurses wonder what they can do. In addition to system or facility wide programs, and adhering to recommended practices, it is important for individuals to stay aware about the issue of infection control. Some ways to make a difference include:

- Reading about, or presenting on, research findings or new initiatives;
- Conducting a study in your operating room;
- Reviewing the Principles of Asepsis on a regular basis and encouraging your facility to implement regular reviews of these principles;
- Keeping current by whatever method is most practical for you – reading journals, viewing information on the internet, attending seminars at provincial or national conferences, participating in sessions at your workplace, inquiring about new programs, etc.; and
- Practicing good habits and setting an example – are you constantly closing doors or monitoring sterile technique?

Reduction of SSIs is an issue faced around the world. The 2004 Adverse Events Study provides some comparisons of what some countries are up against (based on their own studies) as far as occurrence rates of A/E's including SSIs:

**Table 1 – Adverse Event (A/E) Occurrence Rates<sup>6</sup>**

COUNTRY	RATE*
Canada	7.5%
New Zealand	12.9%
Australia	16.6% recalculated to 10.6%
United Kingdom	10.8% & 10.9% (2 studies)
United States	3.7% recalculated to 3.2% & 2.9% (2 studies)

\*Not all studies used the same criteria and each was done independently of the others.

*Continued on Page 41*

# SURGICAL SMOKE



## RISK

Surgical smoke can carry dangerous bacteria and viruses, including HIV. It can produce upper respiratory irritation and may have mutagenic potential.

## FACT

An estimated 23,000 operating room professionals are exposed to electrosurgical smoke each year in Canada, including surgeons, nurses, anesthesiologists, and surgical technologists. Sadly, many existing operation room smoke evacuation systems are underutilized due to bulky handpieces that nobody likes to use.

## NEED

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**MONDAY, APRIL 23**

- 0830 – 1000 Opening Ceremonies
- 1015 – 1130 Val Shirreff Memorial Lecture  
Sister Carole Taylor, Georgetown University, Washington, DC
- 1300 – 1400 IFPN Speaker  
Kim Hepper, Australia – *Preventing Swab Counting Errors*
- 1400 – 1500 IFPN Speaker  
Betty Shultz & Mary Jo Steiert, USA – *Correct Site Surgery*
- 1515 – 1615 IFPN Speaker  
James Harrison, President IFPN – *Workplace Harassment, an Australian Perspective to an International Problem*

**A REGISTRATION FORM IS PROVIDED IN THE CENTRE OF THIS JOURNAL**

**SOCIAL EVENTS**

**SUNDAY** Welcoming Reception

**MONDAY** - J&J Medical Product Print Reception  
- A Night at the Royal British Columbia Museum

**TUESDAY** 20<sup>th</sup> Anniversary Celebration  
ORNAC Pep Rally Featuring 'The Timebenders'

**THURSDAY** Comedy Night Featuring 'Leave It To Cleavage'

**TUESDAY, APRIL 24**

- 0830 – 0930 Concurrent Sessions
  1. CORL Speakers  
Kelly Campbell, Terri Kitowski, Fran Riley, & Denise McLaughlin – *Safety and Quality Makes a Difference in the Perioperative Setting*
  2. Dr. Norgrove Penny – *Clubfoot Project*
  3. Linda Socha - *Transplantation*
- 1000 – 1100 Concurrent Sessions
  1. IFPN Speaker, Lesley Fudge, UK – *Migration and Ethical Recruitment*
  2. Monica Sager – *Tumour Tissue Repository*
  3. Presentations from *Call for Abstracts*
- 1500 – 1600 Concurrent Sessions
  1. CORL Speaker, Loretta Morrison – *Chicken Soup for the Manager's Soul*
  2. Leslie Slater – *Medical Legal*
  3. Presentations from *Call for Abstracts*

**WEDNESDAY, APRIL 25**

- 0900 – 1000 Concurrent Sessions
  1. CORL Speakers, Valerie Zellermeier & Team– *Waitlist Management*
  2. Dr. Michele Alfa – *Pandemics & Emerging Diseases in the 21<sup>st</sup> Century*
  3. Dr. Jim Dooner - *EVAR*
- 1400 – 1530 Concurrent Sessions
  1. CORL Speakers, Dr. Susan Kleinbeck & Monique Perazzelli - *PNDS*
  2. RNFA Panel Discussion
  3. Presentations from "Call for Abstracts"

**FRIDAY, APRIL 27**

- 0800 – 1015 CORL – Tim Porter O'Grady: Leadership – *Creating an Empowered System Igniting the Light for the Future*
- 1030 – 1200 Keynote Speaker – Mark Tewksbury
- 1200 – 1230 Closing Ceremonies

**Keynote Speakers:**

Sister Carole Taylor  
Mark Tewksbury



The Fairmont Empress Hotel, Victoria

**THURSDAY, APRIL 26**

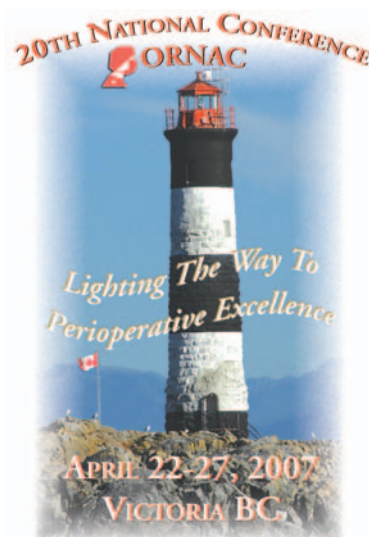
- 0830 – 0930 Concurrent Sessions
  1. CORL Speakers, Dr. Susan Kleinbeck & Monique Perazzelli – *Applying PNDS to Practice*
  2. Dr. Eike Kluge – *Bioethics*
  3. Dr. Brad Amson – *Bariatric Surgery: Roux en Y / Banding*
- 1000 – 1100 Concurrent Sessions
  1. IFPN Speaker, Jane Reid, UK – *Global Workforce Solutions*
  2. Barb Bolding – *Sterilization Topic*
  3. Dr. H.P. Marshall – *Bariatric Patient Related Endocrinology*
- 1400 – 1500 Concurrent Sessions
  1. CORL Speakers, Pat Pocock & Muriel Shewchuk – *Emerging Issues for Leadership in Perioperative Care*
  2. Lynn Walters – *Care for Caregivers*
  3. Dr. Ken Smith and Narina Pokosh – *Bariatric Pt. Plastic Surgery & Exercise*
- 1515 – 1615 Concurrent Sessions
  1. Dr. Khan – *Health Care Quality Improvement*
  2. Dr. Mike Van der Wal – *Bariatric Surgery, Anaesthesia Considerations*
  3. Presentations from *Call for Abstracts*

Please note the above schedule is subject to change

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## LE MENTORAT : PARTENARIAT MAGIQUE

*Auteure : Sheila L. Allen, infirmière autorisée, baccalauréat en science infirmières BSN, CNOR, CRNFA, est une infirmière depuis plus de 38 ans. Elle donne des discours et des sessions de formation à travers le globe. En 2003, elle fut la première Américaine à présenter le discours Daisy Ayris à l'ancienne NATN (maintenant la AfPP). Elle occupe actuellement le poste de secrétaire pour la International Federation of Perioperative Nurses (IFPN) et fut la présidente de l'Association of periOperative Nurses (AORN) en 2001-2002.*

### RÉSUMÉ :

L'auteure explore l'histoire et la définition du mentorat. Un mentor peut être une personne prestigieuse occupant un poste supérieur ou bien un collègue ou formateur averti. Ces personnes peuvent inciter le changement tout en guidant, en conseillant, et en facilitant le développement des personnes qui les entourent.

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## MENTORING: THE MAGIC PARTNERSHIP

*Author: Sheila L. Allen, RN, BSN, CNOR, CRNFA, has been a perioperative nurse for more than 38 years. She is a self-employed speaker and educator who has spoken at seminars and meetings around the world. She was the first American to present the Daisy Ayris Lecture at the former NATN (now AfPP) Conference in 2003. She currently serves as Secretary for the International Federation of Perioperative Nurses (IFPN) and served as the Association of periOperative Nurses (AORN) President 2001-2002.*

### ABSTRACT

The author explores the history and definition of mentoring. Mentors may be persons of rank, achievement and prestige, or they may be a knowledgeable colleague or teacher. They serve as a catalyst to transform as they instruct, counsel, guide and facilitate the development of others.

### INTRODUCTION

Mentors may be persons of rank, achievement and prestige, or they may be a knowledgeable colleague or teacher. They serve as a catalyst to transform as they instruct, counsel, guide and facilitate the development of others. Mentors not only help mentees learn about their field, they also learn from the mentor-mentee relationship. Mentoring is a humanistic, confidential and social relationship between people in which one individual functions as a sponsor, guide and role model. To be effective mentors should possess patience, enthusiasm, knowledge, a sense of humor and respect. Mentoring is the process that awakens our confidence in our abilities and opens doors that lead to personal or professional growth. It goes beyond teaching knowledge or skills or the mere passing on of information. It is a complex nurturing, developing and empowering relationship that requires mutual learning, sharing and growing. Mentoring is the linchpin of recruitment and retention. People come in and go out of our lives all the time. Some of these relationships help us grow and through them we learn the personal and professional lessons of life. These special relationships create a transformation as individuals and help us grow, open doors to new capabilities, and create new ways of being in the world around us. These relationships constitute the reciprocal, interactive process of learning we call mentoring. The process helps us connect so that we can reach our goals and grow together.

### MENTORING IS NOT NEW

The history of mentoring reveals that the goddess of wisdom, Athena, disguised herself as Mentor and was left in charge of Odysseus' household for ten years during his odyssey. Mentor tutored Telemachus (Odysseus' son) in his father's absence so that he would become a successful ruler. In the United States there is a rich history of nursing leaders who knew the

value of mentoring. Amy Armor Smith authored the first perioperative nursing text in which she shared her views. Dr Connie Vance, a more current leader, often writes of the importance of sharing the one's experiential wisdom to guide the next generation of nurses. In the UK, Edna Doreen Ayris, affectionately known as Daisy, is an example of one who spoke not only of the value of passing along knowledge but also demonstrated the worth of mentoring by her actions.

So what is a mentor? We could use words like: guide, mediator, encourager, coach or tutor. However, a noun for further consideration could be 'exemplar'. The word means a story. We all have stories that demonstrate our passion for perioperative nursing. Sharing those stories with each other and with young people who might be interested in joining our profession could be just the thing that sparks a young mind to seek the rewards of theatre nursing. Author Chip Bell states that, '*Mentoring is an honor. Except love, there is no greater gift one can give another than the gift of growth*'. The framework of mentoring is much like the nursing process: there must be an awareness of the need; openness to the opportunity to share; action to accomplish the sharing of information and expertise. There must be a mentor and a mentee to make the relationship work. In order for the relationship to be productive it must be based on mutual respect. History is full of famous pairs that have experienced this reciprocal relationship: Socrates and Plato, Annie Sullivan and Helen Keller, and Sir Henry Herbert and Florence Nightingale to name three, have all shared relationships that went beyond that of teacher and pupil. Current-day movies also portray the value of the mentoring relationship. How does one characterize this very special state? Words like non-competitive, nurturing and reciprocity come to mind. However, the real characterization can be summed up with the fact that this relationship is a gift exchange. Never before has having wisdom been more critical and acquiring wisdom been more challenging.

### WHAT DOES MENTORING REALLY MEAN?

The mentor/mentee journey involves active

listening. Most people think of listening as a passive state. Perhaps the term should be expanded to mean mindful listening: that of giving your undivided attention. In our busy lives we are often thinking of what time we need to collect our children from school, or how many jobs we must do after we leave our workplace. But mindful listening means devoting your attention to the speaker, rather than thinking of your next remark. Mentoring involves utilizing the skills of coaching and often confrontation techniques, as well as creative methods of resolving conflict.

If one were to place a cost on recruitment and retention, then administration may be more inclined to place a higher value on mentoring. For example, on a recent visit to an infection control nurse, a hidden cost was discovered that had not been previously considered. The nurse explained that management was 'giving her grief' about the increased cost of having to administer vaccinations to new employees. It was hypothesized that those costs would not be quite so high were a higher value placed on keeping qualified nurses rather than the constant need to keep training new ones.

If a random sample of people were asked to list famous athletes, film stars or Nobel prize winners, what would be the outcome? Most people could name a few, but perhaps not many. However, if that same sample were also asked to think of:

- a teacher, or someone who made a difference in their life;
- a colleague, or someone who taught them something; or
- a friend, or someone who helped them in a time of need;

it is probable that most of the sample could immediately bring a special person to mind.

Using phrases like: '*I'm just a nurse*', '*Nurses eat their young*', '*We are our own worst enemy*', and '*I wouldn't encourage anyone in my family to become a nurse*' are discouraging at best. Negative imagery of nursing will not attract anyone to the profession. Instead, we need to remember those exemplars and stories of the passion we feel for nursing and share them with others.

## MENTORING (cont.)

### THE 'GOOSE' MODEL

It could be argued that by participating in the mentoring process, an individual could be seen as a 'silly goose'. However, lessons learned from geese could be applied in this situation.

- Geese fly in a 'V' formation because it provides an increase of 71% in uplift: People with a common sense of direction and purpose accomplish more. When a goose falls out of formation, it feels the drag and resistance of flying alone: We need the help of others and they need our help at times. We should accept that help and give it generously;
- When the lead goose tires, it rotates to the back and lets another take a turn: If we share the challenges of leadership, we will not get tired out. We need to celebrate each other's uniqueness;
- When a goose gets sick or wounded, two geese drop out to stay with it until it dies or can rejoin the group: If we have the sense of geese we will stick by each other in difficult times or support each other in teaching others; and
- Interestingly, geese honk encouragement to each other: Encouragement is a powerful tool in the mentoring toolbox.

The effects of this mentoring process can be very positive. For the mentee there can be an increase in the access to information, self-esteem, job satisfaction and professionalism. The positive outcomes can also lessen stress, worry, absenteeism and waste. Moreover, it is possible for a mentee to have more than one mentor simultaneously. As an example, the author cites a cardiothoracic surgeon named Dr. Page Acree who shared his expertise generously and often.

### MENTORING IN PRACTICE

The terms role model, preceptor and mentor are often used synonymously. However, they are rather like layers of an onion or a mosquito stat, hemostat and Crile. Each role adds a layer or adds depth to the previous one, so that the mentoring role is the most complex. Everything that is done in the presence of others may have an impact on the future. Remember: 'a moment lasts but a

second, while a memory lasts forever'. Sometimes the way we behave can have a lasting impression on another. It is up to the individual whether that will be a positive or negative experience.

### QUALITIES AND ROLES

There can be no greater compliment to a person than to have another ask them to be a mentor. A good mentee or protégé should be open and honest, as well as able to take advice and accept constructive criticism in the spirit in which it is offered. In this relationship, the mentee would share goals and seek input. The mentor should keep all discussions in confidence.

To become a mentor, watch for someone you think you'd like to help nurture along the journey. Try to identify a good personality match. The mentor should be trustworthy and keep in confidence the ideals, goals and dreams that are shared with the mentee. The good mentor would not head straight for the nurses' lounge and say, 'Do you know what Sally told me today!' A mentor enjoys the success of the mentee and looks for ways for the mentee to succeed. He or she encourages the mentee to set high but realistic expectations and offers opportunities to rise to a challenge. Mentors have never-ending compassion, crystal-clear communication and a sincere joy in helping others along the way. Think about a candle lighting another candle: as the first candle lights the other, for a moment, there is a flash where both are brighter. So, in the mentoring relationship, the flame of both the mentor and mentee will be brighter while the relationship exists. A candle loses nothing by lighting another.

There are many roles that the mentor plays in this association. As a counselor, the mentor provides guidance and advice, assists in planning strategies and establishes a support system in stressful times. As a communicator they listen and interpret feedback. As a coach or advisor they clarify goals and share open, honest feedback. Advice that could be helpful to remember for the potential mentor: 'You are not eligible to change my view until you first show me that you understand my view'. As a referral agent or broker the mentor advocates, intervenes

*Continued on Page 37*

## Vital Acute Care Hospital in the GTA seeks Nursing Professionals to join its Surgical Program Team



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## PAPUA NEW GUINEA (cont.)

the groups, encouraged and motivated where there appeared to be insurmountable problems and wrote endless notes.

We devised application forms, membership cards, and flyers for advertising and spent a great deal of time at the photocopier, so that everyone had a record of all the work undertaken.

Action plans were distributed and role descriptors for the agreed positions in the Steering Group were given to all participants. By the end of the second day, we had already got members signed up (including two overseas members!), and the Steering Group elected. It was time to get the interim president and secretary to meet the chief nurse at the Ministry of Health. They were thrilled to bits when she told them that they had beaten the midwives to setting up a professional organisation, and promised her support to the new group. The official launch was discussed prior to our leaving the country and we left the nurses with short, medium and long-term action plans. We had no doubts that with the enthusiasm shown by everyone, and with dates for the Steering Group meetings already set, that action would follow. The overriding goal of this group is to provide education and to enhance knowledge and skills within the perioperative environment. A number of goals were identified during the workshop:

- Develop new knowledge and skills through research;
- Provide advice and assistance to the national Department of Health and the Nursing Council of PNG in relation to policy development;
- Conduct in-service education, workshops, and a national conference; and
- Effectively communicate with the national and international perioperative community.

### JOINING TOGETHER

The Steering Group had given themselves six months until the official launch of the organization to get everything in place including the bank accounts, the terms of reference and a great deal of fundraising. We thought this a short time but, in November 2004, the Association was officially launched with great ceremony, with a

number of Ministry of Health officials and dignitaries in attendance. Support was given to the nurses, by preparing a press release for them, by the IFPN project team, and welcoming them as pre-members of IFPN. At the meeting during which the organisation was launched, there was also an infection control study day, and over 50 perioperative nurses were present. Once again, hospitals had supported their nurses, and there was much joy at seeing colleagues within the organisation. Phyllis and a colleague, Sue Resnik, from the New South Wales Infection Resource Centre, were once again generously sponsored by Johnson and Johnson to travel. Many books, educational tools and gifts were taken as raffle prizes, kindly donated from Sydney hospitals. Phyllis chaired the first Annual General Meeting of the Papua New Guinea Perioperative Nurses Association and substantive positions were elected. Some seed funding was given by the Patron, the Honourable Bob Danaya to add to the funds raised by the nurses in their local areas.

### CONTINUING SUPPORT

Work with the organisation continues to focus on developing the membership base, the terms of reference or constitution and further support as identified by the organisation's officers. Through close working ties with Australia and continued support from Johnson and Johnson Australia, a member of the Papua New Guinea Perioperative Nurses Association will travel to the ACORN



Photo by/par K. Woodhead

*The enthusiasm from the nurses was evident as they showed us around the operating theatres.*



Photo by/par K. Woodhead

*Participants at the first workshop with Kate and Phyllis.*

conference this year. Continuous support has been given by the IFPN project team, as well as boxes of textbooks and other gifts. Experience gained in PNG, Uganda, Zambia, Tanzania and Malawi with start-up perioperative organisations has encouraged the development of a generic toolkit to assist individuals with enthusiasm to set

up their own organisations. This is an on-going piece of work which, when completed, will be distributed via the International Council of Nurses. IFPN has been delighted to have been involved in the developments in Papua New Guinea and thanks Phyllis Davis and Johnson and Johnson Australia for their invaluable support and assistance.

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### REFERENCES

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2. Davis P 2003 *The Essence of Perioperative Care* British Journal of Perioperative Nursing 13 (5) 196-205 ♣

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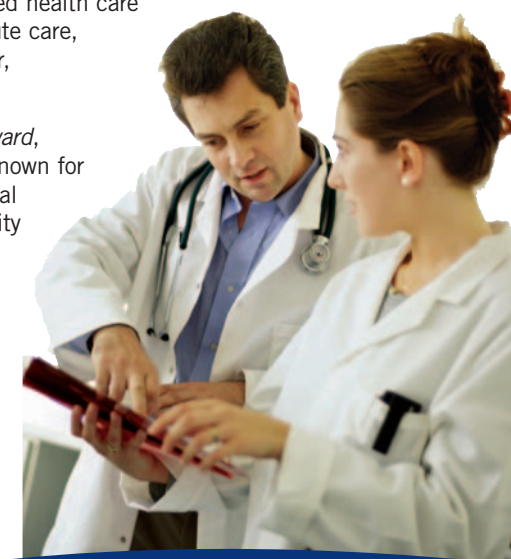
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## MENTORING (cont.)

and arranges opportunities for growth in the mentee. The following eight pieces of advice should be heeded by the potential mentor:

**Listen mindfully;**

**Affection:** the kind we must all have for one another;

**Laughter:** humour can lighten the burden of everyday activity – post a joke or cartoon;

**Written note:** leave a post-it on someone's locker telling them what a good job they did;

**Compliment:** a sincere one, for people know when you mean them;

**Favour:** where you do something for someone and don't expect anything in return;

**Solitude:** remember that at one time you were connected to someone. Take the time to reflect on those with whom you need to connect; and

**Cheerful disposition:** you don't have to be Pollyanna, but if you count your blessings frequently, your attitude will be positive.

### THE NEED TO QUESTION

While the relationship may last a lifetime, there could be obstacles along the way. If there is jealousy, oppressive control, loss of objectivity, or exploitation, either the mentor or the mentee may lose heart. If there is fear of failure or over-dependence, expectations may prove disappointing. When the obstacles are identified or the relationship becomes unhealthy, both parties must be willing to recognize the limits of the relationship. Every nurse must examine himself or herself and ask if they have the qualities to be a mentor. It is our responsibility to be a role model and to foster professionalism in the next generation. The following principles of training may be employed:

present meaningful information;

use repetition;

present one concept at a time; and

use feedback and frequent summaries.

Nursing is back up to first place career choice in the Gallup poll. AfPP's John Beesley told the author recently that UK nurses are being valued more than ever before. While there are days

when nurses may feel like they've been worn down and stepped on, they should remember that they do make a difference. What they know and are willing to share may make the difference in someone's life.

### BENEFITS FOR THE FUTURE

Mentoring is the linchpin of recruitment and retention where everyone is guaranteed to benefit. The mentee builds self-esteem and learns diverse skills. Within organizations that employ a clinical ladder or advancement opportunity one can achieve professional advancement. From the mentor's point of view they can sharpen their skills and achieve a sense of fulfillment and satisfaction. They can also experience career rejuvenation. Healthcare systems' outcomes are numerous because the system will foster leadership development, teamwork and retention.

There is a dynamic interaction between the gardener and the garden. These two distinct living entities have a unique relationship. The garden has a dependency on the gardener, and the gardener must consider the unique properties of each plant as well as the forces of nature. The following are some tips for the gardener: don't over-water or over-feed, don't crowd: prune and weed, allow to grow at own pace, appreciate garden and each plant, and share with others. These same tips could be applied to the mentoring relationship. In your garden remember to plant three rows of peas: *peace of mind, peace of heart, peace of soul*. Plant four rows of squash: *squash gossip, squash indifference, squash grumbling, and squash selfishness*. Plant four rows of lettuce: *lettuce be faithful, lettuce be kind, lettuce be obedient, and lettuce love one another*. No garden is complete without turnips: *turnip for meetings, turnip for service, turnip to help one another. With a bit of 'thyme' you will reap what you sow*.

Our future is in the faces of the young and new to our profession. Mentoring is a magic partnership that awakens our confidence in our abilities. It goes beyond teaching knowledge or skills or the mere passing on of information. It is a complex nurturing, developing and empowering relationship that requires mutual sharing, growing and learning.

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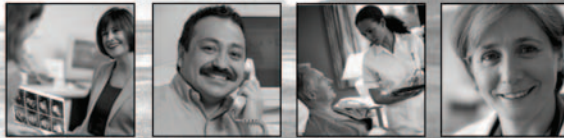
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## INFECTION CONTROL (cont.)

The battle for infection control is not being fought alone. It has the support of perioperative professionals across Canada and internationally. Among other programs, the following have been launched in recent years:

- The United Kingdom Department of Health launched a program, in 2005, titled *Saving Lives: A delivery program to reduce healthcare associated infections*;
- Australia established the Council for Safe and Quality in Health Care in 2002;
- The United States is currently running its *100,000 Lives Campaign* through the Institute for Healthcare Improvement and Canada's *Safer Healthcare Now!* campaign was modeled after theirs; and
- The World Health Organization (WHO) launched a World Alliance for Patient Safety in October 2004. Its goal is *Primum non nocere* (First do no harm). A focal point of its campaign is the worldwide reduction of surgical site infections.

The campaign to increase infection control, and eliminate SSIs, is truly a global push.

### CONCLUSION:

The study of research relating to instances of, and the reduction of, A/E's (including SSIs) shows the following:

1. The location and type of surgery is irrelevant – microorganisms do not discriminate so all surgeries must be performed using all the infection prevention strategies available;
2. All perioperative professionals must adhere to accepted infection control practices and the Principles of Asepsis;
3. Infection control practices and sterile technique must be considered our usual and normal theatre behaviour whenever and wherever;
4. We must acknowledge the threats posed to patients in the operating room;
5. By working together healthcare professionals at all levels can help make the OR a safer place;

6. One of the greatest risks our patients face in hospital is the possibility of an infection; and
7. We increase our likelihood of success if we share our information.

This 1863 quote from Florence Nightingale appeared in a book on safety purchased at the 2006 European Operating Room Nurses Association (EORNA) Congress:

*"It seems a strange principle to enunciate, as the very first requirement, in a hospital that it should Do the Sick No Harm."*<sup>12</sup>

This quote holds as true today as it did when first spoken nearly 150 years ago. OR nurses, along with others in the healthcare industry, have an obligation to ensure the highest possible safety levels for our patients.

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