NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

PERIOPERATIVE NURSES COLLEGE N.Z.N.O

# The Dissector

## Journal of the Perioperative Nurses College of the New Zealand Nurses Organisation

December 2018, Volume 46, Number 3


**PROFESSIONAL**

• Laser Safety • Perioperative Nurse Surgical Assistant role

**EDUCATION**

• Evolution of ENT Nursing • Effective Management of Anaesthetic Crises


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# The Dissector



## INDEX TO ADVERTISERS



## Touching Base



### AUTHOR GUIDELINES

For writing articles intended for publication in *The Dissector.* The Editorial Committee of *The Dissector* welcomes articles, reports, book reviews, letters to the editor, exemplars, case study experiences, research papers/projects, theatre or section news etc. Guidelines that are designed to help first-time authors as well as those who have published previously are available on request from members of the Editorial Committee.

# Communication is key . . .

Well done Nelson-Marlborough region for hosting a thoroughly enjoyable annual conference and reminding us that 'Communication is key' in our interaction with colleagues and our patients and yes, the sun did finally shine on your lovely city.

The final issue of the year provides a summary of the 2018 PNC Conference presentations along with the National Committee annual reports detailing another productive year.

At conference time I am also reminded of the valuable part medical industry companies play, enabling us to acknowledge the writing and presentation skills of colleagues and supporting education of our members.

## Memorable presentations

There were many memorable conference presentations, but personal favourites were Dr Paul Woods. Paul used his challenging personal journey of imprisonment for murder in his late teens, survival in prison and discovery of learning to shape his life for the better. He spoke of the importance of positive self-communication to recognise our potential. While Paul readily admitted that achieving his Doctorate in Psychology was made possible through the support of his ever-present father and his tutors, it is never-the-less a courageous, remarkable story and I would recommend listening to his TED talk.

Another favourite but very different presentation was Elsie Truter's retrospective on the development of infection prevention and control through the ages and the challenges ahead with the increasing range of surgical procedures and growing antibiotic resistance.

*The Dissector* committee plans to publish an issue next year featuring infection prevention and control with a contribution from this great presenter.

The passion, enthusiasm and warmth of Tui Lister, senior Maori Health Practitioner at Nelson Marlborough DHB, was also particularly engaging and her dual role as patient, whanau support person and staff educator is clearly very valuable and much appreciated.

The presentation from Derek Sherwood, Chair of the Council of Medical Colleges and clinical lead of Choosing Wisely also resonated as we all see instances of over-investigation and treatment with little likelihood of benefit for the patient. Also, worth following up is an important publication from the Foundation for Informed Medical Decision Making. Shared decision-making ensures that patients get 'the care they need and no less, the care they want, and no more' (Coulter & Collins, 2011).

## Education awards

In this end of year issue we include feedback reports from two recipients of education awards.

Sarah Millis, recipient of the Johnson and Johnson award last year, looks at the evolution of the RNFSA role in Australia, based on her attendance and research at the ACORN conference. Kirstie Cook, recipient of the Culpan Medical Education award in 2017, reports on her attendance at the Effective Management of Anaesthetic Crisis simulation course at the University of Auckland.

The December issue also includes an article from Elissa O'Keefe, Nurse Practitioner and founder of Bravura Education on laser safety and the new Australian and New Zealand Laser Safety Standards.

Regional reports from the Hawkes Bay and Auckland-Northland regions are also included, along with a report on the Otorinolaryngology Nurses National Conference, so plenty of holiday reading.

## Committee changes

*The Dissector* Editorial Committee farewells Sandra Millis, RNFSA from Dunedin, and welcomes two new members to the team: Rebecca Porton-Whitworth, RNFSA and Acting Clinical Nurse Specialist Cardiothoracic and Vascular Theatre Christchurch Hospital, and Sarah Winship, Perioperative Nurse Educator, Whakatane Hospital.

Along with an issue focused on infection prevention and control next year, we would like to publish another predominantly paediatric issue and also look at the impact of obesity across the perioperative continuum. Please think about what you could contribute and do not be surprised if you are contacted by an Editorial Committee member.

Wishing all of our readers a safe and happy festive season with family and friends and we look forward to hearing from you in the New Year with your great ideas for articles.

*Shona Matthews, Chief Editor*

## Reference

Coulter, A., Collins, A. (2011). Making shared decision-making a reality; no decision about me, without me. The Kings Fund, London. Retrieved from www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf

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# The role of Chair . . .

Welcome to the December issue of Table Talk. For this issue's column I thought it would be useful to provide some insight into the role of Chair within the Perioperative Nurses College of the New Zealand Nurses Organisation (PNC[NZNO]).

The Chair is a Perioperative Nursing leader. Each individual who comes into the role has different strengths, interests and speciality knowledge. My predecessors have built and guided colleagues, peers and members of the College to where we are today, helping the College to grow and move forward.

New Zealand nursing is well recognised and supported and previous Chairs have represented the PNC both nationally and internationally, maintaining a presence in the perioperative world.

The Chair role is a professionally fulfilling and demanding one, impacted by current issues both nationally and internationally. I had big ambitions coming into the role, to learn, to step up and pack as much into the experience as possible. I have achieved more than I thought possible and have been able to support my own practice and the practice of others through my experience, learning and involvement with a wide group of people and medical disciplines.

I have confirmed that I am passionate about learning and development and have committed to empowering people through learning. I have completed my masters, met experts in the perioperative field and gained knowledge and experience that enhances the patient journey.

## Leadership

Leadership is an essential part of any nursing role and understanding and obtaining knowledge of leadership attributes and skills is an important part of any nurse's development.

Nursing leadership is about influencing others to accomplish common goals. It is complex and multi-faceted and includes providing support, motivation, coordination and resources to enable individuals and teams to achieve collective goals. We do this when orientating new staff or as a nurse leader supporting our team. Putting this into the perioperative context, whether in the post anaesthetic care unit (PACU), operating theatre (OR), medical imaging or a pre-admission area, an understanding or knowledge of how other services or processes impact on staff, patients and patient flow come together to add strength to a leader within an area of practice.

Knowledge, education and experience impact on leadership. Globally there are thousands of people working within the perioperative continuum. There are multiple New Zealand and international websites that are available for our use.

Operating theatre nurses in Australia, our closest neighbour, are represented by the Australian College of Perioperative Nurses'(ACORN). Their purpose, like ours, is to represent best practice through the use of professional standards, conferences, summits and webinars.

For PACU nurses, New Zealand has membership with the International Collaboration of PeriAnaesthetisia Nursing (ICPAN), an international group that provides a platform for anaesthetic nurses, PACU nurses, day stay specialties and pain specialists. We are also part of the International Federation of Perioperative Nurses' (IFPN) a group that that has a strong voice internationally.

*Juliet Asbery, the new Vice Chair of the Perioperative Nurses College*

The Asian Perioperative Nurses Association (ASIORNA) is a group of Perioperative Nurses within Asian and Pacific island countries that maintain close links.

All of these associations provide us with information and discussions from around the world. They give us the ability to network and to compare practices. Topics such as surgical smoke plume, first start times in theatre, infection control and surgical site infections, theatre attire and documentation that come up nationally are also talked about in the international arena. The PNC therefore has a voice internationally and through nursing leadership maintains a positive presence.

## A new leader

At the 2018 Perioperative Nurses College Annual General Meeting on October 13, Juliet Asbery was elected Vice Chair of the Perioperative Nurses College (PNC[NZNO]).

Juliet is a nurse with a passion for promoting the profile of nursing as a highly skilled profession. She says Perioperative Nursing is a hidden, undervalued area of practice and she believes the role of the PNC should be to support these nurses to develop their professional practice and to raise the profile of Perioperative Nursing amongst other nurses and the public in Aotearoa.

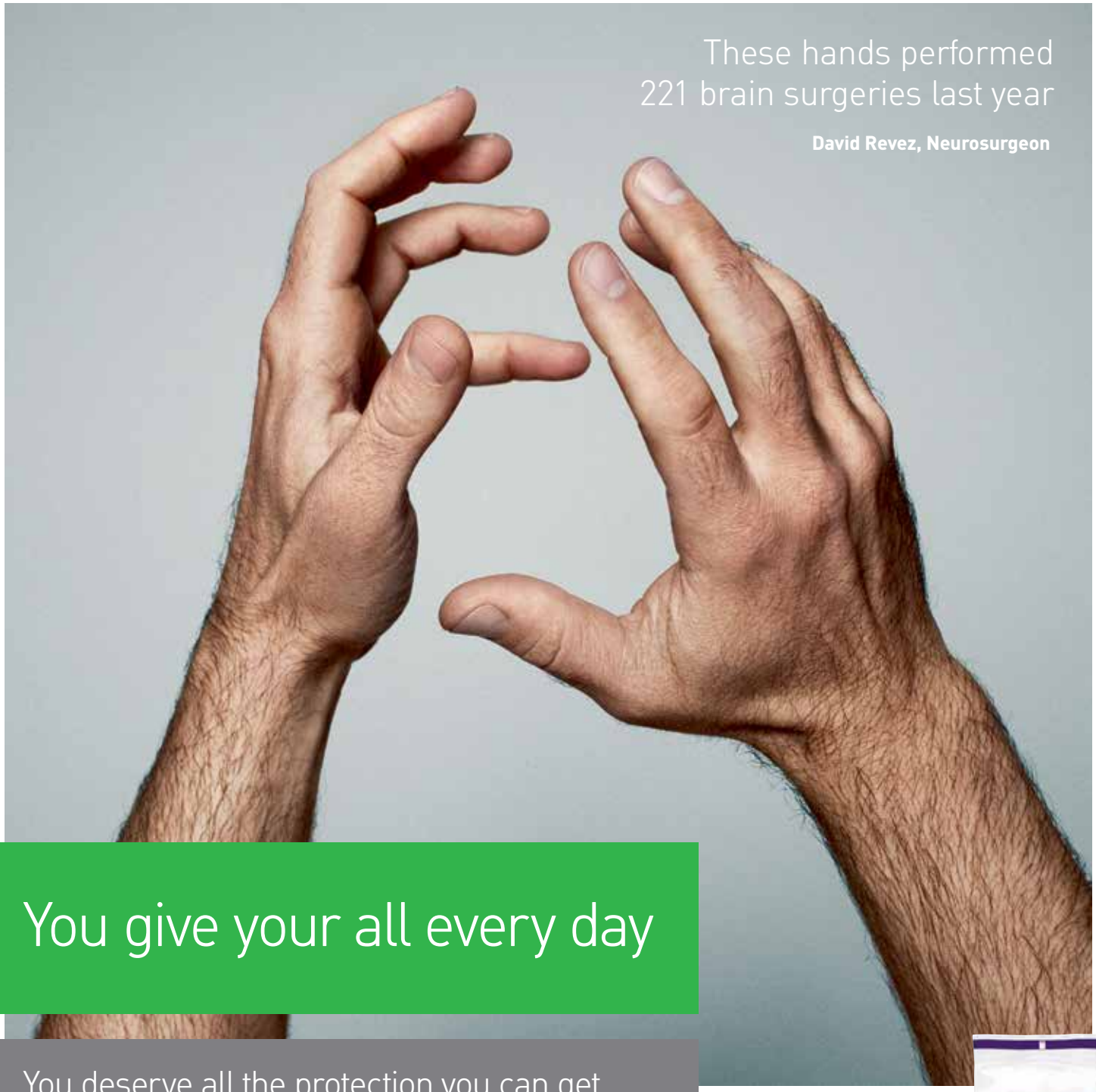
"I believe that communication and collegial support should be promoted across the public and private healthcare sectors to share information, skills and to support perioperative nursing practice," she says.

"I also feel strongly that the Perioperative Nurses College needs to focus on ways in which we can encourage member participation at regional and national levels. As an aging workforce we need to accept the need to embrace new ways of communication and encourage the participation and interests of a new generation of nurses," she adds.

As 2018 comes to an end, I wish you all a merry Christmas and a safe new year. You could always add to your New Year's resolutions: stepping up and being involved in your region's perioperative nursing group.

See you next year.

*Johanna McCamish, Chair, Perioperative Nurses Colleg*

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References:
**1.** MHC on file Report no. 887. **2.** Wigmore SJ & Rainey JB, BJS 1994: 81: 1480.

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# SAVE THE DATE

October 17-19, 2019: that is the date for the 46th Perioperative Nurses Conference. It will be held at Claudelands, Hamilton.

The theme for 2019 is *Lifeblood - the indispensable factor or influence that gives something its strength and vitality.*

The 2019 PNC Conference will be hosted by the Central North Island Region of the College.

"Our goal is to provide you with talented speakers that show how nurses, health professionals and the human body can be the indispensable factor of our healthcare system," says conference convenor Lucy Johnson.

"Research, education, time and passion contributes significantly to the continuing success and existence of New Zealand perioperative care," she adds.

"Come and see what gives these people strength. What is their lifeblood?"

"These are just a few of the topics we will be exploring at the 2019 PNC conference for which planning is well underway," says Johnson.

"We look forward to seeing all of our members and colleagues for an exciting, motivating and limit-pushing conference in 2019."

### About the venue

Claudelands is an award-winning conference, meeting, function, exhibition and events venue located in Hamilton. It was crowned 'Supreme Venue of the Year' and 'Large Venue of the Year' at the 2014 EVANZ Awards. It provides a modern solution for live music, performance, sport, conferencing, meetings, banquet dinners and indoor or outdoor exhibitions.

Claudelands has a rich cultural history, hosting events in Hamilton since the late 1800s. Extensive redevelopment began in 2007 and it was re-opened in June 2011.

Claudelands is owned and managed by H3, a unit within Hamilton City Council, is set on 34 hectares of parkland in the heart of Hamilton city and includes:

- A 6000-capacity entertainment arena;
- A four-star conference centre;
- A combined 10,000 square metres of indoor and outdoor exhibition space.

**FOOTNOTE:** the history of the PNC annual conference dates from October 1973 when the Wellington Theatre Nurses Special Interest Section of the New Zealand Nurses Association hosted a two-day Seminar. This was before there was a national operating theatre nurses organisation. In fact, it was at this inaugural Seminar that the seeds were planted for what is now the Perioperative Nurses College.

## Industry News: Mölnlycke expands in NZ

Mölnlycke Health Care continues to expand its New Zealand team with two new staff members joining Mölnlycke in New Zealand. Abigail Owen has been appointed Surgical Territory Manager for the Auckland-North Territory. Abigail (Abby), has spent the past 16 years in the medical device industry in South Africa and brings a keen business acumen to the role. Joining the Mölnlycke team in the South Island is Lucy Brooker, who has been appointed to the Christchurch Surgical Territory Manager's role. Lucy comes with a wealth of clinical knowledge having worked for the past nine years at Christchurch Hospital, most recently as Clinical Nurse Specialist, running the day-to-day requirements of a busy Neuro Theatre and service. Abigail Owen may be reached on 027 211 9371; Lucy Brooker's mobile number is: 021 859 113.


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# Medical Imaging and PACU sessions well attended at Auckland-Northland education days

Auckland-Northland, like a number of other PNC regions, is struggling to get new people involved with the committee. We have, however, held two successful and well attended education sessions.

### Medical imaging education morning

A medical imaging education morning, sponsored by Obex Medical, has become a highly successful annual event well supported by both Medical Imaging Nurses and medical radiation technologists (MRT).

This year women's health Radiologist Dr Linda Ashley provided an introduction to breast ultrasound and also joined in Shona Matthew's presentation on lipiodol and infertility.

Gillian Martin then presented the thermal ablation of hepatic and renal tumours MRT; Sheree Jobson provided insights into the lithotripsy service she and her colleagues are involved in at Green Lane Clinical Centre.

Radiologist Dr Helen Moore provided an interesting overview of the progressive roll-out of the National Bowel Screening Programme and the part computed tomography (CT) colonography will play in this.

Everyone's favourite presentation of the morning was undoubtedly a very personal and moving insight from Laree Anderson – nurse, former Obex representative, colleague and patient. Laree detailed her journey of discovering she had a genetic cardiomyopathy, supporting her father through heart transplantation and recovery and then her own heart transplant last year. Interestingly Laree found the experience of presenting to such a supportive audience a real boost to her confidence, prompting her to return to the nursing research role she had held pre-transplant.

Another medical imaging education morning will be held next year at a date yet to be confirmed. If you are interested in further information, contact Shona Matthews at shona.matthews@adhb.govt.nz

### PACU Specialty Day: Spring into action

"Spring into Action" was a post anaesthetic care unit (PACU) specialty day run in Auckland on September 1, 2018. There were a wide range of attendees from around New Zealand, although fog at Auckland airport prevented others from attending.

The programme included airway management, paediatric pain management, regionals (why, where and how), experience of teaching a recovery room course and muscle relaxants. The presentations were from a wide range of speakers.

The presenters were experts and passionate about their chosen topics. They brought real experiences to learn from, providing a platform for post anaesthetic care staff to network and to learn from each other was a major aim. Over all good and constructive feedback was received to be able to improve and build on this day in the future.

In 2019 PACU POWER is being held in Auckland on March 23, 2019 at the Ellerslie Event Centre. We have some exciting speakers presenting great topics, including airway management, recycling, fluid management, obesity and the problems we face, care of the day stay patient and pain management 101.

For further information please contact Johanna McCamish at pacustudyday@gmail.com

*Johanna McCamish*

# Finger on the pulse

The origin of the term "finger on the pulse" comes from the literal meaning – to have knowledge of one's own heartbeat. The C in our first aid ABC refers to circulation, determined by manually accessing for a pulse with a finger (or two). A heartbeat can become increased or less rapid depending on a person's circumstances and health, which we see every day in the medical field. Figuratively speaking "Finger on the pulse" refers to someone who has a good understanding of and monitors changes closely in a certain area.

Around 100 participants came to the annual Hawkes Bay Perioperative Nurses College seminar on August 18 to do just that: keep current on situations where every moment counts.

Held in the Education Centre of Hawkes Bay Hospital, the seminar committee was up at the crack of dawn to welcome participants from the Hawkes Bay District Health Board (Hawkes Bay DHB), Royston Hospital and even nurses from Gisborne.

We kicked off without delay with the surgical management of an acute aortic aneurysm presented by Hawkes Bay's own vascular surgeon, Albert Lo. He touched on the ethical responsibilities of a surgical decision in these cases and made a great comparison of open vs closed (endoscopic vascular aortic repair or EVAR) surgical approaches.

Dr Lo is a man who makes complicated, frightening situations look very simple, partly due to his surgical skill but mostly due to his very admirable humility.

This was followed by an out of town speaker, Rob McHawk. Currently based in Wellington with the Ministry of Health, Rob gave us an overview of his PHD thesis which by his own admission he is doing by accident (it was started as a master's degree). Rob's thesis will be based on a combination of two or three studies of Middlemore recovery unit to determine if an updated patient scoring system could improve patient outcome and length of stay in PACU.

### Obstetrics & gynaecology

No seminar discussing emergencies would be complete without mention of emergency obstetrics and gynaecology. Our first presenter, Elaine White, a very animated surgeon from Scotland, gave us a detailed timeline of categories 1-4 of caesarean sections used to communicate the urgency of surgery requirements. Dealing with two lives instead of one is a great reminder of why circumstances and therefore categories, can change within minutes and why obstetrics is often theatre's best customer.

Sarah Sew Hoy, an anaesthetist doubly qualified with two fellowships in obstetrics, explained why pregnant mothers differ to other patients for several important reasons such as increased demand for oxygen. Sarah compared spinals vs epidurals, when general anaesthetic is necessary and the complications of these.

Scott Morgan presented a statistical analysis of how Hawkes Bay DHB is tracking in terms of its elective and acute surgical cases. Volumes appear steady compared to 2017 but this is perhaps more indicative of surgery being outsourced, not less work being done. Nationally the board appears to be tracking well, but then again not all statistics were made available. It is also important to remember population numbers and overall health of various district health boards differ and that not one size fits all. Complex patients such as the elderly or obese require more time in the operating theatre but statistically these factors are not always easy to represent in a positive way.

Morning tea, lunch and afternoon tea were beautifully catered for by Pure Catering from Havelock North and included a great spread of wraps, soup, chicken curry, fruit, sweet slices and more. Participants had the opportunity to network, enjoy fantastic food and be surrounded by several delightful floral arrangements compliments of the talented Flowers by Tania in Hastings.

After lunch we separated into our concurrent sessions which included the following:

- Acute theatre coordinator role by Kerry Oughton and Jan Marie Wilson;
- Awake fibre intubation by Allanah Scott;
- Ureteric stone management by Leanne Shaw;
- Managing the complex pain patient through the perioperative unit by Jill Gauld;
- Anaphylaxis and anaphylactic trends by Paul Lockington;
- Acute laparoscopic cholecystectomy by Betrand Jauffret.

I attended the session on orthopaedic neurovascular compromise – otherwise known as compartment syndrome – a dangerous condition caused by pressure build-up in the tissues due to internal bleeding and swelling. This is a true orthopaedic emergency which requires swift surgical management to avoid permanent damage or loss of the affected limb.

This talk was presented by one of Hawkes Bay DHB's orthopaedic registrars Kenan Burrows.

Bernie McEntee gave us an overview of large and small bowel obstruction which can threaten the livelihood of the digestive tract if left untreated due to ischaemia and tissue death.

Gastric bleeding was the next topic and included signs, symptoms and surgical intervention. Most of the audience was surprised to learn that coffee ground vomiting is not indicative of active gastric bleeding.

*Nicola Hall (left) and Sarah Hasselman (centre) were funded by Peter and Jean Koorey (right) to attend the PNC Conference in Nelson in October.*

*Kenan Burrows presented Compartment Syndrome. Here he is with siminar committee member Rochelle Holder.*

Ange Russel presented a dynamic view on the trials and tribulations of flight nursing. Ange spoke on the complications of flying with sick patients and that environmental conditions in the sky vary greatly with those on the ground.

Ange took us through the simulations that they undergo to be sky ready, such as having to empty out a fire hydrant on a fire and jumping out the plane in the event of a flying emergency. After explaining how often one would have to take some anti-nausea medication, Ange asked for any takers on learning how to become a flight nurse. Not too many jumped on board!

Our final speaker, physiotherapist Sarah Shanahan, spoke on what it was like to be on the other side of an emergency. Fit and healthy, Sarah was quickly admitted to Hawkes Bay DHB for monitoring after becoming profoundly pre-eclamptic. Sarah was kept in hospital for several days before the decision was made to induce labour. Sarah did end up with an emergency caesarean section but made special mention of the calm she felt whilst in the care of the theatre team that day.

A special thanks must be made to Peter and Jean Koorey. Jean is one of our lifetime Perioperative Nurses College (PNC) members and the original driving force behind our seminars. They have provided educational funding for two of our PNC delegates, Sarah Hasselman and Nicola Hall. These lucky nurses travelled to Nelson in October for the annual PNC conference.

An absolute huge congratulations must be made to the seminar committee – Sally Bone, Nicola Hall, Rochelle Holder, Amanda Martin, Janya McLean and Rebecca Rawnsley – for putting together a seminar that was professional, informative and fun. These nurses through their hard work provide us all with the opportunity to keep our "fingers on the pulse".

**About the author:** *Joanne van der Spuy attained her four year degree at Stellenbosch University in South Africa then worked as a registered nurse for three years in theatre followed by eight months in ICU. After emigrating to New Zealand, she worked in the HBDHB operating rooms for 12 years before moving on to various private healthcare facilities in the last ten months, based mainly now in Royston theatres. Joanne has been a member of HB PNC for many years and served on the committee as secretary and chairperson. She has been attending HB PNC seminars for many years now and believes the quality of education is impeccable and valuable in maintaining our professional standards and development.*

Perioperative Nurses College NZNO

# CHAIRPERSON'S ANNUAL REPORT 2017-18

## presented at AGM October 13, 2018

It is with pleasure that I present the annual chair report for the Perioperative Nurses College of the New Zealand Nurses Organisation (PNC NZNO) for the 2017-18 year.

I wish to thank the Perioperative Nurses College National Committee, *The Dissector* Editorial Committee and the Professional Educational Committee for their work throughout the year. It is a pleasure to work with nurses who are passionate about nursing and the perioperative area of practice.

The Perioperative Nurses College has maintained a presence in the world of healthcare and nursing. Our regional activities continue to grow with study days and the annual conference. Key achievements and on-going work and commitment have included:

### 1. Occupational hazards

Crate weights and smoke plume are two major issues that have been on-going. Headway has been made in working with Work Safe New Zealand to set standards. WorkSafe has acknowledged the problem as a hazard.

PNC activated a membership survey in 2016-2017 to determine nurses' knowledge of smoke plume and its impact on nurses and patients. The results of this survey have been collated and analyzed to provide an overview of the knowledge, policies in place and problems in implementing smoke evacuators in the workplace. This was published in the college journal, *The Dissector* (Vol. 46, No. 1 – June 2018).

### 2. Scopes of practice

A robust letter was submitted regarding the proposed Anaesthetic Technician scope of practice. The proposal suggests a name change to perioperative practitioner and broadening the scope of practice to be inclusive of circulating and scrub roles, PACU care and ICU.

PNC is questioning the role as there are direct implications for nursing. This will be on-going. The PNC Knowledge and Skills Framework has been widely disseminated and is available on the PNC website.

### 3. Safe sedation round table

PNC chairperson Johanna McCamish represented NZNO at the safe sedation round table, a multi-disciplinary meeting that allowed for the discussion of standards on safe sedation.

Recommendations have been made to continue representing nurses in this forum, with further representation from emergency care and critical care nursing.

### 4. Membership

On-going strategies by regions to encourage new members and retain member's needs to be a priority in the coming year.

Communication with members is on-going with a perioperative membership newsletter published and distributed quarterly, the publication of *The Dissector*, providing articles, research and information relevant to the perioperative specialty area.

The website is also used as a form of communication, ensuring information and updates are available to members.

### 5. Strategic plan

Updating and aligning the Perioperative College strategic plan with the NZNOs strategic plan has been initiated this year. A draft has been completed to be circulated and discussed.

In the year to come we look forward to further education, on-going networking with peers and relationships with the business sector (Trades).

Thank you for the support of the membership and the National Committee thoughout the year, and into the coming year.

*–Johanna McCamish, Chairperson, Perioperative Nurses College*

# Professional Practice Committee

It is with much pleasure that I present the first annual report of the Professional Practice Committee (previously known as the PNC Professional and Education Committee).

I would like to offer a heartfelt thank you to the members of the committee – Professor Marion Jones, Amelia Howard-Hill, Juliet Asbery (National Committee Representative) and Lorna Davies (secretary). Their on-going commitment and the high calibre of work they produce is a testimony to them all. The committee works hard to ensure that the interests of the PNC members are protected, especially in a changing perioperative landscape.

It is with regret that this year we say farewell to Amelia. Amelia has been a long-standing member of the committee; we will miss her dedication and her experience. Thank-you Amelia for all that you have contributed over your time with us.

The focus of our work this year has been:

- Completing submissions to the National Committee regarding the proposed change of scope of practice for the Registered Anaesthetic Technician position;
- Designing a survey on perioperative practice for the National Committee. Questions were used as part of the annual membership application;
- Working with National Committee to set a strategic direction for both the Professional Practice Committee and PNC as a whole.

*Rob McHawk, Convenor, PNC Professional Practice Committee*

# Orthopaedic Expert Faculty Group (EFG), Surgical Site Infection Improvement Programme (SSII), Health Quality and Safety Commission report

The role of the Orthopaedic Expert Facility Group (EFG) continues to provide expert clinical support and advice in relation to the SSII programme. We continue to meet via teleconference on an infrequent 'as needs' basis.

Over the past year the EFG has published a National Periprosthetic Joint Infection Sampling and Culture Guide.

Arthur Morris, Clinical Lead NZ SSIIP, has also published an article on Surgical Antibiotic Prophylaxis in *NZ Anaesthesia* (Dec 2017), and a further article on BMI as a Key Risk Factor for Early Periprosthetic Joint Infection for the NZ Medical Association (NZMJ Sept 2017, Vol 130 No1461)

A number of hospitals have now tested and adopted anti-staphylococcal bundle of care preoperatively. The aim of this bundle is to see a reduction in staphylococcal infections by at least 20 per cent.

From September 2018, the Orthopaedic quarterly reports are available on the HQSC website.

It has been interesting being involved in the Orthopaedic EFG since its inception. Having been on the group for the past three years, I am nearing the end of my second term and therefore I wish to tender my resignation at the completion of this term.

*Diane Darley, PNC representative to the Orthopaedic EFG*

# The Dissector annual report

It is with pleasure that I present the annual report of *The Dissector* Editorial Committee. I wish to thank committee members Sandra Millis, Tracey Lee (National Committee representative), Feng Shih and new members Devika Cook (Charge Nurse, Post Anaesthetic Care Unit, Auckland City Hospital) and Catherine Freebairn (Radiology Nurse, Hawkes Bay District Health). They are an enthusiastic and able group to work with.

We farewell Sandra from the team after her involvement as a National Committee and later individual representative and will miss her contributions, editing and proof-reading skills.

Two new members – Sarah Winship (Perioperative Nurse Educator at Whakatane Hospital) and Rebecca Porten-Whitworth (Acting Clinical Nurse Specialist Cardiothoracic and Vascular Theatres Christchurch Hospital) will join the committee after the annual general meeting.

The Committee had two face-to-face meetings this year as well as at conference and otherwise communicate by email and through the use of Dropbox.

## Content

This year we published one issue with an otorhinolaryngology theme but have otherwise focused on providing a good range of material across the perioperative continuum. Featured articles covered member research, history, education, medical imaging, post anaesthetic care, new graduate experience, surgical case studies and quality improvement. The Incentive to Publish payment has seen many College members benefit from writing.

National Committee continues to receive modest returns from Gale CenGage Learning Publishers for access to our material. A number of *Dissector* articles have also been republished in a range of international journals.

## Indexing and Binding

Copies of *The Dissector* from 2006-2017 have now been bound into a number of volumes to ensure copy is readily available for archival and research purposes and an indexer contracted. It is great to see this important work undertaken.

## Circulation

The latest circulation data for *The Dissector* includes 854 members (including 35 life members). It is concerning that membership stood at around 950 two years ago.

In addition, the journal is mailed to advertising and public relations agencies (22), tertiary training institutions (36), libraries (19), NZNO offices (18), International Perioperative Nurses (43), non-member subscriptions (54), Government departments and District Health Boards (118), medical company representatives (222). This made a total of 1421 for the September issue.

## Future Plans

Looking ahead we would like to have a themed issue covering the impact of obesity across the perioperative continuum and a paediatric issue. More articles featuring quality and innovation initiates would be welcome and case study continue to feature. Regular feedback from all of the regions on their activities will be actively pursued.

Thank you to members who have supported *The Dissector* by providing copy (articles). It is encouraging to now have a range of articles on hand for future issues and more promised, so please keep these coming.

Suggestions for further themed issues would be welcome. The committee is always willing to assist so please contact one of us with your ideas.

Thank you to Michael Esdaile and his team at AdVantage Publishing for their support and valuable sponsorship of the journal and membership.

*Shona Matthews, Chief Editor, The Dissector*

# Regional Liaison Portfolio report

The PNC newsletter continues to be published three times a year to provide information on events, National Committee business, PNC history and current topics of interest in Perioperative Nursing.

The newsletter is emailed to members and is also available on our website.

If you have any study days you would like advertised or other information which you would like to share, please email the PNC secretary. The next edition will be available in November.

*Kirstie Cooke, Central North Island Regional Representative & Regional Liaison for National Committee*

# Membership report

It is with much pleasure that I present the annual Perioperative Nurses College membership report. (A data sheet was attached for in-depth membership information but we do not have space to reproduce it here).

In April 2017, undergraduate student nurses were invited to join PNC. Student membership is free of charge, with no additional financial costs for PNC. With 114 students joining PNC, this initiative would appear to have been a success. Our new challenge however is to maintain their membership and to continue to attract new students to the Perioperative College. After all, it is vital that we continue to promote Perioperative Nursing as an exciting, viable and rewarding career option to our new graduate nurses. What better way to do this than to capture their interest at undergraduate level!

Excluding students, membership of PNC remains similar to previous years with 748 financial and life members. An increase of 17 members from 2016-2017. Annual membership renewal remains online, with March 31, 2019 the deadline to renew. Annual subscription is just $13.

My challenge to all members is to not only continue to recruit new members to the Perioperative Nurses College, but to encourage students to also join the College. Remember, being a financial member of NZNO is a prerequisite.

*Sarah Eton (Otago) PNC Membership*

# Website Report

The aim of the PNC webpage is to provide new and valuable content and resources to the perioperative membership, to advise members of available events (national, international and regional) and to provide access to documents such as the Knowledge and Skills Framework in a printable PDF format and availability of the AORN standards to members free of charge.

Information including links to smoke plume and relevant standards and documents are also available.

On December 1, 2015 the way a person navigates to Colleges and Sections on the NZNO website changed.

Previously there was a Colleges page with all the Colleges listed underneath, and a separate Sections page with all the Sections underneath. This arrangement caused problems and so a new combined Colleges and Sections page was created, from which users could go straight to the College or Section of their choice.

The page navigation change means that:

From September 1, 2014 to November 30, 2015 the PNC home page URL was: http://www.nzno.org.nz/groups/colleges/perioperative_nurses_college

From December 1, 2015 to date the PNC home page URL became: http://www.nzno.org.nz/groups/colleges_sections/colleges/perioperative_nurses_college

# Professional Nursing Adviser report

Thank you to the Perioperative Nurses College National Committee for the on-going commitment, leadership, professional engagement, and stewardship that is exceptional. Sincere thanks to the Nelson-Marlborough region for hosting the annual conference, which highlights Perioperative Nursing in New Zealand across the health continuum.

This year's conference theme 'Communication is the key' highlights to me the importance of the nursing voice in communication. We continue to strive to ensure clinical areas are safely staffed, resourced and nurses are optimised not replaced!

In the day-to-day challenge of upholding the role and value of nurses in the New Zealand health system, we have engaged with many stakeholders. However, through the New Zealand Nurses Organisation's (NZNO) Strategy for Nursing 2018-2023, there are opportunities and actions for enrolled nursing. The strategy can be read in full at: www.nurses.org.nz

The strategy is a key tool to help resolve structural and systemic barriers that impede nursing effectiveness in Aotearoa New Zealand, such as restrictive models of care and employment, contractual methods, and funding mechanisms. The conceptual model and the interdependent strategy sections and themes provide a strong platform for implementing strategic actions through NZNO membership and in partnership with aligned professional, legislative, regulatory and community agencies.

It is important the section and NZNO continue to advocate for more nursing students, better transition to practice opportunities, improved clinical environs that utilise nurses and full employment of all nursing graduates.

I wish the College all the success for the forthcoming year and look forward to working with the committees to reach your goals.

We have more to do!

*Suzanne Rolls, Professional Nursing Adviser, NZNO.*
*suzanner@nzno.org.nz*


*NZNO Strategy for Nursing 2018-2023 www.nurses.org.nz*

## The headline concerns for the nursing workforce in Aotearoa New Zealand:

- The **lack of investment and resources to create a coherent national nursing workforce strategic plan** that is current, cogent, and has a timeline for implementation is reprehensible.
- The **absence of a Māori nursing strategic plan** and the resources to support and implement it is equally lamentable.
- **Less than 100 per cent employment for graduate nurses** and not all graduate nurses have access to a nurse-entry-to-practice programme (or equivalent).
- **Māori and Pacific nurses are under-represented** for the populations they serve.
- **50 per cent** of the nursing workforce will be **retiring by 2035** .
- A **dependence on internationally qualified nurses** (the rate of 27 per cent is higher than any other Organisation of Economic Co-operation and Development (OECD) country .
- Persistent and serious **underfunding for postgraduate nursing education**.

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# Laser Safety

By Elissa O'Keefe

**Abstract** Lasers are used in a range of perioperative settings and offer many benefits. They do however present unique workplace health and safety issues and it is imperative that staff receive adequate training. The latest Australian and New Zealand Standard AS/NZ 4173:2018 is outlined along with training and competency requirements.

**Keywords** Lasers, Perioperative Nursing, safety compliance, laser education and competency.

## Introduction

Lasers are used in the operating theatre for urology, ophthalmology and gynaecology to name a few specialties and are known to reduce perioperative blood loss, decrease post-operative discomfort, reduce the chance of wound infection, decrease the spread of some cancers, minimise the extent of surgery in some cases and promote better wound healing.

But the use of lasers comes with some unique workplace health and safety issues that are the responsibility of everyone in the operating theatre.

When the users and operators of lasers are not educated and competent in their use, these devices are dangerous pieces of equipment and the adverse outcomes can be devastating for patients and practitioners alike. Two cases of operating room incidents for patients have involved fires in gynaecology cases. One was a drape fire (ECRI Institute, 1992) and the other the ignition of flatus (*The New York Post*, 2016). Both cases resulted in significant burns for the patients.

Other potential hazards include plume, eye injury and burns to the skin. In this article Bravura Education's Managing Director, Adjunct Associate Professor Elissa O'Keefe, Registered Nurse and Nurse Practitioner helps to get your operating theatre compliant by guiding you through some of the things you need to have in place to meet the new Australian and New Zealand (AS/NZ) Safe use of lasers and intense light sources in health care standard AS/NZ 4173:2018 (Standard Australia, 2018).

## New Standard Framework

The safe use of laser devices currently sits within the framework of the principles and legalities of safe work practices and is within the remit of Worksafe New Zealand principles. All health professionals are already familiar with their safe work responsibilities and are held accountable to them too. The new national Australian and New Zealand Standard AS/NZS 4173:2018 Safe use of lasers and intense light sources in health care (Standard Australia, 2018) has been published and now is the time to audit your clinical governance to have a compliant operating theatre.

This standard and the mandatory elements of the document are clear about what is expected of operating theatres, managers and staff alike. The new standards provide a framework to implement strategies to keep staff, patients and hospital visitors safe from non-ionising radiation and are also a valuable resource to have available on site. A common question about these standards though is whether they are mandatory? The short answer is "not necessarily", but the long answer is that it is well worth a closer look.

Firstly, if the standards are written into legislation or regulation then they are mandatory. Where they are not, and an instance of legal action is brought against a doctor, nurse or hospital for negligence or otherwise, the adherence to standards will always be looked upon favourably. For example, a clinician who injures a patient through the use of a laser who has not complied with AS/NZS4173:2018 is more likely to be viewed as negligent than where all relevant standards have been adhered to. So, implementing a radiation safety protection plan for your operating theatres is an essential risk management strategy for both the staff and the facility.

Laser safety programmes should be practical, applicable to the type of procedures undertaken and sustainable in the long term. There are four primary areas that require attention under the new standards which are:

1. Laser education;
2. Competency in the use of lasers;
3. Mitigating risk and protection from hazards;
4. Regular audit.

Do your laser users and operators understand what they are doing and why?

It is mandatory under the new standards that anyone who is a Class 4 laser user or operator has laser safety education. The standards state that "staff shall be trained in operating procedures, including

*the use of lasers comes with some unique workplace health and safety issues that are the responsibility of everyone in the operating theatre*

handling and care of equipment, set-up, intraoperative monitoring, use of the controls and delivery systems, and use of all accessory equipment" (Standards Australia, 2018).

Sometimes this education is done in-house, sometimes it is outsourced – and online learning is becoming more and more popular as it does not require staff to be sent away from the workplace and study can be accommodated within the time constraints of busy theatres. Additionally, maintaining an in-house programme can be time and resource intensive and often falls to the same individuals to take carriage of it.

### Personnel Training

The standards are explicit too about who needs education and training and it is beyond just users and operators and includes anyone who has contact with these devices. The standards define these people as follows:

1 laser safety personnel;
2 laser users, e.g. surgeons, physicians, dentists, nurses and other allied health professionals;
3 laser team members, e.g. laser operators, biomedical engineers, technicians, medical physicists;
4 laser system service personnel, including either in house or contractor service personnel;
5 incidental personnel, including medical photographers, observers, students, family members and industry representatives.

Remember too that not all courses that have been completed are going to be current and meet the requirements set out in the standards. In fact, if your staff have not done laser safety education this year, we recommend a refresher course because the new standards are just that, new, and have only been released since April 2018. The requirements are that education courses include many specific elements, some of which are not covered by all courses. According to the informative section of the standards, the courses are to have subjects on the operational characteristics of lasers, hazards, and principles and procedures for safe use.

### Are your staff capable?

After education, the next most important area to have processes and policies in place is with regard to competency in the use of lasers. What is clear within the standards is that there is an expectation that the criteria for education, training and competency assessment is explicit in your workplace. Your operating theatre should have a policy that is clear about what laser safety education is expected and the process from induction through to the independent use of these devices. It needs to provide direction on who will supervise practice, a progressive list of skills and attributes required and how competency will be assessed and signed off.

### Does your hospital have the right clinical governance in place?

The most common method of reducing risk and protecting against hazards is the implementation of standard operating policy and procedure documents in the workplace that are then adhered to by all staff. The most common ones that are relevant to laser practice are:

1 Ocular/eye safety;
2 Controlled access to laser rooms;
3 Laser generated airborne contaminants (plume);
4 Test firing carbon dioxide lasers;
5 Handling a fibre-optic delivery system;
6 Roles and responsibilities of the Laser Safety Officer;
7 Radiation Safety Protection Plan;
8 Criteria for education, training and competency assessment;
9 Flammability hazards and fire safety;
10 Infection control;
11 Incidents and accidents;
12 Equipment inspection.

*a clinician who injures a patient through the use of a laser who has not complied with AS/NZS4173:2018 is more likely to be viewed as negligent…*

### Auditing requirements

Have you got it all right?

The standards recommend that laser safety audits be completed annually or more frequently if required. Elements of an audit will include: a gap analysis of staff laser safety education with an intent to educate or refresh staff, having a current laser safety plan, the mitigation of risks including eye injury, plume and fire, documentation and observation of practice. There is a sample checklist for audit included as an appendix in the standards to make this process easier for you to complete in your workplace.

Laser clinical governance need not be too hard, if you're interested in talking to someone about the needs of your hospital, please feel free to contact Elissa O'Keefe at elissa.okeefe@bravura.edu.au

### References

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Standards Australia (2018) *AS/NZ 4173:2018 Safe use of lasers and light sources in health care.* To purchase a copy of the standards: https://infostore.saiglobal.com

**About the author:** *Adjunct Associate Professor Elissa O'Keefe is a Nurse Practitioner, a health industry pioneer, a highly-experienced clinician and educator and was the first nurse practitioner in the Australian Capital Territory (ACT). She has published in peer-reviewed journals both nationally and internationally and is often called on for comment in the health industry.*

*Bravura was born when Elissa recognised that there was a need for flexible, high quality post-graduate continuing professional development for health professionals with regard to lasers and other light-based and therapies that was evidence-based and pitched at the high level required of this complex landscape.*

# Communication is the key

With 191 nurse delegates, 35 medical medical product supply companies and a total of 259 participants from around the country, the 45th Perioperative Nurses College Conference in Nelson was a great success.

Held at the Rutherford Hotel from October 11-13, the conference was run on the theme of 'Communication is the key'.

In the perioperative environment, we are the unconscious patient advocates. An integrated team approach involving open communication and respect for our patients and colleagues is paramount. An overview of the presentations is provided for those members who were unable to attend.

## Surgico Free Paper Session

Registration on Thursday October 11 was followed by the Surgico Free Paper presentations.

**Jenny Green** was the first presenter and discussed the preparation of undergraduate students at Massey University prior to their perioperative clinical placement and how to help overcome the fear of the unknown and facilitate students' involvement and comfort in the setting.

**Kathryn Skadiang** presented an audit of paediatric fasting times at Manukau Surgery Centre. The audit produced results of variable and long waits for children. Kathryn recommended that fasting times of clear fluids be reduced to one hour for paediatric elective surgery.

**Tracey Lee** discussed how staff recruitment and retention needed to work hand-in-hand. Filling one position without plugging the other leaves you with a constant drain or not enough to begin with. Tracey outlined the teamwork-based approach used at Auckland City Hospital involving all stakeholders to identify what drives the workforce and what can be done to support them meet their goals.

## Debbie Booth Travel Award

There were four papers presented in the Debbie Booth Travel Award, sponsored by Obex Medical with the runner-up award sponsored by Boston Scientific.

**Stephen Cotterell** from Christchurch Hospital discussed advancements in Central Venous Access Device (CVAD) placement and care. In particular the insertion of tunnelled catheters in the upper arm and chest veins where Peripheral Inserted Central Catheters (PICC) are not recommended. Stephen has completed the required education, competences and supervision to insert these lines, offering another option for patients.

**Shona Matthews** from Auckland-Northland region drew on the conference theme to discuss communicating and rapport-building with

*Surgico Free Paper presenters, from left, Tracey Lee, Kathryn Skadiang and Jenny Green.*




*Debbie Booth Travel Award presenters, from left, Stephen Cotterell, Shona Matthews, Gillian Martin and Andrea Walford.*

patients in the outpatient medical imaging setting. She outlined strategies to quickly establish rapport with patients, put them at ease and ensure they understand their pending procedure.

**Gillian Martin** from Auckland-Northland looked at the evolution and role of the nurse, from Florence Nightingale's time to the current care of patients in a rapidly developing medical imaging setting.

**Andrea Walford** from Hawkes Bay talked about dealing with patients with difficult intravenous access (DIVA). She outlined the development of their ultrasound-guided IV access service utilising their PICC insertion skills. She offered pointers and video footage for those wishing to start such a service.

A welcome reception with refreshments and canapes followed, along with the opening of the trade stands. It is important to acknowledge the contribution of partner sponsor REM Systems, leading sponsor BSN Medical along with Stryker sponsorship of the breakfast session, Manuka Street Hospital the very welcome coffee cart and supporting sponsors Hallmark Surgical, BOC Limited and Southern Cross Hospitals Limited.

Trade support is critical to running our annual conference.

## KEYNOTES & PLENARY SPEAKERS

The Friday programme opened with a mihi whakatau (welcoming speech) led by Tui Lister. This was quite beautiful and set the tone for the conference to follow over the next two days.

### What's your prison?

Dr Paul Wood is an expert in helping individuals and organisations turn adversity to their advantage and ensure change leads to growth. Paul's passion for transformational change comes from his personal journey from 'delinquent to doctor' which he discussed in depth. He was quite simply inspirational.

Paul's mother died when he was 18 and with her declining health and death, any softness went out of his life. His father was a stern man who brought him up hard but fair. His personal identity was battered and he felt he was not enough of a man, so he took drugs and became quite violent to overcompensate. He lived in a tough world where violence and the drug culture was everything.

After his mother's funeral, Paul met with a drug dealer for his latest fix. The man was a sexual deviant and sexually assaulted Paul, who retaliated and beat him to death. Paul was sent to prison.

"My life potential was fixed in the mental prison in my mind," he said. Where you end up in life is your choice.

On turning 20, he was transferred to the notorious B Block at maximum security Paremoremo Prison. Life was bleak but one day in the yard he met another prisoner, who changed his perspective on what he thought

*Dr Paul Wood spoke about his personal journey from 'delinquent to doctor.'*

his reality was. This change in thinking led Paul to begin studying for a degree in psychology despite his limited educational background and the prison authorities making it difficult. His father enrolled him and paid his university fees. After eight years' study, he obtained a Doctorate.

Paul outlined what he called the 'Five Steps to Freedom.' This requires recognition that we are born free; we have no agenda, ideas or expectations. We are a blank canvas. As we grow, we acquire self-defeating beliefs that limit our potential or create our mental prison. Paul had to be in actual prison before he could recognise this.

Step two requires choosing to break out of our prison, be it mental, or in Paul's case, also physical. This depends on what our desires are and how desperate we are for change and what our limiting beliefs are. To

break out there has to be a real emotional commitment to change. Often we don't want to risk failure, when we are comfortable enough with our life.

Determine where you are and where you want to be in your future and make the escape. Change may seem beyond your reach and for Paul this also required quitting marijuana. You need to have specific goals for your life right now and make change, with a focus on the present.

The fight for freedom requires grit and tenacity to overcome obstacles as well as the support of others. In Paul's case, that came from his father who visited him every week and paid for his education and his tutors at Massey University. The tutors also visited him in prison at postgraduate level where face-to-face contact was required.

Paul describes personal courage as being like a muscle; the more it is used the better it works. Finally he talked about keeping it real; acknowledge that sometimes we will slip back. Living free is about trying to be the best version of yourself with the goal of getting better.

Paul gave us so many lessons that will ensure the way we communicate with ourselves propels us towards our potential, rather than holding us back. He was an inspiration and an amazing example of what can be achieved with self-belief and support of others.

Dr Paul Wood's much viewed Auckland TED talk can be accessed at www.youtube.com/watch?v=LjjlsW1MDmc

## Cyclone ITA hits Nelson! Scenario and debrief

Cyclone ITA hit Nelson on Good Friday 2014, with the wind gusts damaging the roof of Nelson Hospital. A 1000kg copper sheet was blown from its fixings and dangled precariously above the intensive care unit (ICU) roof. Code White was declared and when the severity of the situation was realised, this escalated to Code Red.

What happened next was described in the presentation from Emergency Management and Business Continuity Planning manager at Nelson-Malborough DHB, Peter Kara, along with operating theatre and post anaesthetic care unit (PACU) nurses Bronnie Ball, Pamela Millson and Isobel Heslop.

Emergency services were called, the main road outside the hospital was closed and a helicopter was brought to the road outside as the helicopter pad was in the storm damaged area.

It was decided patients in ICU had to be evacuated a soon as possible to PACU and a crane was organised to cut off the copper roof, no mean task on Good Friday. There was a great risk in doing this, as if let loose, the copper sheet would have "guillotined" into the ICU.

Assumptions were made as to who had been told. Unfortunately, theatre and PACU staff were not notified, a major 'communication breakdown'. At the same time, it was necessary to perform an acute caesarean section and two nurses were called in to work. PACU staff did not know the ICU patients were coming. In fact, the theatre manager did not find out about the emergency until after the weekend.

The move, although part of the hospital plan, had not been practised frequently but the eight ICU patients were evacuated. Was everything all right? No it was not. More research was needed and further review of procedures.

After any emergency, debriefing is absolutely critical. The question was raised 'where to from here and how do we do better'? The main issue was clear lines of communication.

## *Thunder Struck* Scenario

Following the presentations on Cyclone ITA showing the need for Emergency Evacuation Procedures, Tim Ellena RN, (surgeon) Matt Crocker RN (Anaesthetist), Andrew Green (Anaesthetic Tech) and Peter Kara set up a practical interactive breakout session incorporating the steps leading up to an evacuation. The simulated situation was very real with only in-house smoke missing from the room.

Tim used two members from the audience to be the scrub and circulating nurse, which helped them feel the stress of the situation. The purpose of this was to familiarise conference participants with the process of practising emergency scenarios (*Thunder Struck* as we call it) and to see for themselves the logical steps that need to be taken for a smooth-running real-life evacuation.

Practise makes perfect and if everyone is communicating and working towards a common goal, lives will be saved. Our goal was to give other hospitals a platform to follow to help them implement their own evacuation scenarios if they so wish.

*The Thunder Struck session familiarised conference participants with the process of practising emergency scenarios.*

This was an idea based on experiences from hospital staff who had been in the Christchurch earthquake. Their experience showed trial evacuations had limitations and research can often lead to the simplest solutions. Hence *Thunder Struck* was born and showed the need to make quick decisions. Knowing the plan ahead of time makes a difference. In addition, exercises only work with engagement from all staff and if there is a defined goal, that has benefit.

Simulation exercises were begun with help of the Fire Service, including smoke-filled rooms, injured people lying on the floor and an anaesthetised patient. It was found that a patient could not be moved very far on the operating table as it was impossible to lift the table across the flooring joins between rooms. Task cards were made, and jerkins hung in "Main St" for each leader.

When it is time to leave or move into another fire cell – it is not a discussion, it is a decision. Good, quick sharp communication will save lives – so communicate and move effectively. In turn, learning needs to be converted into actions and checklists. Debriefing is important.

Invite fire service and staff from other hospitals to learn from the experience and share ideas and information. Nelson Hospital has made up a series of check sheets that can be accessed here:

https://www.dropbox.com/sh/5e0wncwjpoa5nyj/AAAEPAPM2y8b5Wg5Hja5cMr8a?dl=0

## Effective surgical teams

Claudia Teunissen is Charge Manager Operating Theatres at Nelson Hospital and has a background in change management and the introduction of the Surgical Safety Checklist in a range of settings. Claudia's review sought to identify and critically appraise the literature around the relationships between inadequate communication and teamwork within perioperative teams and in turn the barriers and challenges to achieve continuous quality improvements and reduce perioperative harm.

Dynamics within the multi-disciplinary perioperative team and deficient understanding of the respective competencies for individual professions is a barrier to collaboration. This is compounded by restricted availability of and inconsistent team training or simulation. In addition, financial influences, health targets and expenditure priorities take precedence over other developments in service organisations.

Claudia highlighted the need for consistency and permanency in the operating theatre and the importance of the manager understanding the skill mix and competencies of individual staff. There are barriers to effective surgical teams and Claudia described them as high staff turnover, team composition, and perioperative teamwork concept and organisation performance incentives.

She believes the solution is more professional education. There is also a need for incident reporting to highlight any problems.

The effective teamwork was tested in the inter-disciplinary simulation at Nelson Hospital and later Wairau Hospital. The annual exercise addressed existing barriers and challenges to achieve continuous quality improvements in reducing perioperative harm.

Claudia also participated in the *Thunder Struck* stimulations at the breakout sessions to further demonstrate how the model works in reality.

## Rhythm Interactive

As we walked through the door for this session, looks of surprise and smiles were on our faces when we saw a drum waiting in each seat! On the stage two performers did not utter a word. Then they began to drum – and we attempted to follow, directed by actions and body language only.

We laughed! It took us a while at first to correctly mimic the drum beat as a group. The lead performer's pleasure and displeasure was obvious when the audience hit the mark and also when we did not!

Rhythm Interactive showed us the art of non-verbal communication through an interactive drumming session. There was no talking, although singing and humming was eventually incorporated. Audience participation was strong and no one was snoozing following that lovely lunch we had enjoyed. They were so good that one of our international visitors wants them to come to their country!

## Communicating with your colleagues - Personality Plus

Maryanne Coyle has an extensive career in Operating Rooms throughout New Zealand and the UK. After training in Wellington as an RN, she has worked in Sydney, London and Southern Cross Christchurch. Maryanne is currently a Territory Manager for REM Systems.

Over the years Maryanne has developed her public speaking skills, utilised to speak at national health conferences. She also facilitates workshops and seminars for operating room (OR) staff. Maryanne's sessions are always funny, provocative, relevant and important. She did not disappoint in Nelson.

There is no right or wrong personality. Everyone has a different

*Claudia Teunissen's talk highlighted the need for consistency and permanency in the operating theatre. Rhythm Interactive showed us the art of non-verbal communication through an interactive drumming session.*


*Above: Members of the Conference Organising Committee enjoy time with REM Systems, the 2018 Conference Partner company. Below: Maryanne Coyle provided a snapshot of the four styles of personality to assist in working out which personalities are colleagues have*


personality and each style is equally important. So how do staff members utilise their communication style to function and relate to their team?

Maryanne provided a snapshot of the four styles of personality to assist us in working out what personalities our colleagues have. This can help us to understand them better in the work place.

The four styles of communication were identified by Maryanne: analytical, driver, supportive, expressive. These four styles are characterised by their responsiveness. Responsiveness ranges from a people-orientated approach to task-orientated. All types care about people, but their focus is different.

**Analytical** - are more task-orientated. Their emphasis is on working conscientiously within existing circumstances to ensure quality and accuracy. They expect precision, efficiency and high standards.

**Driver** - their emphasis is on overcoming the opposition to accomplish results. They focus on results, efficiency and action.

**Supportives** are people-orientated. Their emphasis is to co-operate within existing circumstances to carry out the task. They want team stability and collegial relationships.

**Expressives** shape the environment by influencing or persuading others. They want challenge, excitement and relationships.

In addition to these communication styles there are varying degrees of assertiveness. They may **ask** – an indirect method of communicating or **tell** – a direct method of communicating.

Both communication styles can influence to the same degree, but their approach is different. For these communication styles to work they have established ways, which require certain environments, attributes and situations.

Maryanne presented her own experiences, giving us a better understanding of the principles of dealing with personality styles in the OR.

## Communication vital in SSI prevention

The ever-changing landscape of infection – how communication is vital in preventing infection in a world of antibiotic resistance was the core of

the presentation from Elsie Truter. Elsie has a background in Perioperative Nursing, a Master's degree in medical ancient history and currently works as the Infection Prevention and Control professional in a small private hospital. She delivered a fascinating presentation looking at healthcare through the ages.

The Romans had excellent public health facilities, with the first recognised hospitals built to treat soldiers and veterans. Roman medicine grew out of what military doctors learnt and demanded. Elsie showed slides of layouts of Roman military hospitals, with separate medical and surgical wards, fresh rainwater collection for dressing wounds and single rooms for patients. Many surgical instruments bear a striking resemblance to instruments used today, including duck-billed speculum!

Elsie then covered healthcare and hospitals in Europe during the Middle Ages. At this time, hospitals were called "spittle houses" and provided care for the sick, insane, and destitute. Persons of means preferred to receive care at home, with the kitchen table often used as a makeshift operating table. Cleanliness was virtually non-existent. Hospitals were crowded and rats ran amok, often over patients. Infectious diseases strongly impacted life in medieval times and bubonic plague killed about one-third of all people in Europe between 1347 and 1350. As well as plague, epidemics of smallpox, influenza, dysentery and typhus were frequent.

The final third of the presentation looked at our healthcare practice from the 1940s until today. Although there have been huge advances in medicine, surgery, including operating theatre design and microbiology, antibiotic resistance has become a problem. It is believed that contamination of surgical wounds mainly occurs at the time of surgery, eventually leading to surgical site infections.

The operating theatre is a complex system in which many risk factors are present. This includes not only the features of the structure and its fixtures, but also the management and behaviour of healthcare workers. Sub-optimal behaviour and equipment can threaten asepsis, such as eating food in theatre, poor cleaning practices, and fabric covered chairs, to name a few. Adverse surgical events may be due to poor communication, bad operative technique, malfunctioning or improperly used equipment and cognitive errors due to stress or inattention.

Communication in the operating suite is often poor and may contribute to adverse outcomes. Studies have shown that improving the physical layout of theatre and improving staff behaviour results in a reduction in contamination and, consequently, surgical site infection.

## Cultural engagements

The next session was about korero mai – cultural engagements with Maori patients and their whanau and was presented by Tui Lister. She has been senior Maori health practitioner for Te Waka Haurora services at Nelson Marlborough DHB for the last ten years. Tui explained how this role provides support for Maori patients and their whanau and she feels privileged to work with patients at their most difficult times.

*Ophthalmologist Dr Derek Sherwood, delivered a thought-provoking presentation on "over treatment" of the patient. Elsie Truter delivered a fascinating presentation looking at healthcare through the ages.*

Tui serves as the bridge between patients and health professionals through their health journey and treatment, relaying health messages and explaining what was said as well as helping whanau access the appropriate treatment. She found one of the biggest challenges for patients is the medical jargon, which she acknowledges took her a few years to master. She will visit whanau in their home and accompany them to appointments.

One of the difficulties when encountering Maori patients is their historic fear of hospitals ("you go there to die") hence their reticence for attending follow-up appointments and treatment. Tui explained how a one-on-one discussion with these patients – taking account all their concerns, which are not always evident to non-Maori – is often all that is needed for patients to be involved in their treatment.

Cultural support is another aspect of Tui's role, such as consulting on cultural practice. Tui applauded our efforts to return body parts to all patients. Some Maori patients were unaware that this is now standard procedure and are thankful that this is an easy event to manage. Tui shared her experience coming to the operating theatre to perform a

*With almost 200 nurse delegates in Nelson, the presentations were very well attended.*

karakia prior to a procedure.

Tui has a gentle accommodating manner. She is able to reassure patients and empower them to actively participate in their own healthcare. Tui is passionate about developing programmes to improve Maori health status and actively works with both hospital and community social workers to support whanau through incidents of family violence and abuse.

## POMRC: who we are and why are we important?

The Perioperative Mortality Review Committee (POMRC) was established in 2010 as an independent review committee that advises the Health Quality and Safety Commission (HQSC) on how to reduce the number of perioperative deaths in New Zealand. Its aim is to reduce these deaths and improve the quality of the health system and outcomes for patients.

Stephanie Thomson is a Rotorua-based Nurse Practitioner in adult perioperative care with a wealth of experience in critical care, surgical nursing, quality and risk management as well as medical ethics both in New Zealand and overseas. She is currently serving a three-year term on the POMRC.

Stephanie outlined the history of the POMRC and its current membership. The committee publishes an annual report and she covered some of the findings. For example, the 2012 report looked at mortality in four clinically important areas: cholecystectomy, pulmonary embolus (PE), patients aged 80 years and older following both emergency and elective surgery and elective admissions for those classified as ASA 1 or 2 (American Society of Anaesthesiologists physical status classification).

Recommendations included VTE (Venous thromboembolism) prophylaxis, use of the Surgical Safety Checklist and informed consent, ensuring patients should know their actual risk of dying and the use of non-operative care pathways when surgery is deemed too risky.

Topics covered in subsequent reports include sepsis, reasons for Maori mortality, documenting ASA, death on a weekend, abdominal aortic aneurysm (AAA) deaths and subsequent recommendation for offering endovascular surgery when possible and hip fractures.

This was a very interesting session and provided a lot of insight into why we now have some of our checklists, and processes, and how they have evolved. See the full reports on the POMRC website.

*www.hqsc.govt.nz/search?q="Perioperative+Mortality+Review+Committee"&start=25*

## More is not always better

Ophthalmologist Dr Derek Sherwood, Chairman of the Council of Medical Colleges and clinical leader of 'Choosing Wisely', delivered a thought-provoking presentation on "over treatment" of the patient.

*Dinner guests prepare to depart for the Trafalgar Centre.*

*With 'Masquerade' as the dinner theme, there was some very colourful attire…*

As clinical leader of the Choosing Wisely campaign, Dr Sherwood informed his audience of how groups of health professionals are facilitating a culture change to stop unnecessary tests and treatments for patients and promote better decision making. "The care they need and no less, the care they want and no more."

Growing evidence suggests assessment of risk versus benefit of treatment is essential with fad treatments found to be of little or no value, with 30-40 per cent of patients not benefitting from this.

Dr Sherwood highlighted attitudes that needed to change in a culture of overuse, for example 'because it has always been done that way, 'patients want it', 'community want it ', poor patient understanding of risk or benefit and the 'referring Doctor wants it.'

He emphasised that Choosing Wisely promotes a culture of shared decision making between health professionals and patients by having well informed conversations around treatment options.

The presentation concluded with four areas of discussion required between health professional and patients to improve decision making and quality of care for all patients. These were 'do I really need this procedure, what are the risks, are there simpler safer options, what if we don't do anything?

Visit the Choosing Wisely website for further information: choosingwisely.org.nz/

## Stress management in high pressure environments

Dave Nicholls provided an informative and hilarious presentation on how to deal with stress in the hospital. Here are some facts about stress:

Stress levels take about 10 days to come back to normal. Two weeks of holiday every six months is recommended.

Food can impact on stress. Sugar-loaded diets are contraindicated. Over-indulgence in alcohol can detract from the balance. Having a meal within two hours of bedtime can also have a detrimental effect.

Stress and sleep: Studies have shown people age 45 plus who are having less than six hours sleep are 200 per cent more likely to suffer heart attack. Less than five hours of sleep can lower killer T-cells and compromise the immune system by 70 per cent.

Health supplements: four-six squares of 70 per cent plus dark chocolate

per day can lessen the risk of heart disease and stroke. Oral **v**itamin C shows no apparent benefit, but intravenous administration has shown some benefit. The use of multi-vitamins it would seem causes a drastic increase in the incidence of head, neck, skin and breast cancers. Vitamin D is helpful to reduce the risk of cancer occurrence. Sun exposure is the source of vitamin D production and the use of sun screens interferes with this, hence 30 minutes of sun exposure each day is advised.

To conclude, we can manage our stress by managing our leave, taking vitamin D supplements, eating a little dark chocolate, and getting some sleep.

## BREAKOUT SESSIONS

### Working in Haiti

Dr Alex Rutherford is head of Orthopaedics in Nelson and Wairau where he has worked for the last 30 years. His presentation provided valuable insight into his work in Haiti as a member of *Medecins Sans Frontieres* (Doctors Without Borders).

Dr Rutherford became a member *of Medecins San Frontieres*, an organisation providing international humanitarian medical non-governmental aid.

Following the 2010 earthquake in Haiti, Dr Rutherford was sent to provide surgical assistance at a 120-bed hospital in Port-au-Prince. His workload for two months consisted mostly of trauma surgery. He faced many challenges during his time there, predominantly around communication. Fortunately, he was provided with two interpreters (Haitian people speak only Creole or French). Haiti is a poverty-stricken country with poor infrastructure and is unable to cope with the frequent cholera outbreaks, earthquakes, hurricanes and political unrest.


*Top: Brett McLean and John Carson make Daphne Fitzgerald comfortable in SkyTron UltraSlide. Above, left to right: Aaron Swales and Alison Oakley on the Jackson Allison stand with Buffalo Filter's Robert Scroggins and Otterbein University Professor Kay Ball (right).*


*Cathy Chirnside (top) was swamped with enquiry for Wock Clogs. BSN Medical's Lauren Hillis (bottom) fields enquiries for Comprinet Pro compression stockings.*

Dr Rutherford shared photos of his time in Haiti via Power Point presentation, introducing the people he worked with, his living environment and graphic images related to the surgical work he performed. Many of the injuries he displayed were from motor vehicle accidents, gunshot and machete wounds. Other images showed infected wounds he had surgically treated and the on-going problems patients develop from these infections. He commented on how rewarding volunteer medical assistance can be to save lives and ease suffering of people in crisis situations.

### ACC injury treatment

Addressing a full breakout session room, Charles Smith provided a succinct presentation around the Accident Compensation Commission (ACC) Treatment Injury: When to lodge a claim, surgical mesh-related claim insights.

Charles explained how ACC's focus had shifted since 2005 from 'medical misadventure' to 'treatment injury,' taking the blame and fault out of the equation and allowing for a more transparent system of assessing claims.

He presented several examples of ACC claims that were either rejected or accepted and explained why. There are links and flyers with information on how to know when to encourage a patient to make a claim, how to step through the process and even if some of the information is lacking, the role ACC plays in investigating this further.

Charles also encouraged any group – hospital or community-based – to contact ACC if similar a presentation on the system and claims process would be helpful. At the end of the session Charles covered outcomes of the ACC research regarding surgical mesh-related claims. Follow this link for more mesh data : www.acc.co.nz/surgical-mesh-claims

*The Conference Organising Committee, left to right, sitting: Pamela Millson, Pauline Manley, Sabine Mueller. Standing: Isobel Heslop, Anne Johnston (visiting Life Member - not committee member), Berice Beach, Valerie Weir-Van Til and Bronnie Ball. Absent - Sandy Tuck, Anne Fryer.*

### Difficult conversation

Biddi Hoskin is a registered nurse with over 20 years' experience working in operating rooms and currently as a Johnson & Johnson product specialist based in Wellington. She has had significant exposure to different teams, team dynamics and personalities. Her 30 minute presentation/workshop was from a book called '*Crucial Conversation*' by Kerry Patterson. The presentation and workshop focussed on keeping dialogue going during difficult conversations.

Biddi detailed how it is important to focus on "facts" and not the "stories" we may already have in our heads as we enter a conversation. Stories are the experiences we bring; some facts can be a number of stories.

Remember to suspend judgement and use the facts we have to avoid emotion. It is stories that bring emotion, not facts.

When emotions are heightened, voices are raised, and participants may leave. If this situation occurs it is time to pause, take a breath and stick to the facts. We act our worst when it matters most. Dialogue is not about winning but if you go back to the facts you are winning.

The workshop involved teams coming up with true, false, or unknown responses to a series of questions related to a situation both read to them and displayed on a whiteboard for 30 seconds.

The exercise was done to make the point that we cannot assume and always need to return to the facts.

There was good engagement in the workshop and it was interesting to see the team dynamics after the other material presented on communication styles. The take home messages was: always stick to the facts and not the stories – and suspend judgements.

### Surgical plume safety

Kay Ball is a Professor of Nursing at Otterbein University in Ohio, USA, a past President of the Association of periOperative Registered Nurses (AORN) and earlier this year published '*Lasers the Perioperative Challenge*'. (See book review, page 38).

More than 500,000 healthcare workers are exposed to surgical plume every year, with staff experiencing headaches, watery eyes, nausea, fatigue and respiratory problems. This is a workplace safety issue.

Cases documented included a 44-year-old laser surgeon and a 28-year-old gynaecology theatre nurse who repeatedly assisted, presenting with laryngeal papillomatosis; a gynaecology surgeon presenting with cancer of the tonsils and another with tongue cancer. Operating theatre personnel have presented with bladder cancer, commonly found in cigarette smokers, despite never smoking.

Research (Tomita *et al.*, 1989) shows that the amount of smoke condensate from one gram of tissue was the equivalent of three unfiltered cigarettes in 15 minutes from laser plume, and six unfiltered cigarettes in 15 minutes from electro-surgical unit (ESU) plume. The mean activation time of ESU plume was 12 minutes 43 seconds. This equates to 27-30 unfiltered cigarettes being smoked in the operating theatre on a daily basis in order to generate a passive air pollution with an equivalent mutagenicity.

The hazards of surgical plume include toxic gases of more than 150 chemical compounds, some of which are carcinogenic and have a cumulative effect. Particulate matter – 77 per cent of which is greater than 1.1 microns in size – ends up in the lung alveoli and is potentially damaging. It also decreases visibility of the surgical site.

Papilloma virus remains active post laser excision, potentially causing subsequent infection elsewhere. In addition, laparoscopic plume from low temperature devices is absorbed by the patient and is known to cause post-operative nausea and vomiting, headaches, and double vision.

AORN, the International Federation of Perioperative Nurses (IFPN) and other professional organisations in the USA recommend the use of plume evacuation systems while Denmark prohibits the use of energy devices without plume evacuation systems. The best solution is protection with good room ventilation, workplace practice controls using plume evacuators and adherence to written policy and procedures.

Smoke evacuation equipment collects and filters large amounts of plume and these devices should be quiet, easy to use, readily moveable and effective. Education of both medical and nursing staff is very important as this will create 'buy in' from those using the equipment that creates plume.

Create a sense of urgency – your lungs are NOT the place to filter plume.

### PACU – implementing 'protective pause'

Cath Greep spoke on the journey the Nelson Hospital Post-Anaesthetic Care Unit (PACU) team has been on, working to introduce a 'protective pause' at the time of patient handover from theatre team to the PACU nurse.

Cath discussed the timeline of how this eventuated for the Nelson Hospital PACU team. It resulted from three of the Nelson Hospital PACU nurses attending an education day and presentation by Dr Adam Hollingworth on a project he had done on improving PACU handovers.

She presented the adapted format that has been developed to suit the Nelson Hospital PACU unit, described how the idea was introduced and adopted by the Anaesthetic department and how all the team members, including theatre nurses, have got on board with it. She discussed some of the blocks they had when starting to use the handover tool and how it has improved the care of the patient at handover time.

### Out-of-Hospital STEMI pathway

Kris Gagliardi, an intensive care paramedic and National Patient Pathway Manager for St John's NZ, presented '*the NZ Out-of-Hospital STEMI Pathway : why do we need it?'*

This in-depth presentation of the development of critical time-dependant out-of-hospital cardiac reperfusion therapy related completely to this year's conference theme. Kris laid out the rationale for the collaborative effort between his team at St John and specifically Dr Tammy Pegg at Nelson Marlborough DHB. Together they created an expeditious pathway to reduce the time getting lifesaving treatment to those in the community suffering a heart attack – in particular a ST-segment elevation myocardial infarction (STEMI).

*Device Technologies Keeley Lawson measures the ankle of one of the nurse delegates for correct sizing of Fitlegs compression stockings*

*Kris Gagliardi, National Patient Pathway Manager for St John's NZ, presented 'the NZ Out-of-Hospital STEMI Pathway: why do we need it?' Vicki Smith gave a very good overview of the amount of communication required for planning joint revision surgery.*

The crux of the effort is direct communication via an ECG transmission application and phone conversations between those treating the patient "out in the paddock" and an on-call cardiologist.

Instead of waiting until the patient arrives in the emergency department – potentially an hour or more away in the rural setting – St John staff in Nelson-Marlborough DHB are able to administer clot-dissolving medication by following the STEMI Pathway, while under the direction of the cardiologist. The on-call cardiologist then makes the decision to direct St John staff where to take the patient. Sometimes this would be airlifting the patient directly to Nelson Hospital. After hours, the patient will be transferred to Wellington where a waiting team would have been assembled to take the patient to a cardiac catheterization lab for emergency cardiac angiogram and percutaneous cardiac intervention (PCI) care.

During the question and answer time following the presentation, Kris was asked about the "medical staff only" Facebook page set up to aid further communication and learning opportunities. Through this venue, the national roll-out of the STEMI Pathway, along with episodes of pre and intra hospital care, is discussed. This collegial process has led to improved communication and to improved timelines, providing even better cardiac service to the people of New Zealand.

### Planning complex revision hip surgery

Vicki Smith, a registered nurse working as a Clinical Support Representative for Zimmer-Biomet, has many years' experience in orthopaedic nursing. During her travels around New Zealand operating theatres, she witnesses the frustration from both nurses and surgeons in the organisation of revision joint surgery. The poor communication between joint revision surgery booking, theatre preparation and staff information sharing is apparent.

Vicki reflected on her first-hand experience as an RN and the lack of information available for the theatre prior to revision surgery. Confronted with limited details at the beginning of a theatre list – for example MR X Hip Revision Surgery – only created a number of questions. What equipment is needed? Do we have the equipment? Is it a total hip revision, the cup or the femoral component we are removing? What are we inserting?

These frustrating circumstances motivated Vicki to develop a revision hip booking form to improve communication in the theatre environment so staff were better informed prior to the start of a theatre list. The booking form covered important information: the procedure, operative side, surgery date, reasons for revision, implants to be removed, implants *insitu*, replacement equipment required, and extra equipment needed.

Vicki stressed the importance of communication with joint revision

surgery because of the many types of revision, each requiring specialised equipment, and the many people involved from booking surgery to implanting the new joint. Deciding factors when planning each revision case centred around the questions, why are we doing the surgery? Is it for infection, dislocation, wear or fracture, and is partial revision or total revision required and is it cemented or uncemented?

Vicki gave a very good overview of the amount of communication required for planning joint revision surgery. She also provided essential information and encouraged hospitals to develop and use planning charts to ensure better preparation and management of a joint revision surgery theatre.

## Dermal fillers and botulinum toxin

Juliet Asbery, is a nurse practitioner (Acute Care) in the plastics and reconstructive surgery specialty, member of the Preoperative Nurses College (PNC) Professional Practice Committee and Vice Chair of PNC presented a session entitled *'Dermal Fillers and Botulinum Toxin-a reconstructive or cosmetic tool?'*

Botulinum Toxin is a neurotoxin produced by Clostridium Botulinum and while eight types exist, only A and B are used medically. Dermal fillers include collagen, synthetic and hyaluronic acid fillers. Dermal fillers are usually used to correct creases and lines, to plump up the lips and cheeks, and to enhance facial contours. They are all commonly used in cosmetic and reconstructive treatment.

Juliet acknowledged the billion-dollar industry behind these products but encouraged us to look beyond the initial assumption of purely cosmetic applications and showed the products as treatment options for cosmesis and moderate or severe disorders like Frey's syndrome or hyperhidrosis or excessive sweating, strabismus and blepharospasm.

She also advised a non-judgemental approach in the products' use for cosmetic treatment and consideration that what might be perceived as purely cosmetic by the practitioner could be perceived as very detrimental for the body image and identity of the client. She encouraged us to consider different concepts of beauty - rounder and softer facial features are often seen as more feminine and socially acceptable in females. For example, in some Asian countries an asymmetric or square face may be seen as an undesirable characteristic and socially limiting. Juliet highlighted that a comprehensive and professional client assessment, good communication skills and informed consent are crucial.

The skill of the injector combined with their clinical knowledge of facial anatomy and pharmacokinetics can be used to treat patients safely and effectively.

## Find your leadership style

Laura Jordan is a registered nurse currently working in a casual post anaesthetic care unit, perioperative role at Nelson-Marlborough DHB.

*Juliet Asbery (right) presented a session entitled 'Dermal Fillers and Botulinum Toxin - a reconstructive or cosmetic tool?' Laura Jordan's presentation, focused on learning how your specific leadership style can bolster your approach to team leading, management, direction and delegation.*

Her presentation, '*Find Your Leadership Style (No–Doze Leadership)*', focused on learning how your specific leadership style can bolster your approach to team leading, management, direction and delegation in the perioperative environment.

She spoke of her experience working at the National Outdoor Leadership School and of the correlation between this environment and nursing. We have to work as a team every day, be able to face new things but always with safety in mind, and be able to adapt as we go.

This was a good session to have after lunch as Laura had an interactive component to her talk. We all had to choose half of the room depending on whether we related our personality to Laura's description of 'water' or 'wind' and then 'hot tamale' or 'cool cucumber'. She then explained how the four different personality types might react in the perioperative environment and how our different personality types cope in leadership roles.

## Masquerade Dinner

After a full-on Friday of serious and more lighted-hearted presentations on ways of communicating, stretching our personal boundaries and discovering what personality types we were, we headed down to the newly rebuilt Trafalgar Centre for the conference dinner.

The dinner theme was "Masquerade," which gave people licence to dress up as much or as little as they liked. There were some wonderful outfits on display. Juliet Asbery won the prize for the best female costume and Andrew won the best male costume.

The Challenge quiz tested people's knowledge about wines and the winemaking history and was great fun. It was a close call between Nelson-Marlborough and Hawke's Bay, with Hawke's Bay winning the 'Percy the Peacock' trophy in the end.

It was a great night with a great band, food, entertainment and fun with everyone mixing and mingling, even a touch of 'break dancing' with the Caterpillar being done.

The organising committee hopes everyone enjoyed it as much as they did. ■

*The Hawkes Bay team won this year's Challenge with their superior knowledge of wines and wine making history.*

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# 2018 ACORN 2018 Conference:

# Examining the Perioperative Nurse Surgical Assistant role

*At the 44th Annual Perioperative Nurses Conference in Napier in 2017, Sandra Millis was presented with the Johnson and Johnson Advancing Practice Education Grant. She used this award to attend the Australian College of Perioperative Nurses (ACORN) Conference in Adelaide in May. Sandra has a keen interest in the development and evolution of the Nurse Surgical Assistant role within New Zealand and used the opportunity provided by Johnson & Johnson to explore the evolution of the role in Australia…*

## Different Titles used for Non-Medical Assistants

The Non-Medical Surgical Assistant (NMSA) title is not internationally acknowledged but it is a useful term to cover the multiple titles used around the world.

In New Zealand (NZ) the title of Registered Nurse First Surgical Assistant (RNFSA) came about around 2009 when the Nursing Council of New Zealand (NCNZ) examined the role and scope of practice and the University of Auckland offered the first of its RNFSA papers. In some centres this has changed to Registered Nurse Surgical Assistant (RNSA) with the word 'first' being dropped because in some settings, such as cardiac surgery, the registered nurse (RN) works as the second assistant.

Some RNSAs have taken the role further and have gone on to complete their nurse practitioner (NP) accreditation with the NCNZ and so work as a NP perioperative.

In Britain, roles identified include Surgical Care Practitioner (SCP), Surgical First Assistant (SFA), Physician's Assistant (PA), and Nurse Practitioner (NP).

In Canada, Registered Nurse First Assistant (RNFA), NP and PA roles are described (Hains, T., Strand, H., Turner, C., 2017).

In Australia, the role of surgeon's assistant has traditionally been carried out by a medically qualified assistant, but with changes to the healthcare workforce regulations and shortages of medical practitioners, the role of Perioperative Nurse Surgical Assistant (PNSA) has emerged.

## Credentialing PNSA Pathway

The major challenge with this Non-Medical Surgical Assistant (NMSA) role is to ensure there is a standardised pathway in place to regulate the role, thereby ensuring patient safety and professional standards of care.

The Nursing Midwifery Board of Australia (NMBA), like the Nursing Council of New Zealand, regulates the practice of nurses and midwives in Australia. But unlike New Zealand, this Board does not regulate the PNSA role and so the Australian Association of Nurse Surgical Assistants (AANSA) has developed a credentialing pathway.

"AANSA represents both practicing and student PNSAs in order to support the profession, provide information to the general public, surgeons and health facilities…. and to lobby the healthcare authorities

and relevant health departments of the Australian Government to recognize and remunerate the benefits that a PNSA is able to provide," (AASNA, 2018).

The development of this pathway was the topic of a presentation given at the 2018 Australian College of Perioperative Nurses (ACORN) Conference in Adelaide by Dr Alessandra Doolan, a member of the Health and Technology Advisory Group in the Faculty of Medicine at the University of Sydney and Leonie Ballantyne, a PNSA working at St Vincent's Private Hospital, Toowoomba.

The PNSA is defined by Dr Doolan as registered nurses who undertake an advanced practice nursing role as the first assistant in surgery. They work collaboratively with surgeons and other clinical staff to provide patients with the best possible quality of care and provide patients an expanded role of care in all perioperative areas including pre-operative, intra-operative and post-operative care. This is very similar to the New Zealand RNFSA role as defined in the RNFSA in Operating Theatre in New Zealand Service Guidelines (2015).

The AANSA "Credential" Pathway is the only nationally consistent standard for the recognition of specialist PNSAs. The applicant must be a registered nurse with the Australian Health Practitioner Regulation Agency (AHPRA). They must have either five years perioperative experience or three years and have completed a perioperative certificate. They must be studying towards or have achieved at master's level of study with PNSA specialization. The four topics covered must include the role of the PNSA, preoperative, intraoperative and postoperative care. The initial credentialing requires the applicant to submit the same documentation required for accreditation to individualized hospitals including:

- University transcripts for completion of PNSA course;
- Continued Professional Development (CPD) record- 20 hours;
- Basic or Advanced Life Support Certificate;
- Professional indemnity insurance;
- Two written references, one from a surgeon who they work with;
- Resumé.

The PNSA then needs to re-credential every three years by submitting:

- Annual CPD record - 20 hours RN and 10 hours PNSA;
- Professional indemnity insurance;
- AHPRA registration;
- Basic or Advanced Life Support Certificate.

## Remuneration

This credentialing process formalises the PNSA role, giving it longevity and a level of professionalism needed to maintain high patient care standards for healthcare users. The AANSA ensures this group of advanced nurses have representation and a voice in the development of health policy.

One of the main differences between the PNSA role and our New Zealand RNSA role is remuneration. In New Zealand, most RNSAs are either employed by the hospital where they work, or the surgeon directly, or are self-employed and contract directly to the surgeon. However, in Australia the PNSA bills the patient directly. The Australian Government does not offer reimbursement for services provided by a PNSA but does provide a Medicare rebate to medically qualified assistants.

In 2012, AANSA submitted a Medical Services Advisory Committee (MSAC) application requesting for the Medical Benefits Schedule to include PNSAs. The MSAC is an independent expert committee that provides advice to the Minister for Health. This submission was supported by the Royal Australian College of Surgeons (RACS) and

*Sandra Mills*

ACORN. The application is on-going but moving forward with the AANSA group working hard to research and document evidence of the benefits a PNSA adds to patient safety and care.

## New Zealand on par

I was expecting to find the Australian assistant role and credentialing system to be more advanced than in New Zealand, but I now believe we are on par. Our RNSFA in Operating Theatres in New Zealand Service Guideline (2015) provides a clear role description and a continuum to guide RNs working as assistants to surgeons. The credentialing process for New Zealand Nurse Practitioners-Perioperative is probably more comprehensive than the AANSA credentialing.

The main difference between Australia and New Zealand is the way in which NMSAs are remunerated and this is what sets us apart.

## Acknowledgement

The ACORN conference was a great opportunity for me to advance my knowledge and skills and provided me with up-to-date research findings which will support changes in my practice. From simple things like the use of appropriate positioning devices to how best work alongside and support different generations of nurses.

I am hugely grateful to Johnson and Johnson for giving me this opportunity.

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# Back to the future . . .

## Otorhinolaryngology Nurses National Conference

**By Kerry Webb**

The Otorhinolaryngology Nurses Special Interest Group held its annual conference in Christchurch in August with attendees coming from around New Zealand. The venue, the Commodore Hotel, provided beautiful surroundings, fantastic food and a great conference facility.

The Conference theme, "Back to the Future," looked at how ENT nursing has evolved over the years – past and present – and covered topics such as tonsillectomy, sleep apnoea, hearing aids, tinnitus, "ENT bugs" and cholesteatomas.

The conference also provided a great opportunity to catch up and network with nurses who work within the ORL specialty, both hospital and community-based.

The main sponsors for the conference were Lohmann and Rauscher and Endoventure who both provided excellent displays and samples to trial.

Dr Tom Kuruvilla was the first speaker of the day and set the mood, aided by his great sense of humour as he discussed tonsillectomies through the ages. He reiterated the prevalence of allergens as the main reason for medical and surgical intervention, required for increasingly common conditions such as recurrent tonsillitis, asthma, rhinitis and obstructive sleep apnoea.

Gurjoat Vraich (Audiologist, Christchurch DHB) talked about hearing aid devices and how these have altered over the years. Not only have they changed in appearance, but numerous advancements have been made in amplification technology of these devices, reflective of modern-day cost. Gurjoat recently attended an audiology conference which discussed the future of hearing aids which is fast approaching connectivity to accessory devices e.g. mobile phones, televisions, lap tops and even electrical devices such as toasters!

*ORL Nurses network at their annual conference.*

*Microbiologist Ben Harris, one of several engaging speakers who presented at the 2018 ORL Nurses' Conference.*

### BUGS...

"Bugs of ENT" provided some thought-provoking information as microbiologist scientist Ben Harris's session covered the overuse of antibiotics and stated "we are in an epidemic depletion of microbes due to the introduction of antibiotics". Ben provided some great statistical information on tuberculosis, influenza and vaccinations. His passion and knowledge for this topic was evident and attendees were very interactive during his session.

A guest speaker, Professor Grant Searchfield from Auckland, shared information relating to tinnitus, causes and management of the disease. He shared a great analogy of sitting at a campfire and how the auditory system is our "survival sense". He provided information around the management of this condition and explained the need for more clinical trials for future advancement in this area.

A client provided a personal view of living with tinnitus and by sharing her experience, attendees gained a great insight into how this condition can have a major impact on everyday life.

With improved support services, treatments and management, living with tinnitus can be achieved successfully.

**About the Otorhinolaryngology Nurses Special Interest Group**

Founded in 2007, ORL Nurses is a national organisation providing education, networking opportunities and peer support for all members. It maintains a close affiliation with the Australian Otorhinolaryngology Head and Neck Nurses Group (OHNNG).

Membership is open to any health professional with an interest in the Ear Nose and Throat area of nursing care. ■

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# Effective Management of Anaesthetic Crises (EMAC) Course

In 2017 I was the lucky recipient of the Perioperative Nurses College Education Award of $1000 sponsored by Culpan Medical. The award was used to attend an Effective Management of Anaesthetic Crises (EMAC) course. This course is designed to improve skills in anaesthetic crisis management. It is a two and a half day course run under the supervision of the Australian and New Zealand College of Anaesthetists and taught by specialist anaesthetists. In Auckland it takes place in the Simulation Centre for Patient Safety (SCPS) at the University of Auckland.

SCPS is a purpose-built facility providing simulation-based education for medical, nursing, pharmacy and optometry undergraduate and postgraduate students and offers external courses in resuscitation skills, anaesthesia simulation and emergency medicine.

The EMAC course has five modules:

- introduction to human factors;
- cardiovascular crises;
- airway crises;
- anaesthesia crises;
- trauma crises.

The course was composed of scenarios, skills stations and group discussion.

Nurses and anaesthetic technicians are invited to attend the course to provide a more realistic team environment. The course provided a fantastic opportunity to experience emergency situations in a realistic setting. The key lessons I gained were:

- the importance of establishing a leader when faced with an emergency;
- direct communication with the leader and avoiding unnecessary chatter (emergencies can get very noisy!);
- using cognitive aids such as The Vortex and Bradycardia Algorithms.

Communication was a significant part of the course, for example putting to use the acronyms that we are all aware of:

- SNAPPI (Stop, Notify, Assessment, Plan, Priorities, Invite ideas) – a recap to gain situational awareness;
- ISBAR (Identify, Situation, Background, Assessment, Requirement) – a succinct briefing tool;
- PACER (Probe, Alert, Challenge/Call, Emergency, Response/Request/React) – for graded assertion.

Simulations were recorded and during reflection examples of these communication tools in action were replayed which demonstrated their effectiveness or in some situations how they could have been used to improve communication.

It was a busy two and half days but well worth it and I would highly recommend it to all nurses working in the perioperative environment. If you would like information on the course please contact Emma Glebocki: e.glebocki@auckland.ac.nz ■

**About the author:** *Kirstie Cooke completed her Bachelor of Nursing in 2001 at EIT and has spent most of her working career in post-operative surgical departments. Kirstie completed her Clinical Masters through Massey University and became a Nurse Practitioner in 2016. She has been a member of PNC for four years and has just completed three years on National Committee. She continues to be involved in PNC in the Central North Island region and is part of the conference committee for 2019. Kirstie works as a Nurse Practitioner at Grace Hospital in Tauranga.*

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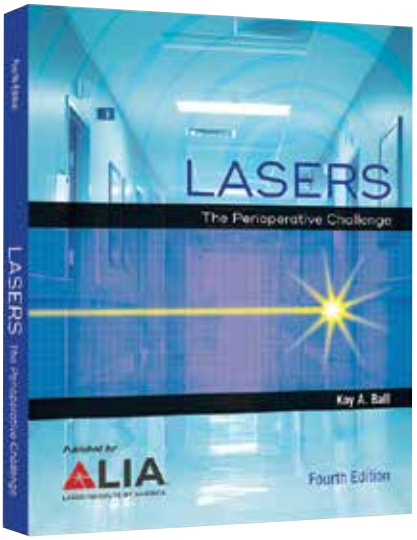
# Excellent Guide to Laser Technology

**Title**: *Lasers, The Perioperative Challenge* - 4th Edition 2018
**Author**: Kay A. Ball PhD, RN, CNOR, CMLSO, FAAN
**Publisher**: Laser Institute of America (LIA) 2018.
**ISBN**: 978-1-940-16812-8
**Pages**: 410, Paperback
**Reviewer**: Johanna McCamish
**Price**: US$90.00




At the recent Perioperative Nurses College conference it was a pleasure to meet Kay A. Ball, the author of *Lasers, the Perioperative Challenge*.

Kay Ball is a professor of Nursing at Otterbein University in Westville, Ohio, where she teaches bachelors, masters and doctoral students. She is also a Perioperative Nurse educator and consultant working with Perioperative Nurses, professional organisations, healthcare facilities, industry and legislative groups.

Kay has served as the laser programme director for Mount Carmel Health and Grant Medical Center in Columbus, Ohio. She has also had many years' experience in managing an operating room suite and Post Anaesthetic Care Unit.

*Lasers the Perioperative Challenge* was first published in 1990. In this, the fourth edition, Kay provides updated laser technology information to healthcare professionals. She notes that much has evolved in the laser world since 1990. However, Kay states her goal is still the same "to provide laser information in a simplified format for use by nurses, physicians, technicians and other health care professionals."

The content of the book is split into three parts. Part one, Laser Biophysics which includes the history of laser technology, laser systems and laser safety. Part two concentrates on clinical laser applications with chapters relevant to all specialties. An example of this is a part on gynaecology laser applications, and laser application in ophthalmology. Part three of the book concentrates on administrative aspects including financial, legal and educational aspects.

The information provided in the book is well referenced with supporting information provided.

Throughout the book there are sample safety policies, procedures and guidelines, including a sample surgical smoke evacuation policy example. There are also examples of discharge instructions and information relevant to provide to the patient on discharge.

Within its 410 pages, the book contains more than 300 illustrations and graphics that are intended to deepen the reader's understanding of foundational physics, safety, and administrative aspects. There is also an extensive glossary that offers an easy reference for laser terminology.

There are explanations of procedures, including anatomy diagrams to enhance the understanding of where why and how laser treatment is used. Overall the book is well set out, provides a large amount of information that covers areas that are relevant to lasers and as Kay has aspired to, provides information in a simplified format.

I enjoyed learning more about lasers in clinical practice. ■

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