

# International Journal of Perioperative Care

The Official On-line Journal of IFPN



**International Federation of Perioperative Nurses**

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*Information for readers: The Journal is designed so that articles may be downloaded singly or you may wish to read them all ( as it is hoped). However, colleagues in all corners of the globe, do not have ready access to the internet at home, or colour printers. The journal team has these readers in mind to promote a truly internationally accessible journal. We hope that you enjoy it.*

## **Introduction to International Federation of Perioperative Nurses.**

The primary reason for IFPN's existence is to enable education in the perioperative speciality to be available to those who could not otherwise access it, and to provide greater understanding of international perioperative practice issues, sharing information amongst the more developed healthcare systems' members. The Federation serves as a dynamic connection for perioperative nurses around the world.

Members of the Federation are perioperative organisations in countries around the world. The Federation represents around 100,000 perioperative nurses globally and is the only perioperative organisation to be an affiliate of the International Council of Nurses. Member organisations send a representative to the annual meeting of the Council of National Representatives (CNR), and communicate regularly using electronic communication to effect business and make decisions between meetings. Membership in the IFPN provides an opportunity for CNR members to network and interact with their colleagues globally, to gain knowledge and participate more directly with the International Council of Nurses [ICN], and to enhance and share their knowledge with perioperative nurses throughout the world to assist in providing the safest, most efficient care to perioperative patients.

The website of IFPN is a virtual resource for members, the wider perioperative community, and those interested in the global perspective it affords. There are further plans to extend its' value to all by the provision of free educational downloads. [www.ifpn.org.uk](http://www.ifpn.org.uk) is regularly updated with new documents and information and currently attracts an excellent number of monthly visitors.

The Executive Board of IFPN consists of officers from member organisations, who represent their country and the global community of perioperative nurses to further the mission and values of the Federation. They usually meet twice in each year in a variety of locations, in conjunction with member organisations' conferences.

Current members of the Executive Board are:

Kate Woodhead, President	UK
James Harrison, President Elect	Australia
Betty Shultz, Vice President	USA
Sheila Allen, Secretary	USA
Lesley Fudge, Treasurer	UK
Margaret Farley, Board Member	Canada
Villi Pieterse, Board Member South Africa	
Kim Hepper, Board Member	Australia

Membership in IFPN and further information is available on the website, and all perioperative organisations are invited to participate via membership to enhance their ability to share information and join the global perioperative community.

## **Current and Future Activities**

IFPN will present educational programmes at the Association of Perioperative Practice [AfPP, formerly NATN] Congress, in Harrogate UK, October 2006 and also at the Operating Room Nurses Association of Canada in April 2007. For further details please visit [www.ifpn.org.uk](http://www.ifpn.org.uk) or [www.afpp.org.uk](http://www.afpp.org.uk) and [www.ornac.ca](http://www.ornac.ca)

Guidelines for developing practice are available as downloads from the website [www.ifpn.org.uk](http://www.ifpn.org.uk) with grateful thanks to the many medical device companies who support us in publishing the guidelines. New guidelines are continuously being written and published, enabling a more comprehensive overview of 'best principles' which are referenced from a wide variety of worldwide texts. Look out for new guidelines in October 2006!

IFPN has published in the last twelve months, an International Code of Ethics for Perioperative Practice. It is available as a free download from the website.

Position statements are being prepared on a number of different issues about which IFPN feels strongly. Recent collaboration with the European Operating Room Nurses has resulted in a joint Position Statement and a joint Guideline for Developing Practice. Further position statements are currently out for consultation with member organisations and will be available soon!

These documents provide our members and the global community of perioperative nursing with guidance to positively impact the care of the patients to whom they serve.

Member organisations will soon have access to the revitalised and refreshed Operations Manual, online! In addition, members have recently ratified a new Constitution for IFPN.

IFPN's support to the development of a perioperative organisation in Papua New Guinea over the last two years may set the framework for further developments around the world. Reports on PNGPNA's activities are on our website. It has been an exciting and rewarding experience to observe perioperative nurses coming together to organise to promote safe patient care. Because of the knowledge gained from this endeavour, a toolkit for the formation of new perioperative organisations is being created. Interested parties should contact IFPN via the website.

IFPN, in collaboration with our CNR and perioperative colleagues, will feature the first perioperative online journal, entitled The International Journal of Perioperative Care. This informative publication will be available at the website to additionally connect our world with articles about the latest innovations, clinical expertise, and issues of importance from around our world. The journal will contain something of interest for perioperative practitioners and other healthcare providers and will be available as a free download at [www.ifpn.org.uk/journal.htm](http://www.ifpn.org.uk/journal.htm).

This dynamic, young organisation provides a forum for perioperative nurses to exchange practices, ideas, and innovations that enrich their personal and professional lives. If you are a perioperative organisation, consider becoming a part of this vibrant group to advance perioperative nursing care around the globe.



Welcome to the first issue of the online International Journal of Perioperative Care! I hope that this will be the first of many such issues, that we can all share, to promote developments and exchange expertise around the globe, in our special area of care.

Nursing is such a dynamic profession with technological and research benefits constantly impacting our practice, that at times it is difficult to keep pace with everything! By sharing our developments, as widely as possible within our professional perioperative community, we can magnify and provide catalysts for change in other places. This, in the context of the International Federation of Perioperative Nurses (IFPN), is core to our motivation and mission.

The International Federation of Perioperative Nurses is delighted to provide the forum for the first international journal of perioperative care and it is hoped that it will become a key source of information and sharing for perioperative nurses. My sincere thanks must go to all the authors who have patiently waited to see their work in print and also to Kathryn Schroeter for her expertise in helping to get this issue ready for publication. I would like to echo her call for further submissions and would encourage you all to write letters and articles for the next issue.

IFPN celebrates the contributions from authors all around the world, mirroring our membership which covers every continent. I would particularly like to draw your attention to the introduction to the Executive Board of IFPN within the journal and to highlight our current activities. We look forward to welcoming more members and invite your enquiries.

Meanwhile, good reading!  
Best wishes

*Kate Woodhead.*

Kate Woodhead RGN, DMS  
President IFPN



Kathryn Schroeter, PhD, RN, CNOR - Editor

Welcome to the first issue of the ***International Journal of Perioperative Care*** - the online journal for the International Federation of Perioperative Nurses (IFPN)!

This journal is designed to explore the similarities and differences of perioperative nursing on a global level. It is also to serve as a forum for sharing and for promoting quality perioperative nursing practice. It will be a vehicle to preserve the vision and mission of the IFPN – which is to actively promote perioperative nursing globally and to support perioperative nurses to work towards globally improving patient care by promoting evidence- based best practice standards, through research and education in collaboration with member organizations.

The driving force behind this online journal has been Kate Woodhead, RGN, DMS, - current President of the IFPN. She has been networking and gathering information for the past year or so in order to facilitate this online journal. She has been most instrumental in getting it up and running. Without her diligence, we would not be reading this information online today!

As your Editor, I would like you to consider submitting an article to us for publication. Even if you have never written before, I encourage you to do so. We are most willing to help you and work with you to get your ideas in print. We are seeking a variety of topics, ranging from education to perioperative practice techniques and tips! Tell us about your training and practice programs so that we may learn from each other. Tell us about issues of concern in your country so that we may develop understanding and support for all of our nursing practice colleagues around the world.

If you have any ideas, activities, programs, research, or educational topics that you would like to share with us here at IJPC, please feel free to contact me by writing, emailing, or phoning. Remember - when we share with each other as perioperative nurses – we become stronger, more enlightened and, hopefully, better patient care practitioners in the surgical environment.

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# Cuttings

*This page is for your topical news and views! Please contact IFPN via the website or send your news direct to the editor, to contribute!*

IFPN supports the current campaign by the International Council of Nurses to instigate an agency at the United Nations for Women.

**Geneva, Switzerland, 13 June 2006** - As the global representative of the world's 13 million nurses, the International Council of Nurses (ICN) is adding its voice to the wide-spread and growing demand for an effective, funded international women's agency, able to redress the unacceptable lack of gender equality worldwide and the exclusion of women from decision making at almost every level. ICN encourages its member national nurses associations to lobby their government representatives and to press the ongoing United Nations Coherence Panel to establish a women's agency as an urgent priority. The Coherence Panel, key in establishing reform of the UN's operational work, is mandated by Secretary-General Kofi Annan to identify how gender equality can be more fully addressed in the work of the UN. As such, the Panel provides a unique opportunity to establish a women-specific agency, with sufficient resources, power and authority to have a real impact on the condition of women and girls worldwide. The Panel will deliver its recommendations to the UN General Assembly in September. *Further information and download available from [www.icn.ch](http://www.icn.ch)*

AORN has announced the imminent retirement of Tom Cooper, CEO and Executive Director of the Association of perioperative Nurses. Paula Graling, AORN President said of his tenure " Tom Cooper was responsible for implementing many key strategies to support perioperative nurses and their patients, including AORN's Patient Safety First initiative and Industry Partners for Patient Safety. Cooper also launched National Time Out Day and played a significant role in forming the Council on Surgical and Perioperative Safety, a consortium of perioperative organisations working together to improve patient care."

Also announced by AORN, the Interim Executive Director is to be Ellen Murphy. Dr Murphy amongst many other influential positions in perioperative practice, was a member of the Steering Group convened to set up IFPN prior to its' launch in 1999.

## Call for Abstracts

Currently, there is a Call for Abstracts for ORNAC conference, prominently displayed at [www.ornac.ca](http://www.ornac.ca) for their conference, dates: April 23-27 2007, submissions due by 15 September 2006.

Also: AORN World Conference in Seoul, South Korea is due to close to Abstract submission for both posters and oral presentations on 1<sup>st</sup> September 2006, and can be found on [www.ifpn.org.uk](http://www.ifpn.org.uk) or AORN website.

## **Perioperative Conference Dates 2006-2007**

Association for Perioperative Practice, Harrogate North Yorkshire, UK 9-12 October 2006.

Perioperative Nurses College of New Zealand, Invercargill, South Island, New Zealand, October 12-14 2006.

Association of perioperative Registered Nurses, Orlando Florida March 11-15 2007

South African Theatre Sisters, Bloemfontein South Africa March 13-16<sup>th</sup> 2007

Operating Room Nurses Association of Canada Victoria British Columbia, April 23-27<sup>th</sup> 2007

World Conference Seoul South Korea October 1-4<sup>th</sup> 2007

*A date for your diary!*

The ACORN National Conference will be held at the Gold Coast Convention and Exhibition Centre, Broadbeach, Queensland, Australia from 21 - 24 May 2008.

*Please add to this information for all perioperative practitioners around the world by advertising your conference dates in the International Journal of Perioperative Care by emailing the editor with your dates or Call for Abstracts notices! We will be pleased to help you increase the global influence of your conference!*

# A-Muses Corner

## The Husband Shopping Center

A "Husband Shopping Center" was opened where a woman could go to choose from among many men, to be her husband. It was laid out in five floors, with the men increasing in positive attributes as you ascended up the floors. The only rule was, once you opened the door to any floor, you must choose a man from that floor, and if you went up a floor, you couldn't go back down except to leave the place.

So, a couple of girlfriends go to the place to find men. First floor, the door had a sign saying: "These men have jobs and love kids." The women read the sign and say: "Well that's better than not having jobs, or not loving kids, but I wonder what's further up?"

So up they go. Second floor says: "These men have high paying jobs, love kids, and are extremely good looking". "Hmmm", say the girls, "But, I wonder what's further up?".

Third floor: "These men have high paying jobs, are extremely good looking, love kids and help with the housework." "Wow!" say the women. "Very tempting, BUT, there's more further up!"

And so again, they go up.

Fourth floor: "These men have high paying jobs, love kids, are extremely good looking, help with the housework, and have a strong romantic streak." "Oh, mercy me. But just think!?!?! What must be awaiting us further on!"

So up to the fifth floor they go.

The sign on that door said: "This floor is just to prove that women are impossible to please. Thank you for shopping and have a nice day!!"

## ANYWAY

People are unreasonable, illogical and self-centred,

LOVE THEM ANYWAY

If you do good, people will accuse you of selfish, ulterior motives

DO GOOD ANYWAY

If you are successful, you win false friends and true enemies,

SUCCEED ANYWAY

The good you do will be forgotten tomorrow,

DO GOOD ANYWAY

Honesty and frankness make you vulnerable,

BE HONEST AND FRANK ANYWAY

What you spent years building may be destroyed overnight,

BUILD ANYWAY

People may need help but may attack you if you help them,

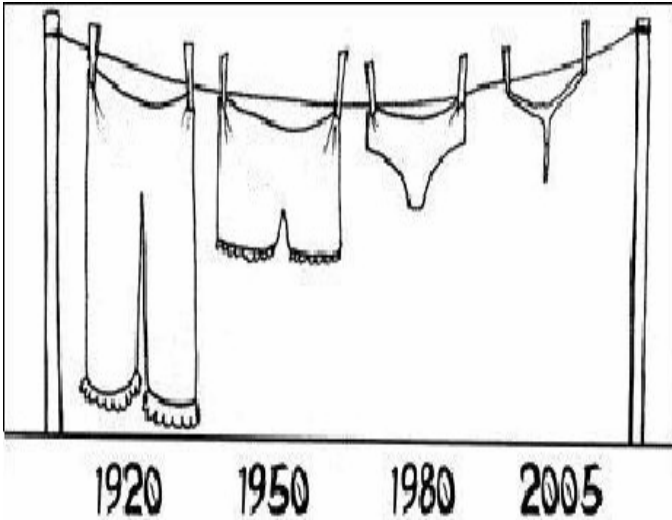
HELP PEOPLE ANYWAY

Give the world the best you have and you'll get kicked in the teeth,

GIVE THE WORLD THE BEST YOU'VE GOT ANYWAY

( from a sign on the wall of Sishu Bhavan, the children's home in Calcutta)

## Proof of Global Warming:



### Double Standards

When you take a long time, you're slow.  
When your boss takes a long time, he's thorough.

When you don't get something done, you're lazy.  
When your boss doesn't get something done, he's too busy.

When you make a mistake, you're an idiot.  
When your boss makes a mistake, he's only human.

When you do it your own way, you don't do what your told.  
When your boss does it, he's showing creativity.

When you do it on your own, you're overstepping your bounds.  
When your boss does it, he's demonstrating initiative.

When you take a stand, you're being bull-headed.  
When your boss takes a stand, he's being firm.

When you violate a rule, you're self-centered.  
When your boss skips a few rules, he's being original.

When you please your boss, you're brown-nosing.  
When your boss pleases his boss, he's being co-operative.

When you help a peer, you're not busy enough.  
When your boss does it, he's a team player.

When someone else does your work, you're passing the buck.

When someone else does his work, he's assigning responsibility.

When you're out of the office, you're wandering around.

When your bosses out of the office, he's on business.

When you call in sick, you're going golfing.

When your boss calls in sick, he must be very ill.

When you apply for leave, you must be going for an interview.

When your boss applies for leave, it's because he's overworked.

When you're seen shopping during work hours, you're a slacker.

When your boss is doing the same, he's picking up office supplies.

When you get a raise, you're lucky.

When he gets one, he really earned it.

When you do a good job, you get a pat on the back.

When he does a good job, he gets a bonus.

*All contributions to A Muses Corner, are gratefully received by the editor!*

## **Supporting victims of domestic violence in the preoperative environment.**

Authors: Cheryl Conroy – RODP, BA, PGCE and Rita. J. Hehir – RGN, RM, BA (Hons), MA, PGCE.

**Senior lecturers Diploma in Higher Education Operating Department Practitioner programme.**

**Edge Hill HEI – Faculty of Health, Aintree Campus Liverpool, England.**

*Note to readers: Victoria Climbié was an eight year old, who died in tragic circumstances as the victim of abuse and neglect. Victoria was seen by dozens of social workers, nurses, doctors and police officers before she died but all failed to spot and stop the abuse as she was slowly tortured to death.*

Historically, domestic violence / abuse was a topic shrouded in silence. The most common explanation for ignoring this unlawful and appalling occurrence seemed to hinge on respect for the sanctity of the ‘the family’. The idealised concept of “perfect” families being the cornerstone upon which to build a “perfect” society is one favoured by politicians of all shades when appealing for votes.

Perhaps the most notable example of this rhetoric being British Prime Minister Major’s rallying cry to return ‘Back to Basics’ and call for ‘self-discipline and respect for the law, consideration for others, to accepting responsibility for yourself and your family, and not shuffling it off on The State’ (Major 1993). ‘Family values’ is a phrase commonly used with the implicit inference that these values are always good and to be replicated throughout society.

The emphasis placed on the balance of power within marriage by the major Christian churches further endorsed the notion that this union blessed by both Church and State invariably led to “happy ever after” if the recipe of love, honour, obey, and ‘til death do us part was adhered to with no outside interference being either welcome or necessary.

Domestic violence is a disturbing and emotive issue. Discussion around this subject gives rise to many responses. Relying on anecdotal evidence these responses include; individuals who consider that it should be left to those involved in a ‘domestic’ to sort out, as quite clearly

some people 'live like that' anyway. Others may argue that inquiry into these areas give rise to witch hunts citing debacles such as the Cleveland Inquiry in 1988, (Pragnell, 2002) and the Orkney Islands child abuse Inquiry of 1994 (BBC, 2006).

Both these inquiries involved the removal of a large number of children from their homes into foster care on the advice of health care professionals and social workers to protect them from alleged further abuse by their parents. The findings of these respective investigations revealed errors, mistakes and misdiagnoses on the part of the health and social care professionals and the wrongful allegation of abuse.

To counter that particular argument, the more recent and tragic case of Victoria Climbié (2001) illustrates the consequences of ignoring or dismissing evidence of violence and harm to an individual presenting as a patient in hospital. There is ample room for the opportunity to support these patients without having to choose between the extreme ends of the spectrum i.e. make instant and potentially incorrect assumptions or ignoring the plight of the patient who may well be too ashamed or afraid to seek any help.

Further, the Department of Health (DoH) and other professional bodies allied to healthcare have established protocols to help the practitioner address this complex issue without compromising the patient's safety or confidentiality.

These protocols were published in March 2000, at their launch the then Public Health Minister, Yvette Cooper stated that: "All health care professionals have the opportunity to identify those who are experiencing domestic violence and take steps to help and support them" (DoH 2000:1). This observation refers to all perioperative care nurses and practitioners who are considered to be front line care providers.

Domestic Abuse/Violence (DA/DV) is said to have occurred when one individual subjects another individual to **ONE** or **MORE** of the following actions: Hitting, pushing, shoving, yelling,

forced sex or forced oral sex, psychological harassment, verbal abuse, isolation, possessiveness - Women's Aid Foundation (2004).

According to the UK Government's crime re-education document (2005), one in four women and one in six men will be a victim of domestic violence in their lifetime, with women at greater risk of repeat victimisation and serious injury and of those suffering four or more incidents, 89 per cent are women. Approximately one incident of domestic violence is reported to the police every minute and an average of two women per week are killed by a current or former male partner. Overall, domestic violence accounts for 16 per cent of all violent crime in the United Kingdom.

So how does this information affect our role and those of our colleagues in the perioperative environment? In 1985, the American College of Obstetricians and Gynecologists (ACOG) began a campaign to screen all women for spousal abuse. Since that time, it has been recognized that abuse can occur in multiple intimate relationships, regardless of age, race, ethnicity, gender, cultural background, socio-economic status, or education. Their findings also noted the following; that a large number of female victims of DA/DV often present with conditions closely associated with Post Traumatic Stress Disorder (PTSD) e.g. – Irritable Bowel Syndrome (IBS). The majority of violence against women by their partners or ex-partners has been found to escalate during pregnancy or in the immediate post partum term. Therefore, many of the female victims of DA/DV presented with a majority of Obstetric/Gynaecological problems and a high proportion are also admitted with facial trauma. Both scenarios may require surgical intervention.

Finally, the literature suggests that women who had experienced childhood abuse, abuse as an adult by an intimate partner or both, underwent a significantly higher number of surgeries and more major surgeries than women with no history of abuse.

Research carried out for an article in the American Journal of Surgery in 2000 stated that health care professionals in the Emergency Department (ED) are 'first responders' and are important in the care of DA/DV patients.

Timely identification and intervention of any suspected domestic violence is important. 35 per cent of all ED visits by women are a result of DA/DV, whether due to acute injury problems or stress-related complaints (Guth and Pachter 2000)

Theatre practitioners, working in Accident and Emergency theatres in the UK, are likely to encounter an array of patients suffering from acute injuries sustained in a recent domestic abuse situation. These patients are possibly just the tip of the iceberg and it is often obvious to all concerned in the care of the patient what the circumstances are. However, there are many patients who present for surgeries both elective and emergency, who may currently or recently have suffered the effects of domestic violence and who may not be suffering from obvious signs of acute injury.

So do perioperative practitioners need to be educated in the management of domestic violence/ abuse victims? The answer is quite simply **YES**. As patient advocates we need to be aware of all their psychological needs, in addition to their physiological needs. An article written for the Association of Operating Room Nurses (AORN 2003) stated that all emergency care staff, inclusive of surgeons and surgical practitioners must be educated regarding presentation and management of DA/DV patients. They also recommended that screening for victimization history in the perioperative setting could aid the facilitation of appropriate intervention (Hastings and Kantor 2003).

This is a useful lead to take from American colleagues who seem to have already adopted a perioperative screening protocol. It is by no means an easy situation for most perioperative care practitioners to handle. If we are honest, most of us would hope that the initial screening of the patient will have taken place on admission and that the necessary 'paperwork' filled in and the

patient given all of the correct advice, regarding the agencies available to help. In most respects dealing with these patients places us outside our comfort zone.

However, in reality this is not always the case. During the initial evaluation, many patients deny past or current exposure to violent situations. Incidents of DA/DV are often **NOT** always disclosed voluntarily by patients. Therefore, DA/DV incidents can be overlooked, unintentionally by those involved in patient care.

Male patients who are victims of DA/DV are even less likely to disclose incidents relating to domestic abuse situations. Approximately 89 per cent (of 100 men interviewed) felt that the police, social services and health professionals, had not taken their complaints seriously (Dispatches UK 1999).

Another social group whom perioperative practitioners encounter in care settings are the elderly. The Community and District Nurses Association U.K. (CDNA 2005) estimate that 77 per cent of violence reported towards elderly people is carried out by a member of the victim's family and 82 per cent of incidents occurring in the victim's home.

Responding to the needs of patients who are or suspected victims of violence requires skill and sensitivity. There is also the issue that many health care professionals could potentially be victims or perpetrators of domestic violence themselves. A rather strong statement to make, however, we as health professionals are members of the wider population. Therefore, aside from being health care providers, generically we are included in the statistical numbers of abusers amongst the population. Although bound by various Codes of Conduct, some health care professionals do not lack the motivation or opportunity to inflict abuse upon those supposedly in their care.

For example, a 54 year-old male nurse from Chell, Stoke on Trent UK, has been removed from the Nursing Register following a recent hearing in London. The nurse, who was learning disability trained, admitted using excessive force to restrain a patient and to verbally abusing the same patient (NMC 2004).

There are a number of do's and don'ts, which apply to supporting patients. **DO** offer support - whatever format that takes – silent physical contact e.g. hand holding or simply listening to a patients anxieties. **DON'T** ask, “Are you abused?” Many patients who have suffered DA/DV

do not see themselves as abused – particularly with first time occurrences and also, many victims of domestic abuse are distrustful of health care professionals.

As this is a topic suffering a poverty of information in the context of perioperative care, a good starting point is to go to the DoH website at [www.departmentofhealth.org.uk](http://www.departmentofhealth.org.uk). Available here are two excellent resources, which (a) demonstrate the implications of domestic violence on the individual who is a victim, (b) the role of all health care professionals be they in community, hospital, residential or acute settings to be able to recognise potential signs of domestic violence and make an appropriate response, and (c) the financial cost to the National Health Service (NHS) both currently and in future terms.

‘Domestic violence: a resource manual for Health Care professionals’ (DoH 2000) is one of these publications. The other - a ‘best practice guidance’ publication - ‘Responding to domestic abuse’ (DoH 2005) is also an invaluable learning resource as it provides very specific guidance on the particular needs of women from atypical backgrounds e.g. women from ethnic minorities, middle class women, sex workers, asylum seekers, women in violent same-sex relationships and older women.

This latter publication also includes names and addresses of statutory and voluntary organisations, which offer advice, support or refuge to victims of domestic abuse.

Two key issues in the management of a victim of domestic violence is confidentiality and a non-judgemental, non-discriminatory approach to care.

The Nursing and Midwifery Code of Professional Conduct: standards for conduct, performance and ethics (2004) demand of nurses that they practice respect for the patient as an individual, and the Code of Conduct clearly states that ‘you must treat information about patients and clients as confidential’.

It goes on in the same paragraph; ‘you must guard against breaches of confidentiality by protecting information from improper disclosure at all times’. (2004:8). Within the culture of some

operating theatre departments this requirement for absolute confidentiality needs to be reinforced from time to time.

The Royal College of Nursing (2004) outlines the need for training to be provided for health care professionals. This training would involve recognition of the signs of domestic violence, reporting of the evidence to the appropriate agency and understanding the roles of the multi – agency network required in response to the victims needs.

On an everyday basis it is not necessary to suspect every bruise, laceration or history of broken bones as indicative of domestic violence. However, as the most recent statistics suggest, as many as 1 in 4 women is a victim of domestic abuse, it might be beneficial to them, if practitioners adhere to best practice and local protocols by ensuring that if the perioperative team in the anaesthetic room is predominantly male, a female chaperone must be present.

### Useful International Websites.

[www.dvirc.org.au/](http://www.dvirc.org.au/)

[www.safehorizon.org/](http://www.safehorizon.org/)

[www.womensaid.org.uk/](http://www.womensaid.org.uk/)

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## Occupational exposure to HIV Infection in Perioperative Practice, its ethics and legal issues.

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### **Background HIV/AIDS**

Blood borne viruses have elicited fear for large numbers of people since the early 1980's when the spread of HIV came to the attention of the worlds' media. In many developed countries where there is easy access to non-curative but effective life restorative anti-retroviral drugs, the profile has largely disappeared - other than the annual prevalence reports. However, the overall issue has far from disappeared.

It is estimated that worldwide, 40 million people are living with HIV/AIDS. In Africa, HIV/AIDS has a disproportionate impact, where some 62% of the world's 15-24 year olds live with HIV. Botswana has a 40% prevalence rate. Nearly 57% of those living with the disease in Africa, are women.

The legacy of this is a huge number of orphans, 12 million in 2003. This number is set to soar to 18 million by 2010. This pandemic presents an extraordinary human, human rights and humanitarian crisis. Average health spending in Africa in 2001 was between US\$ 13 and US\$ 21 and, in the developed world, it is more like US\$2,000 per person per year. (1)

### Uganda

Uganda lies in Africa's Sub-Saharan region. It is a landlocked country situated in the eastern part of Africa, bordering with Kenya to the East, Tanzania and Rwanda to the South, the Democratic Republic of Congo to the West and Sudan to the North.



According to the report of the 2002 national population census, Uganda's population size is estimated at 24.7 million people. Life expectancy at birth was estimated at an average of 43.2 years. Life expectancy without AIDS was estimated at an average of 54 years in 1998.

Literacy rates in 1999/2000 were estimated at 77% for males and 51% for females. The majority of Ugandans (about 87%) live in rural areas where subsistence agriculture is the major source of food and income

Uganda is categorised under the least developed and resource constrained countries in the world. The Human Poverty index was estimated at 37.5% in 2001 with a high proportion of the population without access to health care facilities at 51% of the general population.

The country is, however, perceived to be addressing poverty and making gains in income poverty reduction and primary school enrolment but is still burdened by the health vulnerability due to diseases like HIV/AIDS, malaria and tuberculosis. (2)

## **HIV in Uganda**

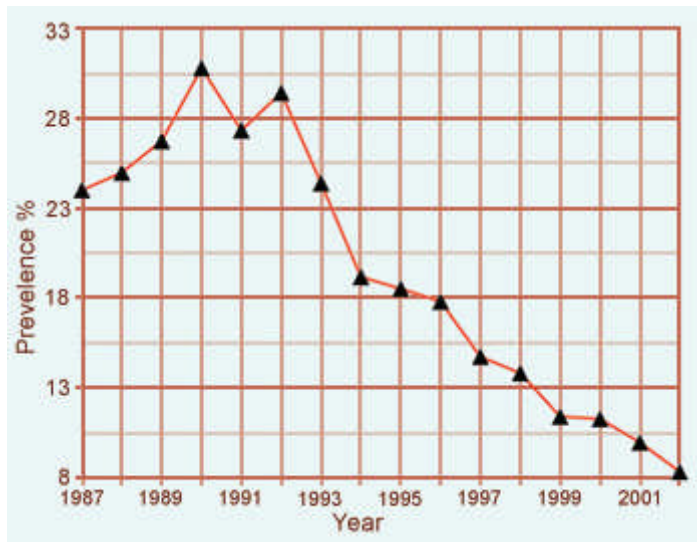
The first HIV/AIDS case was identified in Uganda in 1982 along the shores of Lake Victoria. Superstitions and witchcraft characterised the initial response from communities amidst lack of clear government response to HIV/AIDS. Consequently, the epidemic progressed very fast to a national prevalence of 18.3% with some centres registering prevalence above 30% by the end of 1992. Spontaneous community responses and the inevitable responses from health care facilities were reinforced in 1986 when the new National Resistance Movement (NRM) government established the first AIDS Control Program in Ministry of Health.

As early as 1987, the Government of Uganda recognised that the magnitude and impact of the HIV/AIDS epidemic cut across all sectors of life. The Multi-sectoral Approach to the Control of AIDS (MACA) was developed and adopted in 1992 to ensure a concerted response. This policy and strategy calls for the involvement of everyone, individually or collectively to fight the epidemic within their mandates and capacities at all levels.

The Uganda AIDS Commission (UAC) was established in 1992 to ensure a focused and harmonised response. Uganda's response to the epidemic, spearheaded by President Museveni, has been marked with high political commitment at various levels, openness about HIV/AIDS that enhanced behaviour change, communication interventions, unprecedented support from international development partners; and action from sectors of government and civil society

The response within Uganda to the alarming rise in HIV infections was uncommon amongst sub Saharan countries and as a result, the rapid decline in the number of new infections, is unusual. The spirit of openness led to effective mass communication and information strategy such as the ABC campaign. This is simply described as sexual Abstinence before marriage, Be faithful to a single partner or reduce the number of partners and to always wear a Condom, particularly where there is more than one partner.

The graph below shows the rapid decline, although there has been some discussion about one of the most recent studies, questioning the validity of the data, and thus the claim of such a reduction in prevalence. A study was undertaken by a non governmental organisation and revealed prevalence of 17%, which was nearly four times the rate acknowledged by the Ugandan government whose official statistics showed that, at the end of 2003, only 4.1% of adults had the virus.(3)



The study, undertaken by Joshua Kakuhi, was performed at a busy Ugandan Hospital located on the Uganda border with The Democratic Republic of Congo in Kasese District

### Research objectives

- To determine the awareness among the Nurses and Midwives of the occupational risk of HIV infection in the course of their clinical service delivery.
- To determine how much they are exposed to HIV infected patients and how much they are exposed to potentially infectious fluids like blood from their patients.
- To evaluate awareness and compliance with universal precautions.
- To assess awareness on ethics and legal implications with HIV infection

The design of the study to achieve the objectives was determined to be by a questionnaire which would be given to Theatre Nurses, Midwives and Clinicians involved in routine invasive procedures and patient care.

### Introduction

Nosocomial HIV transmission was a particular worry for many health workers in low income countries, such as most African countries. The question was: why this should be the case.

In sub-Saharan Africa the rate of HIV infection has been devastating the populations of many countries, with unprecedented economic and social consequences. In Uganda, the prevalence of HIV infection among patients cared for is high, 7% Uganda and 15-16% Zambia.

In addition, many new health workers (newly qualified Nurses, Midwives, doctors) are relatively inexperienced, due to attrition, to HIV. Healthcare workers were also seeking higher standards of living by re-locating to “greener pastures”.

Many of the countries worst affected by the HIV epidemic are countries that also lack the resources to implement Universal Precautions adequately, thus raising the risk of occupational exposure.

Poor or inadequate equipment and facilities are much more often encountered in developing countries added to which the pressure of work and work load means that precautions are often not taken.

The risk of acquiring HIV infection following exposure by any of the different ways of HIV transmission has been estimated as follows:

<b>Type of Exposure</b>	<b>Risk of HIV Infection</b>
Mucous Membrane contact	0.09%
Penile vaginal intercourse	0.1%
Anal intercourse	0.5%
Sharing needles	0.7%
Percutaneous exposure to healthcare workers	0.3%

*Note: These values are subject to modification by the prevailing conditions at the time of exposure*

### **Healthcare Workers Risks**

In caring for patients with HIV, health care workers are exposed to HIV in any of the following ways:

- Needle prick injuries
- Cuts from other sharps
- Fluid splashes to mucous membranes.
- Fluids splashes to broken skin.

All the above are commonly encountered in perioperative nursing and surgery.

Other studies identifying the specific risks, usually involve studying surgical teams and particularly the surgeons. A study reported in the British Medical Journal, reviewed nosocomial HIV exposure in a rural district hospital in southern Africa. 25% of all patients attending for antenatal care were positive for HIV. Most medical staff were reported to be relatively junior doctors from Europe spending a year or more doing general medical duties, including surgery and obstetrics, that regularly expose them to blood and other body fluids. The findings from this study found that the doctors were exposed to 0.75 exposures per doctor per year. All incidents were considered serious as each was percutaneous, involving a bloody needle drawing the healthcare workers own blood.

Three doctors were exposed while using faulty or incorrect equipment for an operation or resuscitation. In two cases inexperience contributed to the exposures, which occurred during routine operative procedures. All staff took post-exposure prophylaxis and sero-conversion did not occur in any. (4) A further study specifically undertaken in a rural Zambian hospital, found the frequency of exposures not to be unusual.

A group of five Dutch doctors working in Africa, reported an annual average of five needle stick injuries. They estimated the risk to acquiring HIV infection through their work was 1.5% over five years.(5)

### **Methodology**

Data were collected via self-administered questionnaires with structured and open ended questions. Interviews were carried out to determine further key information and in addition the researcher undertook visits to the units and departments where invasive procedures are done. The researcher identified that the limitations of the study were the small sample size and the short duration of the study.

## **Findings and results**

All 50 questionnaires were returned by the 50 respondents (100 % response), which for a study of this kind was exceptional. All respondents (100%) identified that they are in contact with HIV positive patients and all were aware of the risk of HIV infection in their clinical service delivery. Forty, (80%) of the respondents believed that there is no policy of screening the patients, or having patients classified as HIV positive or negative and so all patients are handled the same way. Everyone responded that the highest exposure was in operating theatres, followed by labour suite.

All respondents said that personal protective equipment such as gloves, aprons, face wear (masks and visors or goggles) reduce the risk of infection if used correctly. Three quarters, 75% responded that they washed their hands or any other body surface after exposure to infectious materials immediately. While 70% have had an accidental prick or cuts while dealing with patients but interestingly the incidence decreased with the more experienced. The immediate reaction in such instances was removal of gloves, washing with a lot of water, and soap, then disinfecting with commonly sodium hypochlorite and chlorhexidine.

While 80% said they were familiar with universal precautions, only 30% said that universal precautions should be used for all patients, rather than just HIV infected patients, indicating a fundamental misunderstanding of the policy.

More than half, 60% said they were aware of the current guidelines that health workers who are HIV positive are advised to inform their employer, if considered to be of 'no risk' to patients the person concerned can continue working. However, they concurred that most don't report their status for fear of losing jobs without compensation even when they contracted HIV in line of their duty.

Half of the respondents did not know what the hospital has to offer after injuring themselves and of those aware, 20% (5) say post exposure prophylaxis is not easily accessible. Only 4 respondents had bothered to have an HIV test after needle prick of any kind and also bothered to know the HIV status of their patients after injury.

## **Discussion**

Are governments and other organisations that recruit and employ nurses, midwives and other health workers under any legal obligation to provide cover for occupational health hazard such as needle stick injuries?

How many health workers can prove that they did not acquire HIV through the most common route, via sexual intercourse? In Britain for example, anyone exposed to HIV in a work setting would expect to have immediate access to prophylaxis.

## **Conclusions**

All health workers are exposed to nosocomial HIV infection. Risk is much higher in departments carrying out invasive procedures mainly operating theatres. There is insufficient protective gear in place for surgical teams to prevent accidental exposure – in some areas reported in this study.

Needle prick injuries are common in perioperative environment and that most staff do not make a report.

Post exposure prophylaxis policy is not well explained or implemented.

HIV positive health workers do not inform their employers for fear of losing their jobs.

The risk increases with a number of risk factors but most of the exposure can be prevented by

- Adherence to universal precautions.
- Proper training
- Improved equipment design.
- Post -Exposure prophylactic treatment.
- Continuous HIV Surveillance programme.

Grateful thanks are extended to the staff and clinicians of Bwera Hospital for assistance with this study.

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## **Setting the standard: the role of the Australian College of Operating Room Nurses**

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This paper describes a portion of an evaluation of the Australian College of Operating Room Nurses (ACORN) that was conducted in 2003. The fundamental aim of this evaluation study was to identify the role of ACORN and determine if it was perceived by perioperative nurses to be an effective organisation<sup>1</sup>. The paper presents the background to the research and reports the results that answered the first research question, about the role of ACORN.

### **Introduction**

ACORN was formed nearly three decades ago with its focus being improving and standardising perioperative nursing care and educating/supporting perioperative nurses. ACORN's mission statement is to 'represent perioperative nursing' and the organisation undertakes a range of activities to accomplish its mission. For example, the *ACORN Standards, guidelines and policy statements*, which were first published in 1980, have been regularly reviewed, revised and updated ever since its' inception<sup>2</sup>. In addition, ACORN conducts other activities such as organising a conference biennially and publishing the ACORN Journal, to name but two.

In Australia in 2002, there were 15,257 registered or enrolled nurses (7.6% of the total nursing workforce) employed in the operating suite, with about 3000 being members of ACORN via membership of their state or territory perioperative nursing association<sup>3</sup>. These state and territory organisations are branches of ACORN but retain their own integrity and independence of action<sup>4</sup>

Perioperative nurses have a role that many other nurses see as highly technical and task focused. Even patients are often unaware of a nursing presence during surgery<sup>5</sup>. Yet competent, well-educated perioperative nurses are believed crucial for patient care to ensure good surgical outcomes. Further, perioperative nurses in Australia govern their own practice and, as a group of specialist nurses, act to construct knowledge that informs practice on a wider professional level<sup>6</sup>. But still they remain invisible and some doubt exists as to whether perioperative nursing can even be considered nursing<sup>7</sup>.

It has been suggested that perioperative nurses themselves fail to understand their roles<sup>8</sup>. This perspective is strengthened by the realisation that many patient care activities, previously the purview of perioperative nurses alone, are increasingly being completed by other categories of health care worker such as technicians<sup>7,9</sup>. However, these technicians, in contrast to nurses, are

generally unlicensed and unregulated. Further, and notwithstanding the ever more diverse nature of perioperative staff, the significance of a nursing presence during surgery, in terms of nurses' ability to ensure safe outcomes for patients is being increasingly identified<sup>10</sup>.

The disciplined practices and knowledge that guide perioperative nursing practice and which aid patient safety are underpinned by professional standards. These, amongst other things, help distinguish perioperative nurses from other categories of health care workers in the operating room.

### **The study of ACORN**

The study of ACORN was important for two reasons. Firstly, there is an increasing demand for competent, well-prepared perioperative nurses, and ACORN purports to represent perioperative nursing. An examination of the organisation clarified how ACORN achieved this representation. Secondly, there has been no previous attempt to examine ACORN systematically. The nearest to this was the '*The History of A.C.O.R.N.: from little A.C.O.R.N.'s grow*' (sic)<sup>2</sup>. An earlier board of ACORN commissioned the writing of ACORN's history and the document provides a linear view of the organisation and its growth over time. In contrast, this study attempted to identify the role and effectiveness of the organisation and from multiple perioperative nurses' perspectives. In particular, it sought to establish if there was a perceived relationship between various ACORN activities and the delivery of perioperative nursing care and surgical patient outcomes. In doing so, it attempted to establish the validity of those activities. The first question to be answered by this research study was:

- What is the role of the Australian College of Operating Room Nurses (ACORN)?

Two other questions derived from this first question:

- Is ACORN perceived to have an effect on nursing practice in perioperative settings?
- Is ACORN perceived to have an effect on patient outcomes in perioperative settings?

### **Research method**

The decision to use a formal model of evaluation as the research method to explore ACORN followed scrutiny of a range of approaches, which are addressed in detail elsewhere<sup>1</sup>. Considered broadly, evaluation is the discovery of the nature and worth or merit of something<sup>11</sup>. Given that ACORN was (and remains) an evolving social entity and because the worth, effectiveness and utility of ACORN were the issues of concern in this research then evaluation as a method to examine ACORN had utility. Organisations can and have been evaluated in the areas of organisational structure, administration and management, morale, effectiveness, planning and following change, and via a cost-benefit analysis previously<sup>12, 13</sup>.

Additionally, the evaluation method chosen needed to consider a number of factors, not least the nature and context of the organisation studied, as well as the ideas and values expressed in the literature. Consequently, the illuminative model of evaluation<sup>14</sup>, which is eclectic, holistic and adaptable, provided the ‘best fit’ for a study of ACORN. Parlett and Hamilton<sup>14</sup> recommend four broad forms of data collection; observation; questionnaires and other objective data; interviews and focus groups; and examination of documents and other background information. The methods used in this evaluation were interviews, questionnaires and documentary and background information. In Table 1 each of the methods used and the research question they addressed is tabulated. It is important to note I was not looking for cause and effect; rather, I was seeing if there was any relationship between the different variables, such as the production of standards for perioperative nursing practice, and what perioperative nurses do and achieve when they base their practice on these standards.

Table 1: How the research activities address the research questions

<i>Questions addressed</i>	<i>Questionnaire for operating suite nurse managers/NUMs-the role of ACORN (NUM questionnaire [Q])</i>	<i>Questionnaire for ACORN competency workshop attendees (competency questionnaire)</i>	<i>Interviews with current and former ACORN board members</i>	<i>Documentary review</i>
What is the role of ACORN?	✓ Parts A, B & F		✓	✓
Is ACORN perceived to have an effect on nursing practice in perioperative settings?	✓ Part C	✓	✓	✓
Is ACORN perceived to have an effect on patient outcomes in perioperative settings?	✓ Part D, E		✓	✓

## **Respondents**

There were three broad groups of perioperative nursing participants identified; I believed they would have special insights or viewpoints. These groups were: all perioperative nurses who had

attended one of a series of half-day ACORN competency workshops offered in 2000 and 2001; a sample of operating suite nurse managers or nursing unit managers (NUMs) drawn from all states and territories; and a much smaller group of current and former ACORN board members. The informants surveyed and the methods of selecting them are shown in table 2.

Table 2: Summary of procedures used to contact participants and criteria for selection

<i>Informants</i>	<i>Method</i>	<i>Criteria for selection</i>
Operating suite nurse managers & nursing unit managers (NUMs)	ACORN Board (2000-2002) approached for support. Contacted by letter, via their Director of Nursing.	Systematic selection using the <i>Australian hospitals directory</i> (ATA, 2001) to identify hospitals with perioperative settings. It included every fifth organisation and was proportional by state and stratified by setting i.e. public or private hospital.  N=220
ACORN members and other perioperative nurses	ACORN Board (2000-2002) approached for support and a list of ACORN competency workshop attendees.  Contacted by letter, sent to their last known place of work.	Must have attended an ACORN competency workshop.  N= 214
Current and former ACORN board members	ACORN Board (2000-2002) approached for support.  Contacted by telephone, letter or email. 'Snowballing'- personal contact with current or former board members, who then recommended others; and via local state or territory perioperative nursing associations.	Current and former ACORN board members, from across the life span of the organisation, in all roles and representing all states and territories.  N=18

### **The study tools**

The *NUM questionnaire* had several purposes. It sought to identify the beliefs of this group of participants about the role of ACORN, and their knowledge and use of the *ACORN Standards, guidelines and policy statements* (2002) (the ACORN standards)<sup>15</sup> and the *ACORN Competency standards for perioperative nurses* (1999) (the competencies)<sup>16</sup>. It sought detailed information

about one standard in particular, *A3-counting of accountable items used during surgery* (2002) (the ACORN counting standard). It also sought information about the nature and incidence of miscounts during surgery in respondents' operating suites. These data were necessary in order to answer each of the research questions. Finally, it sought demographic data about the respondents and their organisations. Two hundred twenty questionnaires were distributed.

The *competency questionnaire* sought to identify if and how the respondents used the competency standards; if they believed the competencies were useful and effective in their own practice and the practice of other perioperative nurses; if they had a positive effect on the nursing practice in their operative suites; and how else they could be used in the future (e.g. for credentialing). The questionnaire also collected demographic data from the 214 respondents surveyed.

A total of 18 current or former board members (about 20% of the total number of ACORN Board members from across the lifespan of the organisation) were approached for an interview; 17 interviews eventuated. This was considered to be sufficiently representative to elicit a comprehensive range of responses as an effort was made to ensure that interviewees were selected from all states, from a variety of roles and from across the life span of the organisation. The interviews provided interviewees with the opportunity to use their personal experience as members of the ACORN board. They were able to explore the activities of ACORN (such as the production of standards and so forth) and how the board functioned during their tenure. As well, they were able to provide an opinion about the effectiveness of ACORN's activities. The questions asked, in part, mirrored what was asked of the NUM questionnaire respondents.

### **Ethics**

In August 2002, the University of Technology, Sydney (UTS) Human Research Ethics Committee (HREC) gave approval for the research project to proceed. In addition, the research was unanimously supported by the 2002-2004 Board of ACORN.

### **Results**

One hundred and twenty eight operating suite managers responded from public and private hospitals in all states and territories out of a total distribution of 247 (54.4%) (this included pilot data). Seven who replied noted that their organisation did not undertake surgery; therefore, they were removed from the original distribution number. Four responses were unusable. Thus the final, usable response rate was 124 (51.6%), which is considered adequate<sup>17</sup>.

Analysis of the data gathered via the NUM questionnaire used descriptive statistics, and included frequency displays and measures of central tendency related to the numbers of operating rooms, amounts and types of surgery completed and length of service of the respondents. Nominal

data, such as ownership of the standards and the competencies or membership of local state perioperative nursing groups yielded categories rather than amounts, and frequency distributions were used to describe such data, and these were expressed as percentages, or graphically<sup>18</sup>. A number of open ended questions sought opinions from respondents about the use of ACORN standards and competencies, the role of the organisation, and issues around the ACORN counting standard; these were subsequently analysed to identify themes. Where appropriate, the results were compared with analyses of data gathered via other methods in this study.

The overall response rate to the survey of 214 perioperative nurses who had attended an ACORN competency workshop was 116 (54.2%). Analysis of the data gathered via the competency questionnaire also used descriptive statistics and included frequency displays and measures of central tendency of items such as years of service of the respondents, and their roles and qualifications. Nominal data, such as knowledge, ownership and use of the competency standards or membership of local state perioperative nursing group yielded categories; these were expressed as percentages or in graph form (Nieswiadomy, 1998).

A number of items sought opinions from respondents about the effect of the competencies on nursing practice and asked them to rate their opinion of a series of statements on a five point Likert scale. Frequencies were determined from this data and results were presented as a percentage and graphically. Open-ended comments about the ACORN competencies were analysed for themes. The results were compared to analysis of similar items on the first questionnaire along with analysis of data generated during interviews that were related to the competencies.

Finally, 17 (mostly former) board members were interviewed during 2003; only two were members of the Board at the time of interview. The transcripts of the taped interviews were analysed for key issues. Consequently, similar concepts or clusters of concepts were grouped together, with the themes beginning to emerge from these. A theme in this case was taken to be a common meaning or idea that ran through the data, or a minority idea that captured a particular emotion or factual idea<sup>19</sup>. These themes were also compared for congruence with data from other sources, namely, open-ended questions on questionnaires. Issues to do with reliability and validity or, more accurately, the rigour or trustworthiness (of qualitative data) remain crucial<sup>20</sup> and were addressed in detail. They are reported elsewhere<sup>1</sup>.

### Discussion

The results reported here address only the first research question about the role of ACORN. Firstly, the NUM questionnaire data are presented, followed by the results of the board member (BM) interview data analysis. Initial analysis of the NUM questionnaire data revealed 15 constructs. However, this number was reduced by grouping constructs which were associated, that

is clustering by conceptual grouping<sup>21</sup> resulting in six themes. Subsequently, these themes coalesced into two broad concepts or domains. These were **the standards** and **a professional body**. These domains are presented graphically in Figure 1, which shows the two domains, the themes within each domain, and the various subthemes. The board member data analysis revealed many similarities with the NUM data.

Figure 1: Domains, themes and subthemes identified by NUM respondents

<i>Domain</i>	<i>Theme</i>	<i>Subthemes</i>
<i>NUM domain one: The standards</i>	Developing or setting standards	Standards for practice
		The competencies
	Perioperative practice	Maintenance of standards or care
		Enhancement of standards or care
<i>NUM domain two: A professional body</i>	Leadership	Representation of perioperative nursing
		Provision of guidance
		Governance or oversight
	Provision of support	Promoting perioperative nursing
		Supporting perioperative nurses
	A resource	Educational activities
		Networking and collegiality
		Research
Political activities	Providing a voice	
	Informing	
	Influencing	

### *NUM domain one: The standards*

The *ACORN Standards, guidelines and policy statements* (the standards) were frequently the first and the most often cited item when the respondents were asked about ACORN's role. For more than half of the respondents it was the only aspect of ACORN's role that was mentioned. Only 19 NUM respondents (15.3%) did not specifically mention the standards. Two themes

emerged within this domain. Within the first theme of ‘developing or setting standards’ were two subthemes. The first was about *standards for practice* in perioperative settings and, in most instances, this was specifically about the ACORN standards. These standards, which are comprehensive, cover many facets of OR practice, including OR design, utilisation, equipment, management and staffing, as well as specific guidelines for the delivery of direct patient care<sup>15</sup>.

Formulating, revising and updating these standards was the role most respondents readily identified with ACORN, for example: “*professional organisation that provides best practice guidelines (our Bible) & policy statements for perioperative settings*” (NUM Q: 91). Many claimed the standards underpinned or influenced day-to-day nursing practice and education in their operating suites; they were the foundation of local perioperative policies and were used as a reference.

While the dominant theme about ACORN developing and setting standards was evident, it was occasionally juxtaposed with the beliefs of a small number of NUM respondents that not all OR staff were motivated to use them. Some commented that their use was limited or they were only used to settle arguments. Sometimes the belief reflected was that ‘the standards don’t apply here’.

The second subtheme was *the competencies*. This term had two meanings. Firstly, this was in relation to the specific ACORN document, *Competency standards for perioperative nurses* (1999)<sup>16</sup>, which was the aspect discussed most often. That ACORN had developed these specialty-specific competencies enhanced the credibility of the competencies and no respondent challenged the validity or usefulness of them. The second meaning referred to the competency of perioperative nursing staff. For many respondents ACORN’s role was to help them develop competent staff. As one stated (The role is): “*guiding/supporting professional competence for OR nurses*” (NUM Q: 27). *The competencies* were discussed less frequently than the standards.

The second theme in this domain **the standards** was about ‘perioperative practice’. Again, a large number of respondents believed ACORN’s role was to determine practice in perioperative settings; and to guide, maintain, contribute to, enhance and monitor perioperative practice. The ACORN Standards, *guidelines and policy statements* were identified as the mechanism by which these activities were achieved, mostly. This theme had two subthemes; the first was *maintenance of standards or care*. Most respondents saw the standards as a way to set or maintain perioperative nursing care but there was no ‘level’ of practice specified. Sometimes, the way this level of care was discussed, it seemed that it was ‘a floor’, that is, a minimum standard<sup>22</sup>; for example, “*a resource body that supports OR nurses and advises minimum standards*” (NUM Q: 8).

The second subtheme was *enhancement of standards or care*. Other respondents believed the standards achieved more than a minimum or unspecified level of practice; they believed the

standards enhanced or improved practice and care. To these respondents the standards were ‘a ceiling’, that is, an optimal standard<sup>22</sup>; for example, “*to provide guidelines and standards based on current research and best practice on which we base our policies and procedures*” (NUM Q: 108).

### ***NUM domain two: A professional body***

The second domain encompassed four themes and several subthemes. The constructs associated with **a professional body** appeared less often in the data than those associated with ACORN standards. Thirty respondents made a general statement that ACORN was a professional association without defining this, or defining professionalism, for example, “*a professional body that contributes to operating theatres and standards*” (NUM Q: 25). The themes identified within this domain were ‘leadership’, ‘provision of support’, ‘a resource’ and ‘political activities’.

Although the words lead or ‘leadership’ were not apparent in the data, the concept was implicit in many comments about ACORN, which was believed to govern, direct, oversee, represent, communicate, guide, influence and to identify future goals for perioperative nurses and perioperative nursing. For example, “*to act as a governing body overseeing all issues relating to perioperative nursing i.e. policies, standards, guidelines, competencies*” (NUM Q: 23). The belief that ACORN’s role in the ‘provision of support’ related mostly to the support of individual perioperative nurses. While there was evidence that some respondents believed it was ACORN’s role to support and promote perioperative nursing, they also indicated such promotion was lacking and noted that this was a shortcoming.

As ‘a resource’ ACORN provided *educational activities, networking and collegiality* and finally, *research*. The subthemes were often discussed together; for example, (ACORN’s role is) “*professional Body - Research - Education. Support for OR nurses*” (NUM Q: 51). The final theme in this domain was ‘political activities’. Within this there were three subthemes. These were providing *a voice, informing* and *influencing*. These aspects of ACORN’s role were discussed much less than others in this domain and the beliefs expressed were mostly parochial. In presenting the NUM questionnaire data analysis, it is important to note that 72% of the NUM respondents were ACORN members.

Analysis of the ACORN board member transcripts revealed there were many similarities between the views expressed by the interviewees and the respondents to the NUM questionnaire. There were also several differences. The domains, themes and subthemes, which emerged from the interview transcripts, are represented in Figure 2. As can be seen, there were different themes and

subthemes uncovered in the domain **the standards**. Nonetheless, the standards were central to any discussion by the interviewees when asked about the role of ACORN.

The domain **a professional body** also contained some similarities with the NUM respondents' answers but there were differences, too. However, there was a new domain, **ACORN backstage**. For the sake of brevity, only this new domain will be discussed. It had two themes, one about the organisation itself and a personal one. The board members provided a unique insider view of the organisation, which demonstrated how board members interacted when conducting the business of the organisation. They reported that individual states or individual members at times dominated the proceedings and set the agenda. Sometimes these powerful figures appeared to operate in secret.

The smaller states' representatives and/or less assertive board members reportedly found themselves unable to make their voices heard. Moreover, they were actively silenced by the way the board operated, for only the senior councillors could speak at board meetings. This did not change until 2001 following a number of earlier unsuccessful attempts by a more progressive president<sup>21</sup>. Additionally, not all board members were privy to all necessary information. Accountability, or more correctly, *lack of accountability*, was an issue raised often.

Such conduct appears to have occurred, possibly intermittently, across the life span of the organisation. At times, it was claimed, these behaviours had a negative impact on organisational activities and individuals. On a positive note, most interviewees felt privileged to have served on the board and often made lasting, professional contacts and friendships.

### **Conclusion**

The common thread through all data collected and analysed in this study about the role and effectiveness of ACORN was the *ACORN Standards, guidelines and policy statements*. The majority of respondents to this study, both NUMs and the BM interviewees, believed the standards had a positive effect on nursing practice and patient outcomes. These standards guided the delivery of care in perioperative settings and they were perceived by the research participants to be the benchmark for perioperative nursing practice. Other themes about the role of ACORN identified it as a professional body.

Thus, the evaluation study showed the value and worth of ACORN, demonstrating it leads perioperative nursing care in Australia. However, the views of many respondents, nearly three-quarters of who were ACORN members, contrasted with those of a handful who were less certain about the value of the standards. A minority of respondents also identified a need for ACORN to be much more proactive, especially in the political arena, and in the areas of undertaking research,

providing support and resources. ACORN backstage was a domain with its own unique themes and subthemes.

This perspective, from former and (then) current board member interviewees, was about power and where it lay, and about a ‘voice’ on the board, who had one and who did not. The impact of this, individually and for the organisation, was noted to be mostly negative.

Figure 2: Domains, themes and subthemes identified by board members (BM)

<i>Domain</i>	<i>Theme</i>	<i>Subthemes</i>
<b><i>BM domain one:</i></b> <b><i>The standards</i></b>	The standards	Significance Development of standards Expert opinion
	The competencies	For learners
<b><i>BM domain two:</i></b> <b><i>A professional body</i></b>	Leadership	Providing a national voice Governance or oversight Representation of perioperative nursing
	Provision of support	Promoting perioperative nursing Supporting perioperative nurses
	Political activities	Interacting with governments and other organisations
	Educational activities	Organising the conference Influencing professionalism Publishing the journal
<b><i>BM domain three:</i></b> <b><i>ACORN backstage</i></b>	The organisation	A closed shop Accountability Evolution Nationalisation Networking and collegiality
	Personalities	Autocratic leaders Development of councilors Time to be a volunteer

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## **Setting the scene for student experience in perioperative nursing – an Irish experience.**

Adrienne Montgomery

Student experience in perioperative nursing is a priority for ensuring competent registered nurses at entry to practice. Having made this statement I realise that, as a perioperative nurse, I am not necessarily coming from the same perspective as many other perioperative nurses and nurse educators. It is fact that some education programmes do not support perioperative experience as a requirement.

If one examines the literature, there is a dearth of writing to support the importance of perioperative experience as benefiting or enhancing patient care. The literature tends to focus on providing experience in perioperative nursing that result in recruitment to the area. Realistically, only a small minority of students will be tempted back to the perioperative area on graduation, more usually it will be after a period of general experience that this happens.

Walker (1999) conducted a qualitative exploratory study using a convenience sample of second year student nurses. The findings indicated that student nurses wanted experience in perioperative nursing, not for finding out if they would like to work there, but to enhance the care they give to patients in the wards. I wonder if this small group of student nurses is telling us where we should focus the student perioperative experience.

Thus, when the perioperative experience arrived for students on the new undergraduate nursing programme where I teach, listening to these students and drawing on experience, we took the view that competence to enter practice as a registered nurse was to be the focus. We also assumed that if the experience is good then recruitment may be a positive spin off. Within the parameters of the programme requirement for a four week experience, competence measurement and in cognisance of the literature, the perioperative experience was planned and implemented.

### **Structuring the experience**

According to Montgomery (1997) perioperative experience should provide knowledge and understanding of surgical procedures, and pre and post operative care that takes into consideration the individual patient's needs to maintain activities of living. Pollard (2004) proposes that using patient pathways is a strategy to do this. The pathways providing the key to assessment and planning of care and providing a structure for the learning experience. While this strategy is able to provide focus (Montgomery, 1997; Crofts and Taylor, 1996) it is liable to set the student apart from the perioperative team. Lyons (2004) in the multi-method study of how medical students are taught and learn in theatre found three things central to a good learning experience.

\* Firstly, comprehensive orientation which includes knowing what and how to do, for example gowning and gloving, and not feeling like a 'fool'. \* Secondly, legitimacy was important and involves having a rightful place in the environment and being acknowledged as a team member with a role to play.

\* Lastly, peripheral participation was identified as central. Being involved in the team and taking a role in the team to the level of knowledge and skill make this participation a reality.

This position was also proposed by Hart and Rotem (1994) who identified a positive relationship with staff, recognition for contribution to patient care, belonging, busyness, appropriate autonomy, role clarity and learning opportunity as vital to student experience.

In consideration of this evidence, the structure for the perioperative experience was finalised to follow the roles of the nurse, rather than patient pathways. This structure was also proposed by Hughes (2003) and the roles are identified as anaesthetic nurse, circulating nurse, scrub nurse and recovery nurse. The structure is supported by role descriptions, learning outcomes for each role and facilitated by preceptors who practice in the roles.

### **Learning outcomes:**

When setting learning outcomes for the perioperative experience, it was imperative that these were derived from the learning outcomes for the programme as a whole and that they met requirements for competency assessment. Planning the experience (Tanner, 2002) within the identified structure provided the framework for setting learning outcomes which are provided to the students in a learning booklet. The role of the nurse in each of the identified areas of the experience is stated and used to set out the learning opportunities that can be sought by the student. It is also important to be realistic as to what the students can achieve in the available time.

Understanding and awareness as outcomes are reasonable. There are, of course, skills and knowledge they bring with them which must be built on, examples being vital signs, care of the unconscious patient, pressure area assessment and care.

### **Facilitating learning**

If students are to have a chance to meet the learning outcomes set for them and to ensure the set structure does not disintegrate in a busy department it is necessary to set in place mechanisms to promote and enhance the learning experience.

To facilitate the student learning four strategies have been employed –

**Preceptors,  
Clinical placement co-ordinators,  
Link lecturers, and  
Reflection.**

For each role the student takes on in the experience, a preceptor is assigned. The **preceptors**, who are experts in their area of practice, have undertaken a course that sets them up with knowledge of the programme and preceptoring skills. They are, therefore, in the position to guide the students' learning and experience in a positive way that ensures the maximum is gained in the five days they work with the students in their role. For the student it provides a point of reference in the team and affords them admission to the perioperative team.

Silén-Lipponen et al. (2004) from their research into the understanding of teamwork in the context of the operating room found that students identified good team work as a good tutoring relationship and positive communication. In our experience, the use of preceptors has resulted in the students being identified as members of the team, feeling secure and having positive learning experiences. So, while the students may have four different preceptors during their perioperative experience, which may be seen by some as poor practice, in the perioperative area it affords the students a positive learning environment within which they are able to achieve the learning outcomes and competencies required.

The role of the **clinical placement co-ordinator** is to set up the structure of the experience for students, for example the rotation through roles, duty schedules and preceptor availability (in collaboration with perioperative nurse manager) and to provide support for student learning. The clinical practice co-ordinator is not necessarily a perioperative nurse, and in our case covers other specialist areas where students are placed. They maintain regular contact with the students, coming into the perioperative area for this. It is the link lecturer who has the direct relationship with the link lecturer.

The **link lecturer** is vital to our students' experience. The prime role of the link lecturer according to Hughes (2004) is to monitor preceptorship, provide support and feedback to the preceptors or mentor, whichever term is chosen to be used. They also propose the link lecturer has clinical credibility if they are to be successful in their role.

In our experience we have taken a broader view of the link role and each aspect of the role is accorded equal importance. Thus the link lecturer has a relationship with the clinical practice coordinator, perioperative nurse manager, preceptors and students. These relationships are vital if students time spent in the perioperative area is to be a positive learning experience. The link lecturers have perioperative nursing as their primary clinical background, and clinical credibility is essential. The clinical credibility enables knowledgeable collaboration (Hughes, 2004) and so ensures success.

The fourth strategy employed to promote student learning is **reflection**. The reflection sessions, as far as is possible are facilitated by the link lecturer. Two sessions of 2 hours are held during the four week experience. Reflection affords the students time to assess the what, how, why and wherefore of their experience in a structured and supported way that promotes learning. By reflecting on the positives and negatives of the experience the students are able to balance the objective and subjective experiences to demonstrate what they have learned and what their learning needs are.

On evaluating the perioperative experience, the students have identified that the structure and supported learning through the strategies employed have enabled achievement of learning outcomes and a positive attitude toward perioperative nursing.

### **Measuring competence**

Assessment in an area such as perioperative nursing is seen as difficult. The difficulties identified are that perioperative nursing is so different and inherently complex that competence should not be expected and students working with different nurses over the experience.

Pollard (2004) proposes that the key elements of the clinical assessment of competence are the experience, learning outcomes set, reflection and testimonies of persons with whom the student worked. When preparing for students to take experience in the perioperative area, a record of experience form was developed. It was developed from the performance criteria of the assessment tool used for all areas, the learning outcomes set for perioperative nursing and expected learning opportunities and task experience.

The students carry this record throughout their rotation and practice experiences and/or learning are signed off as they occur. This record of learning and competence is then used to validate the self and preceptor assessment of competency achievement. The competency assessment is completed by the preceptor in the last role of the rotation. Evaluation of this strategy has been very positive. Not only does it provide the overall picture, it demonstrates progress and identifies learning needs as the students move from one role to another as well as providing a guide to reflection.

### **Conclusion**

To date 200 student nurses have gained experience in perioperative nursing. It has been a learning time for all. The students have evaluated the experience positively, identifying five central learning outcomes.

Firstly, an understanding of the patient journey through the perioperative period and are better able to support their patients in the preoperative period as they set out on the journey. Secondly, they report a greater understanding of maintaining a safe environment for their patients, including skin care and prevention of infection. Thirdly, the students have identified a greater understanding of caring for the emotional and psychological needs of their patients. The next learning which they report a greater understanding of is that of ethical issues related to nursing practice especially informed consent, patient choice and advocacy. And, finally, the students state they are not afraid to return to the area and would welcome more experience. When asked if they might practice in perioperative nursing after graduation only a minority say no, most would consider the option after gaining a year or two experience in the ward areas.

For the perioperative nurses who act as preceptors and assessors for the students, understanding of students' learning needs has been enhanced. In addition, how students convey their desire to learn has been much discussed among those involved in the process. The student who appears to fade into the wall is no longer seen as uninterested - rather the student is seen as someone who needs extra support to gain the necessary learning. For the link lecturer, it is satisfying to see the growth in the students and the enthusiasm of perioperative nurses throughout the time.

If we are to recruit into theatre, the student experience will always be a cornerstone. Structuring the perioperative experience and identifying learning outcomes that are achievable had been central to the success we have had. More importantly it is the relationship between preceptors and students that engender trust and support that have made it work so well.

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### **From one of our patients.**

Marianne Pitkajarvi, Finland

*This paper was given as an oral presentation at the Closing of the European Operating Room Nurses Conference in Dublin Ireland, in May 2006.*

Dear madam / sir, dear perioperative nurse

You do not remember me, I am sure. But, the other day, I was a patient at the OR you are working at, and you were my nurse. I am now recovering from the surgery, and writing to you while still rather weak, which I hope you understand and remember, if my text at some point seems odd, un-logical and or even un-appropriate. However, the need to explain to you what I have experienced is very strong and urgent, and – knowing that you are busy and anxious to get home - I still will take the liberty of asking for tolerance. You see, when I was in the hospital, there was a picture hanging on the wall. It was taken on a seashore, and showed the foot steps of two persons who have had a refreshing walk together. During convalescence one has time to think, and for some reason, this picture keeps reappearing in my mind. It reminds me of my visit to the OR. I understand fully that there is a lot in your work, which remains hidden from the likes of me, but I was hoping that hearing my side of the story might offer you something new to think about. Hope you do not mind the expression, but this additional moment together just might offer us *a ride on the pig's back*. By the end of the day, I hope you will share this win-win-feeling with me.

You were not there when I learned that I needed to be operated on. I guess, for many reasons, this moment is different for everyone, but to me, initially, it was not such a shock. On the contrary, it felt more like a relief, which must be due to the fact that I had been experiencing such excruciating pain in the right hip joint for months, so finding out that it was curable, was quite a load off my chest. With the new prosthesis and a bit of luck, the good doctor said, I could be pain free. You have no idea, - or maybe you do? – what it feels like to hear that it was not anything bad, like cancer. It is so strange what goes on in one's mind during a long process of feeling uncomfortable and experiencing an increasing amount of pain. Surely, this is something evil, I thought. Eventually, I was sure it was cancer. Besides, one of my next-door neighbours had pain in her hip, and she is dead now, you see, so you understand that I was worried.... But, that day, I actually left the doctor's office feeling *as happy as a pig in heaven*, and hobbled home as quickly as I could.

You being one of them hospital professionals and all, you'd probably understand why I felt the way I did, on the day I arrived to the hospital, a day before the operation. I got scared. Now, I do not have a lot of experience about health care services in general, you know. I've been healthy all my life. We were married for 20 years, the husband and I, until Herbert passed away four years ago. We never had any children, you see, so I never had to see them community health people or midwives and what have you. Mind you, we did want to have children, and it was not that we didn't try, oh yes, we tried, the husband, in particular was very keen on trying, you know...*how's your father*...you know. Heaven knows we tried.

So, no luck with children, but otherwise I've been healthy, so I don't know much about these health systems and nurses and surgeries and stuff. I hope you don't think that I'm

stupid, though, and that due to lack of experience would not understand what is going on. 'Cause I do, I am very observant, they say, them in my home village. Constantly aware of what is going on around me. A bit like Miss Marple, you may know the film star? I am a big fan of hers, and I like to think I'm a bit like her, in my own humble way. Some say I've got a sixth sense, you know, but I will let you in a secret: it is more a matter of knowing how not to be seen while standing at a window. That, and having proper equipment, such as a good pair of binoculars. All in all, I am not a big believer in the sixth sense, I believe in evidence, you see. From what I observed during my visit to your working place, I understood that, when it comes to interpreting people's behaviour and making decisions to guide the necessary future actions in the everyday life, you and I are on mutual grounds. You see what I mean? Evidence and good equipment, this gets both of us far, but there is more to achieving excellence, mind me, there is more...

Anyway, I got to the hospital, and got scared. Not for the knife so much, but for the needle, you know. Knowing that this may sound odd, and even if it is kind of hard to explain, I will try to make you understand this experience. It is kind of silly, you know, when you explained to me, that via the needle, Anastasia would come. For a moment there, I thought you were referring to a person -what a pretty name, I thought, Anastasia. Of course I soon realised that this would not be a person, but a way of being, a status. My status. I would be under anaesthesia. And that it meant that I would not feel any pain, and in fact, would not feel anything at all below the waist line, but would be able to communicate my needs and, sort of, be present while others around me would work to repair my hip joint. This made it all right, dear nurse. You see, the thought of not having any control over what is happening, is a very scary one. So all the things that you did that made me feel I'm a part of it all, that I would be the subject as opposed to being an object, made me feel better.

Thinking about how you explained things to me, I thought you might want to hear this, too. You see, my husband used to do carpentry, and I used to help him with whatever I could. I did this with pleasure, because he often actualised a dream that was originally mine. Often it was something for the house or the garden. In order to make me a good co-worker, before we actually got the job started, he used to explain what he was up to. You know, he was a clever chap, my husband, and understood that if I simply did what he instructed me to do, I would just be *another girl on the street*. He always expected more of me. He understood that the work would be easier to complete, if he spent a moment coaching me with what I could do to achieve a mutual goal. And mind you, good co-operation often did lead to excellent outcomes. Even today, this can be verified by taking a look at our garden gate, which I helped my husband, to construct.

I would like to point out the fact that it was in my garden, where a gate like this first was build. Not in the Everwood garden, no matter what the Mrs is saying. I've heard that she has said to Mrs Lindenwood who had forwarded the message to Mrs Windwood, who then in turn told me that the first garden gate like this had been in the Everwood garden. Well, I'm telling you, that women is *just so wrong*, if you don't mind me saying, her being a widow and all, and my Herbert would never have built a garden gate to her first. And I don't care what she claims to have done with Herbert before he started courting me. Look who got Herbert in the end? And quite without a night at a hotel!

So, where was I? The garden gate? Yes, indeed. When you, my dear nurse, on the evening before the operation, came over and drew that picture of the upper end of my

thigh bone and the cup-like construction it should fit in, I immediately recalled my garden gate, as there is a construction like this in it, as well, you see. At the same time, understanding how it would be repaired became easier, too. If you understand the structure, the construction, it is easier to understand the function, and the necessary repairs and how they are to be done. Indeed, I believe that I now have a profound comprehension of the sort of services you've offered to me in the OR. The medical side of it, I mean. Helping me to understand what was wrong with me by making me think of something that was familiar, like from the ordinary life, was very clever of you, dear nurse. NOT that my life would be *run of the mill*, in anyway.

You never did promise me a rose garden, but there is something about the morning of my operation, which I want to share with you. I do realize that you *cannot make a silk purse out of a sow's ear*, but still, I must say that there are some things I'd like you people in the hospital to reconsider. Why, in heaven's name did they force me to give away my dental prosthesis on the ward? I did understand that their primary aim was acceptable: so it would not be lost or broken or somehow causing danger to me at any point. But still, I found it very embarrassing. Mouth is so important for a person's appearance. Imagine that someone would pull out your front teeth and immediately after that, you'd have to pop into the post office or a grocery store. Haa, try saying "store" or "post" or "operating theatre" without you using your front teeth and you'll see what I mean. I had to leave the ward and enter the theatre just like this, to meet and talk to people I had never seen before in such undignified manner. Surely, you do not want to compromise anybody's dignity because of an operation? This should be written down somewhere, like a law or something...They even tried to take away my glasses, but, with a bit of persistence, I was able to convince them of the fact that this would only do more harm, that I, in order to be able to collaborate fully, would need to be able to see properly. What good would it bring to a team if one of the members would only have a blurred vision of the environment?

Prior to my hospitalisation, my next-door neighbour, Mr Johansson, had warned me about the pre-medication. He claimed that I'd be *as drunk as a skunk*, which made me horrified. You see, I was afraid I'd make a complete fool of myself, both before and after the operation, due to being under the influence. It was very kind of you to ensure me this would not be the case. However, when I first saw the OR personnel and the room I was supposed to be treated in, I thought for sure they had brought me to the wrong place, or else, I had to be drunk, just like Mr Johansson had said. With what I saw around me, I was not sure whether they had wheeled me a couple of hundred years forward or backward in time. I then ended up thinking it had to backwards, because all the people were dressed like the Knights of the Round Table. I must say, it felt quite surreal, and the only thing keeping me in reality and sane at that moment was your voice – just about the only familiar thing I could experience. Well, I got over it, my nerves being of steel. But, dear nurse, in the future, you want your patients to be better prepared for what it looks like at the OR. Take a few photos or something and show those to them during your visit on the ward. Otherwise, one of these days, you are bound to get a patient who will take one look at where he is at, say "I'm not coming" and run away like his tail would be on fire.

You had kindly explained to me that in the beginning, there would be a lot going on in the room, to ensure a smooth progress of the procedure. However, I was still surprised about the amount of traffic and movement and noise in the room. You see, when you are lying there, in the horizontal position, much of what you see are the figures running back and

forth in hasty movements. And all that noise! Surely, no patient is interested in hearing who went home with whom from the party on Friday last week. Nor are they interested in witnessing any kind of arguments among the staff members. Anxiety is present and very real for the patient without these elements. And finally, for heaven's sake, is it not possible to unwrap whatever it is that needs to be unwrapped, somewhere away from the patient? To me, it all sounded and looked like you could put together a band called "the Unwrappers". You've even got the choreography ready.

You know, I was observing you at the OR, hope you don't mind. Much of the time you seemed to be minding your own business, but, whenever anyone needed anything, you were there for the others. You even seemed to know what they needed before they did. I must admit, my first thought was that you had that sixth sense we talked about earlier, or that you are just plain lazy, dozed off for a moment, and then woke up just in time. But then I realised it was neither, you KNEW what they'd need. You knew because you were concentrating on what the others were doing. Here comes this evidence again, evidence being your own professional education and previous experience. Because of your concentration, you were able to anticipate. My Herbert was of Swedish origin, so I know a bit of Swedish myself. Alltid steget före. Always one step ahead. That is how you were working. I can't help comparing myself to you. Your work, in this sense, seems somehow easier than my social life in the village, in particular when I am trying to fulfil my commitments to the well being of the village people. My people say I am always there, even when –and especially when they least expect it.

Most of your fellow workers seemed to be working behind the curtain, and I understood that the curtain was there to protect me. It was very peculiar, being there under anaesthesia, behind the curtain, not being able to feel anything below the waist line. Through my previous experiences, I have learned that once you lose one sense, the others seem to take over. If, for example, one is standing in the dark observing something but cannot see much, you hear and feel things in a much more sensitive manner. I do not know if your colleagues realized this, but there were moments when I doubted that they had forgotten I was there. People were, sort of, talking over me, you see, as if I were not there. And there was, in fact, a person, who actually walked in the room, without even greeting me. This felt bad, dear nurse, as I also noticed that he stayed in the room throughout the entire procedure, so he must have been someone important.

When I was young, my parents were out, visiting my uncle. I did not go with them, but stayed with a friend instead. In the evening, the friend walked with me to our house, and it was then when I realized I did not have the key with me, so I had to wait. It was dark and rather chilly, so, trying to act braver than I actually felt, I said to her she should go home and that the parents would surely come home soon. But, she was persistent, and said she'd stay right there and wait with me until the parents came back. She did not want to leave me alone. I felt so relieved. Later, I have understood that this is a manifestation of caring. You want to be there for the other person. It was this feeling that came back to me at the OR, when you or your colleagues came over to say something or to simply squeeze my hand. Each time it gave me a boost, a booster of strength, and I did not feel so helpless and alone anymore. Someone brought over a warm blanket, to cover my arms and upper trunk. This, too, felt incredibly good, and has stuck to my mind permanently. It was a concrete gesture, which increased the feeling of security and which helped me to relax.

All in all, the operation as such was a good experience. However, I do have one final remark about it: Do you people not understand that after a surgical procedure, such as the one I went through, people feel like they are *off the wall*. They are in no condition to learn about how the wound is supposed to look like on day 8 after the operation, when everything is going well. Not to mention about how to use or how not to use the crutches, the correct position of the toes when you are sleeping and when you are walking, the use of supportive pillows, and 'what have you'. Could you please tell those administrators or yours, that it is not ok to throw people out of the hospital and back to their homes, like a pair of old slippers, without making properly sure that they actually are able to manage there with whatever help there is available. Not all people are as resourceful as I am. When new techniques are being developed, it is never about "advance", only. It is about seeing all the trees in the forest, all the links in the chain. Bringing in enough professional expertise to support the end stages of care of anyone undergoing surgery, seems to be an area which needs more attention. Nobody can assume that a layperson's expertise matches that of an experienced professional.

I want to conclude by using an old saying of the very rich English language, I love you, warts and all. In this context it means that in spite of the few not so nice-experiences, my experience with you in the operating room was a positive one. You understand, of course, that I, being a layperson, am not educated enough to discuss the manifestations of excellence in your area of expertise. You will need to define this yourself, at best, together with your colleagues. This might involve research, publications, congresses and other forms of sharing knowledge and experience – this of course being something you know more about than I do. However, I do know that you cannot, you just cannot achieve excellence without comprehension of what it feels like to lay on the operating table. Furthermore, I must say that since you have chosen to place the likes of me in the centre of your focus at work –this is what you made it feel like- there must be something profoundly good natured and noble about you and your work motivation. To us lay persons, in unique and extreme experiences like having an operation, it is the small and simple things that matter. The kind of things that make us feel that somebody, you, the nurse, is walking through it by our side, ready to catch if we stumble. Remember the picture I mentioned in the beginning of this letter? Taken on the seashore, showing two sets of steps in the sand? That was you and I during the procedure. Thank you for walking by my side, dear nurse. On you journey to achieve the stars, your excellence, I wish you strength and health.

Go in peace, dear perioperative nurse.

Sincerely yours,

And now, I have to take my binoculars to service.

## ***Improving Quality in Peri-Operative Care – by participants at the Leadership Workshop, Nairobi Kenya. November 2005***

This article was derived from a workshop held during Friends of African Nursing Leadership Programme Kenya in November 2005. Gracious thanks to all those who participated in the workshop and assisted with the production of the article.

### **Overview**

There is no doubt that health care both locally and internationally is becoming more sophisticated. Business systems to measure and evaluate performance are slowly evolving and will soon become part of everyday life. But how far will the health services go with the performance management process in order to improve practice and outcomes? It could be suggested to you that there is a possibility that everyone who contributes to the effective outcome of patient care will eventually be performance managed by their organisation.

In November 2005 Friends of African Nursing, (FoAN) facilitated a leadership programme to a group of experienced Kenyan peri-operative nurses. During this event the group discussed what aspects of nursing care could be measured and potentially performance managed or benchmarked.

This article doesn't delude itself with presenting the answers but shares some thoughts from the workshop and suggests that it is better that internationally peri-operative nurses take control and ownership of this before some remote policy maker enforces the changes upon us.

### **The Problem**

Do we still have a huge gap within perioperative care between best practice and the rest of practice? Travelling around the world there still appears to be unjustified variations in the delivery of care and although separate countries have tried to tackle this issue we still have no global uniformity. Surely patients deserve the same standards of care where ever they live, and internationally peri-operative nurses are probably the most advanced out of all nursing specialists to produce a blue print for other specialties to follow.

As a driver for this, benchmarking can be a valuable tool, which can be used to propel continuous improvement throughout patient care. Risk management is probably on the top of the perioperative nurses' agenda. They have a professional and legal requirement to guarantee that the staff, visitors and more significantly the patient remain safe during the patients' surgical journey. Understanding the nature of the risk, using benchmarking standards as a tool to continuously measure and reduce risks, assists the development of a high quality service.

### **So what is a performance standard?**

It's a standard of performance that is a written statement that explicitly outlines how a job should be performed. The performance standard is a useful benchmark that can be used as a learning tool to evaluate outcomes. It's a useful tool that will provide information on whether an individual or company is meeting or exceeding the expectations of their role.

For effective communication, performance management processes should be written in clear and in an uncomplicated language, with a focus on the minimum competencies and outcomes that will be measured. The standards should be for the job - not the specific person undertaking the job - and should be reasonable and appropriate. The standard should describe the expectations and have a built in mechanism for acceptability of errors. This need serious consideration in terms of clinical risk management as some standards will be acceptable to allow for a margin of error whereas other relating to clinical practice may not.

### **Outcomes of the workshop**

The first task undertaken in the workshop was to identify 20 aspects of practice that perioperative nurses deliver to contribute to a quality service. This list reflects the thoughts of a group of Kenyan perioperative nurses during a one hour interactive session:

#### **20 Aspects of Practice that Peri-Operative Nurses Deliver to Contribute to a Quality Service**

1. Continuity of nursing care
2. Pre operative visit to enable effective intra operative planning
3. Post operative visits to ensure continuity of care
4. Patient psychological support
5. Provide high quality education
6. Effective management of operating theatres
7. Awareness of regulation and legislation
8. Risk management
9. Comprehensive documentation
10. Setting and implementing standards
11. Ensuring adequate supplies for specific operations
12. Ensuring proper functioning and maintenance of equipment
13. Ensure principles of infection control are followed
14. Patient safety examples include:
  - a. Proper identification of patients
  - b. Providing trolleys with side rails for patient transportation
  - c. Proper patient positioning
  - d. Diathermy
  - e. Tourniquet's
  - f. Proper swab and instrument count
  - g. Maintaining aseptic technique
  - h. Emergency resuscitation equipment and drugs available
  - i. Continuous patient monitoring
  - j. Post operative tray available when transporting patient
15. Operating team safety such as
  - a. Proper lifting techniques
  - b. Lead gowns during radiological procedures
  - c. Personal protective equipment
  - d. Correct handling of chemicals and hazardous solutions
  - e. Avoiding wet floors
16. Protecting patients dignity

17. Avoid unnecessary noise
18. Patient advocacy
19. Safe custody of patients belongings
20. Collaboration with the health care team

Out of this list the nurses then considered the headings that could be used as key categories they would like to see that could be broken down as evidence based outcomes at a later date.

The results were as follows:

### **Key Categories for Evidence Based Outcomes**

**Infection control**  
**Privacy and dignity**  
**Patient safety**  
**Staff safety**  
**Visitors safety**  
**Documentation**  
**Evidence based standards**  
**Equipment maintenance**

### **Next Steps**

This information is just a start to what is probably a long process. Fundamentally, a tool will need to be produced, collaboratively, and include the following as the foundation for ownership and effective use:

- Prepared by international perioperative nurses and consumers
- Underpinned by research and evidence-based practice
- Each evidence-based outcome that expresses what patients want and need from practice
- A benchmarking tool that includes all the factors that are identified as minimum standards to achieve the outcome
- Key statements suggesting how perioperative nurses may justify a benchmark score they have awarded their practice
- A universally agreed method to be used by practitioners to draw up their own action plans for development

Clearly, with the continued modernisation of health care, there is recognition to put the patient in the centre of all we do. Improving the quality of patient care has always been high on the list for peri-operative nurses. There is now a window of opportunity for perioperative nurses to take up the challenge and produce an international benchmarking tool. We have the energy and the incentive to action this, do you?

# The Final Count

*This is **your** page to identify items of clinical or managerial topical interest in perioperative care. Contributions for future issues should be sent to the editor, please.*

## *Contribution 1 from USA*

Fatigue: Are we too tired to be safe?

Although there is research to prove that fatigue can be a causative factor in errors in many industries, sceptics still exist in the medical communities. "Devotion to practice", "fear of abandonment accusations", and financial concerns drive the medical community to practice long hours. However, is it safe practice? The empirical evidence verifies that there risk is an inherent factor in fatigue.

In order to be safe, we must be vigilant/awake/alert with reflexes that initiate a prompt response. Contrary to the belief of some, there is no fine print on our degrees and licenses that exempts us from the negative impact of fatigue. We all have an obligation to speak up when we feel that fatigue may compromise the safety of our care.

## *Contribution 2 from UK*

Trauma implants should be wrapped. Repeated circulation of implants (screws and plates etc) on our instrument trays attract biofilm, which is not removed completely in the wash process. We must encourage all industry partners that to do the best for our patients, the implants should be individually wrapped and pre-sterilised when we purchase them. Why is it acceptable for larger joint replacements to be pre-sterilised (and traceable) but not for smaller items?

## *Contribution 3 from US*

The following issue was highlighted at EORNA Conference in an excellent paper given by Tony Dawson, of New York- Presbyterian Hospital. Full presentation on [www.eorna.eu](http://www.eorna.eu)

*The objective of the study was to identify issues with and resolve errors with medications used intra-operatively, from the sterile field. It was discovered that 24% of medications given from the sterile field are verbal orders only ( ie never written), that 27% of the cases have at least one calculation and that 14% of calculations are not checked. Using this evidence, the study sought, by multi-professional committee, to resolve the potential for errors by devising a standard evidence based formulary; to use medications in unit-of- use or ready dispensed dosages; and to identify and provide a uniform system for ordering, dispensing, labelling, mixing and administering medications.*

To reduce intra-operative risk of medication error, all perioperative nurses should look at their practice – or there are mistakes waiting to happen. The key message in the above paper was to simplify and standardise, to reduce error potential.

## *Contribution 4 from UK*

The Medicines and Healthcare Regulatory Agency in UK has recently highlighted a study undertaken in 1999, to identify where it is safe to use cell phones in hospitals. There are many myths surrounding interference of electro- medical devices, and subsequent bans on the use of personal 'phones in hospitals in UK. The MHRA says that it is continually asked for the evidence, and has reviewed and re-issued previous advice. Generic advice recommended is that cell phones should not be used in critical care areas where patients are attached to complex devices, but say that local hospitals should set their own parameters. However, the study reports that 41% of medical devices suffered interference from emergency radio handsets at a distance of 1 metre, 35% suffered interference from security radio handsets at 1 metre but by

comparison only 4% showed interference from cell phones at a distance of 1 metre. Cordless phones (in use in many ward and department areas) failed to detect any interference.

It went on to report that some categories of medical device such as physiological monitors, or devices incorporating them such as defibrillators or external pacemakers were the most seriously affected but that models varied in the degree of interference.

*So, the jury is still out then? Where may cell phones be used in your country, in hospitals? Ed*

*There must be a vast array of topical thoughts, questions for peers, clinical conundrums or just issues you would like to share on this international “soap box”. Bring them on!*

## **Guidance for authors**

*The International Journal of Perioperative Care*, published twice a year, provides readers with the opportunity to keep up-to-date with current issues affecting professionals working in the perioperative and related fields.

Welcomed are articles relating directly to operating theatres, perioperative care, anaesthesia, endoscopy, critical care, sterile services, infection control and many other areas.

The following guidelines are designed to be helpful to authors considering submitting articles to *The International Journal of Perioperative Care*:

<b>1.</b>	Articles submitted to the journal may be research based, reportage, or opinion pieces.
<b>2.</b>	In any article, <b>company or brand names</b> should not be mentioned repeatedly. If drugs are referred to, generic names should be used.
<b>3.</b>	Ideally, the text of an article should be about <b>2,000 words</b> . The method of delivery is by <b>emailed Word or Rich Text Format document</b> to: <a href="mailto:kschroeter@execpc.com">kschroeter@execpc.com</a>
<b>4.</b>	One or two <b>pictures</b> or other <b>images</b> to illustrate text are welcomed. Appropriately sized pictures and other images in high resolution (300 dpi for colour; 150 dpi for mono; 600 dpi for line work) j-peg format should be emailed to <a href="mailto:kschroeter@execpc.com">kschroeter@execpc.com</a> A caption for each picture or image should be supplied.
<b>5.</b>	Any <b>references</b> should be clearly set out at the foot of the article.
<b>6.</b>	An <b>author's biographical note</b> of a few sentences should accompany the article.
<b>7.</b>	Full <b>contact details</b> for the author should be supplied.
<b>8.</b>	A <b>photograph</b> of the author is welcomed.
<b>9.</b>	<b>Deadlines:</b> Ideas for articles should be discussed with the editor at least two months in advance of the intended month of publication. Text and associated material needs to be received by the editor no later than the last working day of the month preceding the month of publication. Journal volume deadlines will be posted on <a href="http://www.ifpn.org.uk">www.ifpn.org.uk</a> . Copy will not be accepted after the stated deadline.
<b>10.</b>	The Editor retains the right to edit the article, without reference to the author but will endeavour to undertake this process collaboratively. Articles will be peer reviewed prior to publication. The editor's decision to publish or reject articles is final. Once accepted for publication, authors are required to sign a release form and a declaration that the article is their own work. The article then becomes the copyright of the International Journal of Perioperative Care.