

## Lecture Review Submitted by: Kat Strong

When thinking of the Newfoundland conference, one individual stands out for many reasons. One reason is that he is an incredible story teller, another being that he is a gifted accomplished writer, broadcaster and teacher. All of these attributes were evident during his talk. Rex Murphy is his name, he was born and raised in Newfoundland, a graduate from Memorial University, and presently works with CBC as a news broadcaster.

During his talk he shared a story regarding his father. For many years his father was unwell, but refused to see a Dr. His mother tried countless times to encourage him to go for a physical, only to be denied. Anyway one day while driving he experienced symptoms that caused him to pull over to the side of the road. Fortunately for him, following behind was a well respected nurse McGraw. Nurse McGraw jumped into action, assessed Mr. Murphy and instructed him to go to the hospital immediately to be assessed by a physician. Which Mr. Murphy did. What Mrs. Murphy attempted to do in 20 years, nurse McGraw was able to accomplish in 5 mins. So what has this taught me? Well what have learned is this, that nursing is still a well respected profession. Also, nursing does not stop when you leave the hospital. It is something we do 24 hours a day 7 days a week.

Another point that Rex made that struck a chord with me was his own experience in the OR. And how he felt so very vulnerable and out of control while lying on the OR bed just prior to going off to sleep. He mentioned on several occasions how the nurse is the last person you see prior to going under with anaesthesia and the power and control they have over that patient. They basically have the ability to determine how well the anaesthesia will be received. We as nurses have the ability to help comfort our patients in a time of anxiousness and vulnerability. We as nurses have the ability to change the way patients feel about surgery. We have the control/power to make this a good experience or a bad experience for the patient. Having said that, I believe that we have a responsibility to our patients as well as to ourselves to provide the best possible care we can at all times. Although we may not spend a lot of time with a patient prior to them going to sleep, I think it imperative that we make the most of the time we do spend with them.

In summary I would like to say that I learned a great deal of things from Mr. Rex Murphy, but the things that affected me most were the basic. Practice with compassion and skill, be accountable for your actions, always do your very best for each and every patient, and lastly, put yourself in the other person's shoes. And treat that patient the way you would want to be treated. Always be mindful of the power and control you

possess in a patients weakest and most vulnerable hour (when they are on the OR table) RESPECT THEM ALWAYS.

## **Greening an Operating Room:**

### **More than Just the Colour on the Wall**

Presented by: Lucia Pfeuti & Lyndsay Lingard

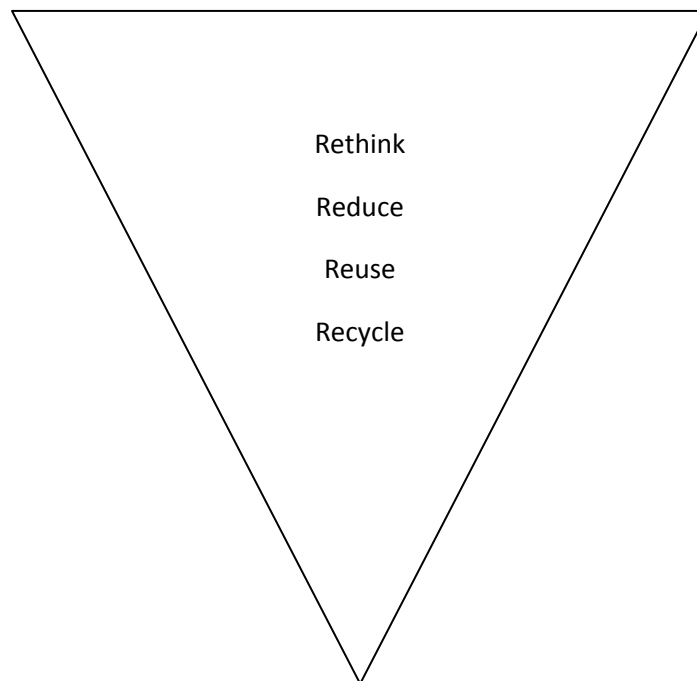
Submitted by: Lisa Varacalli RN

I had the privilege and opportunity to attend the ORNAC 21st National Conference in St. John's, Newfoundland from June 7 - 12, 2009.

The Guest Speakers all had informative information and/or experiences that made us all think about our everyday routines.

Greening an Operating Room: More than just the colour on the wall presented steps that perioperative nurses take in their daily work to help make their operating room greener and also highlighted how some hospitals have taken the green concept even further.

The model is triangular



Rethink how you dispose of all our one time use packages - consolidate shipment by ordering bulk and/or reusable shipment totes, not boxes and have the take back

program. Participation in decision making is needed. Encourage education that all landfills are too full and recycling helps to reduce landfills.

Thinking on a bigger scale, influence legislation, change from the top down. Create waste management policies. Take leadership in energy and environmental design ie. shut lights off in operating room suites, shut computers off, shut anesthetic machines off when surgery is done at the end of the day, save energy. Retrofit water taps to shut off automatically. Environmentally preferable purchases ie. reuseable totes. You also need dedicated coordinators to get all recycle bins in place and implement recycling.

Surgical units now have options, recycling reusable drapes or wrapping with reusable wraps. Each hospital needs to coordinate with the recycling centers to establish how and what can be recycled and put in place proper recycling bins.

In our hospital we started small, we have proper recycling bins throughout the hospital, operating room suites and lunch rooms. Going big in our hospital is the next step. With time and patience coordinators can work with recycling centers or reprocessing centers to reuse and reduce our garbage.

Lisa Varacalli RN

## **Advanced Peri-operative Nursing Practice: Plumbing Hidden Depths**

Submitted by: Kelly Oliver

Globally there are 234 million surgeries performed each year. In the industrial nations there is a 0.4- 0.8% death rate. One half of these surgical events can be preventable. In order to decrease this number our goal is to have a group of well prepared highly skilled workforce. Hence the role of nurses are changing. The aging population is creating an increase in surgical demands. The shortage of Healthcare workers are impacting the ability of hospital ambulatory/day surgery to work smoothly causing cancellations.

There are 274,300 RN's and 70,000 RPN's in Canada. 4.8% of those work in the OR. The average age of an OR nurse is 45.2. In the US scrub-tech's are used and RN's are mainly circulating.

The issues affecting OR nurses are mainly the age factor, recruitment problem and model of care relating to the skill level of these new nurses. All of these challenges present a threat or an opportunity to grow. New roles for OR nurses are currently emerging. Peri-operative nurse, Nurse practitioner, Nurse anesthetist in the US and nurse sedationist, physical surgical assistant to name a few.

In Australia the peri-operative nurse practitioner takes over the case management of the emergency surgical patient. They oversee diagnostic test and prepares the patient for surgery. They also arrange post-operative care. In the UK a surgical care practitioner does the same only they are able to perform minor procedures ie. hernia arthroscopy vasectomy and lumps and bumps.

The RNFA's aim is to improve the patient's surgical journey. Intervention taking place in radiology working interdependently with surgical anesthesia is increasingly becoming more specialized. The changes and growth of our nursing role is unlimited.

### **Old and New Practices**

Today life is moving faster and is much more complex technically than ever before. Teamwork and good communication is critical. OR nurses roles are changing as they are more acutely aware of the needs of today's patients. People are much more educated and they want their needs met now. In the future surgery will become micro invasive, robots and virtual surgery will be common-place. The surgeon may not even be in the same country as the patient, while he is performing the surgery. All of these new challenges will only broaden our nursing roles and goals. It is a very exciting time. As a nursing body we need to open ourselves to the new opportunities awaiting us.

## **Safe Surgery Saves Lives**

Submitted by: Donna Casagrande

Dear WDPONA Members, and President,

I first would like to take this opportunity to thank WDPONA for being one of 6 chosen to attend the 2009, National ORNAC Conference, ST. John's, Nfld. I had a wonderful time with everyone from WDPONA and other O.R. nurses from across the country.

I especially was impressed with Dr. Bryce Taylor's presentation on "Safe Surgery Checklist: Supporting Implementation". Dr. Taylor is currently Surgeon-in-Chief and Director of Surgical Services of the University Health Network (UHN), comprising of 3 hospitals in Toronto.

Safe Surgery Saves Lives is a campaign established by the World Health Organization (WHO). The Canadian Patient Safety Institute (CPSI), along with several Canadian organizations endorsed the initiative in, 2008. The CPSI in collaboration with UHN, one of the eight global pilot sites for the WHO checklist, have partnered with fifteen organizations to adapt the checklist. Dr. Taylor session highlighted a number of successes as well as barriers encountered and the method Dr. Taylor utilized to overcome these challenges.

Dr. Taylor reviewed the "Surgical Safety Checklist", he may have modified the checklist to accommodate his facility, but the following is the general description of how it should be performed through the World Health Organization; before the induction of anaesthesia, the surgeon states in the room with the patient on the operating table and all staff present for this patient's surgery, the identity, site, procedure and consent of the patient. He continues with confirming the site is marked and then introduces the doctor of anaesthesia and asks if they anticipate difficult airway, risk of blood loss, and known allergies.

Before skin incision or before the induction of anaesthesia the surgeon will continue with the checklist; introducing all team members and their role, anticipate critical events, e.g.; unexpected blood loss, unexpected steps in surgery, any concerns regarding sterility, proper equipment in place or issues with equipment and any other concerns. He confirms with anaesthesia, that an antibiotic was given and the appropriate scans or x-ray are present.

Before the patient leaves the operating room, the nurse verbally confirms with the team, the name of the procedure recorded, instrument, sponge and needle count are correct

or not, how the specimen is labelled, equipment problems to be addressed. Last on the list is reviewing with the team, concerns for recovery of this patient.

This checklist took just under 3 minutes to perform and Dr. Taylor had the attention of every team member pre-op. He encouraged all team members to verbalize any difficulties they encountered of those who choose not to participate in this checklist. He stated in a letter to at least one surgeon, his O.R. day would be taken away if this happens again, and if this surgeon were too continued with his noncompliance, Dr. Taylor would then have the surgeon suspended.

This simple set of surgical safety operating room standards is applicable to all countries and settings and again can be modified to fit any local practice. This checklist is not a regulatory device or official policy, it is intended as a tool for the O.R. team to improve safety in the surgical setting and reduce unnecessary complication. There are exceptions when the checklist cannot be completed in its entirety, e.g. when the patient is incapacitated or in an emergency.

In my opinion, at Hotel Dieu Grace Hospital, we are too relaxed about the time out. No one is paying attention, team members will question if a time out is done, when patient and consent stated, too much talking, hustling and bustling to get the case started. With this said there is still potential of surgical error, and it has occurred even with a time out, e.g. wrong leg operated on. Surgeons question anaesthesia if pre-op antibiotics were given; they question this after the surgery has started. I also find anaesthesia is in a hurry to get the patient to recovery room before the nurse can get the proper procedure written down and the specimen labelled or the proper post-op attire on the patient.

For this to be successful, hospital leaders, such as the chief of surgery, head of anaesthesia, the director of the O.R. , surgeons, and nursing staff must embrace the belief that safety is a priority. There will be few people who will be defiant, and consider it a waste of time. With proper education and leadership, barriers can be overcome. I wish to see this checklist become a regulation and then there is no question it must be completed.

To view a copy of the Surgical Safety Checklist Implementation and Manual, please visit [www.who.int](http://www.who.int), and under search enter the title of the manual. I've attached a copy of the checklist.

This was very educational to be present in Dr. Bryce Taylor's session and even more so in researching this information to write this paper.

Thank you,

Donna Casagrande

## **A Review of Kay Ball's lecture on "Smoke Exposure: Can Clean Air Be a Reality?"**

Submitted by: Jenny Brown

Kay Ball's lecture on "Smoke exposure: Can Clean Air Be a Reality?" fascinated me and actually inspired me to become active in promoting a safe surgical environment in my own Operating Room.

Kay is a perioperative nurse educator and consultant working with perioperative nurses, professional organizations, health care facilities, industry, and legislative groups. She is the author of many books and papers. Recently she defended her PhD thesis entitled "Effects of Surgical Smoke."

Perioperative nurses and the other members of the surgical team are exposed to laser and electrical surgical plume everyday. The offensive and pungent odour from the plume can carry dangerous bacteria, carcinogens, and viruses, including HIV, Hepatitis and HPV.

Chemicals present in surgical plume include toxic gases and vapours such as benzene, hydrogen cyanide, sulphur, carbon monoxide, formaldehyde, and live and dead cellular matter. As such, these can cause double vision, headaches, watery eyes, sore throat, nausea, weakness, and upper respiratory irritations. More serious effects include increased risk of stomach cancer, lung cancer, and leukemia.

This is an important and often ignored workplace health and safety issue. We must act now. We must make surgical smoke exposure a thing of the past. Ball tells us to "Become NASTI" (Nurses Advocating Smoke Free Theatres Immediately). In conjunction with AMT Electro Surgery, Ball has provided healthcare professionals on the website [www.becomenasti.com](http://www.becomenasti.com), with articles and research documentation on the hazards of electrosurgical smoke plume and proven best practices on how to safely and effectively remove these hazards. Also provided are sample policies on evacuation of surgical smoke and tips for hospitals on how to implement them.

Smoke evacuator technology is available to properly evacuate all surgical smoke. Smoke evacuators are filter suction devices that suction smoke away from the surgical site. These filters are comprised of high efficiency particulate removing filters and odour reducing mediums such as charcoal. Ball shows through her evidenced based research that effective equipment and supplies are available on the market. But as always there are barriers to implementing these technologies. Hospital management is reluctant to implement policies. Even knowledgeable staff is complacent with the status quo. Most

surgeons are unsupportive or simply lack knowledge related to the dangers. Existing equipment is noisy and cumbersome.

Since promoting a safe surgical environment should be a top priority for all perioperative nurses, lets all become champions and make our OR theatres smoke free so we can all breathe a little easier.

Visit [www.becomenasti.com](http://www.becomenasti.com) for further information on this campaign and/or visit [www.ORNAC.org](http://www.ORNAC.org) to view Kay Ball's lecture.