CANADIAN
# OPERATING ROOM
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March 2006

## Paediatric Surgical Liaison Nurse

## Greenlight Laser

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# President's Message

We have two ongoing choices in life – to move or to stand still. If we always choose to stand still we will cease to grow and to develop. It is important to keep moving in order to keep up with the ever-changing demands of our day-to-day lives. ORNAC is doing just that – and things are moving very quickly these days! The growth of our website (www.ORNAC.ca), ongoing development of this journal, and the promotion and use of our standards mean that ORNAC is raising the profile of perioperative nursing locally, provincially, and nationally.

ORNAC is now a voting member of the Canadian Patient Safety Institute (CPSI). CPSI has a national mandate to build and advance a safer health system for all Canadians. The institute provides leadership on patient safety issues and helps to create a culture that is open to disclosure and is committed to any changes that will improve care.

One of the ways the CPSI will achieve its goals is through encouraging the use of a quality improvement tool (Root Cause Analysis Framework) to help determine the factors that contributed to a sentinel event (or a close call). It is important that we all learn from each other, through the evaluation of both positive and adverse events, so that we can work towards safer and better care for our patients.

A recent event in Pennsylvania, USA, tells the story of the use of the impact of colour-coded wristbands for patient identification. The trouble was that different colours meant different things at different hospitals. At one hospital the yellow band signified a "DNR" order. At another, yellow marked an arm that should not be used for blood work. With nurses working at both facilities and you have the makings of a potential disaster. In this particular case, the system only resulted in a close call. The reporting of this incident prompted the state patient safety authority to issue some advisory information on the use of colour-coded wristbands. Through the reporting of this incident everyone learned a better way to achieve the goal of patient safety. To learn more about reporting incidents, and patient safety, visit www.patientsafetyinstitute.ca.

Closer to home, ORNAC is working hard to improve the day-to-day experiences of perioperative nurses. *Canadian Operating Room Nursing Journal* is one of the best ways to learn about what is going on! Those of you who have been receiving this journal will note that the look and content of our journal has improved steadily over the past couple of years and we aim to continue to do so.

You may be aware that the ORNAC member subscription rate for the Journal has remained the same for many years. As the Journal continues to grow so do the production and distribution costs. In November 2005 the ORNAC board voted to subsidize the 2006 member subscriptions in order to delay the need to pass on cost increases to our members. We hope the Journal is a valued part of your membership benefits.

As we head toward spring we prepare for a new season of learning and professional development. Canadian OR Leaders (CORL) is hosting a two-day Leadership conference in Toronto on May 8th and 9th. Learn more about this and other conferences at www.ORNAC.ca. Many provinces will host conferences in the near future – make an effort to attend yours!

As always, if you have concerns or ideas, please do not hesitate to contact me at president@ornac.ca. I always have time to listen!

*MMcKay*


***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.*

***Marcy 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.*

# Message de la présidente

Dans la vie, nous avons toujours deux choix – de progresser ou de rester sur place. Si nous décidons de rester sur place, notre développement cessera. Les exigences de nos vies quotidiennes changent continuellement, et il faut constamment s'adapter pour demeurer au courant. C'est exactement ce que fait L'AIISOC – et, constatons-le, tout change très rapidement! La croissance de notre site Web (www.ORNAC.ca), le développement de cette revue et la promotion et l'application de nos normes font ensemble que l'AIISOC réussit à faire mieux reconnaître le domaine des soins périopératoires aux niveaux local, provincial et national.

L'AIISOC est maintenant membre votant de l'Institut canadien pour la sécurité des patients (ICSP). Le mandat national de l'ICSP est de concevoir et de promouvoir un système de santé plus sûr pour tous les Canadiens. L'Institut assume un rôle de leadership en matière de sécurité des patients et aide à créer une culture ouverte et engagée aux changements qui amélioreront les soins.

Une des manières dont l'ICSP atteignera ses objectifs est en encourageant l'utilisation d'un outil d'amélioration de la qualité (Root Cause Analysis Framework) afin d'identifier les facteurs contribuant aux erreurs critiques évitables. Il est important que nous apprenons tous les uns des autres en évaluant les événements négatifs come positifs afin d'œuvrer en vue des soins plus sûrs et de meilleure qualité pour nos patients.

Récemment, en Pennsylvanie aux États-Unis, l'utilisation de bracelets à code de couleurs pour identifier les patients s'est révélée problématique car différents hôpitaux utilisaient des codes différents. Dans un hôpital, un bracelet jaune désignait « ne pas réanimer ». Dans un autre, il désignait qu'il ne fallait pas prendre de sang du bras qui le portait. Étant donné qu'il y avait du personnel infirmier qui travaillait dans les deux hôpitaux, le potentiel d'erreur était très élevé. Dans ce cas, le système n'a produit qu'un seul incident, lequel a pu être évité. Lorsque le rapport de cet incident a été soumis, l'organsime réglant la sécurité des patients dans l'état a émis des avis de sécurité relatifs à l'utilisation des bracelets à code de couleurs, le résultat étant que tout le monde a appris comment mieux protéger la sécurité des patients. Pour plus de renseignements sur comment faire le rapport d'incidents, ainsi que sur la sécurité des patients, veuillez visiter www.patientsafetyinstitute.ca.

Plus près de chez nous, l'AIISOC se penche sur l'amélioration de l'expérience quotidienne des infirmières et infirmiers périopératoires. La revue de l'AIISOC est une des meilleures façons de demeurer au courant! Ceux et celles qui sont abonnés depuis un certain temps remarqueront que le look et le contenu de la revue s'améliorent continuellement depuis quelques années, et cette évolution n'est guère terminée.

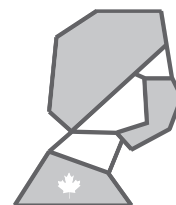
Vous êtes peut-être au courant du fait que les frais d'adhésion à l'AIISOC n'ont pas changés depuis plusieurs années. Cependant, la croissance de la revue ne peut qu'augmenter les coûts de production et de distribution. En novembre 2005, le conseil de l'AIISOC a approuvé la subvention des adhésions de l'année 2006 afin de reporter le besoin de transférer l'augmentation des coûts à nos membres. Nous espérons que la revue constitue une partie importante des avantages offerts par votre adhésion à l'AIISOC.

Nous nous préparons non seulement pour le printemps mais aussi pour une nouvelle saison de formation et de développement professionnel. Le 8 et 9 mai 2006, le CORL présentera à Toronto une conférence sur le leadership. Pour en savoir plus sur cette conférence, ainsi que sur les autres bientôt présentées par plusieurs provinces, veuillez visiter www.ORNAC.ca. Faites l'effort et participez à la conférence le plus près de chez vous!

Comme toujours, n'hésitez pas de me contacter avec vos idées et vos commentaires à president@ornac.ca. Je suis toujours là pour vous écouter!

*Marcy McKay, inf., CPN(C)*





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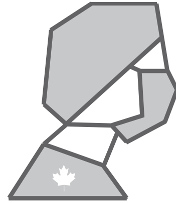

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## IDENTIFIER L'IMPACT DU RÔLE DE L'INFIRMIÈRE DE LIAISON DANS LA SALLE D'OPÉRATION PÉDIATRIQUE


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**RÉSUMÉ**

Une étude quasi-expérimentale comprenant deux groupes (N=92) a été effectuée afin d'examiner les effets de la communication intra-opératoire d'une infirmière de liaison sur l'angoisse parentale. Le groupe 1 a reçu en personne des rapports de l'infirmière de liaison. Le groupe 2 a reçu les soins péri-opératoires standard. Le questionnaire sur l'anxiété chronique et réactionnelle de Speilberger [1] (STAI) et celui développé par les chercheurs ont été distribués aux deux groupes et utilisés comme approche quantitative et qualitative afin de déterminer quelles actions les membres des familles ont trouvées utiles pendant la période opératoire.
Deux cent quatre-vingt feuilles de réponse ont été distribuées à un groupe varié de professionnels de la santé, y compris des anesthésiologistes, chirurgiens, infirmières et autres membres de l'équipe des soins péri-opératoires, tels ceux de la salle d'opération et les services de chirurgie ambulatoire et de salle de réveil. Des feuilles de réponse ont également été distribuées au personnel des services de soins intensifs et de malades hospitalisés. Les résultats ont démontrés que les familles ayant reçu les rapports en personne ont vécu un niveau d'anxiété inférieur, mais que la différence n'était pas statistiquement importante. Les réponses écrites thématiques ont fourni de exemples de comportements démontrant de meilleurs soins et une gestion de temps plus efficace de la part des professionnels de la santé. Les réponses écrites ont validé les scores de questionnaire pour les familles ainsi que pour les professionnels de la santé et ont indiqué un appui pour le rôle de l'infirmière de liaison. Les résultats qualitatifs laissent entendre que l'infirmière de liaison a facilité le transfert de l'information requise entre l'équipe péri-opératoire et la famille, ce qui fournit un mécanisme d'appui pour les familles en situation de stress.



1 Speilberger, C., Gorsuch, R. & Lushene, R. (1969) *The State Trait Anxiety Inventory Manual*. Palo Alto: Consulting Psychologists Press.


## DETERMINING THE IMPACT OF A SURGICAL LIAISON NURSE ROLE IN THE PAEDIATRIC OPERATING ROOM


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*Nadia Drisdelle was a fourth year nursing student at the Dalhousie University School of Nursing in Halifax, Nova Scotia who received the IWK Health Centre Research Summer Studentship to work on this research project.*

**ABSTRACT**
A two-group (N=92) quasi-experimental pre-post test design was used to examine the effects of intra-operative communication by a surgical liaison nurse (SLN) on parental anxiety. Group I received in person progress reports from the SLN. Group II received routine perioperative care. The Speilberger's[1] State-Trait Anxiety Inventory (STAI) Scale and investigator developed family rating scales were distributed to both groups and used as a quantitative as well as a qualitative approach to determine what was helpful for the family members during the operative period.

Two hundred and eighty feedback forms were dispersed to various health care professionals including all anaesthetists, surgeons, nurses and other staff in the perioperative care team, including the operating room, day surgery unit and the post anaesthetic recovery room areas. Feedback forms were also circulated to staff from the intensive care unit and the surgical in-patient units. The results showed the anxiety levels were lower for the families who received in person progress reports but the difference by group was not statistically significant. Thematic written responses provided examples of improved care and effective time management behaviours on the part of the health care professionals. Written responses provided validation for the scale scores for both families and health care professionals and were an indication of the support for the role of the surgical liaison nurse. Qualitative findings implied that the surgical liaison nurse facilitated the transfer of necessary information between the perioperative care team and the family thus providing a support mechanism for families under stress.

**BACKGROUND**
Surgical procedures are known to be stressful events for patients and family members and may even be more so for parents and children. During the hospital experience, parents like to be involved in their child's treatment and provide support for their child. Instead, parents find themselves restricted with their ability to cope, due to their state of anxiety and lack of information. Previous research suggests that family members feel left out during the intraoperative period.[2] O'Connell[3] reports that family members of children undergoing surgery exhibit feelings of anxiety and also verbalize their anxieties and feelings of isolation. One study compared three parent groups; one having no intra-operative support, a second, receiving information shared with families by a nurse, and a third having the family member accompanied by a 'support' person. The anxiety scores for the group receiving nursing support was significantly lower than the other two groups. Research indicates that contact with family members during surgery reduces their anxiety.[2] Information helps people understand what is occurring and reduces fear of the unknown, thereby enabling them to cope better with the situation. In another study with four randomized samples, receiving various types of support during surgery, the group with the intra-operative nursing support had significantly lower blood pressures (MAP) and anxiety scores post operatively than any of the other groups.[2]

*Photo by/par K. MacDonald*

*The family is briefed by the surgical liaison nurse pre-operatively*

In terms of actual surgical time, Donnell has reported that family anxiety levels increase when the length of surgical time exceeds the time originally anticipated.[4] The longer the parent waits, the more anxious they begin to feel.[4] Many unpredictable factors may increase the length of surgical time. By explaining what is happening, the surgical liaison nurse can help reduce family member's tension and it has been commented that general explanations given for delays are especially reassuring.

Clinical research has also examined the role of a surgical liaison nurse as an initiative to improve support, strengthen communication and provide a holistic health approach with the families of

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surgical patients throughout the perioperative period.[5] The SLN role opens the lines of communication between the family and the perioperative team. Communication between the OR nursing staff and the parents during the intra-operative period remains a key principle toward enhancing family members' well being. Reports from families, after having received intra-operative communication, include an increased sense of control, and perception that they have received an increased level of care.[2] Puopolo & Cordasco identified that intraoperative communication prepares the family for a more positive interaction with the child during the recovery period.[6]

Although there are limited studies specifically related to the SLN role, review of available literature has demonstrated that face to face communication by a registered nurse is the best way to provide a communication link with families and to reduce their anxiety while their loved ones are undergoing surgery. Decreased levels of anxiety for family members can only enhance their experience in this constantly changing health care environment.

Given current fiscal restraint, and competition for necessary resources, it was important to research the clinical outcomes of intra-operative nursing support. The purpose of the study was to examine the degree to which the implementation of a Surgical Liaison Nurse's role impacts family members' level of anxiety during their child's surgery when compared to current standards of peri-operative nursing care. Pre-study anecdotal evidence from nurses at the study site had revealed that families described feeling very isolated and detached from what was happening when their child was in surgery. Families had stated it was the most stressful and anxious period during their hospital stay. Based on the literature and experiences of other health centers, anticipated outcomes of the SLN role included a decrease in the feelings of isolation and anxiety experienced by families and an increased understanding of the perioperative process.

We hypothesized that families who were less anxious would be more receptive to the post-operative teaching. Not all family members may wish to receive intraoperative up-dates but, if they are being made available, may feel obligated to remain in the Health Centre in order to receive the updates. This would be a draw back, for some, of offering the surgical liaison nurse support.

## Objectives

There were clearly identified gaps in service when it came to meeting the needs of families with children undergoing surgery. The SLN role was developed to bridge this gap and to enhance the service provided by the perioperative team. The objectives of the role as defined by researchers Fowlie, Francis & Russell[7] & Donnell,[4] can be described as:

1. Establishing communication between the surgical team and the patient's family;
2. Providing a support mechanism for families under stress;
3. Enhancing the perioperative role of the nurse in promoting holistic health care for the surgical patient and the family;
4. Promoting a positive image of the health care facility as a family centered care focused facility; and
5. Fostering the perioperative nurses' professional and personal growth.

## Procedure

All research involving living human subjects requires review and approval by the IWK Research Ethics Board (REB) before the research is started. The REB was established to help ensure ethical principles are applied to research involving human subjects. After IWK REB approval names from the prospective OR list were randomly selected and contacted by phone. Names were drawn from an envelope and families were randomly placed in either the SLN group or the routine care (RC) group. Routine care normally involved no reports being passed on to family members. Occasionally, in some services, if a case was booked for more than a few hours the surgeon might send one telephone message, regarding the progress of the surgery, to the nursing unit to be passed on the family.

Family members were informed that their role in the study involved completing a brief survey package on two occasions – once before their child's surgery and then again after their child was transferred to the in-patient, or same-day, surgery unit. Potential participants were informed there was a 50% chance they would be assigned to either the surgical liaison nurse support group or routine care group.

Parents were notified, on the day of the surgery, as to which group they had been randomly assigned. Written consent was obtained, at that time, from each subject (parent). A copy of the information form was given to each subject and the pre-op survey was completed.

## Instruments

The study package included 5 documents:

1. the information and consent form;
   a demographic sheet;
2. one Speilberger's State-Trait Anxiety Inventory (STAI) survey to measure families anxiety pre-operatively;
3. the same Speilberger's State-Trait Anxiety
4. Inventory (STAI) survey to measure families anxiety post-operatively; and
5. an investigator designed Family Rating Scale (FRS).

Two instruments were used to detect possible changes in parents' anxiety levels and perception of support related to the perioperative and intra-operative period — the Speilberger's State-Trait Anxiety Inventory (STAI) survey and the Family Rating Scale. The STAI survey was administered to both groups of parents no more than one hour before the surgery and the identical STAI survey was administered immediately post-operatively. The FRS was administered post-operatively. Questions were intended to evoke feelings of anxiousness and included participants' reactions to statements such as "I feel secure" and "I feel calm".

The State Anxiety Inventory Form Y-1 of Speilberger's State-Trait Anxiety Inventory (STAI)[1] was used to rate family members' anxiety level. The Form Y-1 is a 20-item self-administered questionnaire that takes approximately six to ten minutes to complete. Although anxiety is not mentioned in the questionnaire, the items are designed to elicit feelings of anxiousness. Respondents indicate on a scale from 1-4 how anxious they are feeling at that moment; a rating of 1 indicates "not at all", while a rating of 4 indicates "very much so". Final scores range from 20 for those who are "not at all anxious" to 80 for those who were "very much anxious". This is well-established instrument with good psychometric properties.

The Family Rating Scale (FRS) was used to determine what specifically was helpful for the family members during the intra-operative period. The FRS elicited feedback on the participants' information needs as they related to the surgical experience and items were scored on a 5-point Likert scale. This survey also included 2 open-ended questions. FRS items included such questions as "did you have your questions answered?" and "Did you receive information regarding your child's condition/progress?" designed to evaluate the effectiveness of the SLN role. The SLN group's FRS had one additional item: "Do you feel that having a contact person helped your anxiety level?" Content validity was assessed prior to the study, by giving the instrument to six families for their review for the relevancy, meaning and clarity of items

In addition to the above-mentioned instruments distributed to study participants; a form was also developed to obtain feedback from health care professionals potentially impacted by the SLN role. Questions were designed to capture the individual's overall satisfaction with the role and any changes in the employee's workload as a result of the SLN implementation.

## Setting and Sample

This study was conducted in a paediatric operating room at a tertiary center-providing healthcare to women, children and families in eastern Canada. The paediatric operating room provides surgical health services to infants, children and adolescents, and their families, throughout the Maritime region and performs approximately 6,000 surgeries each year. Services include general surgery; otolaryngology; ophthalmology; orthopaedic; urology; neurosurgery; cardiac surgery; plastic surgery; dentistry; ear, nose and throat (ENT); and gastro-intestinal (GI) procedures.

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The eligible population included all English-speaking families that had a child pre-booked for an operating room surgical procedure that was expected to last at least one hour. The sample consisted of a subset of 92 families from a total of 145 families invited to participate in the study. Of the total random sample recruited by telephone (n=145), 11 families declined to participate, 47 were randomly assigned to the support (SLN) group and 45 were randomly assigned to the routine care (RC) group. The remaining participants either withdrew from the study (n=11) did not complete all surveys (n=21) or the child's surgical procedure was cancelled (n=11).

**FINDINGS**

All data were coded and analysed using the Statistical Package for Social Sciences (SPSS) Version 10. Frequency analyses were performed to gain demographic information about the sample.

Demographically, the groups were similar in terms of age of child, number of previous surgeries, and length of surgery. The majority of children were between 2-10 years of age (65%), with less than 10% younger than one, and between 25-29% older than 10 years. For SLN group there were more males (n= 26) than females (n=21). The Routine Care group had more males (n=27) than females (n=18) out of a total of 45. Both groups were also similar in terms of surgical procedures performed.

**QUANTITATIVE DATA FINDINGS**

**STAI**

The scores for anxiety for both groups are outlined in Chart 1 and 2. Preoperatively, the anxiety scores for both groups were similar and ranged from 1.8 to 2.3. No significant differences were found between the two groups according to analysis of variance (see Chart 1 & 2). Post-operatively, both groups had lower anxiety scores than they had preoperatively, (see Chart 1 & 2). However, the scores show that families who received intra-operative SLN support had lower anxiety scores than the RC group. There was a clear trend toward a decline in the anxiety scores of the SLN group when means and standard errors were graphed on an error bar chart (Chart 1 & 2). The SLN group also showed less variability in their

## Total Anxiety Scores Pre & Post-Op

**Chart #1 Pre-Op**

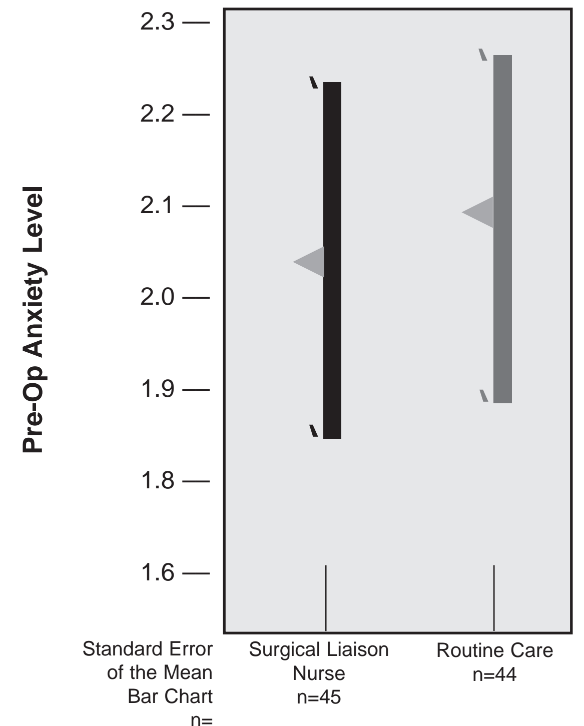



**Chart #2 Post-Op**

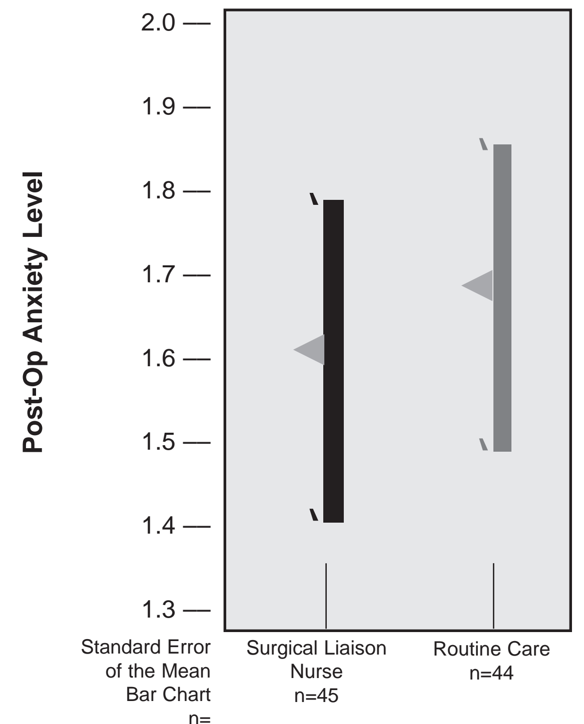


Photo by/par K. MacDonald

*The surgical liaison nurse updates a family member*

anxiety scores than the RC group. However, despite the lower anxiety scores for the SLN group, there was no statistically significant difference between the two groups according to an analysis of variance (see Chart 1 & 2).

### FAMILY RATING SCALE

In the SLN group, 50% of the scores on the Family Rating Scale (FRS) were 4, while for the routine care group 50% of the scores were between 2.5 and 3 in terms of satisfaction with care, which indicates that the parents in the SLN group reported higher levels of satisfaction with care than parents in the RC group. Eighty-seven percent (n=41) of parents in the SLN group responded that having intra-operative SLN support reduced their anxiety level.

Ninety-eight percent of the SLN families responded that they had their questions answered and that they understood the information in comparison to 87% in the routine care group.

Both groups felt the hospital staff cared about their child but when asked about receiving updates and progress reports 54% in the routine care group responded that they received this information versus 94% in the SLN group. Families in both groups consistently received information from the surgeons post-operatively. (This could account for the high percentage of the routine group stating that they received progress reports.) In addition families in the SLN group also received information intraoperative updates from the SLN.

## QUALITATIVE DATA FINDINGS

### FAMILY FEEDBACK

#### Surgical Liaison Group

In the surgical liaison nurse support group, 64% of parents provided thoughtful feedback. Of this feedback, 93% was positive, 3% was negative and one comment was not applicable. Themes that emerged from the parents' comments included:

1. Feeling more informed (n=12 f =26%);
2. Enhanced quality of care (n=4 f =9%);
3. Feeling less anxious (n=6 f = 13%); and
4. Recommendations (n=11 f =23%).

For the category "Feeling more informed" families commented they "very much like the flow of information" and " the surgical nurse was great to have on hand just to let us know that our little boy was doing great".

Enhanced quality of care was recorded as "makes the patient very comfortable" and "as a parent you are never left on the outside".

Comments in the "Feeling less anxious" category included parents descriptions of being "relieved" to be able to "hear so quickly" how their child did when going under anaesthesia. Less anxious comments were also expressed as "very reassuring", "it definitely put me more at ease and relaxed about the procedure" and "helped me feel relaxed".

Recommendations included "continuing the SLN role", having a contact nurse past 1500 hours and increasing the number of surgical liaison nurse reports.

#### Routine Care Group

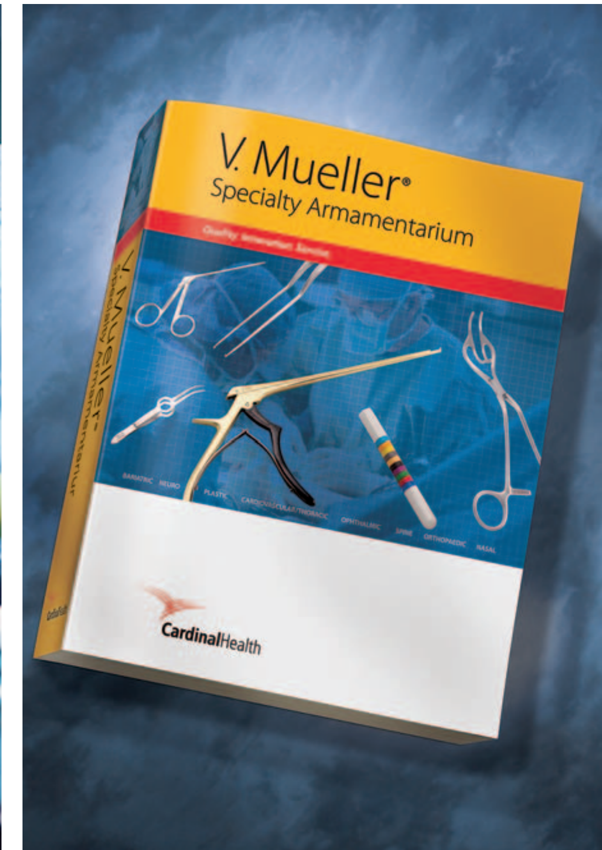
Parents' responses in the comparison group, or routine care group, were categorized according to the same general themes, but reflecting the opposite findings.

Categories of comments included:

1. Feeling less informed (n=10 f= 22%);
2. Feeling more anxious (n=6 f =13%);
3. Positive comments – related to study outcomes (n=6 f = 13 %);



If it's in here... It's in here.

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4. Positive comments – not related to study outcomes (n=11 f =24%); and
5. Recommendations (n=8 f =18%).

For the category "Feeling less informed" families stated, "during the surgery I was given no feedback" or "my husband and I were left with no information". Three parents did specifically stated that they were "given plenty of information" but this was not qualified by any detail about the type of information or any comparison to allow us to determine the definition of "plenty".

Comments in regard to "Feeling More Anxious" included statements such as, "I felt confident leaving my child in their care for his surgery". One parent wrote, "My child was comfortable and at ease which in turn made us comfortable and at ease".

Positive comments related to study outcomes included "I feel confident that the staff took great care in my daughter's surgery and recovery". This exemplifies the parents' positive feedback related to the outcome of the study. On the other hand, comments not related to the study outcome consisted of "very pleased", "very professional" or "thank you".

However, despite the positive comments most families made recommendations around improved coordination of information between staff and that regular updates or mid-term reports to families from the OR are needed.

### HEALTH CARE PROFESSIONAL FEEDBACK

After all data was collected from families the study began to focus on staff perceptions of the role. 280 feedback forms were sent to various health care professionals, including all surgeons, anaesthetists and nurses in the perioperative care team, the Paediatric ICU, and the in-patient surgical units. Written feedback from health care professionals was analyzed using content analysis.

The research team captured four consistent thematic patterns in the data. The themes for both groups were inter-rated with an 85% agreement rate. Of the 280 feedback forms sent to the health care professionals, only 19% (n=53) chose to reply. From these responses, there were 38 comments, 81% of which were positive, and 19% of which were considered 'helpful constructive' feedback.

The themes included:

1. Improved time management for staff (n =13, *f* =31%);
2. Enhanced quality of care (n =17 *f* = 45%);
3. Comments that indicated that parents were more informed (n =22 *f* = 58%);
4. Comments that indicated that parents were less anxious (n =20 *f* =53%); and
5. Recommendations to improve SLN support (n = 12 *f* = 32%).

An example of feedback in the improved time management category included reports that the SLN role was an efficient use of nursing time and "less time consuming to get information to and from the doctors".

Examples of enhancement of quality care comments included "less interruptions in care to other families due to liaison nurse".

Staff identified that parents seemed more informed because they had fewer questions about the status of surgery.

As an indication that parents were less anxious, staff also commented on the fact that parents were calmer coming into the recovery room because they were better informed. Communication with the staff was improved and the health care team stated that the surgical liaison nurse's role filled the void for parents by letting them know their child was safe and provided regular updates to ease further fears.

Several recommendations indicated that this role should be offered for the entire length of procedure (not just until 1500 hours when the usual nursing shift is over). Helpful recommendations identified that coordination between floors could be improved through the use of pagers. A recommendation included the surgical liaison nurse giving the pager directly to the family member so that the in-patient nursing station could be by-passed when information was passed on the family members. There were

*Continued on Page 35*

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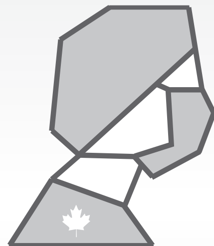


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# ORNAC IN A NUTSHELL — FALL 2005

*Author: Lynn Anderson, ORNAC Secretary*

The Fall Executive & Board meeting was held in Toronto on November 4, 5, and 6, 2005.

- ORNAC President, Marcy McKay, welcomed the newly elected Executive and new Board members Donna Marin (SK), Greg Samson (NS), Thelma MacNeil (NS), Joanna Schubert (ON) and our new affiliate Board members Pam Railton (RNFANC) and Muriel Shewchuk (CORL).
- Farewell was expressed to Diana Mabbett (NS) and Line Boucher (PQ).
- Observers at the meeting included Stephane Delorme Auditor, Pat Pocock (CORL) and Monique Trachy (QC).
- The **Standards Committee** held a two-day meeting prior to the Board Meeting and is now in the process of reviewing and revising Module 2. If anyone has expertise in this area, suggestions for review items, or would like to assist with revision, please contact Bonnie McLeod, Chair of the Standards Committee, at standards@ornac.ca.
- The **Awards Committee** has an ongoing review process to prepare for award presentations that usually take place at the National Conference. ORNAC is also currently developing criteria for several new awards. Check out the award criteria at www.ORNAC.ca.
- The **Scope of Practice Committee** has been very busy compiling the results of a National Survey on the role of Perioperative Nurses in Anesthesia Assistant and developing a document to support the need for the Registered Nurse Anesthesia Assistant. President Marcy McKay attended the Canadian Anesthesia Society meeting in June 2005 and presented the progress, to date, on this document. If you have an interest in this expanded role for the Perioperative nurse please contact Dotty Dewar, Chair of the Scope of Practice Committee, at practice@ornac.ca.

Photo by/par A. Oucharek Mattheis

*ORNAC Committee Chairs (L to R) Alicia Oucharek Mattheis, Awards; Karen Frenette, Research; Donna Gramigna, CORNJ.*

- The ***Canadian Operating Room Nursing Journal*** continues to grow and member support and feedback is appreciated. We do receive some Journals back from Canada Post when people move and do not provide notification of their change of address. Members can now submit a change of address online at www.ORNAC.ca — this information will be shared with both the province and the Journal. Alternately, members can contact both the province and the Journal directly by mail or fax. It is important to notify both organizations as each province currently maintain its own membership database, and only provides mailing information to the Journal at the start of each year. Mid-year changes are not necessarily passed on to the Journal. ORNAC is looking in to the feasibility of creating one national database, in the near future, so it can be updated centrally and shared with all.
- The **website** continues to grow and develop. To date we have had over 2.5 million hits. An increased amount of the Board & Executive work is taking place through our on-line virtual office. We are hoping to soon have a historian page to display ORNAC's history including a President's plaque, the Mission Vision Values Statement, and a copy of all of the J&J Medical Products limited edition souvenir prints.
- **Bylaw changes** effected in May 2005 will result in the first ever election of an Executive member in the year between National Conferences. In the spring of 2006 ORNAC will elect a new Treasurer. The role of Treasurer has changed dramatically over the past several years and ORNAC felt it was more appropriate to change its treasurer in a non-conference year.
- The **ORNAC video** *Because You Care* will soon be updated. Contact Linda Socha at info@ornac.ca if you have any suggestions or wish to get involved.
- The site of the **2011 National Conference** will be Regina, Saskatchewan. Congratulations to SORNG!
- ORNAC is involved with a number of **national initiatives.** Board members are involved with Canadian Patient Safety Institute (CPSI), Canadian Council for Donation and Transplantation (CCDT), Canadian Nurses Association (CNA) Nursing Portal, Canadian Council on Health Services Accreditation (CCHSA), Canadian Standards Association (CSA), *Safer Healthcare Now!* and the Canadian Nurses Association (CNA) certification review, just to name a few. From time to time reports or updates will be made available on the website.
- **In order to keep up to date on all of ORNAC's activities please visit www.ORNAC.ca frequently.**

# L'AIISOC en Bref — Automne 2005

*Auteure: Lynn Anderson, ORNAC Secretary*

La réunion de l'automne des conseils exécutifs et administratifs a eu lieu à Toronto le 4, 5 et 6 novembre 2005.

- La présidente de L'AIISOC, Marcy McKay, a accueilli les nouveaux membres des conseils : Donna Marin (SK), Greg Samson (N-É), Thelma MacNeil (N-É) et Joanna Schubert (ON) ainsi que les nouveaux membres affiliés, Pam Railton (RNFANC) et Muriel Shewchuk (CORL).
- Nous avons dit adieu aux members suivants : Diana Mabbett (N-É) et Line Boucher (QC).
- Aussi presents à la réunion étaient Stephane Delorme (vérificateur), Pat Pocock (CORL) et Monique Trachy (QC).
- Pendant les deux jours précédant la réunion du conseil administratif, le **comité des normes** a tenu une réunion et est maintenant en train de passer en revue et de mettre à jour le module 2. Si vous avez de l'expertise dans ce domaine, des suggestions de sujets de revue ou que vous aimeriez aider avec la mise à jour, veuillez contacter Bonnie McLeod, présidente du comité des normes, à standards@ornac.ca.
- Le **comité des prix** emploie une procédure d'évaluation continue afin de préparer le décernement des prix pendant la conférence nationale. Les critères de plusieurs

Photo by/par A. Oucharek Mattheis

*ORNAC Affiliate Board members Pam Railton, RNFANC, and Muriel Shewchuk, CORL.*

nouveaux prix sont également en cours de développement. Informez-vous sur les critères d'admissibilité au www.ORNAC.ca.

- Le rassemblement des résultats d'une étude nationale sur les infirmières et infirmiers périopératoires et le rôle des assistants de l'anesthésie tient très occupé le **comité du champ d'exercice**. Le comité rédige aussi un document appuyant le besoin d'assistants de l'anesthésie infirmiers autorisés. En juin 2005, Marcy McKay, présidente de l'AIISOC, a assisté à la réunion de la Société canadienne des anesthésiologistes pour présenter une mise à jour sur le développement de ce document. Si ce rôle plus étendu du professionnel en soins périopératoires vous intéresse, veuillez contacter Dotty Dewar, présidente du comité du champ d'exercice, à practice@ornac.ca.

- La revue de l'Association des infirmières et infirmiers de salle d'opération du Canada, le ***Canadian Operating Room Nursing Journal***, est en croissance constante et nous apprécions toujours l'appui et les commentaires de nos membres. Étant donné qu'il arrive parfois que Postes Canada nous en renvoie des copies lorsqu'un membre déménage sans nous aviser du changement d'adresse, nous offrons maintenant la possibilité d'effectuer un changement d'adresse en ligne au www.ORNAC.ca. Ces renseignements seront communiqués et à l'association provinciale et à la revue. Vous pouvez toutefois toujours contacter séparément votre association provinciale et la revue par courrier ou par télécopie. Il est important de contacter chacun des organismes car chaque province maintient sa propre base de données, et ne fournit les adresses postales de ses membres à la revue qu'au début de l'année. Les changements effectués au cours de l'année ne sont pas nécessairement acheminés à la revue. L'AIISOC étudie actuellement la faisabilité de la création d'une base de données nationale qui permettra la mise à jour commune de toutes les bases de données.

*Photo by/par A. Oucharek Mattheis*

*ORNAC Committee Chairs (L to R) Dorothy Dewar, Scope of Practice; Bonnie McLeod, Standards; Dianne Johnson, Perioperative Nursing Education.*

*Photo by/par A. Oucharek Mattheis*

*Muriel Shewchuk, Affiliate Board member, at her surprise retirement party, November 2005.*

- La croissance du **site Web** continue également. Jusqu'à présent, nous comptons plus de 2,5 millions de visites. De plus en plus notre bureau virtuel est le lieu de travail de nos conseils exécutifs et administratifs. Nous espérons bientôt avoir une page élaborant quelques éléments importants de l'histoire de l'AIISOC tels la plaque de la présidente, l'énoncé de mission, de valeurs et de vision, ainsi que des exemplaires de toutes les images souvenir à tirage limité de J&J Medical Products.

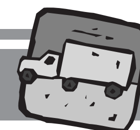
- Les changements faits aux règles et règlements en mai 2005 auront comme résultat la première élection d'un membre du conseil administratif pendant l'année entre les conférences nationales. Au printemps 2006, l'AIISOC élira un nouveau trésorier. Depuis quelques années le rôle du trésorier a beaucoup changé, et nous avons décidé qu'il est maintenant approprié de changer de trésorier entre les conférences.

- La **vidéo de l'AIISOC** *Because You Care* sera bientôt mise à jour. Veuillez contacter Linda Socha à info@ornac.ca si vous avez des questions ou si vous voulez participer.

- La **Conférence nationale 2011** aura lieu à Regina, Saskatchewan. Félicitations à la SORNG!

- L'AIISOC participe à nombre d'initiatives nationales. L'Institut canadien sur la sécurité des patients (ICSP), le Conseil national sur le don et la transplantation (CNDT), le Portail canadien des infirmières et infirmiers, le Conseil canadien d'agrément des services de santé (CCASS), l'association canadienne de normalisation, *Des soins de santé plus sûrs – maintenant!* et la revue des examens de certification en soins infirmers de l'Association des infirmières et infirmiers du Canada (CIIC), parmi d'autres, profitent tous de la participation de membres de notre conseil administratif. Périodiquement, des mises à jour seront disponibles sur le site Web.

- **Soyez au courant de toutes les activités de l'AIISOC en visitant régulièrement le site Web de l'AIISOC au www.ORNAC.ca.**

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***Auteure:*** *Muriel Shewchuk, infirmière autorisée, baccalauréat en sciences infirmières, CPN(C), est consultante en soins périopératoires. Elle vient juste de prendre pris sa retraite après 42 ans dans les domaines de formation et d'administration périopératoires. Muriel est la cofondatrice ainsi que la coprésidente actuelle du Canadian Operating Room Leaders Network (CORL), organisme ayant récemment devenu groupe affilié de l'AIISOC. Muriel sera la représentante du CORL au sein du conseil administratif de l'AIISOC.*

## LEADERNOMIE

### L'équilibre en leadership – s'adapter selon les circonstances

Vous avez raison, vous ne trouverez pas le mot «leadernomie» dans votre dictionnaire. Cependant, je réclame une certaine liberté poétique pour créer ce mot et pour l'utiliser dans cet article. Dans votre rôle de leader, vous devez choisir parmi plusieurs différentes voies, chacune représentant un style différent – laquelle choisir? Pouvez-vous en choisir plus qu'une? Que vous soyez le leader d'une salle d'opération pendant une seule journée ou que vous soyez le directeur à long terme d'un grand service, ou quoi que ce soit entre les deux, vous aurez, afin d'être efficace et connaître le succès, à choisir parmi plusieurs styles de leadership au cours d'une semaine ou même d'une journée. La définition de «leadernomie» serait alors le mélange de styles de leadership en vue de produire les résultats les mieux adaptés aux circonstances et aux personnes concernées.

***Author:*** *Muriel Shewchuk RN, B.Sc.N, CPN(C) is a Perioperative Nurse Consultant. She has recently retired following over 42 years of Perioperative Education and Administration. Muriel is a co-founder, and currently co-chair, of the Canadian Operating Room Leaders Network (CORL) which has recently been granted Affiliate status with ORNAC. Muriel will represent CORL on the ORNAC Board.*

## LEADERNOMICS

### Situational Balance – One Size Does NOT Fit All!

You are right – "Leadernomics" is not a word that is in your dictionary. I have taken editorial license and created the word for use in this article. As you walk down the road of leadership styles, you will have several paths to choose from – which will you take? Can you choose more than one? Whether you are the leader of an operating room theatre for only one day or the long-term director of a large department – or anything in between – you may, in order to be effective and successful, need to choose several different leadership paths over the course of a day or a week. "Leadernomics" would be defined as the blending of leadership styles in order to produce the results best suited to the circumstances and the people involved.

**Leadership Styles**

The purists view of leadership styles are generally recognized as laissez-faire, democratic, autocratic, and dictatorial. Leaders are often labeled as one type of leader by their colleagues and staff. The label is generally the result of a specific encounter or a belief that is held about the leader – it may or may not be fair and may or may not be recognized by the leader. Whether or not it is fair, most employees and colleagues will have an opinion about their leaders. This label is hard to change. To do so, a leader must recognize how he/she has been labeled and make a concerted attempt to develop a new image – ideally one that is situational and appropriate to a range of scenarios. Effective leadernomics blends the various styles of leadership in to one that allows a leader to respond effectively to every situation. When used effectively, it allows everyone involved in a situation to achieve a positive result and to, as needed, "save face". Leadernomics used effectively help a leader achieve the label "The Leader Everyone Wants"!

Selecting and utilizing the most effective leadership style can be not unlike the challenges of dealing with children. A two year old can go from being loving and sweet to laying on the floor in a fit of tantrums. A volatile, emotional, challenging teenager can test your every strength. In the

workplace, senior professionals, with great responsibility and complex roles, can suddenly shift to nonsensical, out of control, behaviour that requires the appropriate leadernomics to effectively manage the situation. "One size leadership" will NOT fit all of the possible, and interesting, situations.

### Preparing Yourself for Effective Leadernomics

Many leaders have little understanding of how they are perceived by their employees and peers. It is important to take the time to do a post evaluation of leadership situations in order to determine how the situation could have been handled more effectively and to evaluate how the other participants might be feeling. It is important to look in the mirror, in order to honestly evaluate leadership style, reputation, and the image held by others. A dogged determination to rule and win at all costs, or a fear of the truth, will result in a lack of understanding. Effectiveness will be diminished in a leader who wants to be everyone's friend, to offend no one, and to avoid the tough decisions. Lack of the right education and experience, or the past presence of inadequate role models, mentors, and supervisors can create major leadership issues. Internal and external pressures can increase a leader's difficulties. All these factors combined with personality, leadership style, and personal expectations contribute to each individual's leadernomics.

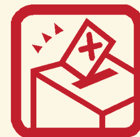
In order to develop effective leadernomics it is important to have a strong understanding of the mission, goals and objectives, as well as the expected outcomes, ramifications and risks, of each situation. Ask all the "what if's"and be prepared for every possibility! It is important to allow enough TIME to form a clear strategy – this may require moments, a few hours, or days. The application of appropriate leadernomics requires a leader with a high acuity assessment for risk factors to patients, staff, physicians, legal processes, material and financial resources, and the entire medical facility.

### Laissez faire Leadership

Allowing everyone to do what they want, when they want, generally has little place, in its true form, in our complex, highly regulated, perioperative environment. A "free for all" with limited accountability to a common goal would raise major concerns. The risks to everyone concerned, and the negative impact on overall efficiency, will usually preclude the role of purely laissez-faire leaders. If credibility and required production are not managed effectively they may well be compromised.

### Democratic Leadership

A true democratic environment would result in everyone having equal access to information and opportunity for decision making through a voting or consensus process. The leader would be expected to fulfill the wishes of the group. A true democracy requires that the staff determine what will occur in most situations. A true democracy requires a great deal of time educating all participants about the situation and its potential ramifications. Many factors – such as the needs of other departments and institutions, administrative and legal requirements, and financial restrictions – will preclude a true democracy. Although staff may want full input, they will also expect that boundaries, borders and limitations are put in place. If they are required to contribute too much input, you may hear "I'm not paid to do your job". Leadership strategies that aim for a full democracy may appear rudderless or leaderless and result in a loss of the leader's credibility.



It is important to establish clearly defined processes that allow staff to have appropriate input through the key experienced personnel. This group will know how to direct the input and facilitate the right procedures. Modified democracy provides the greatest opportunity for teamwork and involvement.

### Autocratic Leading to Dictatorial Leadership

We all know a wide range of autocratic decision makers who may, or may not, have the best interests of the staff in mind. Because they can be unapproachable, true autocrats are usually not in possession of all the information needed to lead effectively. The autocratic leader in its worst, and most unaccessible, form would be a dictator. While it is important to be able to make the tough decisions, no leader can afford to be an island, isolated from feedback and from staff input. The impact of the purely autocratic leaders is usually very destructive for the department, the staff and, ultimately, for the leader.

### Blended Leadernomics

Utilizing the best leadership competencies and incorporating components from all the various leadership styles in a blended manner will lead to success. Understanding the players and the situation, while allowing for risks and timing, will help a leader choose the right mixture of styles to ensure that that everyone is heard and that all rights, issues, and priorities are recognized. Remember one size does NOT fit all personnel any more than it fits all situations.

Elements of laissez faire can be incorporated in appropriate amounts, with the right group of staff, in to situations where there is limited risk, where considerable time is available, and where staff can be trusted to effectively make decisions. This approach can rule out unnecessary micromanagement. Caution, however, is advised. It is important to draw the necessary boundaries, determine in advance the level and areas of accountability, and to ensure follow through on both the impact and outcome.

The urgency of the situation, the experience of the players, and the individual dynamics and tactics will add challenge to a leader's choices. In crisis situations an autocratic, bordering on dictatorial, approach may be the right tactic in order to reduce the risk to everyone. It is important to encourage dialogue after the situation so that all parties can understand the reason that a particular action was taken. But there will come a point when enough discussion has taken place and decisions just have to be made by those in charge. This may seem autocratic, but it is the role of authority figures to make decisions. It is, however, important that explanation, diplomacy, tact and respect remain part of the process.

### Summary

Leadernomics involves effectively blending each of the styles of leadership in a balance that is best suited for each situation, individual, or group. An excellent leader will be able to rapidly analyze the situation and incorporate the strategies that will be most effective.

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# LE LASER GREENLIGHT ARRIVE AU CANADA

*Auteures:*

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**RÉSUMÉ**

Le laser Greenlight – un laser haute puissance utilisé pour le traitement de l'hyperplasie bénigne de la prostate – a été utilisé pour la première fois au Canada en 2003 à Newmarket, Ontario par Dr Liquornik, baccalauréat ès sciences, MDCM, FRCSC. Le laser se révèle utile en éliminant le besoin de séjourner à l'hôpital, en réduisant la période d'utilisation de la sonde à demeure d'une semaine à moins de 28 heures, en diminuant la douleur et en rendant rare la répétition du traitement. Le laser enlève le tissu prostatique sans effets néfastes sur l'urètre parce que le faisceau ne fixe que le surcroissement de tissu de la prostate. Les patients sont très satisfaits et peuvent reprendre leurs routines normales dans une ou deux jours.

# THE CANADIAN INTRODUCTION TO THE GREENLIGHT LASER

*Authors:*

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**ABSTRACT**

The Greenlight laser – a high powered laser used for Benign Prostate Hyperplasia – was used for the first time in Canada in Newmarket, Ontario by Dr. Liquornik BSc MDCM FRCSC in 2003.

The laser is proving to eliminate hospital stay, decrease the catheter indwelling time from one week to less than 28 hours, decrease pain and suffering and make repeat procedures something rare. The laser melts away the prostate and leaves a urethra that is unscathed by the effects of the laser because the beam concentrates on the overgrown prostatic tissue only. The patients are very satisfied and back to normal routines in one to two days.

---

For the men of York Region the days of continuous bladder irrigation (CBI) are becoming a thing of the past. This is relieving news for the aging population and the health care system. The introduction of the Greenlight Laser into Canada by Dr.Liquornik, Urological Surgeon, in Newmarket, Ontario, on November 12, 2003 was just in time for the large increase in cases of Benign Prostatic Hyperplasia (BPH) resulting from an aging baby boomer population. BPH is a condition of prostatic overgrowth in men. Approximately 50% of human males will have symptoms as a result of BPH in their lifetimes.[1]

The past gold standard treatment, the Transurethral Resection of the Prostate (TURP) has proven to be effective in the long term but causes injury to the tissue that requires in-hospital healing time (two or three days on average) involving Continuous Bladder Irrigation (CBI). During TURP the surgeon scrapes out the prostate tissue that has overgrown into the urethra. He uses electrocautery that cuts away the tissue and coagulates small vessels. The area is much like an open wound post-operatively and must heal, as any wound would, by creating scar tissue. The catheter *insitu* stops the wound from swelling the urethra shut during the healing process.

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Laser alternatives have been tried in an attempt to create a better treatment option for the patient. But, until recently, the TURP has remained the most effective way of treating the often uncomfortable and debilitating condition of BPH.

Since its arrival the Greenlight laser has proven itself an exciting and less painful treatment in which patients receive much less tissue injury and are able to be discharged from the post surgical recovery area on the same day. There is only a 50% chance that patients will need a catheter for a short period of time after surgery, and they are able to work and perform other regular activities in only two days. With this treatment there is no need for CBI at any time.

The elimination of the post operative CBI and catheter in BPH patients coupled with the minimal, if any, length of stay, decreases much of the trauma to the patient. Furthermore, large amounts of money expended by the health care system on post-operative care and treatment of complications from TURPs can be reallocated to other areas of patient care.

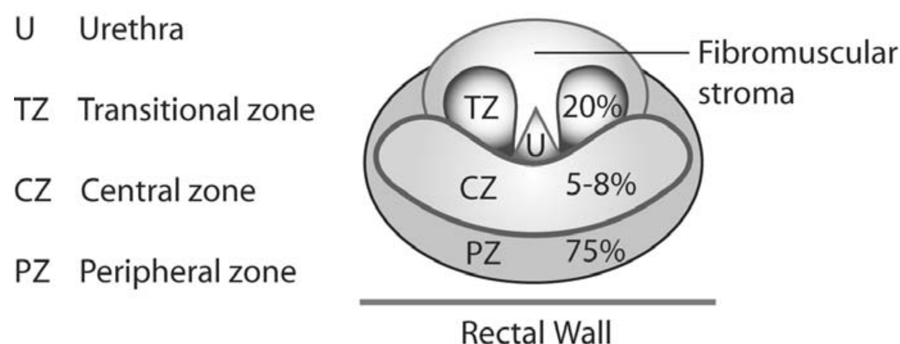
## THE ANATOMY AND PHYSIOLOGY OF THE PROSTATE GLAND

The Prostate Gland is a walnut shaped organ composed of fibromuscular and glandular components. It is located at the base of the bladder neck and completely surrounds the urethra. It is supported by the puboprostatic ligaments anteriorly and by the urogenital diaphram inferiorly.[2] The normal prostate measures 2.5cm long and 4 cm in diameter (3)and weighs approximately 20g.[2] The prostate has four glandular regions-two major regions which are the peripheral and the central zone and the two minor regions which are the transitional and the periurethral zone.[4]

Lowsley's classification of the prostate identifies five lobes: anterior; posterior; median; right lateral and left lateral.[2] Many clinicians prefer to divide the prostate into the intraurethral, lobe, which is the right and left lateral lobes, and the extraurethral lobe, which is the posterior and the median lobes.[4] The posterior lobe is palpable on rectal examination and is prone to cancerous degeneration while BPH generally occurs in the transitional zone.[2]

The true prostatic capsule is a fibrous sheath that covers smooth muscle fibers and collagenous tissue that surrounds the urethra as an involuntary sphincter. The prostatic stroma lies deep to this layer and is composed of connective and smooth muscle fibers that are embedded in the epithelial glands. These epithelial glands drain into the major excretory ducts that open on the floor of the urethra. The prostatic urethra is the segment of the urethra that passes through (traverses) the prostate. This urethra is lined with an inner longitudinal layer of muscle. The periurethral glands are located just beneath the prostatic urethra.[2]

The prostate gland is supplied arterially by the inferior vesical, internal pudendal and middle rectal arteries. The prostate veins drain into the periprostatic plexus which is connected to the deep dorsal vein of the penis and the internal iliac veins.[2] The sympathetic and parasympathetic nerve plexuses supply the prostate gland. The prostate lymphatics drain into the internal iliac, sacral, vesical and external iliac lymph nodes.[2]




The Anatomy of the Prostate Gland

For several centuries BPH has been a known cause of urinary dysfunction. Around the age of 35 years the first changes of BPH can be identified. These changes include the development of microscopic stromal nodules around the periurethral glands. Glandular hyperplasia begins to form around these small nodules. This process takes many years. The microscopic incidence of BPH is consistent amongst the male gender, which is suggestive that BPH is not environmentally or genetically influenced. The prevalence of microscopic BPH increases with age in all male populations (2).

The cause of BPH is unknown, however it has been determined that two factors must be present for BPH to occur. These two factors are the presence of dihydrotestesterone (DHT) and aging. The testes produce the hormone testesterone which is converted into DHT and estradiol (estrogen) in certain tissues. Although, hormonal involvement is believed to induce BPH, the role is considered to be complex and is not completely understood.[2]

The earliest changes of BPH are found in the periurethral glands surrounding the verumontanum. The development of BPH occurs over a long period of time therefore changes affecting the urinary tract are slow and insidious. Symptoms can be either obstructive, irritative or both in nature. One of the early and constant obstructive symptoms is a decrease in the force of the urine stream related to urethral compression. Pathophysiological changes to the detrusor muscle, reslulting in poor tone causes both hesitancy and intermittency to occur. The detrusor takes a longer period of time to overcome urethral resistance and it is unable to maintain the required pressure until the end of voiding. Incomplete bladder emptying and dribbling can also be attributed to the weakened detrusor muscle and/or obstructive prostatic tissue at the bladder neck.[2]

Irritating symptoms include nocturia and frequency. These symptoms occur for a variety of reasons. Incomplete bladder emptying decreases the period of time between voids. The presence of an enlarged prostate causes the bladder to initiate a voiding response more frequently than normal, this is especially true if the prostate grows intravesically and compromises bladder volume. These symptoms are more apparent at night due to normal cortical inhibitions being lessened and normal urethral and sphincter tone being decreased during sleep.[2]

In advanced stages of BPH, large amounts of residual urine cause the weakened sphincter to open and allow urine to escape. Dilation of the upper urinary tract and urinary stasis in the ureters related to detrusor muscle decompensation occurs. Dilation of both the ureter and the pelvis leads to functional renal damage that may develop into ascending infection and pyelonephritis. Acute urinary retention may occur in patients with BPH related to an increased prostate gland.

Systemic symptoms related to the urinary tract are upper abdominal discomfort and flank pain. This occurs in patients with BPH related to vesicoureteral reflux with dilation of the upper urinary tract and hydronephrosis. Symptoms such as chronic fatigue, decreased appetite and malaise are related to uremia resulting from renal failure.[2]

Symptoms not related to the urinary tract include hernias and hemorrhoids due to increased abdominal pressure during voiding.

In the later stages of BPH the patients are predisposed to developing cystitis and pyelonephritis related to the high residual urine volume, urinary stasis, and vesicoureteral reflux. Patients present with symptoms that are

related to complications of BPH such as flank pain, fever and dysuria. Urinary stasis may develop into the formation of bladder calculi resulting in obstruction, frequency, dysuria and hematuria.[2]

## TREATMENT OPTIONS

The history of treatment options includes the TURP, the use of the Nd: YAG laser, the Holmium laser, and now the advent of the Greenlight laser. The most tried and true is the TURP but the Greenlight is emerging, with only five years of statistics, as a plausible replacement treatment option.

## TURP

The perioperative considerations of TURP patients are control of bleeding and time limitations due to the risk of transurethral resection (TUR) syndrome. With it the patient becomes hyponatremic and hypovolemic and could develop hyperammonemia (when using glycine). Possible extreme effects can be cerebral edema and seizures with a serum sodium less than 120meq/L.[2] TUR syndrome can result from the use of excessive amounts of fluid as required for the contiuous irrigation needed during the TURP procedure and usually occurs in surgeries that last more than one hour. The condition, transurethral resection syndrome (TUR syndrome), can become apparent when absorption of chemicals and water found in the irrigation occurs through the open wound left by the surgery. When great volumes are absorbed there are fluid imbalances that take place. The patient that becomes hyponatremic and hypervolemic could develop hyperammonemia (when using glycine).

The patient will have a one to two day hospital stay and 4-6 week recovery time. Immediate complications include the fact that 6.5% fail to void, 2% have postoperative hemorrhage, 3% have clot formation and 2% have urinary tract infections. There is an 80 to 90% chance that, post-operatively, patients have resolved the overgrowth of prostate tissue – and therefore the narrowing of the urethra that was caused by the overgrowth. 60 to 75% of patients have no re-growth of the prostate tissue (to the degree that it would impede their voiding) after five years. There is an 80 to 90% chance that patients will have resolved voiding problems postoperatively and a 60 to 75% chance that patients will have resolved voiding problems after five years. Five percent of the population needs to have a repeat procedure done after five years.[2]

Post-operative nursing considerations are care of the patient following spinal or general anaesthesia, CBI care, assessment for TUR syndrome, (dilutional hyponatremia), preventing sepsis, monitoring for vaso-vagal reactions, monitoring the patient for bladder spasms and assessing the patient's ability to void post-catheterization. The patient is discharged with instructions not to resume non-steroidal anti-inflammatories or aspirin for one week, information regarding the potential for retrograde ejaculation and the potential for impotence and incontinence, and with details on how to watch for the signs and symptoms of urinary tract infections.[5]

## PREVIOUS LASER TREATMENTS

Lasers such as the Nd:YAG laser have been tried but the statistical results are not as solid as the TURP treatment option. The main problem with the Nd:YAG laser is that the energy is absorbed by cellular proteins and the effected area is much too deep, approximately 7mm. In addition, the beam heats too slowly and is not precise. There was a higher incidence of postoperative dysuria and urinary retention with the Nd:YAG laser. The Holmium laser has also been tried as a treatment for BPH but it has failed because of a longer learning curve and the holmium takes a longer surgical time. The procedure is not enough of an improvement to compensate for these two factors. These drawbacks in laser surgery have made surgeons reluctant to replace the traditional TURP with the available lasers.

## GREENLIGHT LASER

By doubling the power of the Nd:YAG laser by using Potassium-titanyl-phosphate (KTP) crystals to receive the wavelength of 532nm (the wavelength of green light) and setting the power to 80W the laser created becomes less damaging and more precise. The higher absorption rate of the laser to hemoglobin allows only a 1 to 2 mm tissue absorption.

The heat is more concentrated and rapidly vaporizes the cellular water. It leaves a small 2mm rim of coagulation. The Nd:YAG heals with a large area of scar tissue whereas the Greenlight laser has virtually no scars. A larger, non-contracted, pliable and relatively smooth cavity is created and sustains its virtues after healing. The procedure is essentially bloodless therefore patients on anticoagulants are able to continue taking them before and after the surgery. The tissue is not subject to absorption therefore there is no fear of TUR syndrome. The catheter, if needed at all, is removed within twenty-four hours. There is no need for bladder irrigation and the patient is able to return to work within 1-2 days.[6]

In a study done by Mahood and Malek complications were minimal.[7] A few patients reported a mild irritation that resolved quickly, most voided in the recovery room and a few had mild dysuria that resolved without treatment. Temporary, two-way, catheters were inserted in 50% of the patients and removed before the patient left (or less than 28 hours later). The patient usually left after recovering from anaesthesia and later reported on average an 88.8% increase in satisfaction score. The average was a 198.1% improvement in urinary flow that seems thus far not to diminish markedly over time. There had been no readmission, recatheterization, reoperation, urinary retention, infection or incontinence in the follow up of one year.[7]

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The only shortcoming with this laser is the brief time that it has been used. So far we have only five years worth of statistics. The procedure is sustaining it's own worth in the statistics that we have but the long-term efficacy is unknown.

Dr.Liquornik, Urological Surgeon, in Newmarket, Ontario performed this groundbreaking procedure on three patients on November 12, 2003 as the first surgeon to perform the procedure in Canada. He had traveled to the Oakwood Annapolis Hospital in Detroit to learn the procedure from Dr. Hai. The three prostates were 40, 65 and 110gms respectively. With his extensive experience in the traditional TURP and in the Nd:YAG procedure Dr. Liquornik quickly and easily picked up the nuances of the new laser. All three patients had their catheter removed within a couple of days and had no postoperative problems.

From a nursing perspective the Greenlight laser follows the same laser protocol as the Nd:YAG and the Holmium laser yet because of the 532nm wavelength different glasses are required. The glasses are orange rather than clear and the laser warning signs are different than the Holmium and the Nd:YAG lasers, which have wavelengths of 2100nm. There is an initial set up of the Operating room as the laser needs a higher voltage of electricity and an external water irrigation system to cool the unit. A water outlet and drainage system must be installed in the room along with the new 50AMP electrical outlet before you are able to use the system. Prior to surgery the system is simply hooked up and the cooling system counteracts the high-powered flow of energy. There are no fibres to cleave or test and there are no tips to connect or exchange during the surgery. The one-piece probe is disposable and the system comes equipped with a light filter to protect your video unit from the distorting green light.

The advent of the Greenlight laser is proving to be very exciting news for all that have access to it, the health care system that funds it and the surgeons who may now offer it to their community. Traditionally, the treatment option was to make the patient initially worse by cutting away the prostate and then having it heal while staying in hospital and being subject to CBI. The new option, through the use of the Greenlight laser, is to melt away the prostate in a virtually bloodless surgery, cause no damage, treat a patient as an outpatient and have the same low risk of complications. It is definitely a breakthrough in prostate surgery!

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*Continued from Page 16*

also suggestions around the SLN arranging a specific time and location to meet family members. However, this lends itself to increasing parent's anxiety levels because if the SLN is delayed for any reason the parents tend to relate the reason to their family member only.

**DISCUSSION**

The researchers wanted to understand the impact of the Surgical Liaison Nurse role on the anxiety levels of parents who had a child undergoing a surgical procedure. For this group of families Speilberger's State-Trait Anxiety Scale[1] did not appear to be a sensitive enough measure of parents worries either pre- or post-operatively.

The total anxiety score for this instrument was 4, indicating high anxiety. The mean for each group, pre-operatively, was 2 on a 4 point scale. Post-operatively the mean dropped to 1.52 for the SLN group and 1.78 for the routine care group.

Despite the fact that there appeared to be a greater overall reduction in the variance around the mean from the routine care group to the SLN group, the results did not achieve statistical significance. Families were indeed experiencing increased anxiety as indicated by their written feedback and results on the Family Rating Scale (FRS). The FRS and qualitative results supported the hypothesis that the Surgical Liaison Nurse reduced family members' anxiety levels, and also indicated that families were more informed about their child's surgery. In addition, health care professionals validated these findings by describing, more often in the SLN group than in the routine care group, behaviours that are consistent with reduced anxiety.

In one month of 2003 20% of cases that had been booked in this study site's paediatric OR lasted longer than the booked time (OR Booking Database, 2003). For this group of families the statistics indicated a higher percentage of cases that exceeded their booked time (25-31%). In addition to this, it was discovered that for those families who had to wait longer, anxiety levels were higher. This is consistent with findings by Donnell.[3] Clinically, a surgical liaison should be able to have a direct influence on relaying accurate information to families regarding delay of surgery.

**IMPLICATIONS**

The Surgical Liaison Nurse had an impact on reducing family members' anxiety levels, and increasing their knowledge level re: surgery.

The surgical liaison nurse role will be continued at the study site. Solutions are being explored for the issues raised by parents and healthcare staff. Now that we recognize the impact that the sharing information has on parents we are exploring different strategies that will help meet the needs of families while remaining within our existing budgets. Key factors in making this research possible included a supportive Program Director, Health Service Manager, nurses and healthcare team members who were committed to seeking new and creative ways to support families.

**FUTURE CONSIDERATIONS**

Both family members and health care professionals were supportive of the introduction of this role. Both groups suggested the role be extended past the elective surgery block time. When implementing this role the team must be flexible with the hours of work to accommodate the families' needs.

A firm commitment is needed to sustain the position on a daily basis. If the position is seen as less important than the circulating or scrub nurse it will likely not be offered on a daily basis. If the position is not offered consistently the pre-op nurses cannot guarantee its existence to the families who are anxious about upcoming surgery for their child. It also makes it difficult for the surgeons and anaesthesia staff to see the SLN as a consistent member of the team.

Communication within the perioperative care team has been enhanced with the introduction of this role. Initially communication between the OR and the in patient units suffered with the introduction of this role. It is important to maintain communication with family members from in-patient units but this should be done without tying up the nurses from the in-patient units. If a nurse from an in-patient unit has to stop what he/she is doing to help the SLN locate a

family member then the nurse will likely resent the role. The use of pagers for family members and/or the designation of specific places to meet will help eliminate this concern. In-patient nurses were happy to hear the update on the family they were caring for as it helped them plan for post-op care.

### LIMITATIONS

One of the difficulties in this study was that, due to limited space, both groups of families were waiting in the same area pre-operatively. Therefore, the routine care group was aware of the fact that some families received different support. Also, families were informed, prior to completing the first survey packet, in which group they had been placed. This may have influenced their anxiety level and expectations. It was observed that it was mostly mothers who completed the surveys. It would have been interesting to learn whether there were any differences between the responses and anxiety levels of moms and dads. Without this information we cannot determine if a gender bias is present in the study.

Families who were being influenced by other anxiety producing factors, already present in their life, would likely have a higher anxiety score regardless of the perioperative and intra-operative experience. We did not ask any questions to determine if there were outside influences contributing to their anxiety level.

The time of day during which the surgical procedure took place may also have had an impact on the anxiety level of families. If a family were required to keep a three year old without food (NPO) until 1200 this would likely make their anxiety level higher than if his/her surgery was scheduled for 0800. Another contributing factor related to time of day is that the surgical liaison nurse support was only provided until 1500. If the surgery ran later than this time there was no support available.

### SUMMARY

The benefit of nurse-family interactions during the intra-operative period cannot be overestimated. Published research clearly demonstrates that having a child in surgery is a very anxiety producing experience. Families do not want to feel isolated when their child is undergoing surgery. Perioperative nurses have the ability to develop caring, respectful, trusting relationships by communicating with families. Perioperative nurses recognize that family centered care means supporting both the patient and his/her family.

This study lends support to the view that the Surgical Liaison Nurse (SLN) role has enhanced an already family-centred care environment by providing more focused care to families and by improving intraoperative communication among perioperative team members. This study is a demonstration of nurses' autonomy in practice and their ability to influence the quality of care provided to children and families.

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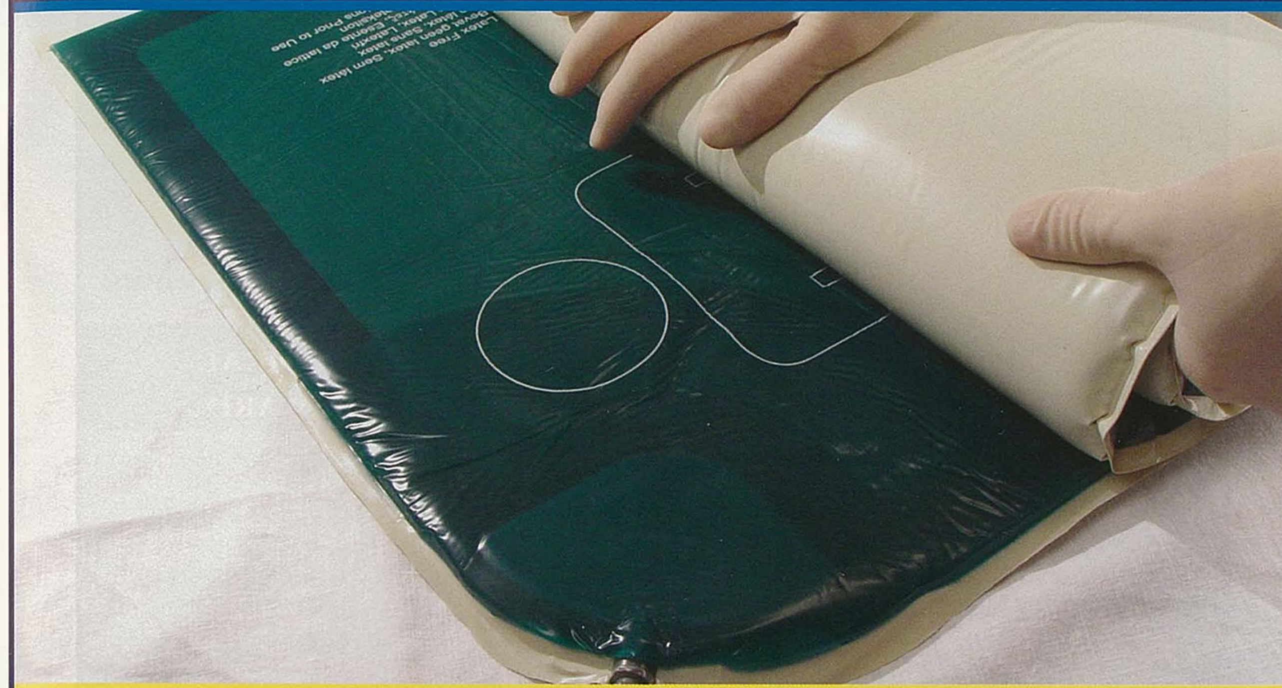

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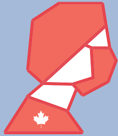

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