

*Dear Colleagues,*

On behalf of the Scientific Committee it is my pleasure to welcome you to Dublin to the 4th congress of the European Operating Room Nurses Association. The theme of the congress refers to excellence in our profession, which EORNA aims towards by promoting high standards of perioperative nursing care.

The Scientific Committee has put together a programme that we hope will be of interest to you, offering 52 oral presentations that run parallel in three sessions and 26 poster presentations that will be on display throughout the congress with two scheduled poster walks. I would like to bring to your attention that many of the oral presentations are repeated on Saturday and Sunday.

In addition to the scientific programme, our industry partners are providing several workshops on issues related to perioperative practice.

The congress is a venue for discussing issues facing our profession, exchanging information and ideas to enhance and develop safe perioperative care and apply scientific research to our practice. We hope this congress will be rewarding for you, both socially and scientifically.

I would like to take this opportunity to thank all colleagues, European and International, that submitted abstracts for oral and poster presentation at the congress. Your contribution is the foundation for making this event possible.

We look forward to meeting you and enjoying an exciting congress together.



**Thorhalla Eggertsdottir**

Chairperson, Scientific Committee EORNAC 2006

# *Committees*

## ***Organising Committee***

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Treasurer: Anette Pedersen

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Kristiina Junttila  
Philokypros Christodoulou  
Karen Rickards  
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Chairperson: Thorhalla Eggertsdottir

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Jaana Perttunen  
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# Programme Overview

Time	Thursday 25th May		Friday 26th May		Saturday 27th May		Sunday 28th May	
	Shelbourne	Concert Hall	Shelbourne	Concert Hall	Shelbourne	Concert Hall	Balcony	Shelbourne
08:30								
08:45								
09:00								
09:15								
09:30			1A The Visualisation of Perioperative Care	1B Caring for the Pediatric patient	1C Partners in education	4A Clinical Wisdom of Perioperative Nursing	4C The visualisation of Perioperative Care	7B II International Session - Trauma The Importance of Teamwork
09:45								6C Stressful Situations
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## Moderator Biographies

### **Session 1A & 4C:**

#### ***The visualization of perioperative care***

Name: Irimi Antoniadou

Country: Sweden

Occupation: EORNA-President, CNOR, RN  
University diploma and certification as RN and ORN, 1985, Uppsala- Sweden. CNOR in the Uppsala Academic University hospital.

Experience from several different operating departments. Since 2000 give lectures in perioperative nursing, for post – education in operating-, anesthetic- and intensive care, at Karolinska Institute in Stockholm. Will accomplish B Sc, during Spring 2006, in Nursing science and Pedagogic-adults learning and competence development. Those studies are part of my Master degree.



### **Session 3A:**

#### ***International Session 1 “Patient safety”***

#### **Session 1B:**

#### ***Caring for the pediatric patient***

Name: Scheide Petra

Country: Switzerland

Occupation: Director of Nursing

Membership:

National Nursing Society SBK/ASI from 1989,  
NA of Operating Room Nurses, Switzerland,  
from 1992 member and  
president 2000-2005,

EORNA, delegate for Switzerland 2000-2005,  
EORNA Scientific Committee 2000-2003,  
member/vizechair chair EORNA Perioperative  
Care Committee 2004 - 2005, chairperson  
Training (Germany/ Switzerland)

1984 RN;

1989-91 Postgraduate Course Nurse Specialist  
OR ;

1991-92 Teacher and Clinical Educator;

1992-94 Postgraduate Course Management in  
Health Organisations;

2004-2005 Postgraduate Study Quality  
Management

Professional development (Germany/  
Switzerland)

1984-1992 OR - nurse;

1992 Teacher in OR-courses;

1992-2003 Headnurse OR;

2004-today Director of Nursing



### **Session 1C & 6B: Partners in education**

Name: Oaug Salthe Helberg

Country: Norway

Occupation: Assistant Professor

Affiliation: University of Stavanger, Norway

- Registered nurse at several hospitals/operating  
room departments (1974-1991). Teaching nurse

at operating room department, University  
Hospital of Stavanger (1991-1999). Assisting

Professor, University of Stavanger (1999-).

- Board member, Norwegian Association of  
Operating Room Nurses (2000-2005)

- Board member, Nordic Operating Room Nurses  
Association (2003-2005)

- Board member, European Operating Room  
Nurses Association (2003- )



### **Session 2A & 5C: Clinical practice**

Name: Merja Fordell

Country: Finland

Occupation: Head Nurse

Affiliation: Oulu University Hospital, Finland

Ms Fordell trained as a nurse and undertook her  
specialist perioperative education in Oulu in  
1982.

## Moderator Biographies

She started her career as an operating room nurse in 1982 and as an assistant head nurse in 1987. She became a head nurse in OR in 1998. She got her masters degree in health care administration in 2002. She served as an executive nursing director for two years in 2003 - 2004. She is now working as a head nurse and involved with several projects concerning the field of perioperative nursing. Fordell has been a board member of the Finnish Operating Room Nurses Association since 1993 and is also a past editor and vice chairman. She chaired this association since 2001. She is also a board member of the European Operating Room Nurses Association since 2001 and a member of the Scientific Committee of EORNAC. She is a board member of the Nordic Operating Room Nurses Association and a member of the International Education Program Planning Committee for the World Conference on Surgical Patient Care.



### **Session 2B & 3B: Current Challenges**

Name: Karen Rickards RN  
Occupation: Clinical Director, Vanguard Healthcare Solutions Ltd  
Secretary of Association for Perioperative Practitioners

Karen has been a project manager and research nurse, as well as one of the first modern matrons for surgery in a large district hospital. In her current role she has responsibility for the delivery of clinical standards for modular operating theatres and day case wards. She also is responsible for clinical governance and risk management at corporate level and for ensuring that frameworks for practice, education and human resources are in place and current. Karen is an active member of AfPP, and is the national secretary for AfPP, she became the UK representative for EORNA in November 2005.



### **Session 2C & 9A: Perioperative nursing: A complex profession??**

Name: Philokypros Christodoulou  
Country: Cyprus  
Occupation: Nurse Director  
Affiliation: Ministry of Health – Cyprus

Present Post : Member of the Team of Governance, of the Nicosia General Hospital  
Qualifications: Post Graduate degrees in :  
Plastic Surgery Nursing and Burns  
Cardio Thoracic Theatre Nursing  
BA in Health Service Management  
BSc in Clinical Nursing  
President of the Cyprus Operating Room Nurses Association (CORNA)  
Representative of CORNA to the EORNA

### **Session 7B: II International Session Trauma: The importance of teamwork**

Name: Anette Pedersen  
Country: Denmark  
Occupation: Head Nurse Of The Ortopædic Or Nurses In The Hospital Of Aalborg  
Affiliation: President of FS SASMO (Danish OR nurses association)

I was educated as a nurse since 1980 and ever since worked in the orthopedic theaters. For the last ten years as a head nurse. In 2002 I took a diploma degree in interdisciplinary medical leadership I have been a board member of the Danish association of OR nurses (FS SASMO) for seven years and as the president. I came to the EORNA board member in of 2000 and been on the OC for this congress and I am happy to be the OC chairperson for the congress 2009 in Copenhagen.

## Moderator Biographies



**Session 3C & 5A:**

**Current developments in education**

Name: Jaana Perttune

Country: Finland

Occupation: Program Manager

Affiliation: Jyväskylä University of Applied Sciences

Education: MSc (Health Sciences), RN (Perioperative nurse)

Program Manager

Lecturer

Assistant Head Nurse

Infection Control Nurse

Perioperative nurse



**Session 4A:**

**Clinical wisdom of perioperative nursing**

Name: Ora Levy

Country: Israel

Occupation: Nurse

Affiliation: Retired from Hadassah Medical Center Ein Kerem Jerusalem

Retired from a position of director of nursing in Operating Room, Recovery Room, and Intensive Care Unit. Previous to this last position, I served in a several managerial capacities. Graduated the Hadassah School of Nursing in Jerusalem.

Earned a BA degree in Education and General Humanities Studies, at the Hebrew University in Jerusalem. Currently writing the theses for Masters Degree in Public Health, at the Hebrew University. I have been the Chairperson of the Israeli Perioperative Nurses Association, and represent Israel on EORNA Board since 1998.



**Session 4B: Issues regarding anesthetic care**

Name: Henk van Meer

Country: The Netherlands

Occupation: Management Consultant

I started as an Or nurse 25 years ago and have been working on the OR ever since. First as nurse later in the role of manager OR and Management consultant, Since four years I'm a member of the board of Eorna and a member of the scientific committee of EORNAC.



**Session 5B: Stressful Situations**

Name: Sandra Monsalve Gomariz

Country: Madrid, Spain.

Occupation: O.R Nurse

I'm a Spanish O.R nurse. Usually I'm working in emergencies O.R at night. I like to teach the new nurse, and I give course about Operating department and the nursing care. I'm member of Spanish OR Association and member of the board of directors of EORNA.

**Session 6A: OR: a safe place??**

Name: Konstantinos Mintzaridis

Country: Greece

Occupation: RNurse-Perfusionist, Children's Hospital "Agia Sophia"

Affiliation: Treasurer of GORNA (Greek Operating Room Nurses Association) Member of EORNA

## Moderator Biographies

I have been working as R Nurse in the operating theatre for 7 years. I have the European Certificate in Cardiovascular Perfusion and the last five years I 'm working as perfusionist in cardiac theatre. I was member of organising committee and president of scientific committee in national congresses. In addition, I 'm member of Perioperative Nursing Care Committee in EORNA.



**Session 7A & 7A: The professional perspective**  
**Name: Christina Eten Bergqvist**

Country: Sweden

Occupation: RN, ORN, Continenence advisor

Affiliation: Swedish Operating Room Nurses' Association

Reg Nurse 1978. ORN 1981. I worked at the dept of OB/Gynae at Lund University Hospital, Sweden. Research nurse and responsible for continence surgery. Member of the da Vinci robotic assisted surgical team at the hospital. Board member of Swedish Operating Room Nurses Association and EORNA



**Session 7B: II International Session Trauma: The importance of teamwork**

Name: Kristiina Junttila

Country: Finland

Occupation: Special Consultant

Affiliation: Helsinki University Central Hospital / Jorvi Hospital, Nursing Administration

Kristiina is the immediate past president of EORNA; she served 6 years in that role.

She had 18 years of clinical practice as an operating room nurse before entering the field of nursing informatics in 2000. In 2005, she got her doctoral degree in nursing science from University of Turku, Finland.



**Session: The EORNA Klinidrape Perioperative Nursing Foundation Session**

Name: Thorhalla Eggertsdóttir

Country: Iceland

Occupation: OR nurse, clinical educator

Affiliation: Landspítali University hospital, Reykjavík

The Icelandic Nursing School, 1976, Registered nurse.

Worked in surgical and intensive care wards for 12 years. Worked in operating departments since 1993. University of Iceland, Dept. of Nursing, 1996, OR nurse University of Iceland, Dept. of Nursing, 2000, B.Sc.

Clinical educator in OR nursing since 1998

Member of ISORNA since 1996,

Board member 1998-2001.

Member of education committee 1997-2000

Board member EORNA from November 2000

Member of Scientific committee 2000-2003, chairman from 2003

Chairman of Scientific Task Group

## *Moderators: Poster Sessions*



**Name: Petra Ebbeke**

Country: Germany.

Occupation: Nurse Manager of the School for post basic education for Operating Room and Endoscopic Nurses.

Affiliation: Staedtisches Klinikum Braunschweig

1981: Basic education, Nurse

1981 – 1989: Working field: Operating department

1984 – 1986: Post basic education, Operating Room Nurse

1989 – 1991: Post basic education, Teacher for Nursing

since 1991: Nurse Manager of the School for post basic education for Operating Room and Endoscopic Nurses



**Name: Cristiana Becucci**

Country: ITALY

Occupation: Co-Ordinator Of Multidisciplinary Day Surgeon Section

Affiliation: Azienda ASL No 6, Tuscany Region

Scientific Diploma In 1984, Nurse Diploma In 1987. From 1988 I Work In The Hospital. 10 Years Of Experience As A Tutor And Teacher At The Nurse's School And From 2001 Tutor And Teacher In University Nurses Course. From 2004 EORNA Member. About 10 Years Of Experience As Congress Speaker

## *Session 1A & 4C: The Visualisation of Perioperative Care*

Name: Kristiina Junttila

Country: Finland

Occupation: Special Consultant

Affiliation: Helsinki University Central Hospital / Jorvi Hospital, Nursing Administration

Kristiina is the immediate past president of EORNA; she served 6 years in that role. She had 18 years of clinical practice as an operating room nurse before entering the field of nursing informatics in 2000. In 2005, she got her doctoral degree in nursing science from University of Turku, Finland.

### **Nursing Classifications In Preoperative Documentation: The Nurses' Attitudes' Kristiina Junttila, PhD, RN**

#### **Background**

The need to have the right people doing the right things and to achieve the right outcomes with acceptable amount of costs has forced nursing profession to quantify itself. The nurses are requested to move from natural language based narrative documentation into electronic documentation and clinical use of nursing classifications. Nursing classifications have been developed to illustrate the nursing process in a structured form and to be used in documenting patients' care, hence in describing the clinical nursing practice. However, the nurses' attitudes toward nursing classifications have not been widely studied.

#### **Aim**

This paper will discuss the rationale of nursing classifications and issues related to their use in nursing documentation. Particularly, the interest is in nurses' attitudes toward the use of nursing diagnoses in documentation and the factors affecting the attitudes.

#### **Objectives**

This study was carried out to answer the following questions:

- What are the nurses' attitudes toward the use of nursing diagnoses in perioperative documentation?
- What are the factors affecting the attitudes toward the use of nursing diagnoses in Perioperative Documentation?

#### **Methods**

A tailored questionnaire was distributed to a purposive sample of perioperative nurses (N=146) who had participated in clinical testing of nursing diagnoses. Response rate was 60 % (n=87).

Nonparametric tests were applied in data analysis.

#### **Results**

The nurses' attitudes to using nursing diagnoses in perioperative documentation were, in general, positive. Diagnosing was not seen as contradiction to the patient's uniqueness or human interaction between the patient and his/her nurse. However, the use of nursing diagnoses in perioperative nursing was not seen necessary. Documentation on the whole was perceived time-consuming and frustrating.

#### **Key Words**

attitude, nursing diagnosis, perioperative nursing

## *Session 1A & 4C: The Visualisation of Perioperative Care*

Name: Edel Grunner

Country: Ireland

Affiliation: St. Luke's Hospital, Dublin, Ireland

At present working in theatre in St. Luke's Hospital, the National Radiation and Oncology centre in Ireland. I have worked in theatre in the past 16 years in various hospitals in Dublin and am at present studying for B.N.S in the RCSI.

### **Documentation Supports Nursing Care A Quality Improvement Project'**

**Edel Grunnér, RGN.RM, A. Cregan, W. Fair, B. Mulherin, J. Taylor**

Little research has been carried out on the effects of documentation and information exchange on clinical practice in Ireland.

It is the responsibility of nurses to establish and maintain patient documentation. Record keeping must adhere to professional, ethical and legal requirements. An Bord Altranais (2002). The National Association of Theatre Nurses (NATN) Standards and Recommendations goes on to say that the quality and standard of the record keeping within the operating theatre is reflective of the standard of professional practice. NATN (2004). A review of the current documentation illustrated that there was a deficit in the information exchange for patients on radiotherapy requiring surgical procedures, therefore the perioperative nurses set out to achieve an optimum, seamless, and quality care service undertaking a project introducing improved documentation supporting nursing care.

### **Aim of Study**

To improve current documentation making appropriate changes to enhance nursing practice.

### **Methodology**

Design A descriptive survey using a questionnaire with a qualitative dimension

Sampling All nurses

Pilot Study This was carried out with appropriate amendments made.

Results Results not available at time of submission

### **Analysis of Data**

Statistical Package for Social Sciences (SPSS). will be used to analysis the data and Grounded Theory will be used on the qualitative data.

### **References**

An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives: Dublin: An Bord Altranais

Beesley J., Parrie S. (2004) Standards and Recommendations for Safe Perioperative Practice: Harrogate: NATN.

### **Key Words**

Information exchange, Documentation, Perioperative Exchange

## *Session 1A & 4C: The Visualisation of Perioperative Care*

Name: Gudrun Rudolfsson

Country: Sweden

Occupation: Registered Nurse

Affiliation: Swedish Operating Room Nurses Association, Swedish Society of Nursing

Gudrun Rudolfsson, RN, MScPH, Doctoral student. She divides her time between perioperative nursing practice and the PhD programme in Caring Science, Åbo Academy Vasa, Finland. Her research interest springs from perioperative nursing care and focuses on the dialogue between patient and nurse in connection with a patient's surgery.

### **The Perioperative Dialogue – Coherence In A Continuous Whole'**

**Gudrun Rudolfsson RN, MScPH, Doctoral student.**

#### **Background**

The traditional way of working in Swedish perioperative care, from the nurse anaesthetist' and theatre nurse's perspective, means that they will meet the patient at only one occasion, where they often are unprepared for the character of a patient's worries or particular wishes. When the same nurse meets the patient at three different occasions in a perioperative dialogue, i.e. a pre-, intra-, and postoperative conversation, the nurse has an opportunity to receive better knowledge about the goals of the patient.

#### **Aim**

The overall aim for the project was to identify expressions for health and well-being, which became evident through patients' as well as nurse anaesthetists and theatre nurses' experiences from the perioperative dialogue.

Methodology: The research is based on two studies where semi-structured interviews were carried out, with 18 patients and 20 nurses. Data from the interviews were analysed according to grounded theory.

#### **Results**

The results showed, that by using the perioperative dialogue, a continuity of care is created, both from a patient and nurse perspective. The continuity of the patient's relationship with the nurse, and the nurse's relationship with the patient, forms a coherent whole. When the nurse creates a caring relationship and involves the patient into the activities surrounding the surgery, the situation becomes more understandable, manageable and meaningful to the patient. Health and well-being for patients is promoted when nurses give them time and make them part of what is going to happen. Health and well-being for the nurses is promoted when they are allowed to care for the patient throughout the perioperative process. In the perioperative dialogue, the patient, in his or her relationship with the nurse, is guaranteed the responsibility of his or her own recovery and the movement towards health and wholeness. In the relationship with the patient, the nurse becomes responsible for creating a whole, a coherent whole.

## *Session 1A & 4C: The Visualisation of Perioperative Care*

### **Conclusions**

The perioperative dialogue promotes the process of becoming in health and well-being through continuity of care and the sense of coherence, both for the patient and the nurse.

Key words: a caring relationship, perioperative dialogue, continuity of care, sense of coherence

### **References**

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## *Session 1A & 4C: The Visualisation of Perioperative Care*

Name: Lillemor Lindwall

Country: Sweden

Occupation: RN, RNA, RNT, PhD, Senior Lecture

Affiliation: Karlstad University in Sweden

Lillemor Lindwall, RN, RNA, RNT, PhD, is a senior lecturer at Karlstad University in Sweden. Her background is in caring science, perioperative nursing care, and her particular research interests are experiences of the human body, focusing on health, suffering and ethics. She has an interest in qualitative methods such as hermeneutics and phenomenology.

### **Perioperative Caring In The Operating Room'**

**Lillemor Lindwall, RN, RNT, MNSc, PhD**

#### **Introduction**

This study illuminates patients' experiences of perioperative caring and their body. The patient's body is in focus, since it generally is something on the body that needs to be taken care of or examined. Perioperative care includes the nurse anaesthetist and operating room nurse's perioperative caring process and the perioperative dialogue, as well as surgical treatment and techniques in duty of health. Peri refers to the time around the patient's surgery. Time in this context means the time that the nurse anaesthetist or operating room nurse gives the patient in pre-, intra- and postoperative conversations (von Post, 1999; Lindwall et al, 2003; Rudolfsson, 2003). The space is the operating room and the place is the operating bed.

#### **Aim of the study**

was to increase the understanding of the body as a perspective of a human being and how the space is formed in a perioperative caring culture.

#### **Methodology**

The study has a hermeneutical approach (Gadamer, 1989). Open interviews were chosen in order to describe the informants' experiences of the perioperative caring and the body in the space of the operating room. Fifteen men and women (30-60 years old) participated in the study. A descriptive phenomenological method was used in the analysis.

#### **Results**

The body experiences as mysterious when it is afflicted by illness. A battle is fought between the illness that breaks down the body and human beings fighting to keep their unity whole. The body appears as a prison and bears a feeling of powerlessness when it is changed by illness and suffering. It is the illness that forces the patient to sacrifice parts of the body in order to once again become whole. In the operating room the patient abandons him/herself to the hands of the caregiver. The patients expect the caregiver to receive them and protect them from harm and disgrace in a high-technological perioperative culture. Suffering is alleviated when the patient experiences confidence and safety in the space of an operating room. In perioperative caring, the body is experienced as a vessel for health and illness, but also for well-being and suffering.

## *Session 1A & 4C: The Visualisation of Perioperative Care*

### **References**

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- Rudolfsson, G., Hallberg, L., Ringsberg, K. & von Post, I. (2003). The nurse has time for me: the perioperative dialogue from the perspective of patients. *Journal of Advanced Perioperative Care* 1 (3), 77-84.

### **Key-words.**

Human body, caring science, space, hermeneutics

## *Session 1B: Caring for the Pediatric Patient*

Name: Siobhán O'Connor RGN, RSCN, MSc

Country: Ireland

Occupation: Nursing Practice Development Coordinator

Affiliation: The National Children's Hospital, AMNCH, Tallaght, Dublin 24 and The University of Dublin, Trinity College, Dublin.

My clinical experience as a children's nurse spans over a decade, my specialist area being haematology/oncology. Currently my role involves working with registered nursing staff to improve the quality of patient care through the development of evidence-based clinical practice, thus ensuring the care our children and their families receive is in line with emerging research and international standards.

### **Pre-operative Fasting Times for Children Attending The Children's Operating Theatre**

#### **Department: Results of an Audit'**

**Siobhán O'Connor**

#### **Introduction**

Patients scheduled for surgery need to fast prior to anaesthesia in order to minimise the risks of vomiting and reduce the risk of pulmonary aspiration<sup>1</sup>. Unnecessarily long pre-operative fasting can lead to dehydration, hypovolaemia, hypoglycaemia and, if unchecked, metabolic acidosis<sup>2</sup>. Minimising the pre-operative fasting time for children carries numerous benefits, including reduced hunger and thirst, improved fluid haemostasis, easier intravenous access and increased child and parent/guardian satisfaction and ultimately will ensure a minimum length of hospital stay. Research has shown that healthy children may safely be given clear fluids up to two hours before anaesthesia, without increasing the volume or acidity of gastric contents<sup>3</sup>.

#### **Aim of the Study**

The nursing and anaesthetic staff in the children's Operating Theatre Department believe that the children coming to their unit are fasting for longer than the required time. To date there has only been anecdotal evidence available to support this belief.

#### **Methodology**

A short questionnaire was developed to ascertain the pre-operative fasting times of the children coming to the Department. A pilot study was conducted to demonstrate the appropriateness of the questionnaire, following which there were some changes made before finalising the questionnaire. The study was conducted over a six week period. The questionnaire was completed by the staff nurse receiving the child into the Department before the child and accompanying parent/guardian were transferred to the Anaesthetic area.

#### **Results**

Two hundred and eighty nine accurately completed questionnaires were received. Of these 201 (69.5%) involved day-case patients and 88 (30.5%) involved in-patients, while 227 (79%) had elective procedures performed and 62 (21%) had emergency procedures performed. In total, 21 children (7%) were fasting for six hours or less, as recommended in the literature<sup>3&4</sup>. Thus 268 children (93%) fasted for longer than six hours, 13 (5%) of whom were fasting for longer than 18 hours. Nine (69%) of these 13 children had elective procedures performed. There were 110 (38%) children less than four years old included in the study, 104 (95%) of whom were fasting for more than six hours.

## *Session 1B: Caring for the Pediatric Patient*

The parents/guardians of 67 (72%) of those children who had elective procedures performed, were advised to fast their child from midnight. In reality, this means that small children will fast from bed-time, often 19.00 hours. The significance of giving the child a drink at 23.30hrs was not explained to the parents/guardians.

### **References**

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### **Key words**

pre-operative fasting, the children's Operating Theatre Department, elective procedure, emergency procedure.

## *Session 1B: Caring for the Pediatric Patient*

### **Complicated Facial Distortion In Children. Review Of Treatment Of Children With Crouzon And Apert Syndrome From Birth To Adolescent'**

**Ms. Lea Karin**

**Schneider Children's Medical Center, Petach Tikva, Israel**

Craniofacial malformation in children resulted in social alienation. Studies have shown that children with craniofacial malformation have disadvantage and are less successful than normal children. The craniofacial unit in Schneider Children's Medical Center Israel (SCMCI) combine plastic surgery, neurosurgery, ear-nose-throat, maxillofacial surgery, ophthalmic surgery, nursing, social and psychological care to help those children to look better and feel better with themselves.

Crouzon and Apert Syndrome are consequence of early fusion of the cranial sutures and maldevelopment of the base of skull. As a result the skull is deformed and the face is distorted. From the first year of life the children are undergoing several surgeries to solve functional as well as esthetical problems.

#### **Purpose**

The purpose of this lecture is to review the treatment of children with Crouzon Syndrome from birth to adolescent with emphasize on combining the surgical treatment with nursing and psychological care.

#### **Method**

We reviewed all children with Crouzon and Apert Syndrome that were operated in SCMCI during the last two years. We gathered the information on surgery indication, surgical treatment, nursing procedures and psychological care of those children.

#### **Results**

Five children with Crouzon Syndrome and five children with Apert Syndrome underwent surgery during the two years. The surgery included advancement of the forehead and orbitae at the age of 10 months, moving the center of the face at the age of 7 years and repair of the nose and cheeks at the end of puberty. All children had psychological preparation and nursing guidance to them and their parents, before surgery. Developmental evaluation revealed three children with mild developmental delay that resulted from medical limitation. Seven children had normal development to their age. One patient, age 23 years, that underwent partial repair of his face during childhood, had normal development but was not able to accomplish his social and professional potentials. He reported social improvement after surgery.

#### **Conclusions**

Crouzon and Apert Syndrome are characterized with disfiguration of the face. The treatment include combination of surgical care with nursing and psychological support to achieve full psychological and social function during their lifetime

## *Session 1B: Caring for the Pediatric Patient*

Name: Bernadette Lanigan

Country: Ireland

Occupation: Nurse

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Clinical Nurse Specialist Paediatric Ophthalmology, National Children's Eye Centre, Children's University Hospital, Temple St, Dublin, Ireland. Ophthalmic Nursing Diploma (Hons), Moorfields Eye Hospital, London. Have 23 years experience in this specialty.

Currently completing Bachelor Nursing Studies and doing Thesis as part of MBA in Healthcare

### **Paediatric Ophthalmology in the 21st Century'**

**Bernadette Lanigan**

Retinopathy of prematurity, congenital cataracts, congenital glaucoma, eye tumours and other eye disorders which are unique to children have benefited by the many innovations and advances that have occurred in paediatric ophthalmology. In the past these conditions would have led to blindness or severe visual impairment. The use of lasers, intraocular lens implants, drainage valves have helped to prevent or reduce the severity of visual impairment. These innovations/advances will be described and case histories will be presented which will highlight how they have helped children in conjunction with the role played by the clinical nurse specialist.

#### **Key words**

paediatric, implants, nurse specialist.

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## ***Session 1B: Caring for the Pediatric Patient***

Name: Bresan Martina

Country: Slovenia, Medical Center Ljubljana

Occupation: Operating Room Nurse

Affiliation: Slovenian Operating Room Nurses Association

I was born in 1970 in Nova Gorica, Slovenia. In 1992 I have started the career of operating room nurse in Medical Center Ljubljana. I have specialized in pediatric and cardiovascular surgery. During the year 1997 and 1999 I have worked on Institut of Oncology. I am an external lecturer of the University College of Health Care Ljubljana since 2005. I am an author of many published articles on national level. I am a member of the Editorial Board of the Slovenian Operating Room Nurses Association.

### **Pediatric Patient In Frames Of Perioperative Nursing Care: His/Her Rights For Informed Consent'**

**Martina Brežčan**

**Medical Center Ljubljana, Slovenia**

#### **Background**

A child has his/her rights which can be limited according to his/her age or his/her ability to exercise them. Patient's rights are accepted as a part of the Slovenian legislation according to A Declaration on the promotion of patients rights in Europe. These rights include: respect of a child's personality, human dignity and privacy, highest possible standards of nursing care and treatment. Problems and special measures occur in the case of the right of a pediatric patient to be informed and to give his/her informed consent. In certain points the field of child's rights is in discrepancy with some internationally acknowledged documents and is still in the phase of gradual development.

#### **Aim Of Study**

The research was planned to show the reasons which influence the quality, professionalism and efficiency of treatment and nursing care of sick children in pediatric departments in Slovene hospitals and to enlighten some ethical and legal questions about children's rights during hospitalization. The quality of communication with medical personnel, the organization and spatial arrangements of pediatric departments, the possibility for parents to stay with their child in the hospital, available visiting time, the availability and quality of information for parents and children, information about child's rights, possibility of expressing challenges, wishes and praises were studied.

#### **Methodology**

The research was done in four larger hospitals in Slovenia, from 23rd February to 7th April 2004. Parents were asked to fill in questionnaires. Children were 10 years old or younger. 20 questionnaires were submitted to each hospital. The research technique was anonymous questionnaire, with 35 questions included. With the help and co-operation of head-nurses of pediatric departments, 75% of all questionnaires were returned to the hospital in closed envelopes, the rest 25% of questionnaires were filled in at home and mailed back to the hospital in envelopes having the address of the hospital and a stamp on.

## *Session 1B: Caring for the Pediatric Patient*

### **Results**

85% of parents filled in and returned the given questionnaire.

62% of parents wrote that they were not informed with possibilities of challenges, wishes and praises neither at hospital admission of their child nor during the hospitalization .

22% of parents considered that they were well informed about the rights of their child.

The information about disease, treatment and hospitalization was sufficient in 32% and understandable in 43%.

42% of parents were satisfied with medical personnel and thought it showed kindness, diligence and good sense for working with children.

24% of answers described ignorance of work..

87% of parents had possibility of attending their child or cooperating at some interventions at nursing care or treatment.

71% of parents were contented with available visiting time.

### **Key Words**

pediatric patient, child's rights, humanization of hospitalization

### **References**

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## *Session 1C & 6B: Partners in Education*

Name: Bridie McCarthy

Country: Co Cork Ireland

Occupation: College Lecturer

Affiliation: University College Cork

Bridie McCarthy– is a lecturer in the School of Nursing and Midwifery in University College Cork. She has extensive clinical experience in surgical and perioperative nursing. She has degrees in nursing and counselling and an MSc in nursing. Her research interests include perioperative nursing, person-centred care, communication and education.

Name: Mairin O'Mahony

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Affiliation: Catherine McAuley School of Nursing and Midwifery, University College, Cork. I am a college lecturer with a background in Perioperative nursing practice. I currently co-ordinate and lecture on the Postgraduate Diploma in Perioperative Nursing in The School of Nursing and Midwifery at University College Cork. I also lecture on Perioperative Nursing in The BSc in Nursing Undergraduate Programme.

### **Articulating the role of the perioperative nurse through structured / guided reflection-on-practice'**

**Bridie McCarthy and Mairin O'Mahony**

#### **Introduction**

Health care in Ireland has undergone immense changes in the past decade. This has been accompanied by significant changes in nurse education, rapid advances in science and technology as well as a more informed/educated/questioning patient/client group. Perioperative nurses are one group of nurses who are constantly exposed to the impact of these changes in their everyday working environments as they strive to deliver quality care to patients undergoing surgery.

#### **Literature Review**

Current debates about the role of the perioperative nurse focus more on the technical aspects of care ignoring the other dimensions of this multi-faceted role. A study by Mardell (1998) highlighted that theatre nurses need to make themselves more visible to their colleagues on the surgical wards and to communicate their role not only to members of the health care team but to patients in their care. This was also highlighted by Rothrock, (1990) who advised that theatre nurses must make the care that they deliver more evident for the sake of both patients and perioperative nurses.

Caring for patients in a constantly changing technological environment requires perioperative nurses to be prepared to adapt to such challenges without losing sight of the patient care focus. Life-long learning is a prerequisite in a profession that is in constant change as it enables professionals to be prepared for these changes (Gustafsson and Fagerberg, 2004). According to Durgahee, 1997 and Woodward 1999, registered nurses can develop their professional roles by using reflection.

#### **Reflection**

Patton (2004) suggests that reflective practice can help nurses to define what they do. Furthermore, reflection-on-practice is espoused as a means of making sense of complex situations and understanding what nursing is about (Jarvis, 1992). Therefore, it is suggested here that reflection on perioperative nursing practice is a means for nurses to begin to explore, define and articulate the role of the perioperative nurse. In doing so, perioperative nurses will begin to make visible and articulate what it is that they do.

## *Session 1C & 6B: Partners in Education*

### **Aim of the paper**

This paper proposes the use of Gibbs (1988) reflective cycle with cue questions from John's (1995) framework as a means of empowering perioperative nurses to begin to develop the skills of reflection-on-practice, thus enabling them to articulate their multi-faceted role in an ever changing perioperative environment. This could provide the stepping stone for nurses to consider role development in the current climate of advancing perioperative nursing practice and ultimately enhance patient care.

### **Key Words:**

perioperative nursing, reflection-on-practice.

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## *Session 1C & 6B: Partners in Education*

Name: Dr Alun Morgan

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Occupation: Director, Department of Operating Department Practice, Cardiff University

Affiliation: Association for Perioperative Practice

Alun is Director of the Department of Operating Department Practice and Vice-Dean of the School of Healthcare Studies in Cardiff University. Although currently in Higher Education, Alun previously spent many years in the National Health Service in Medical Physics and in Management Training and Development.

His current interests are in developing CPD opportunities for all theatre staff, reflective practice and learning. In 2004 he achieved his PhD through research into organisational leadership and change.

### **‘The Education And Development Of Surgical Care Practitioners; Experiences Of The Wales Pilot Programme And Potential For The Future’**

**Dr Alun Morgan, Mr P. R Ward, Mrs H.G Fields**

**Cardiff University, Cardiff, Wales, UK**

A host of contextual factors have catalysed providers of healthcare in the UK into re-thinking the skill-mix of their workforce. In surgery, the introduction of new roles and new ways of working is an attempt to address some of issues impacting upon patient care. This paper describes and reports on findings of a pilot study for the education and introduction of Surgical Care Practitioners (SCPs). It outlines the educational programme, identifies some of the impacts of the SCP on the quality and management of patient care, and considers how the SCP role may develop in the UK.

Formal evaluation of the pilot programme consists of two stages. Evaluation of the first year of the programme commenced in August 2004, and involved the completion of an in-depth questionnaire by students and surgeons, followed by a semi-structured interview with all questionnaire respondents. The primary aim of the evaluation was to determine the effectiveness of the pilot programme in preparing students for the SCP role. However, data were also gathered on student background and motivation to participate in the pilot, and the impact of the pilot on the provision of care; views were also sought on the potential future for the role of the SCP. Simple descriptive statistics were employed to summarise the quantitative data gathered from the completed questionnaires. Analysis of the data gathered from the free text sections of the questionnaires and from the interview transcripts was through a modified grounded theory approach whereby themes were developed in an ‘emergent’ fashion, being grounded in, and derived inductively from the data.

The pilot programme concludes in October 2005 and evaluation of the second year of the programme will commence in September/October 2005 and will employ the same methodological approach and methods as described above.

## *Session 1C & 6B: Partners in Education*

Name: Shlomit Izhaki

Country : Israel

Occupation: Infection Control Supervisor.

Affiliation: Board directory, Israel Infection control Society.

R.N, MA, (Education – Curriculum Development). Experienced in a variety of healthcare settings. Was the head nurse of OBGYN emergency department. Administrated several nursing continuing education courses. Graduated Infection Control Advanced Course and Epidemiological Intervention Training Course. Was the Environment Health supervisor and currently infection control supervisor in Lady Davis Carmel Medical Center.

Name: Bruria Moshitz

Country: Israel

Occupation: Operation Theatre Head Nurse

Affiliation: A member of the Israeli Association of Operation Theatre Nurses

RN, MA (Healthcare Administration). Was the head nurse of OBGYN for 18 years. Was a geriatric care manager for 3 years and currently is the operation theatre head nurse of Lady Davis Carmel Medical center. Active member of several national surgical services standards and auditing committees, as well as surgical materials procuring decision-making committees.

### **‘Infection control in OT – Meeting the educational needs of a multidisciplinary team’**

**Shlomit Izhaki – Infection Control Supervisor & Bruria Moshitz – OT Head Nurse**

**Board directory, Israel Infection Control Society.**

**Bruria Moshitz – A member of the Israeli Association O.T Nurses.**

### **Introduction**

Infection control is a key factor in patient perioperative care. Multidisciplinary team in OR and different educational needs create a challenge to OR educators.

### **Aim**

To improve adherence to infection control standards and performance level in OT.

### **Methodology**

An evaluation checklist was formed for each sector of the multidisciplinary team working in the OR. Survey parameters included aspects common to all sectors and unique factors that relate to activities distinctive to a certain sector. Data obtained from the observations showed that the average performance level of all sectors of OT was 76.4 (max=100). The culprit points for nurses, surgeons and anesthesiologists were hand scrubbing/hygiene, attire, surgical site disinfection, sterile field maintenance and adherence to protocols of prophylactic antibiotics. We found a need to change protocols of hair removal that will follow international recommendations and a need to reinforce practice guidelines for visiting sectors. Following survey results, an educational program was constructed for each sector. A second survey was conducted after completion of educational program.

### **Results**

Second survey results revealed a significant improvement in performance level: 94.1 vs. 76.4 before intervention. The improvement was achieved by all sectors in OR. Nurses’ average score in hand scrubbing was 98.7 (vs. 91.4 before intervention), attire average score was 99.2 (vs. 71.8 before intervention). Surgeon’s hand scrubbing average score was 94 (vs. 74.1 before intervention). Anesthesiologists average score improved from 68 to 89. Following survey outcomes, prophylactic medication protocol was changed: the responsibility for prophylactic medications was transferred from surgeons to anesthesiologists, resulting in 98% proper time prophylactic administration. Following the second observation, we have continued to survey OR teams twice a year. Results of follow-up surveys have shown high level of standards performance.

### **Key Words**

Operation theatre, Infection control, education, guidelines.

## *Session 1C & 6B: Partners in Education*

Name: Catarina Augustsson

Country: Sweden

Occupation: Operating room nurse

Affiliation: SEORNA Nurse exam 1981. Operating room nurse at Ear-nose and throat Blekingesjukhuset Karlskrona since 1987.

### **‘Meeting Children And Parents – A New Way Of Providing Preoperative Information’ Catarina Augustsson, Helena Sörbris, Christina Wilhelmsson, Ros-Marie Strömblad**

#### **Background**

Approximately five hundred operations every year are carried out on children as out-patients at the Ear, Nose and Throat Department of the County Hospital, Karlskrona, Sweden. Preoperative information was previously addressed as a rule only to the parents. Insecure parents can transfer their own fear and anxiety to their children, with negative affects on the child`s emotional status. Studies show that if parents are given proper information and support, their stress levels are reduced and they take a more active and supportive role in helping their children cope with the situation. (Ellerton 1993). Both children and parents experience most anxiety just before the induction of anaesthesia. However, this anxiety can be markedly reduced by giving appropriate information. (Ellerton 1993)

#### **Purpose**

To find out whether a new way of informing children and parents before out-patient surgery at our department would lead to increased satisfaction and participation compared to previous routines.

#### **Method**

A questionnaire, KUPP (Wilde 1993) (Quality from the patient`s point of view), was used. The study is based on a consecutive series of children who were operated at the Ear, Nose and Throat Department in Karlskrona comprising a control group of 99 where parents received the conventional information, followed by an intervention group of 98 who received information tailored to the needs of both children and parents, so called ”informing by playing”.

#### **Results**

The intervention group required less time for preparation on the day they came for operation, that is to say, the time from arrival in the reception area to being anaesthetised. The parents in the intervention group experienced a higher degree of participation in decisions about premedication and the method of induction of anaesthesia. Parents in this group who had experienced previous operations thought that the new way of informing both parents and children made things easier. The parents also felt that their child had been more adequately informed about the induction of anaesthesia. The new routine with a ”pre-visit” showed better results compared to the traditional preoperative information routine ( $p<0.01$ ). Parents experienced greater participation in their child`s care ( $p<0.05$ ) in the recovery room.

#### **Conclusions**

The new way of informing parents and children using play techniques at a pre-visit made the work of the department more effective. Because this was obvious to all members of staff, the routines for giving preoperative information were changed.

## *Session 1C & 6B: Partners in Education*

### **Keywords**

child, parent, parental participation, parental care

### **References**

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## *Session 2A & 5C: Clinical Practice*

### **‘Counting procedures in the Operating Room, Is there a difference between theory and practice?’**

**Petra Ebbeke, Germany**

#### **Introduction**

Patient safety in the operating room is of high interest for all healthcare workers involved. Counting procedures contribute to minimize potential risks for the patients, especially in preventing them from leaving the operating room with unintentionally retained foreign bodies.

Based on German and American publications a draft of a quality standard and guidelines for performing the counting -of among others - instruments and needles had been developed to support the colleagues in checking their own counting practice.

#### **Aim of the survey**

It is the aim of the survey to explore the question what is taught in schools for post-basic education for operating room nurses and what is implemented in the operating departments involved in the post-basic education.

#### **Methodology**

Questionnaires were sent to selected schools for post-basic education to be completed by the students and the nurse managers.

#### **Results**

At the point of returning the Essay, the survey was still under construction. The results will be presented in the session.

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#### **Keywords**

Riskmanagement, counting procedures, patient safety

## *Session 2A & 5C: Clinical Practice*

Name: Paul Meijsen

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**'The counting of sponges, instruments, disposables and sharps.**

**Don't count them..... manage them!'**

**Paul Meijsen, Mr. E. Meers**

**Catharina Hospital , Eindhoven, The Netherlands. University Hospital Maastricht, Maastricht, The Netherlands**

### **Background**

Operating room nurses are responsible and liable for the counting of sponges, instruments, disposables and sharps. Although there are guidelines and protocols, (near) incidents still occur in every hospital. Incidents are reported in literature and by hospital liability insurance companies. It is reasonable to assume that not all incidents are reported and that these statistics are an underestimation of the problem.

Every OR nurse knows that he or she can make an error during the working day that could have serious consequences for both patient and team. Therefore the best preventive measures are necessary and all the available knowledge needs to be shared.

### **Research problem**

What are the best practices for the counting of sponges, instruments, disposables and sharps?

Can these practices be improved?

How can count errors happen, despite the use of good protocols and guidelines?

### **Goals**

To identify the best practice for counting methods, share these practices and if necessary improve these methods and confirm them with evidence.

### **Methodology**

The problem is approached as a project with a combination of research methods. The project comprises a European and a national questionnaire, literature research, expert consultation and practical research on the work floor. During the preparations of the research project a new concept for the counting of sponges was developed. This method will be compared with current counting methods in the autumn of 2005.

## *Session 2A & 5C: Clinical Practice*

### **Preliminary results**

The questionnaire studies are currently not completely analyzed. Pilots showed that the counting of sponges is described well by protocols and guidelines, but that the practical execution is sometimes rather primitive, extensive, unhygienic and unergonomic. The counting procedures for instruments, disposables and sharps will need a lot more attention.

Expert opinions about the new sponge count method seem promising.

### **Keywords/MESH terms in PUBMED**

[Surgical sponges] - [Retained instruments] - [Postoperative Complications] - [Foreign Bodies] - [Preoperative counting] - [Gossypibomas] - [Counting sharps & needles] - [Counting disposables] - [Malpractice/economics/legislation & jurisprudence] - [Insurance, Liability/legislation & jurisprudence]

## *Session 2A & 5C: Clinical Practice*

Name: Mary Langan

Country: Ireland

Occupation: Theatre nurse working orthopaedic OR

Affiliation: INO (Irish Nurses Organisation)

Basic Nurse training and Midwifery training in England.

1981 commenced work in Orthopaedic theatre Merlin Park Regional Hospital, Galway.

1999 visited Glasgow Royal Infirmary, Scotland on Scholarship

2001 and 2002 Studied Health Services management at University of Limerick, Ireland to Diploma level

2003 Awarded Higher Diploma in Orthopaedic nursing.

### **‘Do You Have The Correct Patient? Introduction of a Risk Management and Audit Tool’**

**Mary A. Langan**

**Affiliation Working in Merlin Park Regional Hospital, (Galway Regional Hospitals)**

#### **Introduction**

The risk of the incorrect patient arriving to theatre led to the introduction of a Patient Request Form. In the process guidelines and protocol were developed to reduce the margin for error. These have been implemented in the hospital as standard practice. The same document can be used as a simple audit tool to calculate time in theatre, time of surgery, and length of time to get patient to theatre.

#### **Aim of Study**

Reduce the Margin of possible error in the transfer of patients to theatre.

Introduce best practice when patients are being called to theatre.

Return the responsibility, for the delivery of the correct theatre patient to the nurses in theatre and the nurses on the ward.

Implement, as standard practice, a patient request form, which could be used for auditing purposes.

#### **Methodology**

The project looked at best practice in other hospitals, involved a literature review, designing a form, guidelines for its use, a feedback questionnaire and depended on the co-operation of staff members on the wards as well as the theatre staff.

#### **Results**

The findings highlighted the issue of wrong patient and wrong surgery. It also produced an unexpected result around the patients' hospital identification numbers. The fact that there are only local standards in place in hospitals around Ireland pointed to the possibility of looking at accreditation. Most of the literature available on the subject was written in the U.S.A. (United States of America).

## *Session 2A & 5C: Clinical Practice*

### **Key Words**

Patient safety, patient identification, pre-operative checklist, wrong patient, wrong site surgery / wrong surgery.

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## *Session 2B & 3B: Current Challenges*

Name: Melanie van Limborgh

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Occupation: Project Manager Treatment Centre, and Decontamination, Assistant General Manager, Anesthetics, Imaging and Surgery

Affiliation: Association for Perioperative Practice

Registered Nurse with experience in Operating Room, Anesthetics Recovery, Day Surgery, Sterile Services/Decontamination.

Past Chairman of the Association for Perioperative Practice 2002- 2005.

Past board member of EORNA and Council of Nursing Representatives of the International Federation of Perioperative Nurses. Masters Degree Healthcare Management obtained 2000.

### **‘Decontamination Of Medical Instruments, The Relevance To Perioperative Care In Europe’**

**Melanie van Limborgh RGN MSc.**

**Chelsea and Westminster Healthcare NHS Trust, London, UK**

Throughout the history of perioperative care nurses and practitioners have played a key role in the process of decontaminating reusable medical instruments. These roles have ranged from manual hand washing, packing and sterilizing instruments, often with little formal training.

As time progressed custom built sterile services departments were commissioned in a number of European hospitals and dedicated staff assumed some of the duties perioperative staff had been undertaking. As healthcare entered the new millennium perioperative staff were still undertaking decontaminating duties in some hospitals and this is still true in 2005.

The advent of Creutzfeldt Jakob disease started to change the agenda and it was seen that the fatal disease was spread from one patient to another by a protein called the Prion (1). One mode this Prion was seen to transmit was the medium of medical instruments (2). In addition the Prion was seen not able to be inactivated by normal instrument sterilisation procedures. It has been demonstrated that effective decontamination is key to reduce any risk to patients undergoing surgical procedures with re-usable medical instruments.

The paper will discuss how the management of the Prion and other micro-organisms is relevant to safe perioperative practice, highlighting the responsibilities of perioperative staff. The Medical Devices Directive and European Standards relevant to decontamination will be demonstrated as an integral part of a framework forming safe perioperative patient care (3).

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## *Session 2B & 3B: Current Challenges*

Name: Elisabeth Meineke-Wolf

Country: Germany

Occupation: Nurse manager

Affiliation: Klinikum Kassel

- Education as nurse
- post basic education as OR-nurse and working in the OR for many years
- Study and diploma in nurse management and quality management
- At the moment I'm working in a big medical centre in Kassel, being responsible for special project and quality management

### **Classifying and processing Medical Devices**

**Elisabeth Meineke-Wolf**

**Medical Centre Kassel, Germany**

The Council Directive 93/42/EEC of 14. June 1993 concerning medical devices is obligatory and binding for all countries within the European Union. Every country has to transform this law into national right. The German law of Medical Products (MPG), especially the Medical Devices Operator Ordinance (MPBetreibV) and the recommendations of the Robert-Koch-Institute (RKI) give details about the processing of medical devices. The proper authorities are instructed to check the implementation of these guidelines in hospitals practice.

Not only the personnel of the Central Sterile Supply Department (CSSD) are occupied with processing medical instruments but the OR-staff as well is involved.

According to these requirements it becomes necessary to develop methods and standards to classify Medical Devices and to make sure that the procedures are valid and the quality of the results is always constant and documented.

Especially in case of manual processes, detailed working instructions describing the proper procedure are required.

In addition to describing the essential steps requiring in the process, the author introduces working instructions and practical consequences.

**Background:** Council Directive 93/42/EEC concerning medical devices

**Problem:** Implementation of the requirements

**Goal:** To present recommendations to classify Medical Devices and descriptions of working instructions.

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1. BVMed-Bundesverband Medizintechnologie e. V. (2002): Medizinproduktrecht; Lind & Ahlfeld GmbH, Wiesbaden
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3. Robert-Koch-Institute (2002): Recommendation – Hygienic Requirements for Processing of Medical Devices, Bundesgesundheitsblatt 2001; 44: 1115-1126

## *Session 2B & 3B: Current Challenges*

Name: Claire Campbell

Country: United Kingdom

Occupation: Head of Corporate Management & Communications

Affiliation: Morecambe Bay Hospitals NHS Trust/ AfPP Past Officer, Kendal, UK

I started my nursing career in 1979, undertaking a pre- basic Orthopaedic Nursing Certificate and then qualifying as an RGN in 1984. I completed post- registration qualifications in Operating Department Nursing, teaching & assessing, a Diploma in Nursing, and a BSc in Health Management. I moved into general management in 2001 and currently hold the post of Head of Corporate Management & Communications working directly for the Trust Chief Executive since March 2001.

### **‘Corporate Governance- Do you work in a Transparent or Opaque Organisation?’ Claire Campbell, RGN, BSc, DipN**

Corporate governance is the system by which companies, organisations and public bodies are directed and controlled and it is the way in which the affairs of the organisation are handled by their Boards and officers. Current thinking recognizes an organisation’s obligations to society generally in the form of stakeholders. We require good governance of our public and independent service organisations to ensure services of a high standard. Good governance leads to good management, good performance, stewardship of finances and ultimately good outcomes for our patients and clients. This paper will identify the six core principles of good governance, its application, the roles and responsibilities of all involved and behaviours consistent with those roles. Organisational values and transparent decision making support risk management and good governance can develop the capability and capacity of those charged with these roles to be more effective. Ultimately the aim of good governance is to understand accountability relationships to the benefit of all stakeholders, including our patients and clients. The adoption of a comprehensive corporate governance framework is the cornerstone of sound business conduct and is fundamental for all public bodies and organisations. Failure in corporate governance is a threat to the future of organisations; high profile examples include the collapse of Enron due to financial irregularities. Health care bodies in the UK and Europe subscribe to corporate governance reform therefore substandard governance should be challenged by all organisations and those who work within them.

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1. Committee on the Financial Aspects of Corporate Governance (1992) Report with Code of Best Practice, [Cadbury Report] London. Gee Publishing.
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3. Nolan Committee’s First Report into Standards in Public Life (1995). London. HMSO

#### **Key Words**

Corporate Governance, principles of good governance, managing risk, organisational values, challenging standards of governance

## *Session 2B & 3B: Current Challenges*

Name: Diane Gilmour

Country: England

Occupation: Clinical Team Leader Day Surgery

Affiliation: Association for Perioperative Practice (AfPP)

Currently Clinical Team Leader for Day Surgery at Surrey & Sussex Healthcare NHS Trust. Actively involved with AfPP/ NATN since 1992 and in October 2005 was elected as Deputy Chairman. Presented papers and published articles on a variety of subjects, both nationally and internationally.

### **‘Operating as a Team’**

**Diane Gilmour**

#### **Background**

Over the past few years, like so many other Trusts in England, Surrey and Sussex Healthcare NHS Trust has undergone many changes. The theatre teams can be seen as central to the success of the Trust and its provision of surgical services but the very pace of change and limitations of money and resources has meant that morale has not been high and teamwork fragmented. However a staff survey in September 2003, specifically targeted at all theatre staff, revealed that morale was lower than other sites which had also taken part in the survey. In 2004 external facilitators held a series of four staff “awaydays” and theatre staff from both sites were encouraged to attend. These days were aimed at gaining a commitment from the staff to accept that change is inevitable but that this can be positive, increasing ownership amongst staff of any actions/ goals decided, and demonstrating to staff the management’s commitment to working with them to improve the working environment. Everyone who attended clearly recognised that the issues being faced were those associated with ongoing, everlasting change management and not related to and focussing on one single issue or event, and that the solutions required would need to be implemented as part of a long term strategy.

#### **Focus of interest**

Rising to the challenge and the very positive outcome of the initial external facilitation and “away-days” the theatre management team committed to continuing the work. This presentation will outline the actions set as well as detail the progress that has been made to date and ongoing development following these original “awaydays” in 2004. It will detail the continuing commitment by the management to foster a positive approach to communication across both sites, to improve morale and build a more cohesive theatre team. The first part of the presentation will illustrate with examples the initial progress made, such as the continuation of “awaydays”, the Trust theatre philosophy, the Theatre newsletter, improved communication pathways, a Spend Wisely initiative, the continuation of cross-site working and the development of policies such as the wearing of uniform in theatres. Further reconfiguration in September 2005 meant that 2 new teams were established and the skills acquired and the lessons learnt through the “awaydays” have been invaluable for the theatre management team in integrating staff within the new teams. Exciting Changes and challenges continue within the Trust affecting all the Operating Theatre staff and the outcome of the “awaydays” have given the staff the confidence that they can make a difference by continuing to put into action their own ideas and aims, enable the staff and management to reset targets and actions for the future demonstrating that such an initiative is a continuing one and not just at a period of acute change.



## *Session 2B & 3B: Current Challenges*

### **Conclusion**

This paper will highlight the measurable added value and success of investing time and energy into listening to our staff and supporting their enthusiasm to turn their dreams and ideas of improvement into reality.

### **Key words**

Teams, ownership, change management

## *Session 2C & 9A: Perioperative Nursing: A Complex Profession*

Name: Paul Wicker

Country: United Kingdom

Occupation: Head of Operating Department Practice, Edge Hill College, Liverpool, UK

Affiliation: Association for Perioperative Practice

I have been involved in perioperative care for over 25 years. I have recently published a book with Kate Woodhead, entitled 'A Textbook of Perioperative Care'. I am interested in promoting the use of research in an effort to establish a strong base of knowledge to advance perioperative practice.

### **'Identifying best practice – or 'How I survived the information age'**

**Paul Wicker**

Information is knowledge. Gathering information is no longer a problem – ensuring it is the right information is. The quantity of information available today is truly staggering. Even better, it is highly accessible in many different forms to every person in the Western World. For example, books, journals, television, video and the World Wide Web are but a few sources.

However, this massive store of information brings with it the potential for the mismanagement of information. For example, have you noticed the emergence of several major issues in perioperative care related to equipment over the past few years? For example:

- Masks don't need to be worn by circulating staff during surgery – they only last for 2 minutes anyway?
- Surgical smoke is bad for us – we must use smoke evacuators?
- Latex allergy is a major risk to surgical patients – we must eradicate latex from every piece of equipment in the operating department?
- Wound infection is a great risk – we must use expensive, coated sutures?

Everybody has an opinion on statements such as these. Some practitioners even go a little further and demand new equipment, employ new techniques and change practice to take these issues into account. But what are these approaches to practice based on? Can we trust manufacturers to supply us with independent and unbiased evidence about the value of their products? It is easy to talk about evidence based practice – but what does it really mean? How can we tell whether the information that we have found is valid and reliable. If a suture company promotes a product which reduces contamination of a wound, but charges an extra 30% - how can we tell whether it's a worthwhile change to make?

The purpose of this talk is to discuss the use of 'fear' to encourage change and how practitioners can take control of change by accessing good sources of information, appraising it and making an informed decision to take appropriate actions.

Learning outcomes: 1) Discuss how 'fear' is used to encourage change in the perioperative environment. 2) Identify ways of identifying sources for reliable and valid information. 3) Understand how to appraise the quality of information for guiding practice.

## *Session 2C & 9A: Perioperative Nursing: A Complex Profession*

Name: Dr Marilyn Richardson-Tench, PhD, M.Ed.Stud., B.App.Sc.(Adv.Nsg.), Cert.Clin.Teach., Cert.Anaes., Cert. OR Tech. & Man., RN, RCNT(UK)

Country: Australia

Affiliation: ACORN, APP

I completed my nursing at the Alfred hospital in 1972 and obtained a perioperative qualification from the Royal Melbourne Hospital. I am a Senior Lecturer at Victoria University. I am an experienced researcher and have presented papers at national and international conferences. I am the Treasurer of the Victorian Perioperative Nurses Group.

### **'Discursive Constructions Of The Operating Room Nurse'**

**Dr Marilyn Richardson-Tench**

**Victoria University, Melbourne, Australia**

Nursing, as one of the new professions, has worked hard to gain recognition beyond that of handmaiden to the medical practitioner. But thus far, operating room nurses have not generally asserted their role and indeed have played a dependent role, taking orders and assisting the surgeon. Nurses in general are extremely skilled in areas such as patient assessment, independent care decision-making, 'knowing' the patient and providing empathic nurturing care. But in the operating room technical proficiency is awarded more status and prestige than is caring and nurturing. In this highly specialized and complex area the need for technological expertise takes precedence over the traditional role of nurse as carer. Nursing discourses are subsumed beneath a technological discourse. Hence caring and nurturing appear to be devalued in direct relation to the valuing of complex technological management of the patient. Operating room nurses locate their practice within discourses that are powerful, technologised and gendered. The regimes of power that shape the nurse within the operating room are ones which are also those premised on what it means to be a woman. This paper explores the power relations, which mediate the discourses of operating room nursing practice. The role of the nurse vis a vis the doctor is analyzed from a feminist perspective. .

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### **Keywords:**

Nursing , Discourses, Technical, operating rooms

## *Session 2C & 9A: Perioperative Nursing: A Complex Profession*

Name: Caroline Guinan

Country: Ireland

Occupation: CNM1 Theatre Department, Regional Hospital Tullamore  
Registered General Nurse, Dip N, BScNursing,, MSc Nursing(Clinical Practice). Working as Clinical Nurse Manager 1 in Orthopaedic Theatre, Regional Hospital Tullamore. Special interest in educational and professional development of staff and students in the Operating Theatre.

### **‘Caring. The core component of peri operative nursing?’**

**Caroline Guinan,  
An Bord Altranais**

#### **Introduction**

Caring is a theme often described as the essence and unifying domain of nursing (Watson 1988). However many question: “Is theatre nursing caring nursing. Indeed, is theatre nursing.. nursing at all?” The literature is abounded with criticisms of caring behaviours in peri-operative practice. Many studies implying that theatre nurses are quick fix mechanics merely performing a technical role (Kalideen 1999) or that they are failed ward nurses lost behind the mask, who cannot cope with patients who answer them back, and have an obsession about routine and procedure (Castledine 1992). Kalideen (1999) views theatre nurses as handmaidens to the surgeon while Mardell and Rees (1998) insinuate they are removed from direct patient care.

Many patients indeed, not realising that there are nurses actually working in theatre (Walker 1999). But I believe we are more than just that. I believe we are caring nurses. This is based on my experience as a staff nurse and nurse manager in peri-operative practice over the last twenty years. Nonetheless it is getting harder. What with shortages of theatre staff, increased waiting lists, time constraints, high workloads etc... They are making it more difficult to care for and care about patients. They also make it more difficult to care for ourselves and for each other.

#### **Aim of Study**

- Refocus on what “Caring” is and how it applies to peri operative nursing:
- Identify caring and non caring behaviours as perceived by patients and peri operative nurses
- Identify the barriers that may prevent nurses from caring focusing mainly on the concept of bullying and harassment.
- Put forward recommendations, for health organisations, managers and theatre staff to ensure caring remains the core component of peri operative nursing.

#### **Methodology**

Literature Review

#### **Results**

St Francis (cited in West 1993) once stated

- A man who works with his hands is a labourer.
- A man who works with his hands and his head is a craftsman.
- A man who works with his hands, head and heart is an artist.



## *Session 2C & 9A: Perioperative Nursing: A Complex Profession*

We too are artists in our own right in caring for and about patients... blending the art and science of peri-operative nursing.

What we must remember is that caring for today and preparing for tomorrow starts by recognising who we are, what we do, and more importantly, that we have and need each other.

### **Key Words**

Caring, peri operative nursing, caring behaviours, bullying and harassment.

## *Session 3A: International Session I - Patient Safety*

Name: Lesley Fudge MSc BA(Hons) RGN  
Country: England  
Occupation: Independent Healthcare Consultant  
Affiliation: International Federation of Perioperative Nurses

Lesley has a background in Neurosurgery and Burns & Plastic Surgery and Theatre Management in England. She was National Secretary of AfPP (then NATN), and is Vice-chairman of the Latex Allergy Support Group (UK), CEO of Friends of African Nursing and Treasurer of the International Federation of Perioperative Nurses. She is now an Independent Consultant.

### **‘Vertical and Horizontal Violence in the Operating Room: International Federation Perioperative Nurses Paper Presentation’ Lesley Fudge, MSc BA (Hons) RGN**

#### **Aim**

The majority of nurses will be working in establishments where policies and procedures have been in place for some time to deal with conflict in the workplace. More than these are needed to change a culture of bullying and harassment. Recognition of behaviours within a culture where vertical and horizontal violence must become unacceptable in what is deemed to be a caring profession may go some way to improving recruitment and retention. This paper will explore the issues, international research and findings and describe some mechanisms for dealing with destructive behaviours at work.

## ***Session 3A: International Session I - Patient Safety***

Name: Anthony Dawson

Country: U.S.A.

Occupation: Master Black Belt Quality and Patient Safety

Affiliation: New York-Presbyterian Hospital, New York, NY

Tony Dawson, RN, MSN, is a Master Black Belt in Performance Excellence at New York-Presbyterian Hospital. He leads, facilitates, and support significant quality, process, and performance improvement projects using Six Sigma, Change Acceleration Process, and Work-Out methodologies. Prior to becoming a Black Belt he was the Clinical Director of Perioperative Services at NYPH. He had twenty-four hour accountability for the operation and management of Perioperative Services (with 28,000 cases/year) for a level 1 Trauma Center and Regional Burn Unit. He directed the delivery of safe and effective patient care in:

- 38 operating rooms both inpatient and ambulatory
- 65 -bed recovery rooms
- 3 Cysto Suites
- 6 Endoscopy Suites
- Central Sterile Processing
- Materials Management
- Pre admission Testing , Admit Day Surgery and Same Day Surgery Centers

### **‘Determining Medication Error Risk on the Sterile Surgical Field in a United States Hospital’ Anthony Dawson**

#### **Introduction**

The extent to which medication errors occur on the sterile field in hospital operating rooms (OR) are unknown. An exhaustive search of the literature failed to yield any data quantifying the error potential of medication use on the sterile surgical field. The use of medications on the sterile field is unique from other settings and its complexity makes it more susceptible to error. Reports of serious patient injuries and deaths from medication errors on the sterile field from other hospitals lead us to conduct a comprehensive safety analysis of this medication use process at our multiple-campus teaching hospital.

#### **Aim of Study**

The use of medications on the sterile field is unique from other settings and its complexity makes it more susceptible to error. A prospective risk assessment was conducted to determine sterile field medication error opportunities per case (i.e. error risk). Error opportunity (EO) is determined by such factors as the number of medications being used, the number of mixtures on the sterile field, the number of calculations taking place, and the number of calculations that are not double-checked for accuracy, as well as other factors. We hypothesize that the higher the EO per surgery, the greater the risk for a medication error.

## *Session 3A: International Session I - Patient Safety*

### **Methodology**

A series of data collection projects (medication analysis, process survey, focus group, and an analysis of surgeon preference cards) were conducted to create an outline for conducting a Failure Mode and Effects Analysis (FMEA). A multidisciplinary team of OR nurses, OR technicians, and pharmacists assisted in creating a detailed mapping of the macro steps in the process; prescribing, dispensing, medication preparation, labeling, transfer of medication to the sterile field, set up of the sterile field, and medication administration.

### **Results**

This prospective risk assessment analysis determined that there are approximately 6.76 sterile field medication error opportunities per surgical case in our present system. Results show a highly complex system of 247 steps and 547 potential points of error involving 131 individual failure modes. For each error opportunity, an average of 19.4 possible failure modes exists. Our data shows a situation with many medications with high variability in preparation and delivery.

### **Key Words**

Error opportunity, sterile field, medication errors, FMEA

## *Session 3A: International Session I - Patient Safety*

Name: Robert B. Dybec RN, MS, CPSN, CNOR

Country: U.S.A.

Occupation: Nurse Manager Operating Room

Affiliation: Winthrop-University Hospital, New York

Received Nursing degree in 1985, now holds a Masters degree in Health Care Administration.

Currently the Operating Room Nurse Manager at Winthrop-University Hospital in New York.

Has lectured and instructed internationally, consulted and published on the topic of Patient Positioning for over ten years. Received the award for “Outstanding Achievement in Perioperative Clinical Nursing Education” in 2005 from the Association of Perioperative Registered Nurses (AORN)

### **‘Perioperative Nursing Considerations for Positioning the Patient in Surgery’**

**Robert B. Dybec RN, MS, CPSN, CNOR**

#### **Introduction**

An informative program designed for all perioperative nurses which discusses the nurses’ role in the safe positioning of surgical patients.

#### **Aim of Study**

Provide perioperative nurses and practitioners with the information needed to provide safe care in positioning of patients in surgery. Discussions will include the principles of patient positioning, patient assessment preoperatively and potential complications a result of improper positioning. A review of the four basic surgical positions along with an explanation of the use and need for padding in surgery as well as the importance and value of positioning devices.

#### **Methodology**

A didactic presentation with PowerPoint which will include many photographs intraoperatively showing recommended practices, special circumstances in positioning such as pediatrics, geriatrics and the obese patient. Some charts and graphs are also used which will portray areas of risk and liability, the use of positioning devices and complications.

#### **Results**

At the conclusion practitioners will better be prepared to provide a safer surgical environment with regards to positioning and expect better patient outcomes.

Name: Helen Barallon. RN, RM, Cert. O.T., B.App.Sc. (Nsg.), Grad. Dip. Bus. (Mang’t), MACORN, MRCNA,

Country: Australia.

**Occupation:** Clinical Nurse Educator – Perioperative. St. Vincent’s Hospital Melbourne

**Affiliation:** Australian College of Operating Room Nurses (ACORN), Royal College Nursing Australia (RCNA), Association Perioperative Registered Nurses (AORN), Association for Perioperative Practice (AFPP), Australian Nursing Federation (ANF)

## *Session 3A: International Session I - Patient Safety*

Name: Helen Barallon. RN, RM, Cert. O.T., B.App.Sc. (Nsg.), Grad. Dip. Bus. (Mang't), MACORN, MRCNA,

Country: Australia.

Occupation: Clinical Nurse Educator – Perioperative. St. Vincent's Hospital Melbourne

Affiliation: Australian College of Operating Room Nurses (ACORN), Royal College Nursing Australia (RCNA), Association Perioperative Registered Nurses (AORN), Association for Perioperative Practice (AFPP), Australian Nursing Federation (ANF)

I commenced Nursing in 1964 and have attained several postgraduate qualifications. Currently completing Masters of Clinical Education. I am President of Victorian Perioperative Nurses Group (VPNG) and a committee member for 20 years. I was a member of the ACORN Board for 5 years & currently VPNG representative on the National Count Task Force.

### **'The Tyranny Of Distance: The Journey Towards A National Standard For The Surgical Count In Australia'**

Mrs Helen Mary Barallon, Mrs J Bridges

University of Melbourne - School of Nursing and St. Vincent's Hospital Melbourne, Australia. Latrobe University, Melbourne, Australia

Past practices related to the surgical count in Australian hospitals was considered the domain of the instrument nurse or the senior nurse within the operating room. Thus the decision about the scope of what was to be counted during surgery was left to their discretion. By good luck rather than good management, the incidence of items left behind in patients', was not perceived to be a major problem. Nevertheless items from time to time were left in patients, which caused unnecessary morbidity and suffering. In 2002 I along with a VPNG colleague Judith Bridges, received a grant from the Victorian Branch of the Australian Nursing Federation, to examine the scope of practice related to the surgical count in operating suites throughout the State of Victoria. Subsequently I was elected to be the State representative on the Count Working Party for the development of a Count Resource Package by the Australian College of Operating Room Nurses (ACORN). The aim of the Package was to provide a resource which would assist in standardising the surgical counting practices across Australia. Representatives from all States and Territories provided input into the development of the Package. This was to be the first truly national count standard for Australia. This paper presents the results of the research study related to the surgical count that was undertaken in Victoria, and will describe how the results contributed to the development of a national count resource package. Other important issues associated with the development of the package were the integration of specific guidelines for the surgical count, previously developed in NSW. The guidelines, through legislation mandate the process of the surgical count in that State. However it was not the foundation for practice in other States. Local issues such as the need to change hospital cultures and practices will also be addressed. Examples of how these cultures can impact upon the changes of practice for the surgical count in hospitals, will be given. Recommendations are made about implementing a standardised system for the surgical count for the Australian context, where State health departments are responsible for the overall quality of local hospital practices, in a country that has a small population and vast distances.

## *Session 3C & 5A: Current Developments in Education*

Name: Fionuala M O Gorman

Country: Cork, Ireland

Occupation: Nurse. Clinical Facilitator Perioperative Nursing. Cork University Hospital

Affiliation: Cork University Hospital

Trained as a Nurse at the BonSecours Hospital, Cork. Midwifery Simpsons Memorial Hospital

Theatre Course Hammersmith Hospital London ENB 176

Theatre Manager St. Marys Orthopaedic Hospital Cork 1988 -2001

BSc N UCC 1996 - 1999...MSC 2001 - 2003

Chairperson of the Irish Anaesthetic & Recovery Nurses Association 2005/2006

### **‘Changes in Practice following the Completion of a Higher Diploma in Perioperative Nursing: Perceptions of the Course Participants’**

**Fionuala M O Gorman MSc. Ed. BSc.N ENB 176 R.G.N**

**Clinical Facilitator in Perioperative Nursing Cork University Hospital**

#### **Aim of this Study**

The aim of this qualitative descriptive study was to identify and describe the changes in perioperative practice from the perspective of Nurses who had completed a Higher Diploma in Perioperative Nursing

#### **Introduction**

The literature review indicates that perioperative nurses portray a deep concern and commitment to patient care. This care is multifaceted and encompasses caring, holism, advocacy and knowledge necessary for practice. However, the practice of the perioperative nurse lacks clarity and definition and perioperative nurses themselves have difficulty in identifying and articulating their practice or the knowledge they employ in practice. The literature on continuing education indicates that while education is deemed necessary to enhance patient care there was a paucity of research examining the changes in practice following continuing education for nurses.

#### **Methodology**

A purposive sample (n=6) is interviewed. The participants had completed a Higher Diploma Course in Perioperative Nursing. All informants had a minimum of six months experience since completing their course. A descriptive exploratory qualitative design is employed to explore the contribution of specialist nurse education to the informant's perceived changes in their practice since completing the course. The interview guide emulated from the literature review. A semi structured interview guide is employed as a method of data collection. The data is collected by audio taped interviews and the content of the tapes transcribed verbatim. Data analysis is undertaken using the technique of content analysis and is guided by a set of predetermined categories.

## *Session 3C & 5A: Current Developments in Education*

### **Findings**

The findings suggest that the participants perceived their perioperative practice had changed from a task-orientated method of care to a more patient centered approach. The participants reported that they communicated more with patients awaiting surgery since completing the course. The participants also reported that their use of critical analysis and their use of research resulted in a more questioning approach to practice since completing their course. The participants further reported that they had acquired an increased awareness to ethical knowledge relating to patient care issues within the context of the perioperative multidisciplinary team. The participants also reported they now felt more confident in practice and actively sought opportunities to teach undergraduates students.

### **Limitations**

The study is limited by the small sample (n=6) and the investigation is confined to one course.

### **Key Words**

Perioperative Nursing. Higher Diploma Course. Continuing Education for Nurses.

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- Sigurdsson, H. (2001) "The Meaning of Being a Perioperative Nurse" AORN Denver.

## *Session 3C & 5A: Current Developments in Education*

Name: Rosalie Hammarsten

Country: Sweden

Occupation: Operating room nurse, Section Manager in charge of quality and medical technical safety

Affiliation: Rosalie is the former President of the Swedish Operating Room Nurses Association (SEORNA) and a member of the Nordic and the European Operating Room Nurses Association (NORNA and EORNA). She is also member of the Swedish Association of Health Officers and the Association of Humanism.

Rosalie has taken university courses in information technology, scientific methods, and nursing sciences. She has pioneered new concepts and developed them into several projects and publications. She is regularly invited to lecture both throughout Sweden and abroad and received the "Best lecture award" at the EORNA congress in Brussels 1997.

### Publications

1. The computerised material system for an operating department - Medicinsk Teknik (Medical Technique), 1989
2. The Varberg model of medical technical safety – Incitament, 1995
3. The establishment of team organisational structure within the operating department – Incitament, 1995
4. The Varberg model of medical-technical safety - British Journal of Theatre Nursing, 1997
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6. Glove recommendations (book) – Studentlitteratur, 2002
7. Preoperative skin reactions in connection with the application or use of material in surgical procedures - AORN Journal - AORN journal April 2003 vol 77 no4  
Swedish Patients' Perception of Preoperative Skin Test" AORN Journal March 2005 vol 81 no3

### **'Clinical Supervision Of Nursing Students In The Operating Room - The Popsup-Model (Perioperative Supervision)'**

**Rosalie Hammarsten,  
RN, MNsc student, Central Operating Department, Varberg Hospital, Varberg, Sweden.**

#### **Introduction**

The gap between theory and practice is a well-known problem in connection with the education of nurses. Supervision of graduated nurses in the operating room is a qualified task that requires great ability to properly combine theoretic knowledge and clinical education. Inexperienced clinical practice students often focus on developing their manual skills and little time is devoted to reflecting on the cognitive and affective competence. The work of giving the students the time to expand their occupational role by letting them reflect on their various tasks and giving them the opportunity to work independently is a central part of both nurses and supervisors

#### **Aim of the study**

The purpose of this study was to develop a perioperative supervising model as help and support for supervisors when it comes to education of graduated nurses in the operating room.

## *Session 3C & 5A: Current Developments in Education*

### **Methodology**

The method used was a literature review on supervision and nursing theory.

### **Results**

The review resulted in a perioperative supervision model for graduated nurses in the operating room called POPSUP (PeriOPERative SUPervision). By means of this model, the operating nurse and the student preoperatively plan the nursing. This is done by combining Carper's four patterns of knowing and Henderson's need theory. Then, by means of the reflection cycle of Sarvimäki the student and the nurse can postoperatively and jointly evaluate the result achieved through the nursing method. The major objective of the supervision model is to develop and further widening the occupational competence. The POPSUP model makes it possible to develop total understanding of the nursing to be provided, at the same time as the role and evaluation of the student is clarified. It contributes to knowledge, understanding and insight when it comes to the nursing knowledge required and necessary personal responsibility and efforts. Supervision and nursing today is a time for renewal, a time to evaluate our practice, make changes based on evidence, and to see what we do together with the entire health care team. The supervising model could be expanded even more, not only by aiming the activity at what is being done and the manner in which it is done, but also by penetrating the question of how the nursing can be improved.

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### **Key words**

Carper, Henderson, nursing theory, perioperative nursing, POPSUP, supervision model, Sarvimäki

## *Session 3C & 5A: Current Developments in Education*

Name: Rose-Marie Gabrielson

Country: Sweden

Occupation: RN, CNOR, MSocSc, RNT, Lecturer

Affiliation: Department of Nursing, Karolinska Institute Stockholm

1979 RN surgical wards

1985-1999 CNOR general-, orthopedic-, urology- and vascular surgery at St. Görans Hospital in Stockholm. From 1994 Clinical supervisor at the OR department.

1991-1999 board member of SEORNA.

1999 lecturer in nursing; Emergency Care Specialist Nursing – Operating Room Nursing at the Dept of Nursing, Karolinska Institute in Stockholm

### **‘Operating-Room Nursing Students’ Perceptions Of Facilitating Factors And Barriers In Web Based, Part Time Distance Program Versus Campus Full-Time Program.’**

**Rose-Marie Gabrielson, RNT, CNOR, MSc., Dr. E Ramfelt  
Karolinska Institutet, Department of Nursing, Stockholm, Sweden**

#### **Abstracts**

To meet the demands from health care, society and to be more available for potential students, a postgraduate course for operating room nurses as a web based, part time distance program was offered by Karolinska Institutet, Department of Nursing from 2004. The web based, part time distance program runs on three semesters, compared to a campus full-time program which runs for two semesters. The tempo in web based, part time distance program allows the students to work part time during the program. The aim of this study is to identify and compare operating-room nursing students’ perceptions of facilitating factors and barriers regarding web based, part time distance program versus campus full-time program. During autumn 2005 data will be collected through a web based questionnaire, which includes 15 structured items and five open questions. The data will be analysed using descriptive statistical and comparative pattern analysis.

#### **Keywords**

Operating room nurse student, emergency core curriculum, part time distance program, campus full-time program

#### **References**

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## *Session 4A: Clinical Wisdom of Perioperative Nursing*

Name: Liljeblad Teija-Kaisa

Country: Finland

Occupation: Senior Lecturer in Laurea Polytechnic Vantaa Finland

Affiliation: FORNA since mid 1990's

I am a life long learner with clinical experience as ICU and OR nurse. As a nursing educator I have developed nursing education and technical norms for Aseptic Practice, the core skills of perioperative care in OR.

The highlights of my springs are visits to Hungary Semmelweiss University Budapest.

### **'Further construction of Hypothetical Model for Aseptic Practice in Perioperative Care'**

**Liljeblad, Teija-Kaisa, RN, MSc (HC), LicED, PhD candidate**

**1) University of Helsinki Medical Faculty and 2) Laurea Polytechnic Vantaa Finland**

#### **Aim of the study**

The aim of this presentation is to introduce and document the analytical development process of the Hypothetical Model of Aseptic Practice (HMAP) in Perioperative Care as results of analysis and measurements during the early phase of evaluative program aiming to perform evidence based AP.

#### **Methodology**

The integrative approach for development of situation-specific theories (SST) introduced by Meleis and Im is used as the methodological basis in the combination of concepts and formal theories as deductive fashion, and direct observations of AP in OR as an inductive fashion to evaluate, and by evaluation both develop the evidence base and clarify the conceptual model of the clinical AP. The critical revision of the used hypothetical conceptual model has been performed in nominal group decision making, during reflective discussions with perioperative nurses in intervention and comparison hospitals, during several introductions of the findings of program evaluations and during presentations and professional conversations in national and international perioperative conferences.

#### **Results**

SST of AP is focusing in specific nursing phenomena reflecting clinical practice to protect the perioperative patient by controlling the risk for surgical site infection caused by contamination of the surgical site of the patient and to control the occupational exposures of perioperative personnel. It is limited to specific populations, perioperative patients, and to particular fields of practice when direct means of AP are implemented during creation, maintenance and discharge of sterile field in situations where the perioperative patient is having an invasive intervention including blueprints for action. Indirect means of AP are implemented to maintain the safe operating room environment by prevention of air, blood and body fluids, hand and vector contamination. AP facilitates to provide a basis for the development of the knowledge for nursing practices through research and practice efforts by being more than just guidelines or standardized procedures for nursing practice.

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Ten principles of AP construct basic assumptions guiding or constructing a starting point of the situation specific decision making. They are in a higher level than the recommendations for AP giving universal advises to the practitioner how to behave or perform AT in all situations described as sub-concepts of AP. The value system of AP is possible to make visible by measurement of the social relevance and acceptability of AP recommendations through identification of 1) Infection-sensitive, 2) Stress- sensitive, 3) Ethical-sensitive and 4) Reference-sensitive types aseptic actors in OR. The commitment to the value premises and recommendations as technical norms of AP among personnel varies among different groups of personnel.

The construction process of HMAP in OR meets the current needs<sup>6</sup> to develop professional AP in OR by being a practical tool to describe, understand, and facilitate the research, development and education of the multidisciplinary AP aiming to decrease the suffering of perioperative patient , to improve the effectiveness and cost-effectiveness of perioperative care and prevent the occupational risks of perioperative personnel. As technical norms , , , it combines multidisciplinary knowledge, but when inspected as point of perioperative practice view, it needs also the ethical perspective to become as a professional performance. In developmental process of nursing practitioner from novice to expert technical norms are necessary when describing, learning and evaluating the perioperative aseptic practice, but they do not replace the holistic and ethical clinical wisdom of experienced perioperative nursing practitioner.

**Key words:** Aseptic Practice, Perioperative Care, Situation-Specific Theories

## *Session 4A: Clinical Wisdom of Perioperative Nursing*

Name: Dr Judith Tanner

Occupation: Lead for Nursing Research

Affiliation: Derby Hospital Foundation Trust

Judith worked as an operating room nurse before moving into education and research. She is currently the Lead for Nursing Research in a large Trust in England where she is responsible for encouraging nurses to undertake research projects. Judith is the Editor of the British Journal of Perioperative Nursing.

### **'Pre-operative hair removal and surgical site infection'**

**Dr Judith Tanner**

**Derby Hospitals NHS Foundation Trust**

#### **Introduction**

Hair removal prior to surgery is a contentious subject. Traditionally hair was routinely removed from intended surgical wound sites as it was considered to be unclean. More recently, preoperative hair removal has been considered harmful to patients, causing surgical site infections (SSIs) and as such should not be carried out. There does not appear to be international consensus on hair removal and national guidelines from the UK<sup>1</sup>, the USA<sup>2</sup> and Norway<sup>3</sup>, which are based on different levels of evidence, provide different advice.

#### **Aim of study**

This paper discusses a Cochrane systematic review (the highest level of evidence) on pre-operative hair removal. This review considered the impact on surgical site infections of hair removal, the relative effects of shaving, clipping and depilatory creams, the length of time prior to surgery when hair is removed and hair removal carried out in different settings.

#### **Methodology**

A Cochrane systematic review of randomised controlled trials.

#### **Results**

Eleven high quality randomised controlled trials were included in this review. The evidence finds no difference in SSIs among patients who have had hair removed prior to surgery and those who have not. If hair is removed then clipping results in fewer SSIs than shaving with a razor. There is insufficient evidence to say that depilatory cream results in fewer SSIs than shaving with a razor and there is no evidence comparing clippers with depilatory cream. There is insufficient evidence regarding the timing of hair removal, nor is there any research on hair removal in different settings. This review is published in the Cochrane Database of Systematic Reviews<sup>4</sup>. This study was funded by the Theatre Nurses Trust Fund and the Association for Perioperative Practice.

#### **References**

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## *Session 4A: Clinical Wisdom of Perioperative Nursing*

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### **Key words**

Pre-operative hair removal, infection control, systematic review

## *Session 4A: Clinical Wisdom of Perioperative Nursing*

Name: Dr Eileen M Scott

Country: England, UK

Occupation: Registered Nurse and Post-doctoral Research Fellow

Affiliation: Centre for Clinical Management Development, Wolfson Research Institute, University of Durham, England, UK . Paper presented on behalf of the TEMMP Task Force Her clinical specialty is anaesthetics/recovery and her doctoral research was centered on the perioperative environment. She has published extensively and spoken at many national and international conferences. She is Chair of the Royal College of Nursing (UK) Perioperative & Surgical Nursing Forum and is a member of the TEMMP Taskforce.

### **‘Thermoregulation In Surgical Patients: Pan-European Survey’**

**Eileen M Scott RGN, BA (Hons), M.Litt, PhD, Durham, UK, Guido Fanelli, MD, Ph.D, Task Force Chairman, Parma, Italy, Andrea Casati, MD, Parma, Italy, Juan M. Zaballos, MD, Ph.D, San Sebastian, Spain, Juan M. Campos, MD, Barcelona, Spain, Luc Foubert, MD, Ph.D, Aalst, Belgium, Patrick Wouters MD, Ph.D, Leuven, Belgium, Leena Lindgren, MD, Ph.D, Tampere, Finland, Marja -Tellervo Mäkinen, MD, Ph.D, Helsinki, Finland, Robert Lindwall, MD, Stockholm, Sweden, W. Weyland, MD, Ph., Essen, Germany, Hinnerk Wulf, MD, Ph.D., Alexander Torossian, MD Marburg / Germany, Pascal Alfonsi, MD, Ph.D, Boulogne Billancourt / France, Andrea Kurz, MD, Ph.D, Berne / Switzerland, Ratan Alexander, MD, MB, FRCA, Worcester UK**

### **Background**

Thermoregulation is an important issue in the field of anaesthesia and there is scientific evidence that patients for whom normothermia is maintained have a better surgical outcome. However, thermoregulatory practices are thought to vary greatly across Europe. The TEMMP Task Force (Thermoregulation in Europe, Monitoring and Managing Patient temperature) is made up of specialists from across Europe (Belgium, Finland, France, Germany, Italy, Spain, Sweden, Switzerland, and the UK). Our overall aims are to develop European practice recommendations and guidelines for patient thermoregulation during the delivery of regional and general anaesthesia.

### **Aim of Study**

To carry out a ‘snapshot’ of current thermoregulation practices on the same day: October 13th 2004.

### **Methodology**

We surveyed 810 hospitals and clinics in 17 European countries (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and UK). Each facility received explanatory information and was asked to complete a short questionnaire.

### **Results**

Full findings, and their implications to clinical practice, will be reported.

Survey findings will be disseminated through journal publication(s) and several scientific meetings.

This will be the only presentation at a perioperative nursing congress and therefore will be a premiere one.



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**Abstract aims**

- To explain the survey methods and our sampling frame
- To present detailed findings of the survey
- To highlight the implications for clinical practice across Europe

**Key Words**

Hypothermia, thermoregulation, anaesthesia.

## *Session 4A: Clinical Wisdom of Perioperative Nursing*

Name: Alison Rothwell

Country: Ireland

Occupation: Registered General Nurse(1990), Registered Children's Nurse(1992), Theatre nursing certification(1995), Dip. Management and industrial relations(1998), PG Dip in Clinical Practice – peri-operative(1999), MSc. In Nursing(2004)

Affiliation: The Coombe Women's hospital, Dublin, Ireland

Theatre nursing career began in Children's hosp., Temple street (92-94). Theatre nursing certification at St. James's hospital, Dublin (94-95). I then held the position of staff nurse, Clinical Education Facilitator and CNM 2 in the operating dept at St. James's (95-05). I took up the position of Theatre Manager at The Coombe Women's hospital, Dublin in May 2005.

**'Operating department nurses knowledge of Natural Rubber Latex (NRL) allergy and the management of patients at risk of and with NRL allergies within the operating theatre department.'**  
**Alison Rothwell**

### **Introduction**

Evidence suggests that over the past decade, there has been an increase in the number of patients presenting with NRL allergic responses. The onus rests with nurses, to ensure that they are capable of giving the highest standard of care possible to their patients.

### **Aim of Study**

The study explored operating department nurses' knowledge of NRL allergies, and the management of patients at risk of, and with NRL allergies within the operating department.

### **Methodology**

The quantitative research approach was adopted for this study, and a simple random sampling approach was taken in selecting 50% (n=466) of the population of operating department nurses, from the mailing list maintained by the Irish Nurses Organisation (INO), for inclusion in the study. A response rate of 68% (N=312) was achieved. A questionnaire was designed to measure knowledge and to gather demographic data. The data collected made it possible to explore what knowledge levels were and whether knowledge levels had been affected by clinical experiences, education and/or employer initiatives.

### **Results**

Just 9% of participants were identified as being capable of identifying patients 'at risk of' NRL allergy and of providing independent care (no guidelines/guidance required to inform practice), to those requiring NRL safe precautions within the operating department. In total, 26% of participants were found to have sufficient knowledge to enable them to safely manage the care of a patient who has a known NRL allergy, in the operating department, once appropriate guidelines/guidance was available to support practice. They could not however, be relied upon to identify patients without symptoms, who may be at risk of developing NRL allergic responses. Aspects of knowledge found to be deficient, were centred round the ability to recognise the signs and symptoms of NRL allergic responses, and deficiency in the whole area of risk management, from the identification of those at risk, to the identification of healthcare practices that pose risks.

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Whilst a positive relationship was shown to exist between perceived and actual knowledge levels, participants tended to underestimate the knowledge required of them, to ensure the safe management of NRL allergic patients in their care. The evidence from this study, suggested that amongst participants, the most effective way of increasing knowledge relating to NRL allergy, related to attendance at NRL allergy educational programmes. In addition to this, knowledge was shown to increase accordingly with time spent attending such programmes. There was no evidence to suggest that caring for patients with NRL allergies, specialist qualifications, higher educational awards or the availability of NRL policies had a measurable impact on knowledge development.

### **References**

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- 3.Lewis, L., Norgan, G., and Reilly, M. (1998), Are nurses knowledgeable in regards to latex allergy? Seminars in Perioperative Nursing, 7(4), pp,239 -253

### **Key Words**

NRL allergy, Operating department nurses knowledge.

## ***Session 4B: Issues Regarding Anaesthetic Care***

Name: Aphroditi Faitatzidou

Country: Greece

Occupation: O. R Head Nurse, R.N., Msc

Affiliation: AHEPA University General Hospital

23 years of nursing experience in perioperative nursing, anesthesiology, sterilization and infection control.

Accredited trainer for nurses and midwives by the decision of the Greek Center of Accreditation.

Past officer (coordinator) of EORNA.

President of the Greek Operating Room Nurses Association

### **The Current Practice For The Cleaning And Handling Of Anaesthetic Equipment In Greek Hospitals'**

**Prof. A. Faitatzidou, Prof. F. Veroniki, Prof. A Tsiourva, Prof. E. Masmanidou, Prof. V. Metaxa, Prof. O Nikolaidou, Prof. M. Giala**  
**Ahepa Teaching Hospital, Thessaloniki, Greece**

#### **Background**

Anaesthetic equipment is a potential vector for transmission of disease. Insufficient care has been applied in the past in decontaminating and sterilising items for reuse as well as the misuse of single use equipment. Policies should be adopted to ensure that recommended practices are followed and audited for the anaesthetic equipment.

#### **Aim**

The aim of the paper is to survey the level of knowledge and the adherence of the Greek anaesthetist nurses regarding the Association's of Anaesthetist of Great Britain and Ireland and AORN's recommended practices for cleaning and handling of anaesthetic equipment in Anaesthetic Departments of Thessaloniki's Hospitals.

#### **Methodology**

A questionnaire was formed according to published recommendations from the above mentioned professionals Associations. The questionnaire included basic questions regarding the applied nursing practice to the following : handling of critical care items, semi critical care items and non critical care items, handling of single use items, functioning and cleaning of the anaesthetic machine, handling of waste and lastly the nurses training on safe practice. The questionnaire was handed to Nurses Supervisors of all the Anaesthetic Departments of Thessaloniki's hospitals and they were guided to give a positive or a negative answer to every question. The results were recorded and processed statistically.

#### **Results**

Both recommended practices for cleaning and handling of anaesthetic equipment were proved to be followed to a great extend. The nursing staff was highly informed towards the proper checking, safe use and correct cleaning process of the anaesthetic machine as it is well known that this directly affects patient safety. Some imperfections were discovered concerning handling of sharp items as well as the use of protective equipment like masks, gloves that require more attention and compliance. Greater voids were discovered in the organisation of life long education programs and quality assessment programs that were completely absent.

## *Session 4B: Issues Regarding Anaesthetic Care*

### **Conclusion**

Even though high standards of anaesthetic nursing practice implements in Thessaloniki's hospitals however particular attention should be focused on continuing post education courses and involvement according to European and International guidelines are required as well as the development of quality assessment programs that will contribute to professional hazards reduction.

### **References**

1. NATN : Principles of safe practice in the Operating Theatre, Section 2 P9-1 to P9-5, 2. AORN's 2005 Standards, Recommended Practices, and Guidelines, 3. Association of Anaesthetist of Great Britain and Ireland (2002). Infection control in Ana

## ***Session 4B: Issues Regarding Anaesthetic Care***

Name: Sinead Mehigan

Country: UK

Occupation: Principal Lecturer, Middlesex University, Lead Nurse, Education and Development, Royal Free Hampstead NHS Trust

Affiliation: NATN

Clinical background in perioperative practice. Has developed and run post-registration programmes in anaesthetic nursing for many years. Now works as Lead Nurse for education and development in Royal Free, focusing on qualified nurses and midwives, and within Middlesex University, leading curriculum developments in acute and critical care nursing.

### **‘The Caring Role Of The Anaesthetic Nurse – By Anaesthetic Nurses’**

**Sinead Mehigan, Principal Lecturer, Middlesex University, Lead Nurse, Education and Development, Royal Free Hampstead NHS Trust, London, UK**

#### **Background**

This presentation focuses on a recent phase of a larger study, where I looked at how experienced anaesthetic nurses saw their role. This presentation will report on one emergent theme, which was that of the caring role of the anaesthetic nurse.

#### **Methodology**

The way in which data was collected was through the use of self-characterisation reports. Researchers in other disciplines have suggested that this method of collecting data helps capture the richness of the way that individuals construe themselves and their worlds (Fransella & Dalton, 1990). As such, it complements the method used to explore how pre-registration and anaesthetic nursing students saw the role of the anaesthetic nurse, in the initial stages of this research. Following permission by the NATN, the participants from this phase of the study were members of the AARNF, who responded to either a mail-out or email invitation.

#### **Summary of initial findings**

Following textual analysis of each report, emerging themes were identified and noted. Within this type of research, it is important to check out the accuracy of any interpretations, thus a summary of findings was emailed out to members of the AARNF for further comment and clarification.

The initial themes identified were role fulfilment, the perceived visibility of the role and the perceived value of the role. In comparing these themes with those emerging from other phases of the study, and in particular, one which examined comments written by qualified staff about anaesthetic nursing students, one area of contrast is that of the way that delivery of patient care is written about. In the previous part of the work, care seemed to be conceptualised within the anaesthetic room as an innate quality, as in “caring about”.

This had been in contrast to the way that care was described within the recovery room setting, where care seemed to be a more active process, involving actions, such as assessing, planning, implementing and evaluating. For anaesthetic nurses in this part of the study, care is again, a more dynamic process, which involves looking at the patient “holistically”, and, as in the recovery area, assessing, planning, evaluating its delivery, and being constantly aware of the need to respond to patient’s changing needs.

## *Session 4B: Issues Regarding Anaesthetic Care*

What seemed unique to this part of the study was the concept of care delivery being acknowledged as a team endeavour, with both anaesthetic nurse and anaesthetist working seamlessly together to ensure safe, effective patient care. There was also a sense of the importance that qualified nurses place on being able to deliver patient care – for all participants, it seemed to be the part of the role which brought a lot of satisfaction. From some of the participants, there is a sense that part of this care involves “being there” for the patient, allaying their fears, and making them comfortable. This interest in interacting with patients, and seeing patient-nurse relationships as satisfying is something that also emerged strongly from the analysis of the repertory grids, which were completed by pre-registration nursing students, and anaesthetic nursing students in the initial stages of the study.

### **References**

Fransella, F. and Dalton, P. (1990) *Personal Construct Counselling in Action* Sage Publications, London

## ***Session 4B: Issues Regarding Anaesthetic Care***

Name: Josephine Hegarty

Country: Ireland

Occupation: College Lecturer

Affiliation: member of the INO (Ireland) and IARNA (Ireland)

RGN Training Cork University Hospital, BSc, MSc, PhD University College Cork. Currently working as a college lecturer in the Catherine McAuley School of Nursing, UCC. Major interest is in anaesthetic and recovery nursing.

### **‘Discharge Criteria Used In Post Anaesthetic Care Units In The Republic Of Ireland’**

**Dr Josephine Hegarty, Ms AM Burton**

**University College Cork, Cork, Irish Nurses Organisation, Dublin Irish Anaesthetic & Recovery Nurses Association**

#### **Introduction**

Discharge readiness of patients from the Post Anaesthetic Care Unit (PACU) is often determined by specific discharge criteria (Aldrete & Kroulik 1970; Chung 1993).

#### **Aim of Study**

The aim of discharge criteria is multi-faceted: firstly, to ensure haemodynamic stability of patients, secondly to promote patient safety and comfort and finally as guidance for nurses and anaesthetists to use in conjunction with their clinical judgement. This descriptive national study aimed to survey discharge criteria(s) utilised in the Post Anaesthetic Care /Recovery Unit.

#### **Methodology**

This quantitative, descriptive study used a postal self-administered researcher developed questionnaire for the collection of data from 44 hospitals nationally.

#### **Results**

A response rate of 73% (n=32) was elicited. 78% (n=25) utilised specific discharge criteria(s) within their Post Anaesthetic Care Units. The majority of hospitals utilised varied criteria in the determination of fitness of patients for discharge from the PACU. Interestingly many units responded to the questionnaire stating that they were in the process of developing specific criteria for the discharge of patients from the PACU.

#### **References**

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## *Session 5B & 6C: Stressful Situation*

Name: Linda Clarke

Country: Ireland

Occupation: Registered Nurse

Affiliation: Irish Nurses Organisation. St. Vincent's University Hospital

I have been a peri-operative nurse for eight years, having previously worked in intensive care and paediatric areas. I have spent time working in Australia and the United States, but am now enjoying working as a peri-operative clinical facilitator in the operating department of St. Vincent's University Hospital, Dublin.

### **'Stress and the Operating Department Nurse.'**

**Linda Clarke RGN, RSCN, Higher Diploma in Nursing (Sick Children's),  
Perioperative Clinical Facilitator,**

This work will set out to examine stress in nursing, and in particular among operating room nurses. While the idea of workplace stress is not a new concept, this presentation will focus on factors that particularly contribute to the level of stress experienced by the operating department nurse.

The issue of work related stress in nursing has been a cause for concern for some time. While a certain amount of stress is recognised as having a potentially positive effect on an individual, it can also have profoundly negative manifestations, which can affect the individual physically, psychologically and emotionally. It can cause job dissatisfaction, and the potentially negative impacts of persistent stress and frustration can have hazardous outcomes and compromise the safety of colleagues and patients. This paper seeks to explore stress in its various presentations, and how it may affect employees. In this climate of difficulty in recruiting and retaining staff members, it is imperative to explore what causes work related stress, how it affects nurses and what measures can be taken to help alleviate it. Nurses should be provided with the knowledge and means of recognising stressors. Recognising work place stress and its effects on the employee, and identifying and utilising appropriate interventional strategies will improve job satisfaction and quality of life, and promote quality patient care. The work will be a review of relevant literature exploring the issue, the methods used to identify stresses and some of the relieving factors employed.

### **References**

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## *Session 5B & 6C: Stressful Situation*

Name: First Lieutenant Guy Gilissen

Country: The Netherlands

Occupation: Scrub nurses for the Royal Dutch Army

Affiliation: Military Hospital, Utrecht, the Netherlands

Guy Gilissen is in service of the Royal Dutch Army. He has been on missions to former Yugoslavia, Macedonia, Afghanistan and Iraq. When he is not on a foreign mission, he works in the Military Hospital in Utrecht. This hospital provides care for all Dutch service men and women.

**‘Peri operative care in the Royal Dutch Army Subtitle: International cooperation in mission area’s’**

**First Lieutenant Guy Gilissen, First Lieutenant Meike Wolf**

### **Theoretical framework**

The presentation will show information on peri operative care within the Royal Dutch Army during international missions. The Dutch Army has put into use a unique project which involves the use of (civilian) scrub nurses temporarily put in a military setting. These settings may vary from working on a hospital ship to air-conditioned containers. The presentation will show some of the most recent deployments and gear used during these missions. Of course sources are limited in mission area’s so on occasion the military scrub nurse has to improvise in order to guarantee proper medical care.

A similar oral presentation has already been presented at the national convention for operating room nurses in the Netherlands. Because our work as military scrub nurses involves a lot of international teamwork (sometimes a hospital in a mission area will be multinational) the EORNAC is an excellent international moment to discuss this teamwork.

## *Session 5B & 6C: Stressful Situation*

Name: Sara Shapira

Country: Israel

Occupation: Perioperative nurse

Registered nurse 29 years experience as an OR nurse. BSc Hebrew University School of Nursing. MPH Clark University Mss. Educator in the OR for 20 years. Coordinator and head educator in post graduate course for perioperative nurses. Member of Ministry of Health Quality Assurance and accreditation committees for operating theatres and PACU. Ongoing involvement in the perioperative management of terror victims.

### **'The Role of the Perioperative Nurse in the Management of Terror Victims'**

**Sara Shapira RN MPH**

**Hadassah University Hospital, Jerusalem, Israel**

In the last four and a half years 1032 Israelis died and 6964 have been wounded in terrorist attacks, of those 2504 were treated in Hadassah University Hospital. Most of the victims were injured in 43 Mass Casualty Events (MCE).

### **Objectives**

To evaluate the role of the perioperative nurse in the medical and nursing care of terror victims.

### **Results**

Mechanisms of injury were Blunt 27% Penetrating 87% Burns 10% Blast 35%. Cause of injury was Shooting – 380 Explosion – 308 Stabbing - 18

Stoning – 36. Half of the patients had a procedure in the operating room. Average numbers of operative procedures per patient was 1.7. Overall days in ICU were: -1903 (Median - 3 Average – 8.2).

Procedures performed 19 Emergency Department (ED) Thoracotomies, 22 OR Thoracotomies, 87 Explorative Laparotomies, 31 Craniotomies, 194 Orthopedic surgeries, 106 Plastic surgeries, 45 Vascular surgeries, 34 Maxillo – facial surgeries, 25 Eye surgeries.

Discussion: The perioperative nurse is notified during early stages, most of the times, before the terror victims' arrival to the hospital. Elective procedures are halted for awhile during early stages of MCE management. The operating theatre staff should communicate continuously with the ED directors.

They also have to communicate with the families' information center, and the victims families.

Extra staff should be often alerted to extend capabilities to perform urgent and semi-urgent operations. Complicated injuries mandate high skills of all OR staff.

Conclusion: Perioperative management of terror victims presents a special challenge to the perioperative nurse. Coping with such complex situations should be part of these nurses curriculum.

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## *Session 6A: OR: A Safe Place??*

### **The Post-Discharge Follow Up Of Surgical Site Infections'**

**Jaana Perttunen, M.Sc, RN**

**Jyväskylä University of Applied Sciences, Jyväskylä, Finland**

The morbidity and mortality of nosocomial infections detected during the hospital stay has been studied extensively. There are different opinions about the benefit of post-discharge follow-up. In the present the number of operations performed as day-surgery is high and early discharge common. Consequently, the follow-up of infections after the hospital stay is necessary in order to know the real frequency of postoperative infections.

The post discharge follow up of surgical site infections in Central Finland Health Care District started 1988. Several studies have been made in the concerning the need of the follow up. Before, when the information of the surgical site infections were registered from the hospitalized patients, the infection rate was 1.5 – 2.0%. When the post discharge follow up began the rate was around 3%. One third of the surgical site infections were hospitalized patients and two thirds were discharged patients (Palmu, Jakobsson & Pekkarinen 1992).

During three years period (1999-2001) 32 552 patients were operated on in the Central Hospital of Central Finland. The total incidence of surgical site infections were 914 (2.8 %). In 341 cases (37.3%) the infection was detected during the hospital stay and in 573 (62.7 %) after discharge from the hospital. 85 cases was rejected because of insufficient information. So, data from 488 patients was available for further analysis. Antibiotic treatment was started in 77 % of infected patients. Surgical intervention was necessary in 8.4 % and readmission to hospital in 8.2 % of cases. 51 infection out of 488 (10.4%) was regarded to be serious (re-operation, readmission to hospital). Serious complications were most common following amputations, operations for trauma and abdominal surgery. (Perttunen & Palmu 2002)

The practice of the post discharge follow up of the surgical site infections in the Central Hospital of Central Finland goes as follows:

A questionnaire is given to all patients at discharge and this is returned to the hospital by Health Center after follow-up visit. The form includes data of wound healing, criteria of infection and description of consequences on infection. The Infection Control Nurse refers the questionnaires and records the infections. The wards get the information about the surgical site infections of their patients and can ask the patient to come to the ward for a check if necessary.

62.7% of postoperative infections were detected after discharge from the hospital. Consequently, the post-discharge follow-up is necessary in order to know the real incidence of infections. 10.2 % of infections demanded re-operation or readmission to hospital. Registration of consequences of infection detected after the hospital stay is an important tool, which increases the reliability the diagnosis in post-discharge follow-up.

## ***Session 6A: OR: A Safe Place??***

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I have worked as a perioperative nurse for 18 yrs. About five years I have worked as a head nurse or a director of nursing. Three of these five years I have been a director of perioperative nursing in Turku University hospital, in South-West Finland. My interests are development of perioperative nursing documentation, and development perioperative knowledge management.

### **‘Perioperative Anxiety And Patient-Centred Perioperative Nursing – Viewpoint Of Planned Caesarean Delivered Women’**

**Kirsi Kiviniemi RN, MNSc, PhD(c)**

**Director in Perioperative Nursing\*, Associate Lecturer\*\***

**Turku University Hospital\*, Turku University, Department of Nursing \*\*, Finland**

Proportion of anxious patients prior to operation ranged between 27 % and 62 % (e.g. Norris & Baird 1967, Gupta et al. 1994, Sjöling et al. 2003). More patients were afraid of anaesthesia than surgical operation itself (e.g. Ramsay 1972, van Wijk et al. 1990). According to Koivula (2002) coronary artery bypass grafting patients were more afraid of surgery than anaesthesia both while awaiting the operation at home and prior operation in hospital. From elective caesarean women’s point of view regarding perioperative anxiety only few studies were found. Elective caesarean delivered women were the most anxious prior operation (Tatar et al. 2000, Wyatt et al. 2001), and least anxious women were after operation (Wyatt et al. 2001). Pregnant women who would undergo elective caesarean delivery either under RA or under GA were significantly more anxious prior operation than women who would undergo vaginal delivery (Marucci et al. 2003). Intensity of perioperative anxiety was most often measured by STAI (Spielberger State Trait Anxiety Inventory) and by VAS (Visual Analogue Scale) for anxiety.

#### **Aim**

The aim of this study was firstly, to clarify women’s (n = 216) perioperative anxiety level prior and after planned caesarean delivery. The second aim was to study the association between perioperative anxiety level and patient-centred perioperative nursing.

#### **Methodology**

The research design was a descriptive, exploratory, correlational, and longitudinal basic research of perioperative anxiety and patient-centred perioperative nursing. Perioperative anxiety was measured by STAI. Patient-centred perioperative nursing was studied by a questionnaire developed for the study. Statistical analysis was employed in data analysis.

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### **Main results**

70 % of the participants reported being afraid of upcoming caesarean delivery while they were waiting for the operation. Women expressed the highest state anxiety level just prior the operation in the operating room (OR). The difference between the state anxiety level on arrival at hospital ward and in the operating room was statistically significant. Women who reported either moderate or strong anxiety on arrival at hospital got less procedural, sensation, and situational information, were less satisfied with perioperative staff, anxiety relieving, and OR environment. More anxious women reported also deficiencies in individuality and privacy of perioperative nursing.

The results can be employed in developing patient-centred perioperative nursing especially for planned caesarean delivered women.

### **Keywords**

perioperative anxiety, caesarean delivery, patient-centred, perioperative nursing

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## *Session 6A: OR: A Safe Place??*

Name: Áslaug S. Svavarsdóttir, RN, BSc, CNOR.

Country: Iceland

Occupation: Perioperative nurse, safety manager.

Affiliation: Landspítali University Hospital in Iceland

Qualified as a perioperative nurse and worked in OR from 1985. Participated in various assignments concerning reevaluation on work standards and guidelines for perioperative care designed to increase quality and safety for patients in theatres and co-workers. Safety manager for co-workers from 2000.

Interest: Patient safety, co-workers health and safety.

### **‘Hospital Survey On Patient Safety Culture Among Perioperative Nurses In Landspítali - University Hospital (LSH) In Iceland’**

**Áslaug S. Svavarsdóttir. BS, CNOR.**

#### **Background**

Patient safety in hospitals is the main focus in this paper. Improving safety culture among healthcare personnel is considered to be the most effective way to increase patient safety. This can be achieved by raising the awareness regarding patient safety and changing attitude towards incidents. Nurses are key players in the reinforcement for patient safety culture, rendering their consciousness of safety culture in their working environment, is very important. OR nurses work in a stressful environment due to patients that require highly skilful nursing, often lack of staff, demanding atmosphere, new technology and a heavy workload. This kind of an environment can be a threat to the quality and safety of patient care and thus interesting to explore and improve.

#### **Theoretical framework**

Safety culture consists of a few main factors: Commitment of the organisation to patient safety, open communication, organisational leadership and teamwork and incident reporting (AHA, 2001; Pizzi et al., 2001, Page, 2004). Incidents can occur in the treatment of patients wherever and whenever, and are a threat to safety (Page, 2004, Kohn et al., 2000).

#### **Research problem**

Main purpose is to explore perioperative nurses' attitude towards patient safety culture.

#### **Method**

A survey using a well-tested questionnaire from AHRQ, “Hospital survey on patient safety culture”. The sample will consist of all 135 perioperative nurses who work in three OR wards in LSH, that is the largest hospital in Iceland (around 800 beds and around 13.000 surgical operations per year). The research is estimated to start in September 2005.

#### **Results**

Will be known in March 2006 and presented for the first time at the OERNA -congress.

Focus of interest and keywords

Patient safety, peri-operative nursing, hospital survey, patient safety culture, research, incidents, near-misses, commitment of the organization, open communication, teamwork, incident reporting.

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## *Session 7A & 7C: The Professional Perspective*

Name: Sheila Bredin

Country: Ireland

Occupation: Clinical Facilitator for the Higher Diploma in Perioperative Nursing studies

Affiliation: St. Vincent's University Hospital, Dublin

I have 18 years professional experience. I am presently employed as the Clinical Facilitator for the Higher Diploma in Perioperative Nursing studies, which is provided in conjunction with University College Dublin. My roles include teaching and supervision of students, presentation of lectures and professional development and education of all staff within the department.

### **'The Assessment of Self-reported Levels of Compliance with Standard Precautions Among Perioperative Nurses.'**

**Sheila Bredin RGN, RM, H. Dip. Periop, MSc**

The operating theatre is considered a high-risk area in relation to contact with blood and body fluids. Perioperative nurses and medical personnel are repeatedly exposed to body fluid exposures. A series of guidelines to protect healthcare workers from blood borne infections have been disseminated during the past two decades. The purpose of this study was to assess attitudes, beliefs, and levels of compliance with standard precautions among perioperative nurses and to determine correlates of compliance. Two research questions guided this study:

“What are the levels of compliance with standard precautions among perioperative nurses?” And “What factors influence compliance with standard precautions among perioperative nurses?”.

The results of this study have implications for the future development of multifaceted perioperative infection control programmes, including strategies for prevention, education, and policy development, to improve practices aimed at reducing occupational exposure among perioperative nurses.

### **Research Design**

A descriptive correlational survey was employed in this study to explore the variables, perioperative nurses and compliance with standard precautions.

### **Sample**

Perioperative nurses in Ireland were the target population for this investigation. The researcher chose a non-random convenient sample of perioperative nurses. The decision was made by the researcher to select one large hospital with an estimated 90 perioperative nurses employed in the theatre department. For inclusion in the study sample the respondents had to be employed in the theatre (scrub, anaesthetic or post-anaesthetic-care-unit) as a registered general nurse.

### **Procedure**

The researcher distributed 92 self-administered questionnaires in the perioperative department of a large Dublin hospital over a two-week period in April, following approval from the ethics committee of the organisation. All registered nurses employed in the theatre department of the chosen hospital were invited to participate in this study.

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### **Measurement instrument**

Data collection in the current study was achieved through a questionnaire. The questionnaire was designed to focus on three conceptual areas, all of which were thought to play significant barriers to compliance behaviours. (1) Sociodemographic and individual factors and (2) psychosocial factors, and (3) organisational factors.

### **Data analysis**

Data in this study was analysed using the statistical package SPSS for Social Sciences version 11.0. Almost all scale responses in the questionnaire were based on a 4 or 5 point Likert Scale ranging from strongly agree to strongly disagree. Wherever necessary, responses to items were reversed so that the directions of the response to multi-item scales were consistent.

### **Recommendations**

Based on the findings of this study the following suggestions for nursing practice and further research are recommended.

- Further research needs to be carried out to discover the principle reasons why healthcare workers do not always comply with standard precautions.
- Perioperative infection control programmes must aim for 100% compliance with standard precautions through a multifaceted programme that includes prevention, education, and policy.
- Perioperative nurses need a reporting mechanism that is convenient, less time consuming and involves less paper work in order that reporting is made as simple as possible, which in turn will improve occupational exposure reporting rates.
- The organisations commitment to occupational safety needs to be more visible to employees, reduction of work stress through organisational programmes designed to limit work place stressors, requires development and implementation.

### **Conclusion**

The aim of this study was to assess levels of compliance with standard precautions among a sample of perioperative nurses and to determine correlates of compliance by utilising a descriptive correlational design. Previous studies have used varying methods and have looked at different groups in analysing data on healthcare workers' compliance with standard precautions. This has resulted, in a range of compliance rates been reported in the literature. The overall compliance rates with standard precautions among this group, was very high, and not consistent with the low levels of compliance by other healthcare workers reported in the literature. One fact that pervades throughout previous studies, and is supported in this study, is that there is still a less than 100% compliance rate with standard precautions by healthcare worker's. Perioperative infection control and practice development programmes aimed at improving compliance with standard precautions must address this issue.

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Reference: Gershon R., Valahov D., Felknor S., Vesley D., Johnson P., Delclos G., & Murphy L., (1995) Compliance with universal precautions among health care workers at three regional hospitals, *American Journal of Infection Control*, 23(4), 225-236.

## *Session 7A & 7C: The Professional Perspective*

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1977 RN Orthopaedic wards

1982 CNOR general surgery, gynecology, vascular, trauma at South Hospital and Karolinska Hospital in Stockholm

1999 Clinical supervisor

2000 ongoing board member SEORNA

2001 lecturer in nursing; OR nursing and clinical skills at Red Cross University College of Nursing and from 2004 at the Dept of Nursing, Karolinska Institute

**‘To be obvious – the point of belonging to one profession’ Annica Sandelin R.N., CNOR. B NSc. M MSc. Department of Nursing, Karolinska Institutet, Stockholm, Sweden. Board member of SEORNA. Irimi Antoniadou R.N. CNOR. Central Operating Department, University Academic Hospital, Uppsala, Sweden. President of EORNA, vice-president of SEORNA. Anette Richardsson Project leader. R.N. R.Pharm. M Sc, Adviser, Swedish Association of Health Professionals (SAHP).**

All kind of registered nurses belongs to one profession, but what does it really mean to have a professional status and is this a matter for the OR nurses? All kinds of registered nurses have the same perspective of knowledge in nursing. This core of knowledge is expressed in different ways depending of the context in nursing. The nursing performed by R.N. in the operation theatre take place in a sealed room. Colleagues and other health care professionals have very little or no insight of the actions taking place inside this sealed room. The work is performed in teams with other health care professionals. The nursing performed by OR nurses are specific with it's own responsibility according to Swedish laws and regulations. If the knowledge and skills that are performed by the OR nurses are unknown for other health care professionals how can it be visible? Are OR nurses aware of their own knowledge, their responsibility and the nurses' ethic codes? What does professional status means for OR nurses? The aim of the study is to describe OR nurses experience of professional status as an OR nurse. The goals of this study are to empower OR nurses through their professional awareness and give opportunities to develop guidelines in perioperative nursing. Used methods; Group 1. By using the SHAP's organisation with local units seven focus groups of OR nurses, total n 50, participate. At the first meeting they first answered a questionnaire about professional status and then they received a lecture of the meaning of the law, the ethical codes and the meaning of a professional status. The participants then wrote diary notes during three months. At the end of the project, the project leader met them and had a focus group interview about their experience and what they had reflected on during these three months. The participants again filled in the same questionnaire. Group 2; By using SHAP's computer file of members, 202 OR nurses were randomly selected and asked to participate in the study. They got the same questionnaire as group one by mail with information about the aim of the study. A total of 132 operating room nurses returned the questionnaire. The SpSS program was used for the statistical calculations. All diary notes and group interviews were SWOT-analysed. The study showed that almost every one of the OR nurses felt secure and they were reflecting on their work. They also knew what legislation and professional status meant and they participated in daily quality assurance. Patient safety was the most important for the OR nurses, which meant e.g. positioning the patient on the operating table, that hygiene was correct done and all equipments and instruments were sterile during surgery. Also important was the control of sponges, sharps and instruments before, during and after surgery. OR nurses also appreciated teamwork as important and when the teamwork was at its' best were when the team members had respectful attitudes towards each other without any hierarchic structures. There was differences between the competences and knowledge of anaesthetic nurses compared to OR nurses, but value their knowledge differently although they belong to the same profession.

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When two OR nurses work together in the same operating room, one as circulator nurse and the other as scrub nurse, the dialogue will be more creative, they had possibility to discuss, reflect and to develop the methods in the care of the patient. The experienced OR nurse felt proud when they had knowledge and had control of different techniques. OR nurses are the only health care professionals who work in an environment closed/sealed from the other hospital units. The most of the OR nurses had not pre- or postoperative meetings with the patients; it was a lack of planning and a lack of quality assurance of one's own work. The OR nurses described the milieu they worked in as how the team members acted towards each other and that you often "have to maintain one's position". The huge lack of OR nurses meant a stressful time at work. To be visible involved OR nurses to be there as an individual and took an active part in the dialogue in the team. Often they had to defend themselves as a profession. This study shows possibilities to empower nurses to be proud of their profession. This study also showed that the specific knowledge of OR nurses could be useful for health care organisations and the patients in other contexts than the operating theatre.

### **Strategies proposed for the future.**

Respect of everyone's knowledge.

The team members have to have reflections on the meetings with the patients, attitudes, behaviour and cooperation.

OR nurses have to be aware of one's own values and attitudes. Create time for meetings with colleagues inside and outside the operating theatre. To make OR nurses' knowledge visible. It is important that the organisations take OR nurses' knowledge seriously in all kinds of processes. OR nurses are leaders in the specific area; hygiene, logistics and techniques in the perioperative care. It will be better for patient safety if openness and dialogue are held between health care professionals in different kinds of care units.

Important to act now with these strategies before today OR nurses retire and with them all unexplored knowledge.

### **Key Words**

operating room nurse, empowerment, profession, ethical codes

## *Session 7A & 7C: The Professional Perspective*

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Graduation from Helsinki Nursing School in 1982 – RN.

Specialized to OR at 1987.

2002 - Masters degree.

From 1986 to 1990 as ORN - orthopedic surgery.

From 1990 to 2002 - Helsinki University Hospital as ORN - eye surgery. Since 2003 - Turku University Hospital as OR Manager - ambulatory OR (Open heart-, endovascular and thoracic surgery, neuro surgery, plastic surgery, gastro surgery, trauma surgery).

### **‘The quality of perioperative care’**

**Brita Pasila, MNsc, RN, Doctoral student,**

#### **Introduction**

Earlier research into perioperative care has tended to focus on the pre- and postoperative phase, whereas the intraoperative phase has received less attention. In recent years patients have been asked to take more active part in the study of intraoperative care, because of day surgery and regional anaesthesia (Leinonen & Leino-Kilpi 1999). Surgical patients are generally very satisfied with their care, but upon closer search it is not hard to find complaints (Leinonen et. al. 2003). In surgical care, problems are reported especially in information and counselling (Jacobs 2000), but to some extent also in pain management (Archibald 2003), the treatment of nausea and vomiting (Malek et. al 2004), stress and anxiety (Attree 2001), coldness and chills in operating room (Leinonen et.al. 1996), long waiting times and inadequate scheduling (Yellen 2003), initiative, decision-making and informed consent (Leino-Kilpi et.al. 1999).

#### **Research goals**

Aims of the study: To find out how surgical patients (n= 368) perceived the quality of perioperative care they received in an operating department and in the recovery room.

Research problem: How surgical patients perceived the quality of perioperative care they received in an operating department and in the recovery room?

Method The data was collected using a questionnaire (Good Perioperative Nursing Care Scale) (Leinonen 2002). The scale consists of five main categories (staff characteristics, task- and human-oriented activities, precondition for quality care, progress in the nursing process and physical and social nursing environment).

#### **Results**

Physical activities, such as pain management and temperature maintenance were rated as excellent, as were staff characteristics and the physical and social environment. Critical comments were made with regard to educational activities. Patients told that they would have liked more information and that they should have been encouraged to ask more questions about unclear matters.

The patients that suffered from severe pain, the patients that had arrived to the hospital in the night time and the emergency patients were most critical. They felt that they had had to wait too long for the operation.

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### **Conclusions**

Overall the quality of care was considered to be extremely good. The way the patients were treated and supported in the operation department seemed to be the main factors that indicated how the patients perceived the quality of perioperative care they received in the operating department and in the recovery room.

### **Key words**

preoperative quality, surgery, operating room, measurement of quality

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## *Session 7B: II International Session Trauma: The Importance of Teamwork*

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Occupation: Manager Surgical Suite, Endoscopy, Med. OPP  
Affiliation: Sunnybrook and Women's College Health Sciences Centre  
Perioperative experience 26 years  
Manager Surgical Services Endoscopy, Med. OPP  
Manager Sterile Reprocessing  
Educator OR and Related Services  
Nurse Clinical Coordinator Neurosurgery  
Master of Nursing Administration  
Bachelor of Sciences in Nursing  
Created and implemented a new Sterile Reprocessing system and department  
Executive member of Operating Room Nurses of Greater Toronto

Name: Barbara McArthur  
Country: Canada  
Occupation: Nurse Clinical Coordinator Orthopaedic surgery  
Affiliation:  
Began career at Sunnybrook on neurosurgical ward working with neurologically injured trauma patients. For the last 16 years have gained experience in the operating room caring for patients with a focus on orthopaedic injuries. For the last 2 years, have held the position of Nurse Clinical Coordinator for Orthopaedic surgery

Name: Helen Vandoremalen RN, CPN© BScN  
Country: Canada  
Occupation: Manager OR, PACU, Same Day Surgery at the Orthopaedic & Arthritic Institute (OAI)  
Affiliation: OAI Campus of Sunnybrook & Women's College Health Sciences Centre  
Over 30 years of perioperative experience. Staff nurse in OR for 13 years  
Charge Nurse in Ophthalmology service for 6 years  
Educator for Sterile Processing for 3 years  
Manager of Sterile Processing for 5 years  
Manager of OR, PACU, Same Day Surgery for 6 months.  
Currently enrolled in Masters of Nursing Administration Program.

Name: Sandra McDowell RN  
Country: Canada  
Occupation: RN Staff Nurse  
Affiliation: ORNGT  
Registered Nurse at Sunnybrook and Women's for 25 years. Background in Spinal Cord Rehabilitation, Orthopedic, Cardiology and Post Anesthetic Care. Concentrating in the Operating Room for the last 20 years. Focus in Trauma, General, Vascular and Ophthalmology. Implementation of a night shift orientation process and night shift Preceptor

## ***Session 7B: II International Session Trauma: The Importance of Teamwork***

Name: Shirley Lingard R.N. B.Sc.N., C.P.N.©

Country Canada

Occupation: Advanced Practice Nurse, Operating Room

Affiliation: Sunnybrook & Women's College Health Sciences Centre, Toronto

Thirty-six years perioperative nursing experience

Professional Practice Leader

Educator, O.R. and Sterile Processing

Community College Lecturer, Advisory Board Member

Charge Nurse: General, Vascular and Urology

Cardiac Team Member

Executive member Operating Room Nurses of Greater Toronto, including President, Program

Convener and Bylaws Chair

### **A trauma eh? A perioperative nurses' perspective from Canada's largest trauma centre – Sunnybrook and Women's College Health Sciences Centre, Sunnybrook site, Toronto, Canada**

Sunnybrook: Progressive Trauma Care - Presenter: Sandra McDowell, RN

Review the history and programs associated with Canada's first and largest regional Trauma unit. Examine the specialty areas within the Trauma program. Injury trends will be correlated with Canadian culture, lifestyle and climate. The mechanism of injury will be explored to highlight the specific injuries that present to our Trauma Centre.

Exploration of damage control surgery and the management of the multiple trauma patient - Presenter: Barbara McArthur, RN, BScN

An exploration of damage control surgery principles from an orthopaedic perspective will illustrate the importance of efficient transferring of the patient to the operating room. A Sunnybrook case study will demonstrate these principles in use as the O.R. team works towards the initial goal to avoid the critical triad of metabolic failure, as well as the successful outcome of definitive treatment.

The planning, organizing and implementing of a case cart system in a trauma centre - Presenter: Helen Vandoremalen, RN, BScN

The Operating Room has developed a classification system to rank the urgency of trauma cases. Based on the classification priority, sterile processing staff selects the appropriate procedure to assemble a case cart in an expedient manner. Increased educational requirements are needed due to the dynamic environment & proliferation of complex equipment.

Addressing management challenges to facilitate the Trauma Program - Presenter: Alexandra Leeksma, RN, MN, CPN(C)

This includes a set of policies and procedures that govern the priority of Type A and B surgeries. Staffing models are developed to facilitate activity on a 24 hour, 7 day a week emergency/urgent basis. A computerized O.R. appointment scheduling system is essential to manage planned and unplanned activity and generate reports.

Meeting the educational needs of perioperative nurses and students in a trauma centre - Presenter: Shirley Lingard, RN, BScN, CPN(C)

The preparedness of perioperative nurses in our facility is enhanced by many processes; including a comprehensive orientation program, cultural diversity awareness, continuing educational opportunities, preceptor partnerships, effective communication channels and progressive performance reviews.

## *Session 8A: Answering to the Needs of Patients*

Name: Katja Heikkinen

Country: Finland

Occupation: Lecturer, MNSc, RN

Affiliation: Teacher in polytechnic since 2001. Clinical experience in operating theatre 1994–2002.

Doctoral candidate since 2004. The research area: ambulatory surgery patients' empowering education in Internet. Research interests: patient education, nursing informatics and pain. Participation in several other research groups.

### **'Usability of Internet in patients' education – practical issues'**

Heikkinen Katja, MNSc, RN, Lecturer, PhD -candidate\*, Hiltunen Ari, MD, PhD, Head of Outpatient Clinic\*\*, Johansson Kirsi, MNSc, RN, Researcher, PhD -candidate \*\*\*, Leino-Kilpi Helena, PhD, RN, Professor\*\*\*\*, Leppänen Tiina. RN, Head of department\*\*, Virtanen Heli, MNSc, RN, Lecturer, PhD -candidate \*\*\*, Salanterä Sanna, PhD, RN, Adjunct Professor\*\*\*

University of Turku, Department of Nursing Science and Turku Polytechnics (katheik@utu.fi); \*\*

Turku University Hospital, \*\*\*University of Turku, Department of Nursing Science; \*\*\*\*University of Turku, Department of Nursing Science and Turku University Hospital

### **Introduction**

Finland is a forerunner in information technology. Information technology is also used in health care. Internet is a usable method also in patient education; by improving access to information using the World Wide Web, patients are encouraged to become active participants in their own care (empower). Very little information is available however regarding the usefulness and effectiveness of the Web as a clinical tool for patient education.

### **Aim of Study**

To evaluate the possibilities of Internet in orthopaedic ambulatory surgery patients' education.

### **Research problem**

Is Internet a usable method to educate orthopaedic ambulatory surgery patients?

### **Methodology**

In the first phase, we have evaluated expected and received preoperative knowledge of orthopaedic ambulatory surgery patients. In the second phase, we have created and tested a new Internet-based education method. The third phase (in progress), Internet based education is evaluated in experimental pre test-post test study design. The convenience sample of adult orthopaedic ambulatory surgery patients (n=120) will be enrolled. Power-analysis has been done to calculate the group size. Each patient is randomly assigned to the control group (traditional educational program by nurse) and to the experimental group (Internet based education).

## *Session 8A: Answering to the Needs of Patients*

Control group patients are invited to the hospital for a preoperative educational session one week prior their surgery and the experimental group patients get education by Internet. There are seven measurements in patients care. These measurements consist several tools (n=8) which measures patients' knowledge, empowerment and cost-effectiveness. The first measurement is before the education, 2nd after education, 3rd in the day of the operation, 4th in the first and 5th in the third postoperative day, 6th in two weeks and 7th in four weeks after the operation. The data will be analyzed statistically.

### **Results**

Preliminary results (n=40) indicate, that Internet is usable method in orthopaedic ambulatory surgery patients' education. More results will be presented in the congress.

Key words Orthopaedic ambulatory surgery, patient, education, Internet

## *Session 8A: Answering to the Needs of Patients*

Name: Marie Tighe

Country: Ireland

Occupation: Director of Nursing

Affiliation: Royal Victoria Eye and Ear Hospital, Dublin

I trained as an RGN/RSCN at James Connolly Memorial Hospital and Our Lady's Hospital for Sick Children, Crumlin. I worked for 10 years in the operating theatres in Our Lady's Hospital for Sick Children both as a staff nurse and a sister. I then worked in the theatres at Connolly Hospital for 2 years. From there I went on to work as an ADON at the Children's University Hospital for 4 years and before taking up my current position as Director of Nursing in 2002 at the RVEEH I worked for a short period at the Mater Misericordiae University Hospital. During this time I undertook Dip in Communications, Dip in IR and Personnel Management, Dip in Legal and Ethical Studies, BNS (Hons) and an M Sc in Nursing.

**'An exploration of the needs of parents who are present at the induction of anaesthesia.'**

**Marie Tighe**

### **Background**

In an effort to reduce adverse behaviour, the concept of parental presence and their participation in the care of children while in hospital has become increasingly emphasized in sick children's nursing. Indeed the practice of parents accompanying their children to the anaesthetic room remains an emotive subject.

Many parents are requesting to be present at this time and in some instances, expecting that right. Although it is rapidly gaining acceptance among healthcare professionals there are still some hospitals where it is actively discouraged.

### **Aim**

The aim of this study was to generate knowledge by exploring the parent's experience of being present with their child at the induction of anaesthesia. This enabled the researcher to identify their needs in an effort to shape and improve practice for both the child and the parent.

Although much research relates to the practice of parents accompanying their child to the anaesthetic room there is a dearth in the literature as to the needs of parents at this time.

### **Methodology**

The researcher chose a qualitative research approach using a qualitative descriptive design providing the researcher with the opportunity to give an accurate portrayal of the needs of parents who were present at the induction of anaesthesia. Non purposive probability sampling was used. Eight semi-structured interviews were carried out. A systematic data analysis was undertaken where data was sorted into codes, categories and finally into four themes.

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### **Results**

The interviews demonstrated that parents see the practice of accompanying their children to the anaesthetic room as being their role regardless of how emotional the experience is. The participants articulated that it was an emotional experience for the parents but would do so again for the sake of their children. The children's reaction to the experience was a positive one, which appears to be directly related to the fact that they were all pre medicated except for one instance where a child refused the pre medication. This child was distressed prior to and during the experience with the mother mirroring this distress.

The study demonstrated that the lack of information and explanation given to parents regarding this practice and the lack of time given to prepare parents for the experience were areas for improvement in this practice.

### **Keywords used**

parental presence, parental participation, parental involvement, induction of anaesthesia, pre-medication, children, operating room/operating theatre.

## *Session 8A: Answering to the Needs of Patients*

Name: Michelle Griffin

Country: Ireland

Affiliation: RGN, RM, HIG Diploma in Oncology Nursing, BNS

I have worked in gynaecology for the last 15 yrs. The last 8 yrs I have worked in Radiation oncology. I have a big interest in researching women's experiences whilst having treatment for gynaecology concerns.

### **'A Perioperative Perspective Of Women With Cancer Of The Cervix Undergoing Hdr (High Dose Rate) Brachytherapy Treatment'**

**M.Griffin, Edel Grunnér RGN.RM, A. Cregan, W. Fair, B. Mulherin, J. Taylor, P. Walsh, St Luke's Hospital, Dublin, Ireland**

The recommended treatment of carcinoma of the cervix, in stages IB – IIIB (Figo Scale), is a combination of external beam radiotherapy (EBRT) and brachytherapy. At St. Luke's Hospital, external beam radiotherapy is delivered in two phases with a break in treatment of approximately two weeks then Medium Dose Rate (MDR) Brachytherapy (Selectron) is delivered. Approximately 60 patients per year are treated in this way. Prior to the transition from MDR to HDR (High Dose Rate), a pilot study was undertaken. The preparation procedure for HDR, is carried out in theatre, which includes the insertion of intracavity applicators, instigation of pain relief and it's monitoring.

**The aim of the study** is to investigate the experience of women undergoing HDR, in particular to ascertain optimum pain relief methods and control.

#### **Design**

A descriptive survey using a questionnaire with a qualitative dimension.

#### **Sampling**

Ten participants will be randomly selected who are scheduled for HDR treatment.

#### **Pilot Study**

The pilot study was carried out on five women who were randomly selected while undergoing HDR treatment. Analysis of quantitative data was undertaken using EXEL computer software. Grounded theory was used to analysis the qualitative data for the development of themes. Findings illustrated that all participants require multiple media information exchange. The pain and discomfort experienced correlated with the analgesia given. Participants who underwent spinal anaesthesia experienced less pain, discomfort, anxiety and fear at time of procedure.

#### **Results**

of study are not available at time of submission.

#### **Analysis of Data**

EXEL computer software will be used to analysis the quantitative data and Grounded Theory will be used to analysis the qualitative data. The researchers have considered the findings of the pilot study and will make appropriate amendments to the study.

## *Session 8A: Answering to the Needs of Patients*

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### **Key Words**

Brachytherapy, Cancer, Cervix, Pain Relief.

## *Session 8B: The Australia Way*

Name: Patricia Nicholson

Country: Australia

Occupation: Perioperative Stream Coordinator, School of Nursing, The University of Melbourne

Affiliation: Victorian Perioperative Nurses Group; Australian Operating Room Nurses Group

Patricia holds qualifications of RN, RM, Operating Theatre Technique, BA in Education and Community Health (University of Melbourne), PG Diploma in Nursing Management (University of South Africa) and has completed a Master Degree of Education (University of Melbourne) with her thesis title: 'Nurse Educators Use of Scoring Rubrics to Determine Varying Levels of Clinical Performance in the Perioperative Setting.

Patricia has lectured in General Nursing and Midwifery in South Africa. Six years ago, the family immigrated to Australia and she was appointed as coordinator for the Perioperative course at the University of Melbourne. This role includes Deputy Coordination of 4th year programs.

### **'Testing New Ground: Testing The Practitioner And Not The Task!'**

**Mrs Patricia Nicholson**

**The University of Melbourne, Melbourne, Australia**

During 2000, the University of Melbourne in collaboration with nurse educators from six affiliated hospitals undertook the mammoth task of developing a clinical competency assessment tool for the postgraduate students undertaking the Postgraduate Diploma, majoring in Perioperative nursing. The previous assessment tool included the use of a checklist and did not differentiate between the clinical performance of the experienced and novice student. Students enrolling during 2001 entered the course with perioperative experience ranging from greater than 10 years to those with little or no previous experience. This large differential in experience became the motivating factor in the development of new competencies. Another area of concern was the separation of theoretical knowledge, which was presented on campus, and the expectation of the nurse educator during the observation of the student, being able to witness the transfer of knowledge to the clinical setting. With these challenges in mind, a working party was established to examine the competency hurdle requirements. The aim of this working party was to develop a tool that was generic to all specialties, that would assess the student's level of competency by observing their level of practice and application of knowledge in the dynamic and complex perioperative environment.

While many different models of assessment were identified in the literature, it was found that it was difficult to adapt any to the perioperative environment. It was finally decided to base the development of the tool on the models described by Benner and Bondy. Benner's theory would guide the development of the tool in the areas of skill acquisition and the criteria for clinical evaluation, while Bondy's model guided the team in clearly identifying professional standards, including aspects such as the acquisition of knowledge, development of interpersonal skills, and the demonstration of values and attitudes that characterise the nursing profession.

## *Session 8B: The Australia Way*

A rubric scoring chart was designed to accommodate the assessment process, assisting in determining the student's level of practice along a continuum throughout the academic year.

Two years after the implementation of the competency tool, an evaluation was conducted with the required changes made to the tool. What is currently in use for the evaluation of the student's performance is a tool that discriminates the level of practice of the perioperative student in the various specialty areas in the Operating Suite. The effort of the working party and their dedication in supporting the development of a clinical competency tool has elevated the evaluation process of the student in their practice within the perioperative environment.

## *Session 8B: The Australia Way*

Name: Lesley Gilbert

Country: Australia

Occupation: Doctoral of Business Administration Candidate

Affiliation: RMIT University in Melbourne, Australia

Lesley's background is in nursing administration and management in the healthcare field. She has a Graduate Diploma of Business (Health Care Management) and completed her Masters of Business Leadership at RMIT in 2002. Lesley is at present a Doctoral of Business Administration Candidate at RMIT University in Melbourne studying decision making by leaders related to power relationships and the Myers-Briggs typology model.

Lesley has maintained her professional involvement and is a member of the committee of the Victorian Perioperative Nurses Group, having been Assistant Treasurer, Treasurer vice- president and is the immediate past president of VPNG.

Perioperative nursing has always been her passion as it is a diverse, complex and interesting specialty. She recently left her position at the Freemasons Hospital in East Melbourne to take up a position as business manager at Vaucluse Hospital and is now enjoying perioperative nursing as much as the first day she began.

### **'Generation x +Generation Why? = The Future Perioperative Nurse. Management and Leadership in the New Millennium- A Perioperative Perspective'**

**Lesley Gilbert**

**Australian College of Operating Room Nurses,**

This paper explores the new cultural and generational changes occurring in our society. The younger generations of X & Y view the world through a very different perspective growing up as they have with advanced education and technology.

Generation X Generation Y are like no others in history. Computers and the internet are communication tools that have always been present in their lives and have allowed these generations to be informed and thus sophisticated like no other.

The aim of this paper is to review the advances in our society and link the resulting cultural mores that have occurred as a result of the new technological age. Nursing and of course Perioperative Nursing originated from the religious orders administered by Nuns and the Military System which may have at times resulted in a rigid and hierarchical system which may still find today in our operating rooms.

Generation X & Y will not function well in this rigid and hierarchical environment. Authority does not frighten them and adhering to what they may perceive as unproven systems simply for the sake of tradition they do not find worthy of respect.

In a world where there is a rapidly ageing workforce and an international nursing shortage Perioperative Nurses are becoming increasingly hard to recruit. It is imperative that the Nurse Manager is well aware of how to encourage the new generations to embrace Perioperative Nursing as a career. Other aspects such as creating a work place that allows the various generations such a "Baby-Boomers" and Generation X & Y to harmoniously inter-relate to each other within the Perioperative environment must be a priority of the contemporary Nurse Manager . Safe and effective Perioperative Nursing practice cannot take place an environment of stress and conflict. This paper aims to provide information and strategies to assist the Nurse Manager in this daunting task

## *Session 8B: The Australia Way*

A wide literature review has been undertaken to explore the issue of the ageing work force and the impact of the Generational changes of X & Y. Strategies and ideas for overcoming the major issues will be put forward from the literature view and personal experience gained from a long careers as a Perioperative Manager.

The exploration of the literature joined with personal experience underpinned the importance of addressing this issue as a manager. Recruiting and retaining the younger very mobile population is possible and merging the various generations can work if there is strong awareness by both staff and management at all levels of this issue and its high priority to be addressed in the contemporary Perioperative setting.

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## ***Session 8B: The Australia Way***

Name: Nanette Lundie

Country: Australia

Occupation: Lecturer, School of Nursing and Midwifery, LaTrobe University, Victoria, Affiliation: Committee Member of Victorian Perioperative Nurses Group (VPNG), Member of Australian College of Operating Room Nurses (MACORN); Fellow Royal College of Nursing Australia (FRCNA)

Nanette commenced Perioperative Nursing in 1974 working in all areas including managing major Operating Suite complexes. It was during this time she obtained her Diploma in Operating Room Nursing and Post Graduate Bachelor of Nursing. Nanette extended her career by working in Hospital Administration and completed her Master of Nursing Studies. In 2004 she took up her current position teaching Perioperative Nursing in the Undergraduate and Post Graduate programs and is currently completing her Doctor Of Education.

### **‘A Framework Of Excellence In Perioperative Education– An Australian Model’**

**Nanette Lundie Rn, Dip App Sc, Ba App Sc, Mn St, Frcna, Macorn**

#### **Introduction**

This study arose out of my continuing observation of the plethora of verbal and written comments relating to the current shortage of Registered perioperative nurses, their increasing age, subsequent role erosion and the potential replacement by non nurses and/or qualified staff to meet workforce demands. Whilst Australian and international perioperative nurses acknowledge the trends, they are also aware of the implications this has for the future of the perioperative nurse population and the growing concern in relation to the future roles of nurses working in this specialty area. Perioperative nurses believe their role is vital to patient care, however if they are to remain the patient advocate during the perioperative phase, a framework of education based on empirical evidence must be implemented in the University undergraduate curriculum in order to address the issues described.

#### **Aim Of Study**

The aim of this study was to explore the experiences of 3rd year nursing students who undertook a Perioperative clinical placement in their final semester of University study. It may assist lecturers to improve teaching by identifying factors that enhanced or impeded the placement. It may also provide insights into ways of encouraging recent graduates to consider perioperative nursing as a career specialty.

#### **Methodology**

A descriptive qualitative analysis was used. Transcripts of the interviews and journals (when provided) were read and re-read to identify shared experiences which were grouped into emerging themes or categories. Significant statements or exemplars were used to illustrate themes.

#### **Results**

Results showed that the students who had completed a theoretical subject ‘Perioperative nursing theory’ prior to their clinical placement in the operating room (group A) had a greater understanding of nursing care in the perioperative environment, a higher awareness of aseptic technique, risk management and nursing roles than those students who did not complete any specific perioperative theory (group B). Overall the group A students enjoyed their experience more than group B and several have considered returning to the perioperative area during their graduate year and in the future.

## *Session 8B: The Australia Way*

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### **Key Words**

Recruitment, perioperative nursing, undergraduate nursing education.

## Poster Presenters & Abstracts

Name: Irena Schwartzberg

Country: Israel

Occupation: Asst. nurse manager of ambulatory surgical unit

Affiliation: "Rambam" health care campus

Graduated from nursing school at Rambam hospital, Haifa in 1981

Israeli military OR nurse officer 1981-1983

OR nursing specialisation at 1982

OR nurse in the main OR at Rambam hospital for 3 years

Since then the OR nurse at the Rambam ambulatory surgery unit

2001 received my BSc – University of New England College Mass

2003 completed Masters Degree in public administration – health systems from the Clark University at Worcester, Mass

In charge of developing preoperative guidelines and follow up procedures for ambulatory surgical patients. Preceptor and clinical coach for new hires, nursing students and fellow staff.

Member of infectious control committee in the OR

### **'The scope and causes of cancellation for elective surgical procedures at the "Rambam Medical Center'**

**Mrs I Schwartzberg, Mrs. R Assayag, Mrs. A Geiman, Mrs Y Rabinovitch, Mrs I Manor**

#### **Background**

The Operating Room (O.R.) is one of the major centers of hospital activity, financial investment and revenue. It provides services for in and outpatients. Parameters for the quality of activity and service of the O.R. are the percentage operations done within the schedule, the number of delays and cancellations, productivity of the O.R. and satisfaction of patients and staff members. Inefficient utilization of O.R., delays and especially cancellations of surgical procedures are a cause for, substantial financial loss for the hospital and for dissatisfaction of patients and their families.

#### **Objective**

To identify and analyze the causes for scheduled surgery cancellations in the O.R.

Methods: The research focused on groups of patients who were hospitalized in the departments: General Surgery A, General Surgery B, Orthopedics A, Orthopedics B and Neurosurgery. All of the surgery candidates that were expected on an elective basis to conduct the operations and weren't operated on the schedule day. The patients include adults in varying stages of sickness. Ambulatory patients, emergency cases and pediatric patients were not included. Retrospective data collection was done on all consecutive cases during 1.9.2001 – 28.2.2002 and included the following parameters: demographic, diagnosis, hospitalization details, factors and reasons for cancellations and time of cancellation. Data analysis was done using descriptive and parametric statistical methods ( $\chi^2$  for categorical variables).

#### **Results**

According to the O.R reports we found that there were 1,564 planned surgeries. This research focused on 150 cases with full data out of the total 193 cancellations that took place. Out of the sample 58% were males, 34% were singles, 74% were Jewish. The overall cancellation rate was 12.3% (range 10%-16%). Analysis of reasons for cancellations pointed out that 32% are related to unrealistic operating schedule, 31% of the cancellations were related to the pre-operative preparation process. 21% of the cancellations were due to the change in medical status of the patient. 8% of the cancellations were a result of technical or unexpected problems. A Variation was found in factors for cancellation between the departments observed ( $p < 0.05$ ). Approximately 33% of the cases occurred in the afternoon, 30% of the cancellations related to pre operative preparation process took place in the morning. There was no relation between the causes for cancellations, patient's age, gender and severity of illness.

#### **Conclusion**

The research results demonstrate that most of the factors the surgery cancellations are related to organizational factors. Improvement can be achieved using multi disciplinary approach to attack and correct pitfalls in order to minimize the cancellation rate.

## *Poster Presenters & Abstracts*

Name: Aileen Burton MSc, BNS, RGN

Country: Ireland

Occupation: College Lecturer

Affiliation: Catherine McAuley School of Nursing & Midwifery, Brookfield Health Sciences Complex, University College Cork, Ireland

Registered general training undertaken with the Cork Voluntary Hospitals. Clinical experience includes peri-operative nursing, accident & emergency nursing as well as medical & surgical nursing.

Completed a Bachelor in Nursing Studies with Dublin City University Ireland, and read for a Master of Science with the Royal College of Nursing, London, UK. Worked as a lecturer with Dublin City University in the School of Nursing and presently working as a College Lecturer in the School of Nursing & Midwifery in University College Cork.

### **‘An Observational Study To Assess Nurse’s Compliance With Hand Washing And Glove Use In Relation To Patient Care Activities In An Irish Post Anaesthetic Care Unit.’**

**Ms Aileen Burton, Catherine McAuley**

Compliance with hand washing and glove use guidelines is sub-optimal amongst a range of healthcare professional groups. This study examined nurse’s compliance with hand washing and glove use in relation to patient care activities in a post anaesthetic care unit in an acute general hospital in the Republic of Ireland.

The post anaesthetic care unit is an area of the hospital where intensity of patient care and the number of contacts between nursing staff and patients are high. Within the post anaesthetic care unit environment nurses conduct procedures that necessitate cross infection precautions such as wound care and catheter care. There is a high throughput of patients and hence a big potential for cross infection. Positivism was chosen as the research paradigm for the study using a structured observation schedule. Data was collected over three shifts –day, evening and weekend. A total of 473 observations were collected. Hand washing and glove use was analysed in relation to full compliance, partial compliance and non compliance. 62% of the patient care activities showed non compliance, 31% highlighted partial compliance and 7% indicated full compliance. Findings from this study showed a low compliance rate with hand washing and glove use in relation to patient care activities in the post anaesthetic care unit.

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## *Poster Presenters & Abstracts*

Name: María De Vega Fernandez

Country: Spain

Occupation: O.R Supervisor. H.U."La Paz" Madrid

Affiliation: Member of AEEQ

Nursing Graduate in 1981 for the University of Alcalá de Henares of Madrid.

O.R nurse from the year 1983, in Spanish Red Cross Central Hospital in Madrid.

From 1991 to 1994 Surgical Nurse in the Hospital U. of Getafe. Madrid

From 1995 to 2000 Surgical Nurse in the Hospital U. La Paz. Madrid

And from the year 2000 carry out the position of Supervisor of the O.R Block.

She has collaborated as Teacher in the Superior Nursing Diploma in O.R; by the Autonomous University of Madrid. She is author of multiple publications and communications to congresses.

**‘Comparative Study Of The Perioperative Workloads Of Nursing In Hospitals Of Madrid.’  
Maria de Vega Fernandez, Ms. M Becedas, Ms A Escribano, Ms. E Torrijos, Ms C Moreno.  
H.G.U LA PAZ, Madrid, Spain**

Having determined the fundamental perioperative nursing workloads in the surgical area, a comparative study was carried out to determine coincidences and divergences inside the work that has to be done by perioperative nurses, in different hospitals.

It was observed that the perioperative activities are determined by the customs, material and human resources, infrastructures and the management of each centre. The basic and fundamental activities of the perioperative nursing are similar, but differ in the management activities and performance forms.

Therefore the goals of this study were to determine the fundamental workloads in the different centres, workloads similar in all of them, in order to recommend the positive differences of each hospital, to be developed in the other centres of the study.

With this study we want to create a unified work model for the perioperative nursing in the health community of Madrid.

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### **Keyword**

Perioperative nursing, workloads

## *Poster Presenters & Abstracts*

Name: Robert B. Dybec RN, MS, CPSN, CNOR

Country: U.S.A.

Occupation: Nurse Manager Operating Room

Affiliation: Winthrop-University Hospital, New York

Received Nursing degree in 1985, now holds a Masters degree in Health Care Administration.

Currently the Operating Room Nurse Manager at Winthrop-University Hospital in New York. Has lectured and instructed internationally, consulted and published on the topic of Patient Positioning for over ten years. Received the award for “Outstanding Achievement in Perioperative Clinical Nursing Education” in 2005 from the Association of PeriOperative Registered Nurses (AORN)

### **‘Intraoperative Positioning and care of the Obese Patient’**

**Robert B. Dybec RN, MS, CPSN, CNOR**

#### **Introduction**

An informative presentation designed for all perioperative nurses which show the important aspects of perioperative care for obese surgical patients.

#### **Aim of Study**

Provide perioperative nurses and practitioners with the information needed to provide safe care of the obese patient undergoing a surgical procedure. The disease of obesity and bariatric surgery will be examined, the importance of the preoperative assessment and aspects of patient positioning.

#### **Methodology**

A poster presentation which will include many photographs intraoperatively showing recommended practices for positioning obese patients. Charts and graphs are used to show areas of risk and potential complications.

#### **Results**

At the conclusion practitioners will better be prepared to provide a safer surgical environment with regards to intraoperative care of obese surgical patients.

## *Poster Presenters & Abstracts*

Name: Montserrat Garriga Sala

Country: Spain

Occupation: Perioperative Nurse

Affiliation: Hospital General de Catalunya

Born in 1961 in Barcelona.

Studied Nursing in Hospital S.Joan de Deu –Barcelona-Spain(1979-81)

Worked in several hospitals and services (Intensive Care Unit,Oncology)

Working in the surgery room of Hospital General de Catalunya since 1990.

Collaborate with the International University of Catalonia as teacher of the Perioperative Nursing Postgrade.

Speaker at the 1st Congress of Endoscopic Foot and Hand Surgery, that took place October 2005-

“Pre,Intra and Postoperative Nursing Cares in Endoscopic Foot Surgery- Barcelona Spain

### **‘Endoscopic Plantar Fasciotomy Instrumentation In Morton Neuroma’**

**Montse Garriga Sala, Mireia Pesarrodona Isern**

**Hospital General Catalunya, Sant Cugat del Valles, Barcelona, Spain**

Morton's Neuroma is where the nerve, usually between the 3rd and 4th toe is trapped, resulting in a painful swelling and scarring of the nerve.

The patient experience a sharp, stabbing pain and as time goes on the nerve becomes enlarged which makes the pain more constant and severe.

Thanks to endoscopic plantar fasciotomy the nerve is liberated without the need of an open procedure. Morton's Neuroma can successfully be treated by decompression rather than excision

Summary of the poster:

- Definition of the procedure
- Goals
- Pre-Operative Considerations and Cares
- Intra-Operative Considerations and Surgical Set-Up
- Surgical Technique – Instruments
- Post-Operative Cares
- Conclusions
- Bibliography
- Acknowledgments

As Operating Room Nurses, we think that this procedure will give our patients a lot of benefits now and in the future.

## *Poster Presenters & Abstracts*

Name: Salvatore Giampiccolo  
Country: Italy – 94015 Piazza Armerina  
Occupation: Nurse – Operating Theatre  
Affiliation: AICO

Nursing diploma. Since 1981 he has been an operating theatre nurse. He has participated in numerous refresher courses. He has spoken at national and regional events. He has various publications to his name, including a monograph on “Spreading and adopting guidelines for preventing infection in surgical theatres”. He is scientific manager of training events. Since 2004 he has been a member of the National Executive Board of AICO.

### **‘The Importance Of Being Nurse: A Key-Role In Perioperative Care And A Mission Of Responsibility’**

**Salvatore Giampiccolo**  
**AUSL4, Enna, Sicil, Italy**

The nurse has a fundamental role in perioperative care and, in particular, in the prevention of Surgical Site Infection. The nurse is the main guarantor of the level of the care and is becoming increasingly aware of the responsibility held by the role within the hospital. Responsibility means applying your ability. To be able does not require overcoming the Herculean columns of science; rather, ability is constructed day after day in correcting incorrect attitudes and behaviour, in scientific Evidence Based Nursing, in adopting guidelines. Very little is required to guarantee high-level care. In fact, attention will be focused on the incorrect behaviour which is common in the daily life of health workers: all that is needed is a little more awareness of our mission of responsibility to improve perioperative care and drastically reduce Surgical Site Infection. We now have the data supplied by a research carried out at national level, sponsored by AICO (Italian Operating Room Nurses Association) regarding the diffusion and use of guidelines to prevent Surgical Site Infection, which clearly shows that incorrect behaviour is still widespread, which does not conform to the Guideline standards. This makes it clear that we must do more to improve the performance of our nursing staff.

## *Poster Presenters & Abstracts*

Name: Elias M. Giannakoulis

Country: Greece

Occupation: Perioperative Nurse

Affiliation: Argos General Hospital

I acquired my degree in Nursing in 1991 and a degree in Management of Health and Welfare Units in 2002. I am now attending a postgraduate course in "Health Management" at the University of Piraeus. I have been working at the Operating Room in Argos General Hospital since 1993 and I have had a teaching experience in Nursing classes of Technical Senior High Schools since 1998.

### **'Is The Reusable Gowns & Drapes For The Operating Room The Most Profitable Choice In Terms Of Cost?'**

**Giannakoulis Ellias,**

**General Hospital of Argos, Peloponnesus, Greece**

#### **Background**

The aim of the new European Standards is to help prevent the spread of bacteria during operations and specify the adoption of essential material properties used in medical devices - in the case of EN 13795 surgical gowns, drapes and clean air suits. Drapes and gowns of traditional woven cotton will not comply with the requirements of the legislation and they have to be replaced by qualified medical devices with adequate barrier function

#### **Aim**

The purpose of this study has been to calculate how much a multiple-use set of gowns and drapes costs, given the facts in the District General Hospital of Argos in 2004, starting from the purchase of the fabric, which will be used for the production of the set, and calculating the separate costs during the actual use of the set.

#### **Methodology**

The material in question was a clothing set for general surgery, which consists of three surgical gowns, along with three square towels for wiping hands, two sheets, four square towels and one bigger towel, double in size, for the packaging of the set. The research has shown that each of the clothing set is unsuitable for use (due to tears, holes) after 43 uses on average.

The methodology involved defining the cost groups that burden the cost of multiple-use clothing set, and these are: the personnel salaries, the purchase and maintenance of the washing machines, the disposable material, indirect expenses, other functional expenses, the cost of maintenance and sterilization.

#### **Results**

The result of the research has shown us how much each cost group burdens the clothing set, the final cost of which comes up to ? 31,53. What is also interesting is the comparison with the prices of one-use clothing sets.

In conclusion to this research, a multiple-use set is not always more expensive than a single-use set, taking, of course into consideration the quality of the product along with its price.

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B. J. Gruendemann,, Taking Cover: Single-use vs. Reusable Gowns and Drapes, Infection Control Today,2002

## *Poster Presenters & Abstracts*

### **'Preoperative Skin Test – Perceptions Among Patients With Allergy, Asthma And Eczema'**

**Rosalie Hammarsten, Dr K Hildingh**

**Central Operating Department, Varberg Hospital, Varberg Sweden, Halmstad University, Halmstad, Sweden**

Preoperative preparations are important to create a safe and pleasant stay in the operating room (OR). The preoperative skin test has been created to satisfy the specific medical needs that certain patients have intraoperatively, namely the need to avoid allergic reactions caused by the application of adhesive materials. However, nursing is formulated on a holistic basis and in order to retain the quality, the patient's own attitude must also be reflected. The purpose of this study was to describe, with a descriptive, qualitative method with a phenomenographic approach, how patients perceive a preoperative skin test. The result describes how twelve patients with allergy, asthma or eczema in a qualitatively different manner conceive a preoperative skin test. Three equal core categories were obtained; they describe the patients' perceptions with respect to a preoperative skin test, namely Value, Benefit and Function. Study results suggested that the skin test is considered in a positive manner. However, the patients need preoperative instructions that focus on the patient from a holistic perspective and is more clearly understood and individualized.

(This study was published in AORN Journal March 2005 (vol 81, no 3)

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## *Poster Presenters & Abstracts*

### **'Sterilagent 2000 – A Computerised Material Handling System For The Operating And The Sterile Supply Department'**

**Rosalie Hammarsten, Ms L Andersson**

As early as towards the end of the 80's, the development and introduction of an increased number of medical devices made it difficult for operating room and sterilization staffs to handle more than the 2,500 products. Basically, the flow of instruments (sterile and nonsterile) and other equipment was handled manually. We realized that the entire handling procedure could be computerized. After extensive database work, a computer-supported material handling system was started for the Sterile Supply Department and the Operating Department. All instruments and other medical devices are registered. By means of the computer system, it becomes possible to locate almost 11,000 products and spare parts today. This is essential, not least at nighttimes when no staff is available to answer questions on where the equipment is located and how it is used. SterilAgent2000 contains: 1) an illustrated catalogue that can be obtained via the County Council's intranet 2) swift access to facts on instruments, storage location, suppliers 3) sterilized products (a single instrument or sets of instruments) with a storage designation 4) print-outs of control labels and count sheets 5) count sheets with instructions on handling, cleaning, and sterilization as well as information on patient and working environment risks, etc. 6) a link, via Internet, to the supplier's current user directions 7) a tracking function throughout the entire sterilization process 8) a tracking function to products that contain latex, nickel, etc. 9) an "automatic" ordering system 10) Information on suppliers and the central storage 11) fast access to prices 12) statistics 13) a total stock value on which insurances can be based 14) possibilities to directly register used expensive products - e.g. hip prostheses - in the accounting programme of the finance department.

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## *Poster Presenters & Abstracts*

Name: Annegret Horbach

Country: Germany

Occupation: MSc (Nursing and Health Science), Theater Nurse

Affiliation: Martin-Luther-University, Halle-Wittenberg

Nurse, MSc, scientific employee and doctoral candidate at the Institute for Health and Nursing science, faculty of medicine, University Halle-Wittenberg

Working since 1984 at hospital (operating theater, anaesthesia, intensive care)

Further education: quality management, executive theater nurse

### **‘Is Any Damage Inflicted On Patients With Hearing Aids By Applying The Common Presurgical Preparation Standards?’**

**Annegret Horbach, Martin-Luther-Universität Halle-Wittenberg, Institut für Gesundheits- u. Pflegewissenschaft, Halle/Stuttgart, Germany**

#### **Background**

Due to commonly applied clinical standards in Germany patients usually have to remove all aids (hearing aids, glasses, sets of dentures) in the ward before they are taken to the operation theatre. Experiences of operation and anaesthesia staff suggest that hearing-impaired patients, who are severely limited in their ability to communicate due to removal of their hearing aids, are more anxious than those who don't need these aids.

Previous studies on peri-operative stress and fear indicate that anxious patients require more anaesthetics, are more likely to suffer from complications and postoperatively stay longer in hospital.

From an ethical and economic view it is therefore indicated to find out which effect the removal of their hearing aid before transfer to the operation unit has on the fear of hearing-impaired patients.

#### **Research goals**

Aim of the study is to find out whether anxiety can be reduced by leaving the hearing aids to hearing-impaired patients up to the point of initiation of anaesthesia.

Besides the self-reported fear of patients the negative emotion may be evidenced by physiological stress reactions of the body indicated by an increase of the heart activity and rise in concentration of different blood parameters.

#### **Methodology**

It is a prospective, randomized comparative clinical trial with multidrop measuring by questionnaires and vigorous parameters as well as special blood analyses.

The intervention group are patients who may use their hearing aid up to the initiation of anaesthesia.

The comparison group will be comprised of patients who leave their hearing aid behind the ward the morning of the surgery according to common regulations and standards.

#### **Results**

The results shall provide hearing-impaired patients with better pre-operative care and more effective communication. Thus it is hoped that a more favorable condition can be achieved for anaesthesia and the postoperative clinical condition and in future an evidence-based standard for pre-operative care for hearing-impaired patients be developed.

#### **Key words**

pre-operative anxiety, stress, hearing aid, evidence-based standard, communication

## *Poster Presenters & Abstracts*

### **'Preliminary Results Reporting A Reduction In Post Operative Blistering Using A Modified Molndal Dressing Technique In A Glasgow Hospital'**

**Emmerson S, Sayer S, Kinninmooth A, McCowan M, Bianchi J, Graham K  
Golden Jubilee National Hospital, Glasgow, UK**

#### **Aims**

Peri-wound blistering is often observed after orthopaedic surgery. The Molndal technique was developed in Sweden using a hydrofibre dressing with secondary transparent film dressing and has been shown to reduce the occurrence of post operative blistering (Folestad et al, 2002). The purpose of this study was to evaluate a modification of the dressing technique in our patient population.

#### **Methodology**

All patients admitted for either knee or hip arthroplasty were included. Data were collected for over an 16 week period. During the first 8 weeks, our traditional post operative dressing which consisted of transparent film dressing with integral absorbent pad was used. Following intensive training for all the staff involved in the patient journey, the new dressing technique was introduced and data were collected for a further 8 weeks. The modified dressing consisted of:

A 15cmx15cm hydrofibre dressing (AQUACEL®), which was folded to form 3 layers and applied over the incision.

The AQUACEL® dressing was secured using a hydrocolloid dressing (DuoDERM® Extra Thin), in place of transparent film dressing. Care was taken not to stretch the dressing during application and to reduce the amount of air under the dressing.

In knee operations the DuoDERM® dressing was applied with the knee flexed or extended – at Consultant's discretion - followed by padding and compression.

The main point of interest was:

the presence or absence of blisters to the peri-wound skin post operatively

#### **Results**

Over the 16-week period 293 Arthroplasty procedures were carried out. 52.6 % knee and 47.4 % hip procedures.

During the 8 weeks pre evaluation, of the new Molndal technique, using our traditional dressing method, 113 procedures were carried out, blistering occurred in 22(19.5%) patients. In the 8-week period where modified the Molndal dressing technique was applied, 180 procedures were performed in which 7 (3.5%) patients developed blistering post operatively.

#### **Conclusion**

These preliminary results indicate a reduction in postoperative blistering in our patient population using a modified Molndal technique.

Longer-term studies, which will include patient comfort, ease of use of dressing and health economics, are currently being undertaken.

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# Poster Presenters & Abstracts

Name: Maimani SM

Country: Greece

Occupation: Nurse

Affiliation

Senior Nurse with twenty years of professional experience in Clinical Pathology and the Emergency-First Aid Room. Specialized in Anesthesiology and currently works at the Anesthesiology of Sotiria General Hospital in Athens. In addition she works as an assistant at the Nursing Department of the Technological Educational Institute of Athens.

## 'Evaluation Of Nursing Interventions In The Postanesthesia Care Unit (Pacu)'

Maimanh Sm, Karaolia As,

Sotiria General Hospital, Athens, Greece

### Background

The Aldrete's scoring system<sup>1</sup> assesses consciousness, physical activity, oxygenation and hemodynamic and respiratory stability in order to determine when patients can be safely discharged from the PACU to the surgical ward. White et al have proposed the use of a new system<sup>2</sup> that incorporates the essential elements of the Aldrete's system, as well as an assessment of pain and emesis.

### Goal of the study

To evaluate the frequency, type and timing of nursing interventions in the PACU by applying both recovery scoring systems.<sup>1,2</sup>

### Methodology

Recovery data from 102 consecutive patients undergoing thoracotomy (T), laparoscopic cholecystectomy (LC) and ear, nose and throat surgery (ENT) were analyzed. All patients received antiemetic prophylaxis. Times from tracheal extubation to eligibility for discharge from the PACU were recorded at 1-min intervals until 5 min after arrival in the PACU, and subsequently at 5-min intervals using both (Aldrete's<sup>1</sup> and White's<sup>2</sup>) scoring systems. Demographic data and the characteristics of nursing interventions were recorded.

### Results

30 of 102 patients (29%) received 63 parenteral medications for management of pain (22/30), shivering (8/30), respiratory depression (2/30), nausea (2/30) and bronchospasm (1/30). 20 of 30 patients (67%) required additional intervention after achievement of Aldrete's score? 9, but this rate decreased to 40% (12/30) after achievement of White's score? 12. The table shows mean ± SD (range) or numbers.

Need for PACU interventions	Yes (n= 30)	No (n= 72)	P-value
ASA physical status (1/2/3)	16/10/4	32/24/16	0.55 (NSS)
Gender (M/F)	26/4	50/22	0.12 (NSS)
Age (yr)	39.8 ± 17.8 (17-67)	49.2 ± 17.1 (24-80)	0.015
Type of surgery (T/LC/ENT)	18/4/8	28/22/22	0.09
Duration of surgery (min)	148 ± 67 (80-300)	131 ± 76 (40-390)	0.29 (NS)
Maintenance of anesthesia (S/D/P)	12/6/12	34/20/18	0.31 (NS)
Intraoperative analgesia (F/RF)	8/22	26/44	0.36 (NS)
Morphine IV (mg) after RF	17.0 ± 9.3 (5-35)	14.6 ± 9.6 (5-30)	0.34 (NS)
Time from tracheal extubation to:			
- Aldrete's score (AS) 9 (min)	4.3 ± 5.8 (1-20)	2.6 ± 4.0 (1-25)	0.1 (NS)
- White's score (WS) 12 (min)	10.3 ± 7.4 (4-30)	6.4 ± 4.5 (3-30)	0.002
- last PACU intervention (min)	10.7 ± 6.6 (1-20)		
Number of interventions/patient:			
- before AS 9	0.8 ± 0.6 (0-2)		
- between AS 9 and WS 12	0.7 ± 1.0 (0-3)		
- after WS 12	0.6 ± 0.6 (0-2)		
- total	2.1 ± 1.2 (1-4)		

### Conclusion

Younger patients and potentially those undergoing major procedures (thoracotomy) need more often nursing interventions in the PACU. Use of White's recovery scoring system helps to limit the number of additional nursing interventions required in the postsurgical ward.

## Poster Presenters & Abstracts

Name: Carlos Martin Trapero

Country: Spain

Occupation: Operating Room Nurse

Affiliation: Member Of Aeeg (Spain)

Operating Room Nurse Since 1982, Associated Teacher Of Complutense'S Nurse School Of The Complutense'S University (Madrid) Since 1988, Being Responsible Of The Practising Experience Of The Students In The Operating Room.

### **'Laparoscopic Cholecystectomy: Level Of Information Of The Patient'**

**Martín Trapero C, Valderrama Díaz M.J , González Fernández F, Agudo Martínez MA, Sánchez Pernaute A**

#### **Introduction**

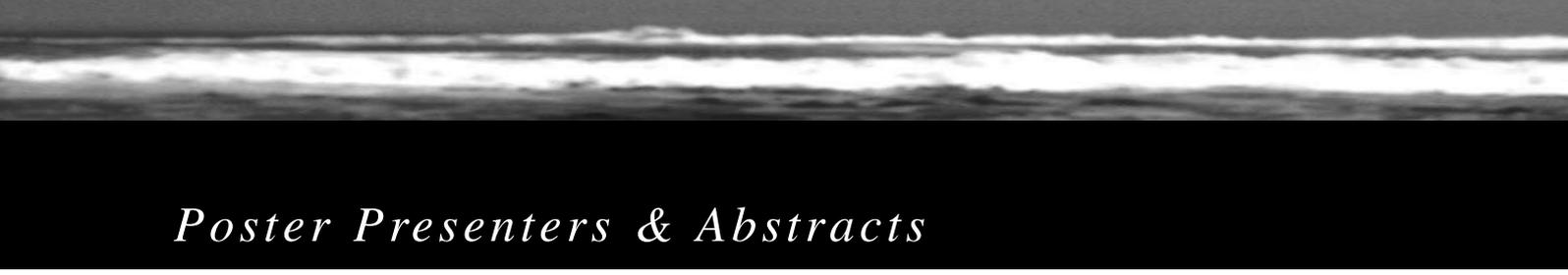
The models of informed consent for surgical procedures must gather in comprehensible terms for the patient, both the expected benefits from the procedure and the possible complications which could present. The patient has to be satisfied with the information received and must have understood the purpose and risks of the therapy. The aim of the present communication is to know the level of information that the patient has about laparoscopic cholecystectomy.

#### **Patients And Methods.**

We present a prospective study including 100 consecutive patients, with diagnosis of cholelithiasis and prepared to be submitted to elective laparoscopic cholecystectomy. Every patient has received and accepted previously a model of informed consent. Sanitary workers, emergency operations, patients with mental damage or retardation, and those already submitted to pre-anaesthetic medication were all excluded from the study. A closed-answer inquiry has been designed and given to all patients in the immediate preoperative period. The inquiry has three different parts, the first one including general questions related to the diagnosis and the surgical technique (one answer out of various options); the second one, where the patient is asked whether it is or not necessary to place a nasogastric tube, administer antibiotics, the use of i.v. solutions, bandage of the legs, use a video camera and a t.v. set, use of laser and gas for inflating the abdomen; the possible answers are YES, NO or DO NOT KNOW; the third part asks about the postoperative period, if it is expected to feel pain, haemorrhage, infection, respiratory distress, subcutaneous emphysema, biliary collections, venous thrombosis or pulmonary embolus. The frequencies for each question are analyzed, and by means of the chi-square test it is investigated if the cultural level, the previous hospital admissions secondary to gall bladder disease, the knowledge of someone submitted to laparoscopic surgery and the understanding of the informed consent, influence on the level of information.

#### **Results**

There are 32 male patients and 68 female ones, with a mean age of  $60.6 \pm 14.5$  years. Eighty-seven accept as a valid option for their diagnosis cholelithiasis, 50 think that surgery consists on gall bladder resection including the stones, 6 that what is excised are the stones, 3 that they are destroyed with laser and 41 do not know or do not answer. Thirty patients had been previously admitted do to gall bladder disease, 52 know someone submitted to laparoscopic cholecystectomy and 35 recognize not to understand the informed consent. In the second part of the interview, except for the i.v. solutions perfusion (68%), positive answers are all under 40%. In the third part about complications, 67% of the patients think that they can suffer from pain in the postoperative period, 26% know that they can develop infection and the rest of the answers are all under 18%, being the percentage of do not know/ do not answer over 50%. No significant differences are found when considering the previous admissions. Attending to the relation to someone operated on previously, 67.6% vs 32.4% think that a video camera and t.v. set are used, 74.1% vs 25.9% do not think a venous thrombosis can present and 70% vs 30% that pulmonary embolus can develop ( $p < 0.05$ ). Between patients which manifest to have understood the informed consent, 26.7% think that it is necessary to use gas to inflate the abdomen, while 2.8% do not, and a bile collection is a possible complication for 23.7% vs 6.25 between those who manifested not to have understood the document ( $p < 0.05$ ).



## *Poster Presenters & Abstracts*

### **Conclusions**

The level of information of the patients is not the desired one. The history of previous admissions, the relation to someone operated on and to manifest to have understood the document do not influence in a significant way. There is a high percentage of do not know/ do not answer responses, and so we think necessary to elaborate a specific model of information.

## *Poster Presenters & Abstracts*

### **'The Frequency Of Surgical Gloves' Perforation After Open Thoracic Operations'**

**Maridaki Eustathia, Prof E Manousou, Prof M Kipriotou, Prof M Armeliniou, Prof E Pavlidou, Prof I Kanavos, Prof N Baltayiannis  
Metaxa" Cancer Hospital, Piraeus, Greece**

#### **Introduction**

The perforation of surgical gloves during various surgical operations leads to serious health problem such as prone to transmitting serious diseases from the blood and the secretions of patients, to nurses and to surgeons.

The aim of the present study is the survey on the frequency of surgical gloves' perforation, during open thoracic operations, the search of special causes as well as the formulation of protective measures of the nursing and the surgical team.

#### **Material-Methods**

With the trial of fulfilment by water, we examined carefully the surgical gloves of the whole surgical team (surgeon, first assistant, second assistant and nurse) during 40 open thoracic operations (39 thoracotomies and 1 middle sternotomy). The surgical team were wearing only one pair of gloves from latex.

In our study were registered the following parameters:

The type and duration of the operation, the number of perforations, the exact place of them, the removal and fractures of ribs which were coming out during the operation.

#### **Results**

362 pairs of surgical gloves were under examination.

Perforations were found in 54 pairs, frequency 14, 91%. The total frequency of perforation during the operations was 75, 5%, that is 31 out of 40 operations, and 31 had the problem of perforation. The biggest frequency was counted on right thoracotomy for scientific research sake, aiming at the peeling because of abscess (27, 77%).

The right pneumonectomy presents increased danger with frequency of perforation 25, 92% in relation to the left pneumonectomy which has frequency 18, 51%.

The frequency of surgical gloves perforation of surgeons was 40,74% and of the two (a and b) assistants, was 22,22% and 18,51% relatively speaking. Very interesting is the recording of high perforation frequency of nurses' gloves (18,51%), showing that they are exposed to dangers the same as the surgeon- assistants despite the fact, that they work in bigger distance from the surgical field than them .

#### **Conclusions**

The increased frequency of perforation of surgical gloves during open thoracic operations imposes:

- a. The usage of absolutely durable gloves.
- b. The usage of a double pair, for additional protection.
- c. Careful by-operative handling, mainly on resection of ribs.

## *Poster Presenters & Abstracts*

### **'Caring For The Care-Giver'**

**Mrs Patricia Nicholson, The University of Melbourne, Melbourne, Australia**

It is widely accepted that when dealing with dying within society, problems are encountered by loved ones during the grieving process. A phenomenon not widely recognised is that professionals and volunteers who are involved in caring for the dying, experience a grief response to the death due to the bonds that are formed during caring for the patient. The death may be as a result of trauma, or may be sudden and unexpected, thus resulting in diminishing the person's ability to cope with the situation. The events surrounding the trauma or death include the investment of time, effort and emotion, and require regular confronting of one's own mortality.

Stress has a resultant effect on health care workers and when assigned a "value" as determined by the Social Readjustment Rating Scale, death is rated as the highest stressor. It is stated that nurses and doctors are more at risk of becoming casualties than the people they care for due to the emotional and physical toll involved in providing the care required.

The world has changes since the catastrophic terrorist attacks in New York, Washington and Pennsylvania, exposing the vulnerability of everyone who witnessed the traumatic events. What was once considered the function of nurses in the military and emergency departments is now required to be considered by all nurses in practice.

Today's highly skilled perioperative nurses work in an environment of tiled walls, bright lights and dust free air. What happens when a perioperative nurse is thrust into an environment with limited supplies, no electricity, and environmental hazards? One aspect of perioperative nursing that will never change is the role of the nurse as the patient's advocate, regardless of the environment. While caring for welfare of others, the welfare of emergency health care workers should not be neglected. When the caring is over – who cares for the care-giver?

Critical incident stress debriefing is a method of crises intervention in order to meet the needs of emergency workers, victim of disasters, and those affected by trauma and violence, reducing the effects of extreme stress that may have occurred as a result of a critical incident.

This discussion will examine the effects of traumatic events on staff dealing with emergencies, and the importance of crises intervention in reducing the risk of post traumatic stress disorders occurring among health care workers.

## *Poster Presenters & Abstracts*

### **‘Nurse Educators Use Of Scoring Rubrics To Determine Varying Levels Of Clinica Performance In The Perioperative Setting: A Study Of Inter-Rater Reliability’**

**Mrs Patricia Nicholson, The University of Melbourne, Melbourne, Australia**

This study was designed to determine the skills and knowledge to be observed by nurse educators and preceptors, which not only meet the requirements of the Australian College of Operating Room Nurses standard (2004), but also enable varying levels of competence to be determined along a developmental, learning continuum. The aim of the study is to examine validity and inter-rater reliability of a set of performance –based on a scoring rubrics that has been designed to measure the competency “peri-operative nurses in the role of the instrument nurse”. As part of this investigation, the study is designed to identify the background factors of the nurse assessors that influence the inter-rater reliability of nurse educators and preceptors judgement.

The methodology included a survey method with the use of a questionnaire to obtain descriptive data from the assessors involved in the observational process. A set of scoring rubrics was developed to evaluate the performance of the student. The intention of the rubrics are to rate specific and uniform assessment criteria in order to decrease the subjectivity involved in the assessment process. The rubrics were specifically designed for the assessment against the ACORN standards, and was developed in accordance with the rules and principles developed by Griffin, Gillis, Keating & Fennessy (2001) and based on the criterion-referenced rating scale described by Patricia Benner (1984) and Kathleen Bondy (1983). The evidence of candidate performance was standardised through the development of a series of video clips that were observed by a group of nurse educators and preceptors. Video clips were produced to match the ACORN Standards for an Instrument Nurse (ACORN standard NR4, 2004). Each video clip was designed to demonstrate varying levels of performance against the standard and the rubrics would enable subtle, yet significant differentiation in performance to be recorded for each video clip.

To examine the reliability of the rubric judgements within each video segment, the data will be analysed using interclass correlations (ICC) and examination of the influence of the background characteristics of the raters on segment rating, a facet analysis using the ConQuest software (Wu, Adams & Wilson, 1998) will be performed.

The results have produced very positive inter-rater reliability with some very interesting correlation between tertiary education and hospital based trained staff. All results will be presented during the discussion.

## Poster Presenters & Abstracts

Name: Anthony Dawson

Country: U.S.A.

Occupation: Master Black Belt Quality and Patient Safety

Affiliation: New York-Presbyterian Hospital, New York, NY

Tony Dawson, RN, MSN, is a Master Black Belt in Performance Excellence at New York-Presbyterian Hospital. He leads, facilitates, and support significant quality, process, and performance improvement projects using Six Sigma, Change Acceleration Process, and Work-Out methodologies. Prior to becoming a Black Belt he was the Clinical Director of Perioperative Services at NYPH. He had twenty-four hour accountability for the operation and management of Perioperative Services (with 28,000 cases/year) for a level 1 Trauma Center and Regional Burn Unit. He directed the delivery of safe and effective patient care in:

- 38 operating rooms both inpatient and ambulatory
- 65 -bed recovery rooms
- 3 Cysto Suites
- 6 Endoscopy Suites
- Central Sterile Processing
- Materials Management

Pre admission Testing , Admit Day Surgery and Same Day Surgery Centers

### **‘Quantifying The Medication Error Risk Of Verbal Orders In The Operating Room’**

**A Dawson, Michael J. Orsini, RPh., K Wollenburg, R Diamente, MR Cooper**

**New York-Presbyterian Hospital, New York, NY, USA**

#### **Background**

Miscommunication of verbal orders is a recognized source of medication error. While safety practices such as repeating an order or spelling a drug name decrease verbal orders in other controlled settings, there is no standardized process for making verbal orders safer in the OR.

#### **Research problem(s)**

Verbal orders in the OR are subject to misinterpretation because masks can muffle speech, music may be playing in the background, and the person receiving the order may be distracted. In addition, during surgery a variety of medications may be added to the operative field without written orders.

#### **Methodology**

The purpose of this research initiative was to quantify the risk potential associated with verbal orders in the OR as they pertain to medications administered by the surgeon on sterile field. Data were collected to document intraoperative processes and identify medications used on the sterile field. The primary sources of these data were a survey of process measures and an interdisciplinary failure mode and effects analysis (FMEA) of the prescribing process. Research on medications used on the sterile field allowed us to determine areas of drug standardization that can be consistent over all surgical procedures. Pre and post intervention scores from the FMEA determine the probability of medication error reduction by eliminating verbal orders and standardizing the ordering process.

#### **Results:**

Our survey results revealed that a number of prescribing methods are used in the OR including written orders, verbal orders, preference cards, or a combination of all. Extrapolation of data over the 20,152 surgical procedures performed in 2004 indicates that a minimum of 20,802 verbal orders are given in the preparation and pre-incision sequence of a surgical case in the OR annually. Sixteen potential error steps, with eight being highly significant were identified in the verbal order process. Thirty-seven failure modes were identified in these eight steps. Process redesign to standardize and simplify the prescribing process and eliminate, to the highest extent possible, the number of verbal orders in the OR will reduce the error risk associated with medications on the sterile field.

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**Key words:** Verbal orders, sterile field, medication errors

## *Poster Presenters & Abstracts*

Name: Edith Højberg Pedersen

Country: Denmark

Occupation: RN

I have been a nurse for 35 years, the last 26 years I have been working as a theatre nurse in the Gynaecological Operation Department. Pelvic Floor centre. Denmark

### **‘Decent Exposure’**

**RN Edith Højberg Pedersen, RN Vibeke Nielsen, RN Merete Nielsen.**

**Odense University Hospital, Gynaecological Operation Department.**

**Pelvic Floor Center, Denmark.**

Gynaecological Operations in local anaesthesia includes several steps in which the patients are partially undressed. In order to evaluate our procedures dealing with this issue, the patients filled in a questionnaire after the operation. The answers imply that our procedures do not violate the patients perception of modesty.

35 patients who had undergone vaginal operation (TVT or operation for genital prolapse) in local anaesthesia were enrolled in the study. A questionnaire was handed out to each patient after the operation but before they left the hospital. The questionnaires were returned in a mailbox in the department. The procedure is outlined in a poster.

The questions in the questionnaires are reported in full text in the figures. Answers are shown in the histograms. Photos illustrates the procedures. The red text in the middle shows statements from patients.

24 patients (67%) returned the questionnaires. Of these 23 patients (96%) were satisfied with the experience in the operating theatre. The questionnaire implies that our procedures are adequate to insure that the patients do not experience violation of their integrity.

In order to conduct further investigations we plan to use structured interviews.

**Key words:** Modesty – Dignity – Sexuality.

### **Literature:**

Pamela Halschow Michell og Anne Loustau : “Nurcery”.

Cinahl. Christopher Turnoch and Michael Kelleher: ”Maintaning patients dignity in intensive care settings”.

Cinahl. Chit Ying Lai and Valerie Levy : Hong Kong Chinese women’s experiences of vaginal examinations in labour.

## *Poster Presenters & Abstracts*

Name: Dr Marilyn Richardson-Tench, PhD, M.Ed.Stud., B.App.Sc.(Adv.Nsg.), Cert.Clin.Teach., Cert.Anaes., Cert. OR Tech. & Man., RN, RCNT(UK)

Country: Australia

Affiliation: ACORN, APP

I completed my nursing at the Alfred hospital in 1972 and obtained a perioperative qualification from the Royal Melbourne Hospital. I am a Senior Lecturer at Victoria University. I am an experienced researcher and have presented papers at national and international conferences. I am the Treasurer of the Victorian Perioperative Nurses Group.

### **‘Why Not Division 2 Nurses In The Perioperative Setting?’**

**Dr Marilyn Richardson-Tench, Victoria University, Melbourne, Australia**

There have been a number of Government committees in Australia, which have examined workforce issues and scope of practice. These projects were initiated as a result of the shortage of Registered Nurses (RN Div.1 in Victoria, Australia) specifically in rural and critical care areas. The perioperative setting is one area of shortage of the RN (Div.1). Whilst other States in Australia have embraced the Enrolled Nurse (RN Div.2 in Victoria) as a member of the perioperative team, this has not been the case in Victoria.

A research project using survey method was conducted to explore the barriers to the utilisation of this level of nurse in the perioperative setting. Questionnaires were sent to Nurse Managers of Operating Room Suites in 200 hospitals in Victoria. Data was managed by content analysis and descriptive statistics. This paper presents the results of this research.

#### **Keywords**

Perioperative, skill-mix, nursing shortage, questionnaire, content analysis

There is a strong Government movement in Victoria to expand the scope of practice of the RN(Div.2). It is imperative that perioperative nurses in Victoria be proactive in ensuring that nurses remain in this specialist area of patient management and embrace the RN (Div.2).

Patricia Heath – Chair. 2002. Commonwealth Department of Education, Training and Youth Affairs. National Review of Nursing Education.

Kenny, A. & Duckett, S. 2005. “An online study of Australian Enrolled Nurse conversion”. Journal of Advanced Nursing. 49(4), 423-431

Messina, J. 1997. “Development and Implementation of a Perioperative Assistant Training Program”. AORN Journal. 66(5),890-904

Shields, M. 2004. “Addressing Nurse Shortages: What can Policymakers Learn from the Econometric Evidence on Nurse Labour Supply?”. The Economic Journal. 114 (November), F464 – F498

## *Poster Presenters & Abstracts*

### **'Nurse Practitioner - What Is This Role In Perioperative Nursing In Australia?'**

**Dr Marilyn Richardson-Tench, Victoria University, Melbourne, Australia**

The professional boundaries for nursing are moving. Nurses have a greater professional role, more autonomy and hence accountability for the care they deliver to patients. Advanced practice is the application of an expanded range of practical, theoretical, and research-based therapeutics to phenomena experienced by patients, individuals, and clients within a specialised clinical area of the larger discipline of nursing. Advanced practice nurses make clinical decisions to manage patient care and promote wellness. They have a critical role in coordinating resources for patient care, articulating patient needs, providing professional leadership to clinical nurses, conducting and applying research and developing collegial relationships between nursing and other health professionals. For perioperative nurses in Australia, this has meant the development of the surgical assistant role - an expanded role, an extension of the instrument role, a supportive role to medicine. The first assistant or surgical assistant role may indeed be an important part of perioperative advanced nursing practice, but more technical support to patients and not surgeons is the key feature of an advanced nurse practitioner. In Australia many of the advanced practice roles meet endorsement for Nurse Practitioner with each State Nurses Board. However the current Perioperative Surgeons Nurse Assistant role does not. The major challenge facing perioperative nursing in Australia is to be able to demonstrate an advanced practice role that is nursing focussed and meets the requirements for endorsement as a Nurse Practitioner. This paper examines the nurse practitioner role currently evolving within Australia and posits the question. Where is the nurse practitioner role for perioperative nursing?

Beschle, J. C. 1997. "The Nurse Practitioner's Role in the OR - 'No Substitute'". Today's Surgical Nurse. March/April, 21 - 26

Hood, P. 1996. "Opportunities for a Specialist Practitioner and Advanced Nurse Practitioner". British Journal Theatre Nursing. 5(11):26 7

Kleinbeck, S. 1993. "What future will perioperative nurses choose by 2010?". AORN J. 58(5):902 - 908

Ladden, C. 1995. "Perioperative Nurse Practitioner". AORN J. 61(6):1067 - 68

#### **Keyword**

Perioperative, advanced practice, nurse practitioner

## Poster Presenters & Abstracts

### 'Comparative Study Of Two Surgical Techniques For Hip Prosthesis'

L. Sanjurjo Gómez, D. Varela Curto, A. Lamata Martínez, FJ Blanco García. Operating Room Nurses. CHU Juan Canalejo. A Coruña-Spain

#### Introduction

The MIS technique is a new surgical technique that is being used nowadays to hip replacement surgery.

#### Objective

To compare the two used surgical techniques nowadays in our hospital for hip replacement surgery.

#### Material And Methods

We have compared ten surgical operations realized by the conventional technique with surgical operations realized with the MIS. Information has taken on variables of surgical time, anaesthesia, post-surgery period and rehabilitation.

#### Results

VARIABLE	NORMAL	M.I.S.
Surgical Time	2.30h	1h
Anaesthesia	Rachial	Rachial
Position	Supine	Lateral
Incision	15-20cm	7cm
Set of instruments		
Chisel	YES	NO
Separator	YES	YES
Saw	YES	YES
"Hemostatic reagents"	YES	NO
Fungible		
Compresses	40-50	10-20
Sutures	5	3
Post-operative period	7 days	2 days
Rehabilitation	90 days	45 days

#### Conclusions

The MIS is faster, less aggressive, cheaper and more beneficial surgical technique for the patient.

## Poster Presenters & Abstracts

Name: Pia Soe Jensen

Country: Denmark

Occupation: Research nurse, RN

Affiliation: Orthopedic ward, Hvidovre University Hospital, Copenhagen

Have worked with orthopedic nursing in 13 years. Have worked with documentation and development in nursing strategies an management to both the elective and acute patients. Have since 2002 been a part of a research team that study the implementation of a multimodal fast-track rehabilitation regime to hip fracture patients

### **'Nutrition strategy and prediction of energy intake for hip fracture patients treated in a fast track regime'**

**P Jensen PS RN, D Sorensen, NB Foss**

**Department of Orthopedic Surgery, Hvidovre University Hospital, Copenhagen.**

**Department of Anaesthesia, Hvidovre University Hospital Copenhagen**

#### **Background**

The treatment and nursing management of elderly, fragile patients with hip fracture, is often complex due to various medical diseases, from which they suffer. The orthopedic ward in Hvidovre hospital, Denmark, has implemented the Fast Track Regime where hip fracture patients are treated in a special unit.

#### **Research problem**

Is it possible to implement a nutrition strategy in the nursing management that ensures patients daily intakes of protein and kilojoules according to the national recommendation ( NR) during the early postoperative days ?.

#### **Goals**

To ascertain patients' daily intakes of protein and kilojoules.

To develop a prediction scale of intakes of protein and kilojoules to identify patients who need a feeding tube with oral supplement.

#### **Methodology**

120 patients with a primary hip fracture, were consecutively included from May to November 2003. All patients where treated according to the fast track regime and offered standard nutrition at 9000 kilojoules and 95 gram of protein, including oral protein supplement. The daily intake was monitored with standard charts showing all meals and the intake was evaluated to a 25, 50 or 75 percent of the meal. The patients were monitored from the day of admission until the seventh day after the operation. The daily intakes were documented as a percentage showing to which extent the patients had met the requirements for protein and kilojoule intakes.

#### **Results**

On the second (N=111) and third (N=98) day, 46 and 41 had intakes of energy and protein below 50 pct of the NR. On the second and third day, 93 and 75 met their requirements for energy, whereas only 60 pct managed to meet their need for protein. To construct a prediction scale, we compared patients' intakes during the first three days to patients' intakes on the seventh day. We set the prediction values at 75, 50 and 25 pct intake of NR and above 50 pct of NR on the seventh day. Five patients (N=84) had intakes below 25 pct of NR during the first three days and 4 did not manage to improve the intakes to 50 pct of NR on the seventh day. Of the 27 patients who had intakes below 50 pct during the first three days, 13 managed to improve their intakes to above 50 pct of NR on the seventh day.

#### **Conclusion**

Hip fracture patients are not able to meet their need for kilojoules, especially protein and are at risk of malnutrition and the results show a need for oral supplement. It is possible to predict a patient's intakes of energy and protein by monitoring the daily intake during the first three postoperative days. The final analysis of the prediction study is not completed. We need to compare the results to other patient outcomes such as complication rate, the patient's ability to participate in rehabilitation and number of days spent in hospital.

## *Poster Presenters & Abstracts*

### **'Measures For The Prevention Of Surgical Infections'**

**Silva Stiploček, General Hospital, Maribor, Slovenia**

#### **Introduction**

It often comes to surgical infections. Facts originating from medical literature prove that surgical infections represent 12 % of all hospital infections.

The article presents procedures how to reduce micro-organisms in the operating areas and how to prevent their intrusion into an operating wound. Surgical infections cannot be prevented. They still occur in spite of all strict preventive measures. Everybody, who works in medical service, tries hard for a better prevention of infections. The prevention has to start with the reasons for an infection. The reduction of micro-organisms in the operating field can be achieved by general sanitary preparative arrangements for the patient, preparative arrangements in the OR, surgical hand washing and disinfection of the operating spot, covering the operating spot, using modern prevention garments for the surgical team, aseptic working method, professional maintenance of instruments after the procedure and an adequate air-conditioning in the operating rooms.

#### **Purpose**

The purpose of this article is to show which procedures from the wide range of activities that nurses have, can help prevent surgical infections.

#### **Aims**

The aim is to ascertain if the operating room nurses carry out the preventive measures in accordance with regulations.

#### **Methods**

Anonymous questionnaire.

#### **Results**

The questionnaire showed that the preventive measures are carried out in accordance with regulations. Certain fields in which it came to slight deviations were exposed with the questionnaire and statements found in medical literature on reasons for surgical infections were confirmed.

#### **Conclusion**

We, nurses perform our work professional and according to standards. We are aware of importance of prevention. Constant education, analytical approach to mistakes and creation of conditions for their suppression help to achieve the best possible prevention.

Key words: surgical infections, operating room, operating field.

## *Poster Presenters & Abstracts*

### **‘Perioperative Cares. The Excellence In Taking Care Of.’**

**M<sup>a</sup> D. Varela Curto; M<sup>a</sup> L. Sanjurjo Gómez; A. Lamata Martínez; F. Blanco García.**

**Operating Room Nurses. CHU Juan Canalejo. A Coruña-Spain**

#### **Introduction**

The nursing cares that are carried out in the operating rooms of urgencies have different characteristics from those from the rest of the operating rooms, because they are developed in very adverse conditions due to the complexity of the environment and the great diversity of taking care of pathologies.

The nursing professionals must be prepared to undertake, in a fast and simultaneous way, the valuation of the situation that allow us to identify and prioritize the problems, to make a planning of the cares, to execute the activities and necessary techniques and finally to evaluate the achieved results.

#### **Objective**

- To achieve a greater quality of the cares
- To achieve an excellent professional practise.
- To achieve a guarantee of security as for the patient as for the professional.

#### **Material And Methods**

For the elaboration of this planning of cares a valuation of the necessities was made according to the model of Virginia Henderson, defining the Nursing Diagnostics (ND) in conformity to the taxonomy of NANDA (North American Nursing Diagnosis Association).

The Nursing Diagnosis was identified: Traumatism risk, risk of alteration of the corporal temperature, anxiety risk.

#### **Results**

The operating room nursing staff receives to the patient guaranteeing the maximum conditions of security and comfort.

#### **Conclusions**

The urgency is a phenomenon that demands rapidity, which entails the imperative of making organized and effective cares in order to achieve the wished objectives.

The planning of the activities with its correct registry in the nursing sheets is essential for the achievement of the wished results.

## *Poster Presenters & Abstracts*

### **'Empowering patient education – developing and evaluating computer-based simulation program'**

**Virtanen Heli, Salanterä Sanna, Heikkinen Katja, Johansson Kirsi, Leino-Kilpi Helena.**  
University of Turku, Department of Nursing Science, Finland.

#### **Introduction**

Patient education is an essential part of nursing. However, studies indicate problems both in content and methods of patient education.

#### **The aim of study**

is to develop simulation program and evaluate the effect of the program on learning of empowering patient education. The ultimate goal is to improve nurse students' readiness to empowering patient education.

#### **Study design**

In the computer-based simulation program the focus is to mimic the reality of ambulatory surgery patient education situations. The program is designed to demonstrate the assessing of different ambulatory surgery patients's learning needs, as well as implementing and evaluating empowering patient education.

The study will be conducted in three phases. In the first phase the content of the program will be created based on systematic literature review. In the second phase of the study the content and strategies of the simulation program will be evaluated using the Delphi-technique. A sample of experts of educational technology, experts of nursing science and nursing teachers and students (N = 80) will be as informants. This data will be analysed by qualitative content analysis and statistical methods. In the third phase of the study the effect of the program on readiness to empower patients will be evaluated using a quasi-experimental study design. The sample consists of Finnish nursing students (N = 50–100). The data will be collected using a questionnaire based on earlier phases and video recording. The data will be analysed using statistical methods and content analysis technique.

The study shows the effect of instruction methods in nursing education. The results of the study can be utilised in developing nursing students' readiness to offer empowering patient education.

Keywords: empowering patient education, simulation program.

## *Klinidrape Winner 2006*

Name: Catherine Tierney

Country: Ireland

Occupation: Nurse

Affiliation: Project Manager, Pre- Registration BSc Nursing and Midwifery Programmes, University of Limerick.

Registered General Nurse, Registered Midwife, Post Graduate Diploma in Specialist Nursing-Perioperative, BSc in Nursing Studies (Hons).

Currently undertaking a Master of Science through Research and Thesis.

### Abstract

The aim of this phenomenological research study is to explore peri-operative nurses experiences of cadaveric organ donation.

A review of the literature highlighted the vital role peri-operative nurses play in relation to cadaveric organ donation and many concerns that warrant further research. The gaps within the literature included a lack of up to date research on many aspects of cadaveric organ donation, especially regarding peri-operative nurses and their experiences.

The peri-operative nurses role in relation to cadaveric organ donation needs to be urgently addressed, as cadaveric organ donation has moved rapidly from legend to reality (Legge, 1997).

I am conducting a phenomenological study exploring peri-operative nurses experiences of cadaveric organ donation. The objectives are to:-

- Gain an in-depth understanding of peri-operative nurses' experiences of cadaveric organ donation in Ireland.
- Establish factors both extrinsic and intrinsic, which impact on peri-operative nurses' experiences of cadaveric organ donation.
- To discover if the findings from the proposed research study are compatible with current research findings from overseas.

# *The EORNA Klinidrape Perioperative Nursing Foundation Session*

## *Presenters Biographies & Abstracts*

Name: Maria Daoussi

Country: Greece

Occupation: Operating room Nurse

I am a RN Nurse. I am working as Operating room Nurse for 16 years. I graduated from Technology Education Institute of Athens.

Name: Nick Grassos

Country: Greece

Occupation: Operating room Nurse

I am a RN, PhD Nurse. I am working as Operating room Nurse for 16 years. I graduated from University of Athens and I performed my PhD in Medical school of Athens.

### **Theatre discipline. A comparison between operating theaters in Greece and Great Britain.**

Nick D. Grassos, RN, PhD; Maria S. Daoussi RN.

General Hospital of West Attica, Athens, Greece

Department of Surgery

AIM: The aim is to examine policies and practices in Greek versus Great Britain operating departments.

MATERIALS: Data collected from 22 operating theatres in Greece with direct observation. Results compared with these of Madhavan's study (Madhavan et al. 1999).

Data collected and examined are as follows:

1. Staff allowed leaving theatre in theatre attire and returning without change.
2. Staff wearing full theatre attire inside theatre.
3. Staff bringing patients to theatre change in footwear required inside and outside the theatre
4. Staff bringing patients to theatre was other than the staff of theatre areas.
5. Female personnel allowed to wear dresses.
6. Staff not required to report potentially infective personal problems.
7. Separate trolleys inside and outside theatre.
8. Theatre shoes cleaned less often than once a week.
9. Table, instrument trolleys and floor were cleaned between cases.

METHOD: Descriptive statistics and statistical analysis with Z-test.

RESULTS: Statistical significance ( $Z > 1,96$  and  $p < 0,05$ ) found to female personnel allowed wearing dresses and staff not required to report potentially infective personal problems.

CONCLUSION: There are not substantial differences between Greek and Great Britain operating departments. Slackness or lack of discipline found both of them. Discipline, education and supervision need to be put into practice in every policy and procedure in theaters.

# *The EORNA Klinidrape Perioperative Nursing Foundation Session*

Name: Groulard Christiane

Country: France

Occupation : Surgical executive (registered theater nurse) in the gynaecology and urology department at Necker Hospital (Paris)

Affiliation: UNAIBODE/AIFIBODE

Thirty years experiment in the operating theatre

- Member of the Commission of the Standards' reading at Gmed (Medical equipment test laboratory group).....
- Member of the Commission for conformity of the operating tables at LNE ( National testing and measurement laboratory).....
- Member of the preparatory technical Commission for Medical Devices tenders

CHU Necker :

- public hospitals (adults and children) with 672 beds (46 in urology and 30 in maternity).
- Operating theatre activities : 3 urology operating room, 1 delivery operating room, , 1day surgery operating room.
- Activity in maternity of level III (pathological pregnancies, Caesareans in emergency). 329 caesareans done in 2004.

CHU Necker depends on the AP-HP group.

The starting point of the project was to improve the welcome conditions of the patient while being more available to answer his questions before the operation

By proposing the custom procedure trays, the surgical staff is less stress, has more time to concentrate on patients.

In case of reduction of staff, or resort to the temporary staff, work is facilitated.

Instructions on the trays to be used are given. The opening of only one convenient sterile tray facilitates handling. There is also less risk of forgetting an item or selecting the wrong one.

How was carried out the project

It was necessary :

- to bring together different persons in charge for disciplines of various hospitals, to imply the surgeons, the pharmacists,
- to find common denominators
- to optimize the use of the procedure trays
- to observe the procedures imposed by the Code des Marches Publics,
- to create protocols

The solution of custom procedure trays enable to face emergency situations (with good quality components)

The budgetary aspect :

- With the price per intervention principle (T2A), it will be necessary to take care of the coding of all the components and surgical interventions to respect the allocated budget. Easier trace-ability for all components of the procedure trays is a factor of undeniable assistance.

# *The EORNA Klinidrape Perioperative Nursing Foundation Session*

**Name: Alvisa Palese**

**Country: Italy**

**Occupation: Associate Professor in Nursing Science**

**Affiliation: Udine University, School of Nursing**

**Short Professional Background:**

Associated Professor in Nursing Science at Udine University from October 2005.

Diploma in Management and Teaching of Nursing Science, Padua University (1994).

Bachelor in Nursing Science, Padua University (2002).

Registered Nurse in the Nursing College of Tolmezzo, Udine (1987-88).

Research activities

Component of the Nursing Research Unit of the Mario Negri Pharmacological Research Institute from 2000.

Member of the Steering Committee of the PARI-Group (Percorsi Assistenziali e di Ricerca Infermieristica) Istituto Mario Negri (Milan).

Member of Research PARI-ETLD research project – multicentre double blind randomised trial on the effectiveness of treatment of pressure sores (still ongoing).

Member of Research PARI Farmacovigilanza – Patient problems and interventions in Residential and Community Care.

Member of the “European Working Group on Nursing Research” (NL) from 2003.

Responsible of the follow research projects with grants

1) The efficacy of learning strategies on the student nurses clinical reasoning, Udine – Verona University.

2) The experience of the first assistant nurses during awake craniotomy, Udine University.

Responsible of the research project ‘The impact of Nursing Care Models in Medical Wards’ (Agenzia Regionale alla Sanità, Friuli Venezia Giulia) from 2005.

Special research interest 1) patients with neuro-surgical and neuroscience problems’ specially, undergoing craniotomy for the removal of neoplasms in an awake state following mapping of the motor and language areas of the brain; 2) patient discharge and education.

## **Teaching/academic activities**

Nurse Teacher from 1989 to 1994 at School of Nursing Tolmezzo (Udine).

Lecturer of Nursing at Scuola Universitaria per Dirigenti e Docenti di Scienze Infermieristiche from 1994 to the year 2001.

Lecturer in Clinical Nursing in Elderly and Chronic Care at the Bachelor of Nursing Science, Udine University (from 2002) and Verona University (from 1999).

Lecturer in Nursing Management at the Bachelor of Nursing Science, Udine University (from 2002) and Verona University (from 1999).

Lecturer in Nursing Management at the Master Course for Chief of Nurses, Udine University (2004), Ancona University (2003) and Verona University (2003).

Lecturer in Nursing Research at the Master Course for Chief of Nurses, Trieste University (2005) and Brescia University (2003).

Lecturer in Continuing Education Course ‘Therapeutic education and counselling to the patients’ (from 2001 to 2003, Cittadella – Padua).

Lecturer in Continuing Education Course of ‘Evidence Based Nursing’ (2001; and from 2004- 2005, Trieste);

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Lecturer at the International Nursing Research Conference (Cambridge, UK 2004).

Lecturer at the Nursing Foundation Studies Conference, (Glasgow, UK 2004).

Member of the Scientific Board of “Master level on Tutor strategies for educators, Verona University (from 2002).

Component of the Scientific Board of “Corso di laurea Specialistica in Nursing Science” Udine University (from 2005).

International Erasmus /Socrates Coordinator at Udine University from 2002.

## **Other activities**

Reviewer for the Scandinavian Journal of Caring Sciences – (SJCS, Blackwell Pub, UK) from 2005.

Reviewer for the Worldviews on Evidence Based Nursing – (Blackwell Pub, UK) from 2005.

Reviewer for the Nursing Education Today (Elsevier Pub, Salford UK) from 2004.

Reviewer of the International Council of Nurses, International Classification for nursing Practice (ICNP) from 2002.

Member of the Scientific Board of “Assistenza Infermieristica e Ricerca” from 2000;

Member of the Scientific Board of “Rivista dell’Infermiere ” from 1994 to 2000;

Member of the Scientific Committee of the Journal “Tutor, Attualità, proposte e ricerche per l’educazione nelle scienze della salute” from 2003.

Visiting professor in McMaster University (CA), Edinburgh (UK), Postgrumn (N), Andorra.

Expert on nursing education problems charged by Minister of foreign affairs (Ministero degli Esteri) in Beyrouth (Lebanon), 2003.

Systematic Review Course, Evidence Based Health Care Master Degree, Oxford University (UK)

Department on Continuing Education, 2005.

Qualitative Research Methods Course, Evidence Based Health Care Master Degree, Oxford University (UK) 2003.

**Publications** :More than 120 publications.

## **The experience of theatre nurses assisting with an ‘awake’ craniotomy: a phenomenology study.**

Palese A\*, Infanti S\*\*.

\* Professor in Nursing Science, Udine University (Italy)

\*\* RN, MS, Udine University (Italy)

## **DISCUSSION**

Surgery is normally carried out on an anaesthetised patient in the neurosurgical operating theatre. This is the reason it is interesting to find out how the instrument nurses feel when they are looking after a patient having an awake-craniotomy, where the results of surgery very much depend on the patient’s collaboration. The fact that emerged was that the feelings of the nine first-assistant nurses appeared to be based on one vital process: the extension of their primarily technical role to one centred on the patient.

The nurses interviewed maintain that assisting with awake-craniotomy surgery is as emotionally draining and stressful as assisting with surgery for a cerebral aneurysm, although for different reasons. The factors that determine stress do not seem to mirror those that have already been documented for staff working in operating theatres, such as relationship conflicts (between professional and non professional staff), organisational problems, availability of resources, or the workload (Santamatia et al 1998, Snape et al 1993; Vickie et al 2001). The element that increases the nurses’ stress levels is correlated to the patient’s reactions, his comfort and his ability to collaborate. The nurses interviewed declared caring to be their main function, this was also documented by Burchiel (1995); their methods of caring for the patient during surgery enrich the list already compiled by McNamara (1995).

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The extension of the nurses' role makes them feel responsible for the patient's personal comfort and for offering reassurance, to reduce his/her anxiety levels which, as documented by Dropkin (2001) are extremely high in those undergoing cranial surgery. Successful collaboration can only be guaranteed when anxiety is kept under control: the nurses use many strategies to support the patient in this quest, demonstrating that they are very perceptive to the patient's needs which is not the case in reports regarding the nurses concerned with pre-operative preparation (Biley 1989 and Novaes et al 1999). The theatre nurses ask the patient how he feels and explain what is being done even if this is typically the duty of the circulating nurses or the anaesthetic nurse who has the opportunity to get to know the patient before surgery (Radwin 1995). This probably introduces an element of confusion in the roles of the various operating theatre nurses (Gillette 1996). The duty of the first-assistant is oriented to communication with the patient: the other operating theatre staff, instead, are limited to using gestures or facial expressions to prevent using words which may be misinterpreted by the patient. The need to interact with the patient emerges particularly when he/she is not able to understand what the neurosurgeon has asked him/her to do. These nurses assume the role of intermediary between the surgeon and the patient which is one of their duties but is not a typical requirement in operating theatres. Comparing the strategies documented by Teasdale (1995), used to reassure patients, the nurses interviewed appeared to allow themselves to be close to the patient and a point of reference for his emotions and were able to help him/her resolve any problems arising during surgery. Further study to understand this strategy and assess its effectiveness on the patients would be interesting. From the technical point of view, instrumentation does not seem complex but the actual operating area is very limited. The patient's face has to remain partly uncovered to allow him/her to breathe normally and so that he/she does not feel smothered. The nurses have learnt to work in a reduced space with sophisticated high-tech instruments and to work well with the numerous staff involved in the operation. Only when they have had experience with this procedure, can the nurses focus on the needs of the patient, assist in reducing the operating time and anticipate the surgeon's demands.

For this reason, as documented also by other authors (Silen-Lipponen et al 2004) they prefer to work with an experienced team that gets on well: they have a considerable amount of difficulty working with inexperienced staff because they have to verbalise demands and supervise the inexperienced nurses' activities (Johnston 1999), taking attention away from the patient. Probably, concentrating on the patient alone and on his reactions, is the principal coping strategy used by the nurses interviewed (Gillespie 2004).

This operation offers the opportunity of experimenting on deep emotions. The nurses who were interviewed felt tense at each stage of the surgery and agreed that cortical stimulation was one of the most critical moments, either because of the risk of complications (epileptic crises) or because of the obvious emotional involvement that accompanies it. The nurses felt most satisfied when the patient was able to interact and contribute to the procedure, but had negative feelings and feelings of regret when participation was less than optimal, taking it almost personally. This factor also enriches the roles of the first-assistant nurses who can verify the results of surgery whereas the surgeon can only do so during follow-up in the ward.

### **Conclusions and implications for practice**

The study describes the real experiences of a group of nurses in the operating theatre looking after patients undergoing awake-craniotomy surgery. Results were obtained using qualitative research methodology not allowing generalisations. Nevertheless, considering the few centres that have developed this technique in Italy and the fact that nothing has been documented in literature about how the instrument nurses feel during this type of surgery, it was interesting to develop the study to add to operating theatre nursing knowledge.

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### **What emerged:**

- a) Instrument nurses experience an extension of their role in regaining a rapport with the patients. They concern themselves with the patient's comfort and his/her anxiety levels: they use many methods of reassurance to lessen anxiety and they feel responsible for the patient's interaction. The emotional involvement with the patient adds to the nurses' technical competence, in which they feel better prepared;
- b) The participants found that the duties of the first-assistant increased to also include those duties typical of the circulating nurse or the nurse assisting the anaesthetist. This could generate a conflict of roles within the operating theatre which needs to be confronted.
- c) The nurses felt the need to work with an experienced team so they could continue to give their attention to the patient and to the techniques used. This pre-requisite prevents the placement of new graduates, or nurses who are experienced in other types of surgery, requiring a new design for the career path and placement ad hoc of neurosurgical theatre staff.
- d) The nurses are very tense throughout the operation, but even more so at the stimulation stage with fears of an epileptic crisis: in spite of the stress, they say this type of surgery is one of the most fascinating carried out in the neurosurgical operating room.
- e) The nurses are very emotionally involved and treat the patient's difficulties as their own. Greatest satisfaction comes from success of the operation from a technical point of view and from the participation of the patient. The nurses are also able to have feedback on the results of surgery.

Being the first assistant for awake-craniotomy surgery is not only hard work from an emotional and a technical point of view, but also in participation in the team. The nurses interviewed gained their experience working in the field. Sharing their experiences with nurses from other countries who are involved in the same area, would be invaluable.

### **Acknowledgements**

The authors thank the nurses who participated in the interviews and so generously gave up their time. Thanks also to Antonella Palese for her advice and suggestions in preparing the manuscript; Mölnlycke Health Care, Klinidrape, and AICO for supporting the project.

## *The EORNA Klinidrape Perioperative Nursing Foundation Session*

**Title:** Techniques used by perioperative nurses in intraoperative dressing.

Authors: Clotet G<sup>1</sup>., Dot I<sup>1</sup>., Chirveches E.<sup>2</sup> , Rosell F<sup>1</sup>., Bigas L<sup>1\*</sup>, Martínez M<sup>3</sup> and collaborators<sup>1</sup>  
<sup>1</sup> Nurse Surgical Unit Vic General Hospital, <sup>2</sup> Nurse Clinical Epidemiological Unit Vic General Hospital, <sup>3</sup> Nurse Infections Group Vic General Hospital

**Introduction:** Perioperative assistance practices should be provided feedback through scientific evidence. Aware of this need, taking into account the incidence of nosocomial infections associated to surgical interventions in our centre, and with the intention of valuing the efficiency in techniques used for dressing performance during the intraoperational, this study was designed with an aim to identify the existing variability in dressing performance during the intraoperative, to assess its efficiency and to standardise different techniques used.

**Material and methodology:** type of study: Prospective transversal study. Study centre: Surgical Unit and surgical hospitalization floors in the Vic General Hospital (Barcelona). Study subjects: Patients hospitalized in the centre to undergo a surgical intervention. Inclusion criteria: Patients older than 18, intervened by programmed surgery on the following specialities: general surgery, obstetrics gynaecology, vascular, traumatology and dermatology requiring a surgical dressing. Exclusion criteria: Patients intervened by ambulatory minor surgery or emergencies, patients intervened of urology, otorrinolaringology or maxillofacial specialities. Variables: sociodemographic and clinical.

**Results:** a 300-patient sample has been collected, input data is currently being entered, and databases and statistical analysis are being debugged. Preliminary results available will be communicated during the congress by means of a poster.

## *The EORNA Klinidrape Perioperative Nursing Foundation Session*

Name: Majasaari, Hilikka

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Paavilainen, Eija, PhD, Professor, Department of Nursing Science, University of Tampere, Tampere, Finland / South Ostrobothnia Hospital District, Seinäjoki, Finland

### **Supporting The Family's Coping In The Context Of An Adult Family Member's Day Surgical Care**

**Background:** An evaluation project was launched in 2005 to measure the outcomes; improvements or setbacks in the family nursing efforts in the day surgical unit of Seinäjoki Central Hospital.

**Aim:** The study to be reported is a description of supporting one family's coping, and a part of a larger evaluation research project designed to evaluate the nursing practice in the day surgical unit.

**Results:** The coping of the family proceeded through the following stages: the family's everyday coping; identification of health-jeopardizing symptoms and seeking treatment; decision-making on day surgical treatment and preparations for the treatment; alleviation of the health problem by the day surgical treatment and the changed, individual coping of the family at home. At home, the preoperative waiting-time and the postoperative difficulties in mobility were stressful. In hospital, the patient received routine instructions, her concerns were listened to, but some decisions were also made on her behalf. Mutual support within the family was important. The staff of the day surgical unit felt that they had succeeded in supporting the family's coping, in spite of limited multiprofessional collaboration.

**Conclusion:** Supporting the family's coping calls for the assessment of each family's individual background and for more extensive collaboration with the family and other professionals.

## *The EORNA Klinidrape Perioperative Nursing Foundation Session*

Name: Anita Rasmussen

Country: Denmark

Occupation: Head Nurse

Affiliation: Ringsted Hospital, at the Operating Ward.

Surgical nurse for 20 years. Head Nurse for 7 years. Two Years at an American Air Force Base in Thule, Greenland. Heart Transplantations on Pigs and Dogs in 1989, training Program. Starting up the first Private Hospital in Denmark, "Hamlet". Working in a Medical Project about Heart Insufficiencies. Registered Nurse Educator. Actual Studies in Prevention of Surgical cite Infections, Hand washing practice for prevention of nosocomial infections and Quality control in Perioperative Nursing.

### **Making a Better Working Environment in the operations ward,through Physical Training.**

"A little project, which gave our personnel the chance to focus on the working environment, through physical training, over a three month period. The goal was to inspire the personnel to start doing something themselves to strengthen the body's motion system, through introduction and testing of different forms of motion training. We must be better to cope with the additional physical demands put on surgical nurses, by the specialization and rationalization taking place in our area of work."

## *The EORNA Klinidrape Perioperative Nursing Foundation Session*

Name: Tórunn Kjartansdóttir

Occupation: Theatre Nurse

Nationality: Icelandic

Registered nurse, specialized surgical nurse with a B.S.-degree in nursing from the University of Iceland. Worked in different chairs as a intendant operating theatre nurse, responsible for various specializations and as a Head Nurs at the Landspítali University Hospital of Iceland. Been the president for the association of perioperative nurses in Iceland. Teaching experience and instructed several lectures in peri-operative nursing and published few articles. Attended several foreign conferences and worked as a operating theatre nurse in Norway, Lund University Hospital in Sweden and for the Foreign Ministry of Iceland in Multinational Integrated Medical Unit in Bosnia.

Name: Arna Sigríour Brynjólfssdóttir

Country: Iceland

Occupation: Theater Nurse

Affiliation: Landspítali, University Hospital (LUH)

1982 Registered Nurse from the Icelandic School of Nursing. 1986 Specialized Surgical Nurse from the New Icelandic School of Nursing. 1998 BSc. in Nursing from the University of Iceland. 2002 Nursing Informatics course from the University of Iceland and the University of Iowa I've been working in the theater at LUH since 1984 in all specialties of operating nursing for longer or shorter periods of time, the longest in a thorax team or since 1991. I am a clinical supervisor for student's nurses since 2005 and designed web pages with educational information for students in the operating room In 2005 I did a survey to evaluate teaching for the nursing students at LUH. To test the reliability of the results, I did the same survey with another group of nursing students in 2006. I've always been very interested in nursing documentation and worked on many projects of this subject. I'm a member of a committee within ISORNA to update recommended practices for counting instruments and sponges.

Name: Arnfríour Gísladóttir

Country: Iceland

Occupation: OR nurse, team leader in urology.

Affiliation: Landspítali University Hospital, Reykjaví. The Icelandic Nursing School, 1975, Rn. Post graduate course in Plastic and Maxillo-Facial surgery and Burns at Bridge of Earn Hospital, Perthshire Scotland. 1977 Ward sister in the department of Plastic Surgery. Staff nurse in the departments of urology and oncology. Wound management specialist in an out-patient clinic. Post graduate course in OR nursing, 1996 and a B.Sc program at the University of Iceland in 2000. Worked as OR nurse since 1996. Member of ISORNA since 1996. Board member leading the educational committee from 2002- 2005.

This study was a part of an implementation project of standardizing nursing documentation in operating rooms (OR) of Landspítali – University Hospital (LUH). The aim was to introduce Nursing Interventions Classification system (NIC) to nurses working in LUH's operation rooms to facilitate its' implementation. A questionnaire was given to all nurses working in the OR of LUH, to assess participants' perceived importance of nursing documentation and their knowledge of the nursing classification systems NANDA (North American Nursing Diagnosis Association), NIC and NOC (Nursing Outcomes Classification). Researchers chose 47 nursing interventions from the NIC applicable to the study group. Participants were asked to quantify their use of the interventions with a seven-stage scale. The response rate was 76%. Results were that 89% of participants stated use of 20 of the 47 interventions either several times per day or daily. The remaining 27 interventions were clearly divided in practice by specialized team members in the OR. It may be concluded that nurses in the OR find NIC to be familiar and applicable to their practice. Only 2% did not know or understand the definition of a nursing intervention by NIC. These findings are promising when standardizing nursing documentation in the OR's.

# *Industry Symposia*

## **Mölnlycke Health Care – Symposia 1**

We will discuss experiences of MRSA in different parts of Europe/ the world. The aim of the symposium will be to identify commonalities and maybe some methods/ideas that can be transferred from one region to another. The current plan is to have three presenters talk about this subject for about 15 minutes each and then we will have about ten minutes for questions.

We have the following speakers in mind, but we haven't booked any of them yet:

- Ann Folin, Clinical Nurse, Mölnlycke Health Care
- Angela Kearns, Health Protection Agency in the UK
- Carolyn Twomey, Mölnlycke Health Care in the US

## **Tyco Healthcare – Symposium –Cybersurgery**

Sir Ara Darzi

Division of Surgery, Oncology, Reproductive Biology and Anaesthetics  
Imperial College London

In no other time in history has such a rapid transition to the future occurred. What had been a century of evolution from the Industrial Age to the Information Age has, over the past decade, become a revolution. Laparoscopic surgery, which provided the "wake-up call to the information age" as the leading edge technology, has become the accepted standard of medical practice; now even more advanced technologies promise further improvements in the practice of medicine.

It is interesting, but obvious, that the changes that led to the birth of surgery were contingent on the discoveries that ushered in the Industrial Age. And just as the Industrial Age is waning, so too is the golden age of surgery. The Industrial Age is being replaced by the Information Age, and conventional surgery is being replaced by a host of minimally invasive therapies and noninvasive procedures. Because we are currently in the middle of this transition, it is unclear now how the next generation of medicine and surgery will appear, although trends in the technologies are toward low-power, miniaturized, low-cost yet highly "intelligent" systems that eventually will transform surgery from minimally invasive into noninvasive procedures whose development will depend on the emerging Information Age technologies. Laparoscopic (or minimal access) surgery is not an end-point; rather, it is a transitional phase between the radical approach of "open" surgery and the emerging forms of noninvasive image-guided procedures (Interventional MR).

Now is the time that all of these separate elements that the unit is currently active involved in such as laparoscopic surgery, telepresence, virtual reality, digital imaging, and networking are coming together. This lecture will attempt to highlight some of these advances and potentials for the future.

## **Mölnlycke Health Care – Symposia 2**

Your thoughts – your possibilities! This symposia will be an inspirational symposia for the audience. The speaker is Lasse Gustavsson a former fire fighter who suffered a terrible gas explosion and miraculously fought his way back to a meaningful life. The aim of the symposia is to inspire the audience to better quality of life and not to be caught up in a frenetic race dashing for the next problem to be solved. To give the audience the freedom to understand the possibilities they actually have!

Lasse conveys this message in an unforgettable way while sharing his experiences of the many hospital stays he have had.

## *Industry Symposia*

### **3M Health Care – Symposium -Patient-safety in perspective and a critical view on evidence based medicine**

G.P. Driessen  
Technical Service Specialist  
3M Medical Markets Laboratories

Patient safety is already a topic in healthcare settings since the days of Florence Nightingale.

The importance of patient-safety is also reflected in several presentations during this conference.

The objective of this presentation is to address most of the patient-safety issues in a modern Operating Room setting, and to put the criteria of evidence based medicine used to validate or justify our current practice in perspective

The other objective is to show that the newest information about patient-safety issues and recommended practices to avoid these issues, are often readily available on the internet.

### **Kimberly Clark – Symposium – Attacking Surgical Site Infections**

**Wava Truscott, PhD**

**EORNA 2006**

Surgical Site Infections are more frequent than current statistics reveal. Onset after hospital discharge can easily triple in-house counts. In many ways, the surgical theatre environment, healthcare practices and patient population have changed; most for the better, some for the worst. Our patients are more vulnerable than they were 20 years ago. Antibiotics are less effective than they were. Resources are stretched further now. The cost to healthcare, personal income and familial suffering is rising but it is avoidable. Bringing together significant new findings and dependable old practices can dramatically reduce patient risk and SSI incidence. This course will explore many of these opportunities addressing the pathophysiological mechanisms affecting the patient, recommendations regarding the very successful “bundle” approach for SSI reduction and the importance of scoring the right assessment factors on our SSI report cards.

Objectives:

- Discuss impact of surgical site infections (SSI)
- Explain the components of established SSI predictive indicators
- List recommendations for reducing SSI risk factors

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