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The Official Journal of
Perioperative Nursing in Australia

VOLUME 26 NUMBER 2 WINTER 2013



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ACORN

THE OFFICIAL JOURNAL OF PERIOPERATIVE NURSING IN AUSTRALIA

ACORN

THE AUSTRALIAN COLLEGE OF OPERATING ROOM NURSES LTD

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Ruth Melville

Welcome to the winter edition of the *ACORN Journal*. Since my last report I have been very busy with many ACORN activities, with my feet hardly touching the ground.

During March I attended the 60th AORN (Association of periOperative Registered Nurses) Congress meeting and International Summit in San Diego, USA. It was an honour to represent ACORN and Australian perioperative nurses.

The overall theme for the Congress was collaboration, which happens to be aligned with my personal and professional objectives. Collaboration can be a local, national and global initiative that can deliver meaningful change and professional development to benefit perioperative nursing and our patients. This was to be an eventful and rewarding week, networking with other international presidents and colleagues with the opportunity to discuss global perioperative issues and build on ACORN's corporate profile. Although this was not my first congress meeting, the physical extent, trade and educational programmes available at AORN is still overwhelming. The total number of overall attendees at the congress at the end of day three was approximately 4773 health care professionals and 4646 exhibitors.

The International Summit was held over the weekend prior to the commencement of the AORN Congress. It was with much enthusiasm that I arrived early for day one of the International Summit for networking with other international attendees. Apart from the USA, other countries that presented at the International Summit included New Zealand, Sweden, Japan, Indonesia, Spain, Turkey, Singapore, UK, Thailand, Belgium and Israel. The audience also included many other countries such as China, South American countries and me from Australia.

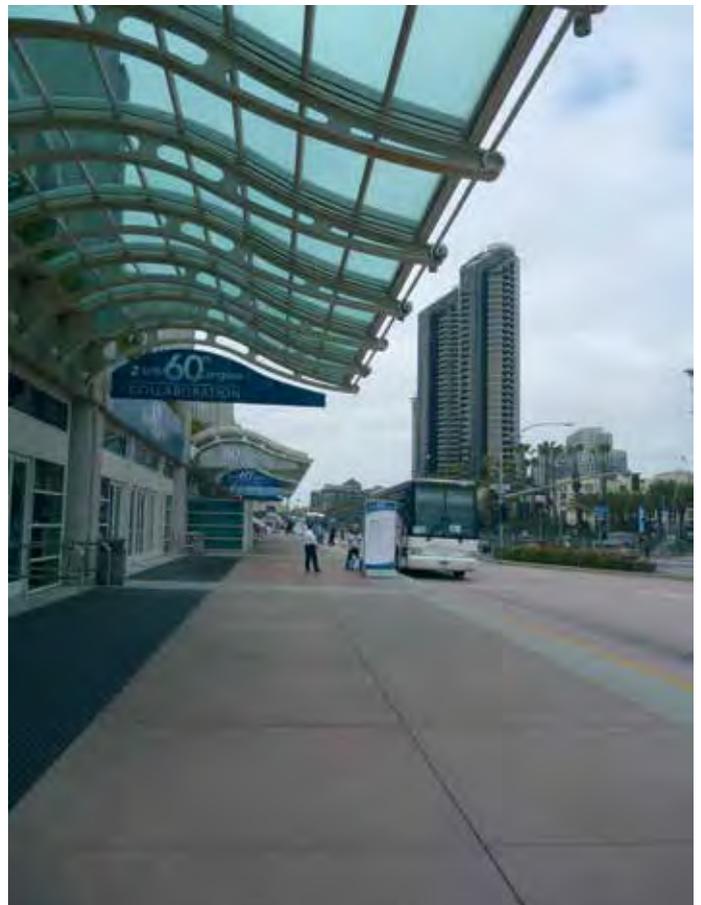
The two days of the International Summit covered many issues in their presentations such as:

- Workforce cultural differences and implementing recommended practices — Belgium and Turkey
- Perspectives on international collaboration — IFPN (International Federation of Perioperative Nurses)
- Sharps management — reporting, preventing and Team collaboration
- Responding to terrorism — UK bombing and Israel bombings
- Role of the perioperative team during and following disasters — Japan's tsunami and earthquake in 2011 and New Zealand's

earthquake 2011 (both of these presentations were extremely emotive: New Zealand as it was so close to home and Japan as they showed a video that was left running whilst a coronary bypass operation was being undertaken and the earthquake occurred).

- International collaboration — about how the team collaborates in the operating room. This was an interesting presentation on the *Surgical Safety Checklist* in China where it was legislated and then the government audited and 100% compliance?
- New models of care in operating room — an amazing Spanish presentation on an initiative called Kirozainbide that is an interactive guide for the perioperative nursing practice that was created by perioperative nurses using their own resources and ideas.

The Congress started with an amazing opening by President Deb Spratt and I felt very proud to wave our flag for the Aussie contingent; although there were not many of us, we still made an impact. Over the next four days I attended many other presentations, including a very topical presentation by Past President Patrick Voight on the new Obama "Affordable Care Act". This presentation described the impact on health care using a different economic model to drive clinical integration from volume to value and standardisation of resources. He also presented data on health care systems worldwide



AORN Convention Centre - San Diego



Some of the Aussie contingent at Ottawa Cheryl Winter, Ruth Melville, Zaneta Smith, Phyllis Davis & Kim Hepper

in comparison to the USA. It was an interesting presentation given the issues of health care that we face within our own country.

My next visit was in April to Ottawa, Canada, where the 23rd ORNAC (Operating Room Nurses Association of Canada) and IFPN Conference was being held. The theme was *International Alliance for Perioperative Best Practice* and it was ORNAC's 30th birthday celebration. Again, the international delegates came from many regions: from Australia, Belgium, Croatia, France, India, Ireland, Israel, Malaysia, Portugal, Russia, South Korea, Sweden, Turkey, UK and USA. Australia was very well represented with eight delegates and of those four presented papers during the conference. These Aussies proudly represented us as they delivered their papers: Zaneta Smith, Phyllis Davis and Caroline Ellis, who were all very well received. Tuesday afternoon was the IFPN Board annual meeting where all the member countries met. The member associations present were ACORN, AORN, EORNA (European Operating Room Nurses Association), PNGPNA (Papua New Guinea Perioperative Nurses Association), KAORN (Korea Association of Operating Room Nurses) and ORNAC. The PNCNZ (Perioperative Nurses College of New Zealand) unfortunately was one of the apologies. This was a lively meeting with the many topics being discussed such as succession planning for the new Treasurer and President Elect for IFPN, new membership categories, website upgrades and review of

the strategic plan. I also participated in a panel debate, themed "As a perioperative nursing association; How have you made a difference in your country/region in the improvement of patient safety linked to the WHO Checklist and Safe Surgery Saves Lives project". The forum was with three other international presidents and moderated by IFPN president Iriani Antoniadou. This was interesting overview of the same challenges that as perioperative nurses we all face in regard to the implementation of the *Surgical Safety Checklist* and the issues that arise in regard to this process, no matter which country you are in. One constant theme from all was "it is not about the checklist or the tool but the process" and "it is about patient safety and we need to ensure that doesn't get lost in the politics".

My next visits were within Australia thankfully as my time clock was sluggish by now. So I set off to Darwin in May to open their 10th Biennial Conference and celebrate NTPN's 21st birthday. It was a privilege to be present for this exciting achievement as I honoured those who had been there for the full journey since NTPN's inception. It made me very proud to be present to witness the show of National Unity that was ever present as all states had sent at least one to two delegates to attend and support NTPN. Well done to all of the NTPN committee as they put on a great weekend of fun and education in the usual Territorian fashion.



ORNAC & IFPN Convention Centre -Ottawa



Ruth with Leigh Anderson President PNCNZ

Lastly, my most recent visit was at the end of May to the ICN (International Council of Nurses) Congress. I was also attending the CNR (Council of National Representatives) meeting representing IFPN on the Thursday, Friday and Saturday. Attendance at this Congress was an excellent opportunity to promote ACORN at an international level. A Congress meeting has only ever been held in Australia once before. ACORN participated as an exhibitor with 65 other national and international nursing organisations. We also presented a paper on our *ACORN Standards* with Jed Duff as the main presenter, which was very well received. I would like to thank Carolyn Williams, Joy Jensen and Jed Duff who participated with me on the booth to answer the many queries relating to ACORN's role, perioperative practice and education. We met perioperative nurses from many countries. My attendance at the CNR meeting was an amazing experience that I will never forget. The set-up is very formal and similar to a United Nations' meeting: there were over 100 member countries present. Many discussions were held in relation to global nursing issues and the conduct of the ICN but one of my highlights was when a resolution was put to the voting members "That the Palestinian Nursing Association be admitted into ICN membership". The first member country to speak on this resolution was Israel. They said that despite their political differences they fully supported this resolution. This sentiment was then followed by others and then an overwhelming unanimous confirmation of this resolution by all, which was met with much applause and cheering. It was a moving tribute and no doubt reinforced that nurses truly do rise above political adversity and overcome political barriers.

While I was attending these many conferences and meetings, I had fantastic opportunities to promote to the many perioperative colleagues worldwide our upcoming national conference in Melbourne 2014. So I hope we will have a great response as there was much interest.

I would like to thank Sharon Harding, Carolyn Williams and Joy Jensen from the ACORN Executive and Board who attended the NSW OTA, TORN and Sunshine Coast PNAQ conferences on my behalf while I was attending to these many activities.

In the last *ACORN Journal* I discussed the strategy "ACORN E-Business Platform". We now have an external consultant who is investigating this strategy in consultation with all of the Board

members and we will have a formal report at our face-to-face meeting in August to discuss these findings.

We are still progressing towards tax minimisation strategies with the application for charitable status. Both Joy Jensen as Treasurer and Stephen Born as Executive Officer are busy working with our financial advisors and legal representatives to get this prepared for a meeting to be set for later in the year.

Don't forget that our AGM will be held on Thursday 8 August 2013 as part of the VPNG's conference *50 Years of Perioperative Education*, a celebration not to be missed. I hope to see you all there!

Lastly I would like to leave you with these words, "Collaboration starts with me and you so let's ensure as perioperative nurses that we support each other during the financial and ever-changing health environment that we are currently experiencing to ensure that the perioperative area remains safe for our patients and staff."

Yours in perioperative patient safety,

Ruth Melville
ACORN President



Australian College of Operating Room Nurses Ltd

The Annual General Meeting of the College
will be held at the
The Pullman Albert Park,
(previously The Sebel)
65 Queens Road Albert Park VIC 3004
on
Thursday 8th August 2013 at 2.00pm
All members are welcome.

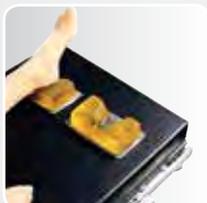
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Pauline Walker

It has been a great honour for me to have been appointed the very first Editor-in-Chief of the *ACORN Journal*. I have enjoyed my term as Honorary Editor and Honorary Editor-in-Chief over the past five years as indeed I did in my previous seven-year term.

Since my first term as Editor, what became patently obvious to me in my second term is the improved quality of the articles that are coming through now compared to 12 years ago. Research has added a new dimension and nurses are now a part of that in the academic and clinical arenas. Research-based evidence is mandatory in nursing today, as it should be. As a new graduate (many years ago) I felt that the theoretical component of nurse education was totally inadequate. I welcomed the chance for nurses to receive an academic education and for nursing to become a profession that is recognised in academia. I supported that change wholeheartedly at the time and still do.

When I applied to do an undergraduate degree at university I was denied the opportunity because nursing was not recognised as an education source. When I reapplied, stating that I had a TAFE certificate in art and distinctions in art history, I was accepted because TAFE certificates were recognised sources of education. At the time I viewed the TAFE certificate as being of no consequence; clearly it was not. In essence, my three nursing certificates and my 20 years' experience counted for nothing. Not so now: times have changed and nurses can hold their own with any profession; they have the evidence to prove it (an academic degree).

One of the reasons I enjoy being an editor was that of supplying an educational source for nurses; giving them the information that they require by publishing articles relevant to the perioperative field. I also have a passion for helping novice authors to get published. Our talented reviewers are only too happy to review articles and give useful information to the authors. They show writers how to make their article the best that it can be for publication.

So keep up the good work all you talented nurse authors. Thank you for making the journal what it is today.

A year ago it was decided by ACORN to appoint an Associate Editor for the journal — the successful applicant was Mary Polzella and she has been a great support to me in the production of the journal.

This is my last editorial as Editor-in-Chief; however, I will still be on the editorial committee as editorial consultant for the *ACORN Journal*.

The interviews were held this week for the Editor-in-Chief position and I am happy to say that the successful applicant who will fill my

shoes is none other than Mary Polzella. Congratulations Mary. I know that you and the journal will go from strength to strength.

The advertisement for the Associate Editor appears on this page of the journal.

I would like to thank all of the people who have assisted me: my editorial committee, the ACORN editorial committee, the *ACORN Journal* review board, the publishers and all who participated in the production of the journal. I could not have done it without you.

So, for now my friends, I bid you all a fond farewell.

Take care,

Pauline



ACORN JOURNAL ASSOCIATE EDITOR

ACORN is seeking expressions of interest for the position of Associate Editor who will work with the Editor-in-Chief to produce the quarterly *ACORN Journal*. The Associate Editor will collaboratively liaise with the ACORN Board's Journal Committee and the Local Associations to produce the state news.

Please submit an expression of interest addressing the position responsibilities outlined in the Associate Editor's Schedule of Contract. The schedule is available by contacting the ACORN Secretariat or via the ACORN website. For further information, please contact the ACORN Secretariat at acorncompany@senet.com.au

Applications should be sent via email or mail to the ACORN Secretariat by 30 July 2013.

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2nd June 2013

To whom it may concern

I am writing to you to voice my concern over an article published in the Autumn 2013 issue of your journal.

The article I am referring to is titled "Perceptions of self-competence in theatre nurses and operating department practitioners" and was written by Brigid M Gillespie and Eloise Pearson.

My concern with this article is the amount of incorrect information contained in this document.

I am a qualified ODA, this is the qualification prior to the creation of the ODP training course, which was first utilised some 50 years ago not 25 as represented in the article. I have great respect for my profession and the ability of that profession to change to meet the demands of a dynamic department such as Operating Theatres.

This article demeans the role of the ODP to one of "technical support" rather than the one of the highly skilled anaesthetic assistant with the same knowledge and ability to "care" for a patient or have "empathy" for a patient as any registered nurse who has completed the anaesthetic and post-anaesthetic course.

I have to question the authors ability to carry out research as they managed to get some very important information completely wrong. This casts doubt on their conclusion and on their entire research project.

Currently in the United Kingdom a registered nurse must complete a recognized Diploma or Degree to allow them to be registered. This is currently a 3 year full time course offered by multiple Universities in the UK.

An Operating Department Practitioner must complete a recognized Diploma or Degree to allow them to be registered. This is currently a 2 year 4 month Diploma or a 3 year Degree offered by multiple Universities in the UK.

Since the Bachelor of Science for both qualifications require the same amount of reflective practice and analytical discussion preparing both candidates to undertake a multidimensional role that includes all aspects of caring including empathy and advocacy, I fail to see where the authors derive that this applies solely to the nursing profession.

I would also like to point out to the authors that bringing the escalation in adverse events into this article with the sole intention of discrediting the ODP practice is both incorrect and insulting. Also the registered nurse in the operating theatre in the UK does not assume the responsibility for the patient care since the registration of ODPs in the UK their role and responsibility gives them the responsibility for the patient under their care. This bi-partisan approach to patient care is supposed to reduce the likelihood of an adverse event.

I can only assume that an article like this was published in an Australian magazine due to the increase in ODP practice in this country and the imminent registration in Australia of this

LETTERS TO THE EDITOR

qualification, with its supporting recognition of our abilities in the operating theatre, that the authors feel some form of competition for what they purport to be the role of the registered nurse.

Having worked through the integration of nursing and ODAs in the UK in the 1980s I have some experience of the methodology used by some to demean both the qualification and abilities of operating department practitioners, but at the end of the day as far as I am aware the frontline practitioners from both professions agree that patient care is our primary concern.

I would have been far more impressed and less saddened if this article had been accurate with its information which would have given the result and conclusion far greater kudos than what was published in this article. In fact was this article accurate in all the information it contained then I would seek to improve the content of the qualification of anaesthetic assistants throughout Australia.

I do not hold the Australian College of Operating Room Nurses in any way accountable for this article but seek to better understand how such an incorrect article made it to the pages of such an informative journal.

Best Regards



James Orr

City & Guilds 752 Operating Department Assistant

Registered Member of the Australasian Society of Anaesthetic Paramedical Officers

9 June 2013

Dear Pauline,

Thank you for the opportunity to respond to the letter written by Mr James Orr, 2 June. It is pleasing to know that the paper¹, written by Eloise Pearson and me, published in the *ACORN Journal*, Vol 26, (1) 2013, has inspired scholarly debate.

It was never our intention to offend or demean the professional standing of any healthcare group through the publication of this study. It is unfortunate that this work has been construed in this way. This study was not motivated by a lack of “respect”; rather its aim was to “compare Operating Department Practitioners (ODP) and nurses’ perceptions of their perioperative competence across six context specific domains using a previously validated perioperative competence scale”¹ (pp.30). Mr Orr’s comment that the primary intent of this paper was “to discredit ODP practice” is in itself “inaccurate”, a word used by Mr Orr several times throughout his letter. We were only making empirical comparisons between professional groups which in research, is appropriate.

Mr Orr questions our “ability to carry out research” and intimates that the conclusions we have drawn are flawed. This piece of research has been informed by a series of previous studies using the Perceived Perioperative Competence Scale-Revised (PPCS-R)²⁻⁸, a scale which I developed over numerous iterations (and years). The PPCS-R has undergone rigorous psychometric testing and is the first validated scale to measure dimensions of perioperative competence⁶. These dimensions within the scale have demonstrated robust construct validity and reliability⁶. As testament to the scale’s robust psychometric properties, we were able to identify statistically significant differences between ODPs and nurses in two of the six perioperative competence domains—*empathy* ($p < .0001$) and *foundational knowledge and skills* ($p = .002$).

Mr Orr expressed his concern about the “inaccuracy” of the views expressed in our article. However, the perspectives presented were based on the work of the authors of these previous studies. In keeping with academic integrity and ethical reporting in publishing, the current study¹ has been fully referenced, acknowledging the ideas and contributions of the authors cited. Ironically, of the 33 papers cited in our article, 6 (18.2%) were published in *The Journal of Perioperative Practice*, a UK journal that is widely read and supported by ODPs and nurses alike.

Our results echo the findings of previous studies. For instance, qualitative studies conducted by Williams and Jarman⁹, Gillespie et al.⁵, Richardson-Tench¹⁰ and Bull and Fitzgerald¹¹ have identified the unique skill and abilities that nurses bring to the table when “caring” for patients in the perioperative environment. Our quantitative study has added to the growing body of literature on the essence of “caring” in perioperative nursing. In this context patients are at their most vulnerable and need someone to advocate on their behalf. In the context of sentinel events, nurses have long been recognised as patient advocates in the perioperative setting. It is nurses’ innate ability to provide *holistic care* that separates them from their non nursing counterparts¹⁰, whose focus has traditionally been based on the technical nuances of clinical practice. Indeed the position we have argued indicates this stance and hopefully challenges nurses to

reflect on the unique contributions they make everyday to patient care in the perioperative environment. I do not retreat from this stance, and nor do I apologise. There is a litany of research to support these statements.

If we are to retain a nursing presence in the perioperative setting, then we need to clearly articulate the contribution to patient care that we as nurses make: Undoubtedly the imperative to contain healthcare costs, coupled with the difficulty in recruiting qualified nurses—has led to a fall back position to recruit non nurses in many perioperative healthcare facilities across Australia⁹. If we are to have a steady stream of nurses pursuing perioperative careers, then we must continue to encourage our undergraduates—and include perioperative courses and placements in undergraduate and postgraduate nursing curricula.

Let’s keep nurses in the operating room.

Sincerely,

Dr Brigid M Gillespie RN PhD

Senior Research Fellow, Griffith University, NHMRC Centre for Research Excellence in Nursing (NCREN), Centre for Health Practice Innovation, Griffith Health Institute

G16 Clinical Sciences Bldg_Rm 2.63, Gold Coast Campus QLD 4222

Email: b.gillespie@griffith.edu.au

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Stephen Born

The 2012–2014 Board members are working consistently towards the strategic direction set by them at the November 2012 board meeting.

Enterprise: Governance

One of the main goals within the e-Business platform for ACORN is looking at the viability of a virtual office. To assist in this achievement, ACORN has moved to new phone numbers. This will mean for you our member that no matter where ACORN does business, the number will stay the same. Please note the new numbers and postal address on the first page of the *ACORN Journal* under ACORN Secretariat.

Joy Jensen, ACORN QLD Director and Honorary Treasurer, has collaborated with all committee chairs to establish each committee's budget needed to finance their vision, goals and strategies. Joy is still driving the finalisation of the tax minimisation strategy in relation to ACORN's application to the ATO to achieve charitable status. This is now looking very likely for ACORN. This status will provide ACORN substantial tax savings. Joy is also leading the Executive and Board in the development of a governance and risk management plan. This will assist the Board in decision making when managing the finances, to ensure that ACORN has the right procedures and processes in place to administer the College and strategies to grow the College and increase the influence it has in setting the standards for perioperative nursing.

Sharon Harding, NT Director and 2014 Chair of the Conference Committee, reports that planning for the 2014 Biennial National Conference is proceeding full steam ahead. We hope you love the date claimer postcard magnets posted with this journal. It was originally planned for inclusion in the last issue, but like the best-laid plans, things don't always go to plan. So get them on your refrigerator to start you thinking about what paper you are going to present at this conference. The theme is, *All for one and one for all: Achieving our common goals*. Sharon and the Executive will next meet with the advisory committee to assist with the planning of the 2014 Conference. This committee aims to bring ACORN's corporate members and major sponsors together to share ideas and resources so that ACORN and our corporate members are able to produce a better educational experience for all delegates. Please keep the date of 21–24 May 2014 free so you won't miss out on the best ACORN Conference yet!

Carolyn Williams, Victorian Director, Honorary Secretary and Chair of the Journal Committee and her team continue to support the Editor-in-Chief and the Associate Editor.

Pauline Walker will finish in her role as Editor-In-Chief following this winter edition of the *ACORN Journal*. Carolyn, Pauline and a member of the Board are currently interviewing for this role. This is a significant role for the production of the *ACORN Journal* and Pauline wants to ensure that the new Editor-in-Chief will continue the great work that she has achieved in this role. The ACORN Board thanks Pauline for her significant contribution to the improvement of the *ACORN Journal* over the many years. She has contributed in various roles and we wish her the best for her next endeavours!

Elissa Shaw, Tasmania Director, Chair of the Education and Research Committee, and the committee are working on the ACORN accreditation of courses process and how to ensure that members are aware of the financial assistance process, particularly for research grants. They are also exploring broadening educational services for ACORN.

Enterprise: Alliances

Our membership in the category of corporate membership continues to grow. We now have 10 corporate members and the growing numbers means that our corporate members' page has now become two! Over the next few additions of the *ACORN Journal* we hope that we will be able to highlight the importance of this great alliance with our health industry partners to improve the educational resources and opportunities for perioperative nursing.

The ACORN President Ruth Melville continues the great work of forming strategic and beneficial alliances with international organisations such as ACORN. These alliances are important in order to bring the state, national and international associations together to share ideas and resources to continually improve the body of knowledge needed for perioperative practice. Ruth also represented the IFPN (International Federation of Perioperative Nursing) at the recent International Council of Nursing Congress in Melbourne. This is a significant role for her to have when 120 countries were represented at the ICN Council Board Meeting. Members of the IFPN are made up of all the national perioperative associations from around the world working collaboratively to improve the care of perioperative patients.

The Board continues to strengthen the strategic alliance with each member state and territory in promoting National Unity. ACORN has again entered into an agreement with IIR in supporting and running the 5th Annual Operating Theatre Management Conference 22–23 August 2013. The program is supported by many great speakers who are also members of ACORN.

Wisdom

Jed Duff, NSW Director and Chair Standards Committee, continues to manage the ever-increasing member enquiries from members about the *ACORN Standards*. The revised Staffing and Surgical Plume Standards are now completed and our Secretariat is now about halfway through sending them to everyone who purchased the current edition of the *ACORN Standards*. If you or your organisation purchased the 2012–2013 *Standards*, the updates will be sent to you as a matter of priority and please remember that we have sold to date around 1,000 copies of these *Standards* so that's a lot of manual work for our Secretariat.

The major initiative of this committee is the establishment of a Standards Editor role. Jed and his team are currently interviewing for this role. This important new role will support the Standards Committee and the Board to ensure the systematic and evidence-based review and development of the *ACORN Standards*. The Standards Committee has decided on the following reviews for the next *ACORN Standards* edition:

- **ACORN Standard S5:** Electrosurgical Equipment
- **ACORN Standard S7:** Infection Prevention
- **ACORN Standard S11:** Perioperative Attire
- **ACORN Standard S25:** Management of Sharps in the Perioperative Environment
- **ACORN Guideline G3:** Planning and Design of the Perioperative Environment
- **ACORN Perioperative Nursing Roles NR5:** Role of the PNSA

New Standards to be introduced in the 2013–2014 period will include:

- Recycling in the Perioperative Environment
- Fatigue in the Perioperative Environment

The Committee has also started negotiations for the next partnership with JBI to produce the evidence summaries to inform the review and development of Standards.

Communication

Our communication strategies continue with this report in providing you the membership with more information into the strategic direction and activities to achieve this vision of ACORN.

The ACORN President wants to ensure that the communication with our membership continues. Ruth will attend many local association conferences and when she is not able to will send her representative. There will be an ACORN presence at each conference and someone there to ensure that you the member have an opportunity to discuss anything with the President and Board.

Lyell Brougham, SA Director and Chair of the Website Committee, is really passionate about the website being a good communication channel for members. He is currently working with our web developer to update the current website and his committee will be involved in the e-Business platform as the website will be a major focus of this strategy.

Spirit

Cath Scott, WA Director and Chair of the Marketing and Membership Committee, is in the process of developing a suite of perioperative photos which ACORN can use for any purpose such as in conference brochures and on our website. It is important to the Board that all the images show patient care and nursing practice, which reflects the high standard of care within the *ACORN Standards*. You will have noticed that this *ACORN Journal* has the new National Unity branding. The Committee has used the same

branding for the corporate members' pages to promote this alliance and the importance this alliance is to you the membership through improved educational opportunities. ACORN is a national college and gains its strength from being the national voice of each state and territory local association.

I hope you gain understanding through reading this report of how the Board is making a difference, and the work that it does to ensure that the College is the Spirit of perioperative nursing.

Stephen Born

ACORN Executive Officer



STANDARDS REVIEWER

Are you interested in being a reviewer or lead reviewer for the *ACORN Standards*?

The ACORN Board invites expressions of interest from perioperative nurses to be a reviewer for the 2014–15 *ACORN Standards*.

The Standards being reviewed or developed for this edition are:

- **G3 Planning and design of the perioperative environment**
- **S5 Electrosurgical equipment**
- **S7 Infection prevention**
- **S11 Perioperative attire**
- **NR5 Perioperative nurse surgeon's assistant**
- **Recycling in the OR (new)**
- **Fatigue management (new)**

You will work in a team to critique the available evidence and update the standard as required. Each team will be coordinated by a lead reviewer and supported by the Standards Editor, Standards Committee and Joanna Briggs Institute.

For your effort, you will be acknowledged in the *ACORN Standards* and presented with a copy of the latest edition at the 2014 ACORN Conference. You will also contribute to your professional development and develop your networking links in perioperative nursing.

If you are willing to share your expertise, passion and time, then please send your expression of interest, including a summary of your relevant experience, to acorncompany@senet.com.au by 22 July 2013.



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Pneumatic tourniquet safety: a literature review

Kylie Cross • St John of God Healthcare, Ballarat, Vic

Abstract

The use of a pneumatic tourniquet within the theatre environment, particularly in orthopaedic surgery, is fairly commonplace. However, are we as perioperative nurses aware of the potential injuries to our patients that they can cause if not used appropriately? This paper involves a review of the literature pertaining to pneumatic tourniquet safety in the area of orthopaedic surgery. The literature will be used to compare and contrast the different methods used to protect the skin beneath a tourniquet as well as the different types of cuffs that can be used to aid in reducing the risk of injury to the patient. Recommendations for the development of a departmental policy on pneumatic tourniquets are also discussed.

Introduction

This paper provides a literature review concerned with pneumatic tourniquet safety in the area of orthopaedic surgery. The issues that will be discussed are whether skin protection beneath a tourniquet is necessary or not in helping to prevent skin injuries and whether wide, contoured tourniquet cuffs can reduce cuff pressures, thereby also minimising potential injuries to the patient.

Definitions

A pneumatic tourniquet is defined as a system consisting of a pressure-regulated control unit, tubing and an inflatable tourniquet cuff. The cuffs inflate with air, oxygen or nitrogen to a preset pressure to compress the patient's blood vessels during surgical procedures¹.

The literature review

Of the literature that was reviewed, all but one of the articles clearly state that pneumatic tourniquets are commonly used in orthopaedic surgery to provide a bloodless operative field by improving visualisation of anatomic structures and to decrease blood loss.

Despite the well-documented benefits of surgical tourniquets and despite many advances in technology, their use is not without risk and complications still occur². The complications that are stated throughout the articles as a result of not having skin protection beneath a tourniquet include those that are confined to the superficial tissues such as indentation, redness, blistering, abrasions, lacerations, haematomas and oedema, and those that can involve the deeper tissues such as compartment syndrome, nerve palsy, muscle weakness, wound effusion, circulatory impairment distal to the tourniquet cuff, venous congestion, emboli, damage to nerves distal to the tourniquet cuff or pulmonary emboli.

Complications associated with high pressures under a tourniquet were not as specifically stated with only three of the articles mentioning these, in particular the Association of periOperative Room Nurses (AORN) which had the most extensive list, stating that over-pressurisation may cause pain at the tourniquet cuff site; muscle weakness; compression injuries to blood vessels, nerves, muscle, or skin; or extremity paralysis³.

Contraindications for the use of pneumatic tourniquets is also important when investigating their safety; however, the literature review revealed not every article acknowledged this issue. In those articles that did, the only contraindication that was repeated throughout was that of patients with peripheral vascular disease. Of the articles stating contraindications, AORN again had the most comprehensive list and these included, extremity infection, open fracture, tumour distal to the tourniquet, sickle cell anaemia, impaired circulation, previous revascularisation of the extremity, extremities with dialysis access (for example, AV shunts, fistulas), venous thromboembolism, increased intracranial pressure, and acidosis³. In contrast, the US Food and Drug Administration article was the only one to state that tourniquet use is contraindicated for use in neonates¹.

When discussing tourniquet safety, all of the articles stated various ways of protecting the patients from injury when applying the tourniquet. However, first and foremost when thinking about safety, the issue that initially needs to be addressed in the preoperative phase is, are the pneumatic tourniquet and its accessories in clean and proper working order? The reason for this is that nerve injuries have been reported when malfunctioning equipment has caused excessive pressure³. Surprisingly, only two of the articles happened to mention conducting this safety check prior to each use of the pneumatic tourniquet.

The specific ways of preventing skin injuries in patients having a pneumatic tourniquet applied basically came down to two methods in the articles reviewed: firstly, protecting the patient's skin underneath the tourniquet cuff; and secondly, using wide, contoured cuffs to minimise cuff pressure. All of the articles mentioned applying skin protection beneath the tourniquet in varying forms. However, three of the articles didn't state anything about using wide cuffs to decrease cuff pressures as a way of reducing injuries.

In establishing the benefits of skin protection underneath tourniquets, two of the articles reviewed conducted studies on this topic. Although both studies came to the same conclusion, that is, it recommended tourniquets be used with skin protection beneath them, they had different methodologies. The study by Din and

Geddes⁴ used a prospective, randomised trial on consecutive patients undergoing elective total knee replacement or knee arthroscopy. The patients were randomly allocated to one of three treatment groups: group 1, tourniquet without skin protection; group 2, tourniquet with Soffban skin protection; and group 3, tourniquet with the Atlantech skin protection drape. All patients had identical tourniquets, tourniquet pressure and skin sterilisation method. At the conclusion of the case, the tourniquet was removed and the skin beneath the tourniquet was inspected and recorded into one of four categories: skin normal, skin abrasions, skin blisters and skin break. The overall skin complication rate was lower in the tourniquet skin protection groups. Total skin complication rate in the non-skin tourniquet protection group was 12 patients out of 50. In the skin-protected tourniquet groups, the number of skin complication was six out of 100. This was statistically significant⁴.

The study by McEwen and Inkpen used a technique of making and analysing an imprint of the cuff-to-skin interface to quantitatively compare wrinkling and pinching of the skin under various types of padding or limb protection. From multiple trials on five healthy adult volunteers, they demonstrate the results of the following combinations of skin protection: a first brand of disposable cuffs applied directly to the bare skin; the same cuffs used with cotton-cast padding; a second brand of disposable cuffs with a built-in layer of 'gel' padding applied directly to the bare skin; a third brand of disposable cuffs used with the stockinette sleeve supplied with each cuff; and the first brand cuffs used with tubular elastic material

sleeves matched specifically to these cuffs. Based on a total of 55 trials of five different limb protection types on the upper arms and thighs of the five adults, stretched sleeves made of two-layer tubular elastic material and matched to specific tourniquet cuffs produced significantly fewer, less severe pinches and wrinkles in the skin surface than all other padding types tested. When using typical disposable cuffs, wrinkling and pinching were clearly more severe with no padding and with two layers of typical cotton-cast padding compared to both the two-layer tubular elastic and the four-layer loose stockinette sleeves. Cast padding gave only a slight reduction in maximum wrinkle or pinch height and did not reduce the overall amount of wrinkling significantly, compared to applying the same cuff on bare skin. The new disposable cuff with built-in gel padding applied on the bare skin was worse or not significantly different than the typical disposable cuff applied over either bare skin or cast padding⁵.

When looking at the issue of using wide, contoured cuffs as opposed to standard cuffs, of the articles reviewed there were two that had conducted studies on this topic. However, it should be noted that these studies were almost identical in their purpose, method, design, results and conclusions, the difference being that one article used a thigh tourniquet, whereas the other one used the tourniquet on the calf. Another significant factor in the similarities of these two articles is that two of the co-authors are the same. In both studies their purpose was to compare limb occlusion pressure (LOP — the minimum cuff pressure that stops arterial blood flow distal to the cuff)

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using a wide, contoured cuff compared to LOP using a conventional cylindrical cuff. Both studies used adult volunteers tested in a controlled laboratory setting. And both studies came to identical results that the wide, contoured cuff occluded flow at a lower pressure than the standard width cylindrical cuff on all volunteers^{2,5}.

Considering the common use of pneumatic tourniquets, there was little discussion in the literature reviewed on tourniquet injuries with only three articles demonstrating this. In particular, Choong states that there is little consensus in the literature of the optimal position, duration and pressure of tourniquet application and some even question the accepted role of tourniquets in some common procedures such as knee arthroscopy⁶. Due to the sparse literature on tourniquet injuries and proper limb protection techniques, the protocols for the use of tourniquets in limb orthopaedic surgery vary considerably from institution to institution, and best practice at present is still unclear.

However, McEwen and Inkpen suggest that present recommended practices for operating room personnel, intended as guidelines adaptable to various practice settings, refer clinicians to cuff manufacturers' recommendations for limb protection. However, some manufacturers do not make specific recommendations and refer the clinicians to the established protocols at their practice setting⁵. Therefore, this situation becomes a vicious cycle and until better guidelines for the use of tourniquets are formulated, surgeons should accord tourniquet injuries a high level of importance and ensure that they inform their patients of the potential risks of their use as part of the process of obtaining informed consent⁶.

Even though there are gaps in the literature on the topics of tourniquet limb protection and the use of wide cuffs to decrease cuff pressures, both of which are aimed at reducing the incidence of skin injuries beneath tourniquets, what research has been done is clear in stating that using skin protection under the tourniquet and reducing cuff pressures is best practice. Yet, many clinicians continue to use a standard pressure for any given cuff on any limb that they have found through experience gives a bloodless field. In many cases, this pressure is substantially higher than necessary for the individual patient, and this condition of excess pressure is never detected⁷.

Four of the articles also mention another important factor to consider when preparing for a case when a pneumatic tourniquet is being used and that is during the skin preparation time. Here, care should be taken to ensure that the skin preparation fluids and/or irrigation fluids do not enter beneath the tourniquet. Their recommendation is by way of sealing the edge of the tourniquet to prevent a build-up of fluid as this may compound skin damage during tourniquet use.

A final issue that was mentioned in all of the articles is that of tourniquet times. Interestingly, all of them except one say that pneumatic tourniquet inflation time should be kept to a minimum, to help in preventing skin injuries. However, Din and Geddes, after conducting their study, stated that the time of tourniquet use was not significant in terms of the incidence of skin abrasions when the tourniquet skin-protected groups were compared with the tourniquet skin-unprotected group⁴.

As well as providing evidence from research conducted in the literature review, four of the articles also provided recommendations for tourniquet use. Those described by AORN were quite extensive,

with 28 recommended practices, whereas in the other three articles their recommendations were summarised to just nine points:

1. Select the widest cuff suitable for the selected limb location and the surgical procedure and, if possible, use a contoured cuff able to match the taper of the limb at this location. Ensure that the cuff is clean and in good working condition.
2. If possible, select a limb protection sleeve specifically designed for the selected cuff. If such a sleeve is not available, apply two layers of tubular stockinette or elastic bandage.
3. Apply the tourniquet cuff snugly over the limb protection sleeve and prevent fluids (such as limb preparation solutions) from collecting between the cuff/sleeve and the patient's skin.
4. Using the applied cuff, measure the patient's LOP and set the tourniquet pressure.
5. Exsanguinate by elastic bandage or elevation, as appropriate for the patient and procedure.
6. Inflate the tourniquet cuff and monitor the tourniquet during use, as recommended by the manufacturer.
7. In the event that arterial blood flow is observed past the tourniquet cuff, increase tourniquet pressure in 25 mmHg increments until blood flow stops.
8. Minimise tourniquet time.
9. Immediately upon deflation of the tourniquet, remove the cuff and sleeve from the limb^{2,5,7}.

Conclusion

In conclusion, this paper has discussed the main points that help prevent patients from developing skin injuries beneath pneumatic tourniquets. These include using skin protection under and around the tourniquet cuff, using wide, contoured cuffs, thereby decreasing excessive cuff pressures and minimising the duration of tourniquet inflation times. Ensuring departmental policies and procedures are present and up to date, along with staff education in the use of pneumatic tourniquets is also essential. The importance of providing appropriate assessment, planning, implementation and evaluation of patients undergoing procedures requiring a pneumatic tourniquet can not be underestimated as we aim to provide optimal perioperative care to ensure the best possible outcomes for our patients.

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Introduction of the Professional Educational Series

June 2012

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As we are all aware, continuing education and professional development have become essential components of not only registration each year, but both are needed to stay in touch with the fast-paced, changing world of surgery.

Background

In 2011 because of staff not being able to get to professional development or continuing education offerings during work hours (due to many reasons), we ran, in conjunction with a prostheses supplier, a hands-on workshop on a Saturday morning for four hours. We had 12 attendees who all attended in their own time. Their feedback was that it was a great session and well worth repeating.

Our clinical nurse educator, Trish Keating, took ownership of the idea of running Saturday morning sessions and from this beginning, the St George Perioperative Professional Education Series was born.

Professional Education Series

In 2011, in addition to the prostheses workshop, we ran a further four workshops. The topics were: update on anaesthetics; ENT surgery (reflecting our current case mix); vascular surgery updates; and women's health issues. Trish sought out the subject experts from within our own facility to present on relevant topics. We also identified a supplier of equipment for that speciality and invited them to sponsor the morning and to also provide a hands-on session at the conclusion of the morning.

We sought out a room in which to hold the workshops and the only viable space was the perioperative seminar room. While this room is set up with audiovisual equipment, it is relatively small. When set up in lecture style, it only just holds 22 people. We reasoned that this would be more than ample room. While there are many other rooms available within the hospital, they are not able to be used on weekends due to access and air conditioning issues.

Fliers were posted some four weeks in advance and as we were not sure of the response, fliers were also sent to other facilities within our Area Health Service. There was a closing date of one week prior to the workshop. This would allow us time to cancel if there was no uptake. As staff would be attending in their own time and not being paid, we were not expecting a large response.

The response to the fliers was overwhelming. Staff were very keen to attend. We did not need to worry about not having the numbers to run the workshops; we had to create waiting lists in case some staff dropped out.

The format to the workshops is quite straightforward. The morning runs from 7.50 am to 12 noon. Registration takes 10 minutes and then the sessions commence promptly at 8 am. Each session generally runs for 30 minutes. A morning tea break of 20 minutes is usually held at around 10 am.

At the conclusion of the workshop, staff are asked to provide feedback via a written tool. Generally the response rates have been exceptional, with staff coming up with ideas for future workshops they would like to see. Certificates of attendance are given at the conclusion of the workshop. From the feedback a report is generated to highlight areas that are great, areas that need improving and other areas never to be repeated!

During the work-up of the workshop, Trish contacts all the speakers some three days prior to the workshop and has the presentations loaded onto the laptop. This enhances the flow of the day. On the odd occasion that a speaker has not provided their presentation, there are inevitably some issues (usually relating to the internet).

As a result of the success of the workshops in 2011, it was decided that we should continue them into 2012. So far in 2012, we have run two workshops — one on the urgent craniotomy and one on pulmonary issues. A further two are scheduled for 2012 — another anaesthetic workshop as well as one on urology.

Concerns

The waiting lists for each workshop are of concern to us. We would like to be able to offer the session to more staff, but the room is our greatest limitation. Having said this, there is a certain "cosiness" in having a limit on the attendees. It makes it a little bit more personal and allows staff to participate in the hands-on components. If we were to get bigger, this might be lost.

The other concern, if it is such, is the amount of work required to coordinate the workshops. With sometimes four or five presenters, it is often difficult to ensure that they are available (often as we book them months in advance) and that their presentation is able to be "read" by our laptop. Trish works diligently on this throughout the year.

Future

We plan to continue with the Professional Educational Series in 2013. We already have topics planned, including a session on men's health, the neuro spine and a further orthopaedic workshop.

Management of multi-resistant organisms (MRO) in the perioperative environment study tour

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Judith Meppem Scholarship Recipient

Abstract

Preventing and controlling infection is a concern every day for every surgical patient. It is no secret that a bundled approach to fighting infection can lead to better patient outcomes. But what factors go into a comprehensive plan to fight infection and what new approaches can facilities, and in particular, perioperative nurses, take to reduce their infection rates in 2012, especially within the perioperative setting?

In general, multi-resistant organisms (MROs) are defined as microorganisms — predominantly bacteria — that are resistant to one or more classes of antimicrobial agents. Although the names of certain MROs suggest resistance to only one agent (for example, methicillin-resistant *Staphylococcus aureus* [MRSA], vancomycin-resistant *Enterococcus* [VRE]), these pathogens are usually resistant to all but a few commercially available antimicrobial agents.

Background

Currently in Australia, the approach to the management of multi-resistant organisms (MROs) in the perioperative setting has taken a scatter-gun approach. Every perioperative suite and department is writing its own policy on how to manage MROs. The only consultation is the exchange of draft policies, from which each suite picks and chooses points that may be relevant to them. While policies are written, what happens in practice may be quite different. Constraints within both fiscal and human budgets result in very different practices. The terminal cleaning of operating theatres following an MRO case is clearly documented. What is not covered is how these patients are managed within the hospital and operating suite.

A review of the literature and practices within Australia has shown that there is not a standard approach to the intraoperative management of patients with an MRO. When reviewing overseas literature, there appears not to be a great deal published on how the intraoperative management of patients with an MRO should be undertaken. In fact, the literature is silent on the intraoperative management of patients; articles focus on terminal cleaning and other environmental issues within the general hospital setting.

Judith Meppem Scholarship study tour

The Judith Meppem Scholarship study tour to the United States (US) was to examine, not the cleaning methods used, but rather how perioperative departments manage the patient with an MRO.

Method

The facilities chosen for inclusion in the study tour were in California, Nevada and Hawaii. These facilities were stand-alone facilities or part of a larger hospital group. The facilities were selected

as they have tertiary affiliations and are of a similar size and case mix to St George Public Hospital, Kogarah, New South Wales.

In preparing for the trip, I contacted all of the facilities, firstly via their directors of nursing and then as a follow-up to the perioperative managers. As some of the facilities are members of commercial groups, and thus would need permission from head office for any release of information, I also included documentation on areas that I would be discussing and wanting information. Also by providing them with the areas that I would like to review and discuss before the visit, meant that the appropriate people would be aware of my visit and could make themselves available.

In planning the visit, I had allowed two working days to be spent at each facility. All facilities kindly accommodated me. This length of each visit allowed me to see what happened in practice as well as to compare with their written policies.

I confirmed my appointments with each of the facilities the day prior to the scheduled appointment. This allowed for any unforeseen scheduling issues. In the case of Doctor's Medical Center in Modesto, California, this was important as the nurse manager I was scheduled to meet had resigned and had left no follow-up. As a result, I met with the perioperative nurse educator.

I met with the appropriate staff member and after about an hour of exchanging information, answering my specific questions and obtaining copies of the relevant policies, I was then "embedded" into the operating room to observe the actual practice.

This enabled me to observe if policy was practised in reality and also what worked and what did not work. It also allowed me to observe other areas of the perioperative service and compare and contrast these in relation to my own facility, St George Public Hospital in



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Kogarah. I was given total freedom within each of the suites and this allowed for very rich data collection.

Results

General

The majority of the facilities were in the US state of California.

Cases of MRSA increased fourfold in California hospitals between 1999 and 2007 to 52,000 cases, according to a new state report, which also suggests the annual number of MRSA deaths are 3.2 times more than estimates for seasonal influenza¹. As a result of this incidence, in 2008 California passed legislation governing the use of antibiotics and the monitoring and reporting of hospital-acquired infections (HAI). This Act, known as the *Medical Facility Infection Control and Prevention Act* (or Nile's Law)² sets out which HAIs are monitored, how they are monitored and reported. It even goes into how patients should be tested.

The effect of this law on the perioperative, and indeed hospital-wide setting is that patients who meet the criteria must be tested for MRSA within 24 hours of admission. These include patients undergoing surgery with a documented medical condition, making the patient susceptible to infection (based on CDC recommendations), patients who have been admitted and discharged from an acute facility within the previous 30 days, patients to be admitted to the ICU or burns unit, patients undergoing dialysis and patients being transferred from a nursing home.

It was interesting to note that the facilities visited also added additional testing for MRSA with a specific cohort of patients. Both cardiac and orthopaedic patients were tested for MRSA prior to surgery. This testing consisted of nasal swabs. Patients who tested positive were given both written and oral instructions regarding after-care and precautions to prevent the spread of the infection to others. In addition, there is an MRSA colonisation eradication protocol to be followed.

Given this need for testing, it was interesting to see who paid for the testing, given the costs associated with this. The health insurance companies have stated that the costs associated with testing are incorporated in the benefits they already pay the facilities. With regard to those patients that are covered by Medicare/Medicaid³ (US public hospital type coverage), this is also absorbed by the facility.

The results of the screening and decolonisation have been reported for the first time in January 2012. The results showed that there was a 57.1% incidence of MRSA and a 46.3% incidence of VRE in Californian facilities.

In 2009, NSW was the first state in Australia to introduce mandatory monitoring and reporting of HAIs. Current data shows that the reductions in infections in 2009 are being maintained in 2011⁴.

A snapshot of the data for both California and NSW for March 2011 shows that per 10,000 bed days NSW had a rate of 0.8 and California had a rate of 1.0 for MRSA blood stream infection (BSI). This illustrates how similar the problem of HAI is to both states.

By comparison, the rate in 2010–2011 is 1.56 at St George Public Hospital.

Perioperative

The specific areas I was interested in seeing related to the management of the patient during their perioperative journey. This was facilitated by having a set of questions to guide this process. These questions were developed by reviewing the current practice at St George. These questions can be grouped into a number of common themes:

1. Documentation
2. PPE
3. Cleaning
4. Physical management

Documentation

All of the facilities visited used a computer system that communicated information to the staff. The infection status of each patient is documented on the master schedule and this in turn appeared on the theatre list for that day. It was up to each staff member to review the list and put in place the required precautions. This included the orderlies who were assigned to retrieve the patient's from the specific wards.

It was expected that at each point of the patient's journey a nursing "hand off" or handover occurred and that the patient's infection status was included.

The patient's notes or chart were placed in a clear plastic bag.

All paperwork that is generated in the theatre that is hard copy (that is, not soft copy) is discarded at the end of the case. This includes the instrument tracking sheet and count sheet. All counts are documents on a white board!

PPE

Contact precautions were implemented for all patients with a known MRO. For the transporting of patients throughout the facilities, gloves only, no gowns, were worn as to protect the patient's confidentiality regarding their known MRO status.

Patients were not held in either preoperative holding or anaesthetic bays but were taken directly into the operating theatre.

It was interesting to note what attire the nursing and medical staff wore both inside and outside the theatre. All staff throughout the facilities wore scrubs. These were provided by the facilities and were of the "pull over head" style (rather than the front opening style of scrub top). On leaving the theatre complex, staff did not wear cover gowns but rather wore either white coats or no gowns at all.

Visitors to the suites, such as maintenance teams and so on wore a disposable "jumpsuit" made of paper, similar to the single-use surgical gowns. Shoe and head covers were also required. Scrub attire was only required if a staff member was going into a theatre where a case was under way.



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At the entrance of each of the suites, an antistatic mat was to be found. This was for the purpose of attracting stray particles from shoes and wheels of trolleys to prevent them being transported into the theatre complex.

Cleaning

The scope of the study did not include the general cleaning of rooms and so on following a case of a known MRO; however, the cleaning of specialised equipment was of interest. Specialised equipment can be classed as monitors, keyboards and other sensitive equipment. All keyboards were of the standard type. They were, however, covered with a clear plastic "skin". This allowed for the keyboard to be wiped over at the conclusion of the case. Monitors and keyboards were wiped down with a neutral dermacidal detergent.

Specialised equipment, such as anaesthetic carts were exchanged out and then terminally cleaned and restocked.

It is interesting to note that due to nursing awards in the US, nurses do not clean the theatres between cases. There is a housekeeping team available to clean the room and turn it over, making it ready for the next case. This does slow down the turnaround time of cases and makes for large gaps in the theatre list.

Physical management

Patients who are admitted via day surgery or ambulatory care are treated in the same manner as patients who come from the wards. They are nursed with contact precautions in situ.

Cases with a known MRO are not placed at the end of the theatre list. The theatre list order is based on patient acuity and availability of equipment. When the case is under way, there are no additional staff assigned to that theatre. If additional equipment or supplies are required, the staff are reliant upon available staff outside the theatre to act as "clean" staff.

When the patients are transferred to the post acute care unit (PACU), again contact precautions are instituted. If room allows, the patient is sectioned off from the other patients. In the PACU in one facility visited, they have a negative pressure room where, if possible, they recover the patient.

Other

It was interesting to note that through discussions with staff, the hand hygiene message is having difficulty being implemented. They are attempting to implement the *5 Moments of Hand Hygiene*⁵ but are finding great reluctance. In one facility, the nurse manager reported to me that only about 20% of the staff (both medical and nursing) washed their hands (outside of the surgical scrub).

It is also of note that one facility has implemented use of an alcohol-based rub in place of the surgical scrub. This has not increased their surgical site infection (SSI) rate over the last three years.

Discussion

From the extended stay with a number of US facilities, I found that their practices are both similar and behind those implemented within my own facility in Australia.

The practices that are similar are those related to treating the patient with a known MRO are nursing the patient with contact precautions in place, using the master schedule (or theatre) list as the means of communicating the status of a patient, cleaning specialised equipment and managing the patient within the suite.

Areas in which we in Australia appear more advanced include the abolition of antistatic mats, wearing of overshoes and in the turnover of theatres between cases. Mats with tacky surfaces placed in operating rooms and other patient-care areas only slightly minimise the overall degree of contamination of floors and have little impact on the incidence rate of health care-associated infection in general. An exception, however, is the use of tacky mats inside the entrances of cordoned-off construction areas inside the health care facility; these mats help to minimise the intrusion of dust into patient-care areas.

There is continued debate within Australia as to whether cover gowns should be worn outside the operating suite. As found in the US facilities, this is not the case. The use of cover gowns is not universally worn but many staff wear white coats when they leave the suite.

Research has shown that clothing, uniforms, laboratory coats, or isolation gowns used as personal protective equipment (PPE), may become contaminated with potential pathogens after the care of a patient colonised or infected with an infectious agent, (for example, MRSA, VRE, and *Clostridium difficile*). Although contaminated clothing has not been implicated directly in transmission, the potential exists for soiled garments to transfer infectious agents to successive patients.

There were a number of areas observed that were not related to the management of MROs that were of interest in all facilities. These included the overcrowding of the departments with equipment. This is a common problem with all operating suites the world over. There is never enough storage space. Most notable was the vast amount of equipment each site had. Not only was equipment stored in corridors, but also the operating theatres themselves were used as storage areas. The theatres were considerably smaller in size compared to those at St George and with equipment stored in the theatres, this reduced the amount of workable area.

Another area in which Australian perioperative settings are more advanced is in the placement of nursing students and new graduate nurses. In the facilities that I visited, they did not have undergraduate nursing students or new graduates. Nursing staff were required to have at least two years' postgraduate experience. Those staff who were not perioperative experienced undertook a course entitled "Periop 101". This is a course that is run by the Association of Operating Room Nurses (AORN). It is a generic course conducted by course work and interactive computer skills.

At St George Hospital, we accept new graduates for a six-month placement and they undertake a 20-week "Transitions to Perioperative Nursing" course. This is based on the now defunct "Foundations in Perioperative Nursing" previously run by the Area Perioperative Educators.

At St George Hospital perioperative services, we accept first, second and third year nursing students as well as Bachelor of Midwifery students. We have developed a plan that ensures the students are exposed to perioperative nursing. This has formed the basis of recruiting perioperative nurses for the future.

Another area in which facilities differ from those in the US is that in the US they do not have anaesthetic nurses nor do they have nurses as instrument nurses. This means that the only registered nurse in each theatre is the circulating nurse (scout nurse). This means that the nurse is responsible for the running of the room. It may also mean suboptimal patient care. From a career perspective, this means that the nurse is never in a position to scrub for cases and it was explained to me that the nurses are not particularly happy with this.

Conclusion

The trip was a great success. I was able to experience firsthand the manner in which a number of selected facilities managed MROs in the perioperative environment. I found that our practices at St George Hospital are comparable with those in the US. In some instances, our practices are more advanced. In addition, by embedding myself, I was able to observe and learn more about how

the different suites were managed and was able to bring "home" some ideas that might be worth trialling.

I would like to thank the Judith Meppem Scholarship Assessment Committee for the opportunity to travel to the US and to review and contrast different perioperative settings to our own.

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NTPN 10th Biennial Conference

Pauline Walker

The Northern Territory Perioperative Nurses (NTPN) held their 10th Biennial NTPN Conference celebrating *Coming of Age* on 4 and 5 May 2013 at the Holiday Inn, Esplanade in Darwin, Northern Territory.

The NTPN group was established 21 years ago. The NTPN President Sharon Harding welcomed the attendees, the delegates from Bali and the interstate visitors, of which there were many who, like me, just love to attend the NTPN conferences. The events that happen in the Northern Territory are so unique that the conference ensures a very different view of perioperative nursing and nursing in general.

The conference was opened by Karen Parish, Chief Nursing and Midwifery Officer, Northern Territory.

ACORN President, Ruth Melville gave an update on the work that the ACORN President has and is undertaking and highlighted the activities of the ACORN Board and its various committees. These perioperative nurses volunteer their time (usually four years) to progress and update perioperative services. The Board works under the supervision of the President and the guidance of the Administrative Officer. The President and Board members are active on many nursing and health committees, both national and international and are the voice for perioperative nurses in Australia.



Sharon Harding, Karen Parish, Ruth Melville



Gift from NSW OTA

The conference venue was decorated and a cake was produced to mark the 21st birthday of the NTPN group. A gift was presented to NTPN by Karen Hay, NSW OTA representative.



21st birthday cake

Trade fair

The trade fair was opened by ACORN President Ruth Melville, assisted by Sharon Harding, NTPN President. The sponsors put on a grand show that was well attended by the delegates. A cocktail party followed, which ensured a festive occasion enjoyed by all.



Opening the trade fair



NTPN stand

Conference sessions

The conference sessions were well attended and well described by Kerry Schroder in her report. An accident on the way to the conference didn't stop Franya Cowlard (TORN Secretary) from attending.

Conference close

Libby Webb, NTPN Secretary, presented a historical report on the 21 years of perioperative nursing in the Northern Territory, followed by



Delegates at the cocktail party



Nicole Lewis, Aboriginal Cultural Awareness Officer

Sharon Harding and her team, who created a very comical theatrical skit acting out the history and the future and the connection with ACORN.

Cocktails and the cutting of the 21st birthday cake was a fitting conclusion to a very enjoyable conference.

The conference dinner was held poolside at the Mirambeena Travelodge. The theme was "Cocktail with Sparkle".





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NTPN 10th Biennial Conference

Kerry Schroder • Victoria



The NTPN 10th Conference, celebrating 21 years *Coming of Age* was held in Darwin on 4 and 5 May 2013. It was well attended, with nurses from every state and territory in Australia represented as well as some sponsored guest nurses from Sanglah Hospital, Bali. The conference began with a very warm and friendly “Top End” welcome by NTPN President Sharon Harding and the following two days provided a wide range of interesting topics presented by dynamic speakers.

Karen Parish, the Chief Nursing and Midwifery Officer for the Northern Territory, officially opened the conference, giving a historical background of perioperative nursing and noting that it was the first speciality in nursing. ACORN President, Ruth Melville, followed with a presentation on the strategic developments of ACORN, such as achieving charitable status and the development of an e-business platform. The following day, she also shared information about the National Labelling Standards and the developments that have been made now that ACORN had representation on the committee and has been able to provide input and feedback into the labelling standard.

The topic of organ retrieval in the Northern Territory (NT) was addressed by three presenters: Kelly Ansley from Donate Life, and Royal Darwin Hospital’s (RDH) nurse Lisa Murphy and consultant surgeon Dr Ruth Hardstaff. Kelly Ansley shared about how they have improved the organ donation rates in the NT with the introduction of specialised doctors and nurses in the major hospitals and significant funding for advertising to increase community awareness. Perioperative nurse Lisa Murphy spoke about the challenges and changes over the years associated with organ retrieval at RDH, from their first retrieval performed in 2001 with a visiting team to the appointment of resident Dr Hardstaff and performing their own retrieval surgery in 2011. Lisa also spoke about the technology improvements such as the new organ care system, which assists with decreasing ischaemic times of donated organs.

After lunch Dr Ian Norton gave a dynamic presentation on surgical disaster teams and the changes and improvements they have made in how they respond to mass casualty events with the development of new world standards, highlighting the need for teams to remain compliant with minimum standards and ethics in an area of disaster. He shared information about the rigorous simulation training that the response teams undertake and it was interesting to note that the NT has the only perioperative response team in Australia.

NT nurse Brigid Robertson then gave a very informative presentation on pain management in Indigenous Australians and the cultural differences and communication barriers that many encountered in

the PARU. She highlighted some strategies that nurses can utilise when it comes to assessing and managing pain such as observing body language, the use of hand signals and the importance of physically stopping and taking the time to listen to Indigenous patients.

The next day was followed up with a presentation by Mr Shiby Ninan, Director of Plastic and Reconstructive Surgery at RDH which included a very interesting, graphic slide show of before and after images of trauma reconstructive surgery performed at the “Top End”. RDH’s consultant general surgeon, Mr John Treacy, then presented on weight loss surgery and the different types available while focusing on the laparoscopic banding procedure that he frequently performs for his patients, outlining the overall short-term and long-term health benefits for these patients.

Next was a forum on the WHO *Surgical Safety Checklist* with panel members consisting of a RDH surgeon and nurse, and a nurse each from Alice Springs Hospital and Katherine District Hospital. The forum commenced with the panel providing key insights into how each NT hospital is performing in this area and it was then opened up to conference delegates to participate in the discussions. It was evident that the checklist was done better in perioperative departments where there are passionate champions to lead and drive the process.

The afternoon included a cultural experience with RDH perioperative nurse Eileen Goerdsorf sharing about her experiences, challenges and rewards in working in surgical teams in Third-World countries with Médecins Sans Frontières (Doctors Without Borders). This was followed by RDH’s Aboriginal Cultural Awareness Officer, Nicole Lewis, who provided conference delegates with a very informative presentation about Aboriginal culture, kinship systems and how this may impact gaining consent, and included a practical session involving delegates having a go at pronouncing Aboriginal tribal surnames.

The conference came to a finale with NTPN Secretary Libby Webb giving an interesting historical report of the last 21 years at NTPN, followed by a special treat for conference delegates, a very theatrical, entertaining, comical skit showcasing the NTPN team’s creative talents by acting out the history and future of NTPN. It was a great close to a wonderful conference that had all of the delegates in fits of laughter, and was complemented by the official cutting of the 21st birthday cake and celebratory drinks outside by the beautiful water feature. Well done to the NTPN team on providing such a fantastic conference and trade exhibition with plenty of great learning and networking opportunities.

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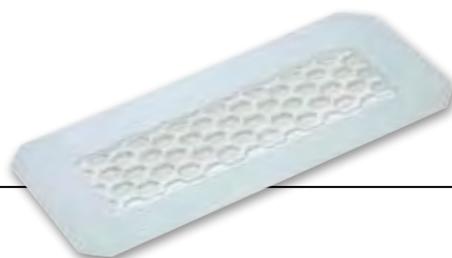


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Tasmanian Operating Room Nurses Conference Hotel Grand Chancellor Hobart 19–20 April 2013

Julie French • Tasmanian Operating Room Nurses, Conference Convenor 2013

The opportunity to facilitate the TORN Conference as Conference Convenor was an unexpected challenge. Without a very driven committee who shared a positive desire to support perioperative nursing education, such an event would not have been possible. The committee grappled with a shortlist of themes and from our first meeting the consensus was to highlight perioperative nursing's most current issues. It was important to support each topic with quality presenters, encourage debate around challenging topics and support practical skills experience with our planned master classes, which covered smoke plume, an anaesthetic skills workshop, a writers' workshop and leadership, all included by popular demand.

You may have asked yourself why a perioperative conference would be titled *The Elephant in the Room* and what this has to do with what happens in an operating room. If you found a relationship with this analogy and were able to pinpoint a few of your own experiences, then we hope this event brought about debate and a challenge for you to change behaviour and speak positively about those events rather than ignoring them completely or placing them in an invisible corridor in your work environment.

Close to 100 delegates registered for the conference and 30 trade exhibitions shared the opportunity to review and exchange dialogue over our one and a half day event. The positive result was achieved by the tireless work from the Trade Liaison Representative, Elissa Shaw, whose skills achieved a full trade area within the current harsh economic environment. Elissa's talents also entered the entertainment realm, revealing a much-loved appearance of our fancy dress elephant in the room who made an appearance during the dinner and games evening as "Elvin". Those who attended will not forget the amusing sight of our dancing 'gang gang' Elephant parade, our Oreo munch competition, stocking grapplers and skittle swingers, nor the final twist of trivia. The dinner event was full of laughter and exquisite food, combining to create a very memorable experience of the Hotel Grand Chancellor in Hobart.

Saturday brought an early start for delegates with breakfast with the trade. Delegates were somewhat bemused to listen to Chris Jones (Graeme Bowman), keynote speaker, who engaged us with facts and fantasy, weaving his most amazing vocabulary into vivid word pictures of people, places and surgical mayhem. Few were able to identify the hoax until he revealed himself. The scene was set for an excellent

day of discussions, debates and information central and including, infection control, extraordinary consent, open governance and obesity and anaesthesia. Jacqui Smith provided a stark reminder of the challenges faced by nurses and communities in West Africa, with her work and support of obstetric fistula hospitals.

Christine Hepburn's presentation revealed the many interpretations of just one simple message, graphically demonstrated with a paper-folding exercise. The result was a room full of different paper folds each as the individual had perceived the information, in most cases not a match to the original. The task revealed how easily messages sent are interpreted and changed without any awareness of a fault or change to the original instructions.

Professor Sandford's discussion about disclosure, "When Things Go Wrong", provided insight into the difficulties associated with open governance. A panel discussion followed with input from Professor Cathryn Murphy, sharing her extensive background within the infection control arena, together with orthopaedic surgeon, Gary Fettke. The panel discussion supported open, honest dialogue with a sincere attempt to include all relevant information. The audience participation was a true indication of the need for further debate to explore this area more fully. Gary Fettke, orthopaedic surgeon and author provided the audience with some thought-provoking



Accommodation voucher won by Cathryn Farrell with Kevin Holliday from Aidacare



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information and combined his insights into changing our thinking or inverting our thoughts with the final presentation “The Elephant in my Boot”.

I wish to thank Multigate for their sponsorship, including support for Cathryn Murphy to speak, and Covidien for the Education Grants, which were won by Kate Frey (HDS), Debra Stronach (LGH) and Julie Haas (LGH).

Reflecting on the TORN Conference, we were privileged to gather so many perioperative nurses together. I am sure those who braved the cold, wintry weather in Hobart on Friday afternoon to attend the workshops and skills stations found a common ground. Those who were able to share Saturday found something to inspire and challenge new ways of thinking. It is hoped our perceptions of the ‘elephant in the room’ did evoke a change in culture, which will open a discussion in the future to explore the difficult experiences found in the perioperative environment.



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ACORN

Australian College of Operating Room Nurses

We asked Pete Turnbull, National Sales Manager, Big Green Surgical Company, ACORN's most recent Corporate Member, Why is Corporate Membership important to our Healthcare Industry Partners?

“ At the outset of 2013, Big Green Surgical revisited its Core Corporate Values and assessed ways in which we could better align ourselves with our Key Strategic Partners who share the same values. Having long been a supporter of ACORN its State Organizations, it was decided that we would refocus our resources towards our local and national nursing bodies. In meeting with Stephen Born at the most recent NSW OTA and learning of the partnership opportunities available with Corporate Membership, we quickly and excitedly committed.

Corporate Membership for Big Green Surgical is an opportunity to demonstrate our ongoing commitment to the areas that we feel are most important to establishing ourselves as a partner in the delivery of quality, value added healthcare solutions:

- Continuing support and education
- Professional growth and development
- Innovation to achieve best patient outcomes

The above initiatives/ideals are fundamental to Big Green's development as we continue to look for new and innovative ways to partner with our Hospitals, all of which are reflected in ACORN's SPIRIT Acronym. Teamwork is another core element outlined in that acronym and we are thrilled to be a part of the ACORN team going forward. ”

Pete Turnbull

National Sales Manager



Pete Turnbull, Carolyn Williams & Lauren Harpur

Corporate Membership is the realisation of **ACORN** aligning itself with our health industry partners to support the education of perioperative nurses. Our health industry partners continually support **ACORN** through attendance at state and national conferences and support of perioperative nursing education. Their membership assists in the development of educational materials specific to the speciality of perioperative nursing.

If you see our Corporate Members in your operating suite assisting you in your education of products, please say a big thank you to them for being Corporate Members!

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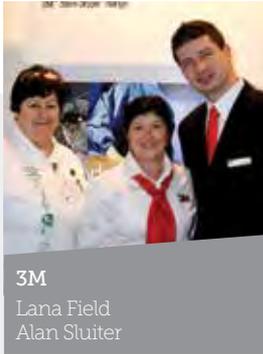
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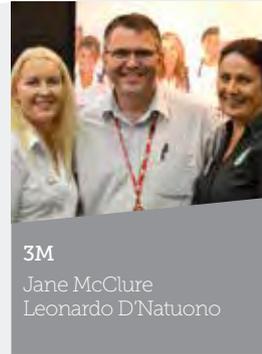


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Atta, Sharon Meere



NTPN
Conference
Darwin
4-5 May

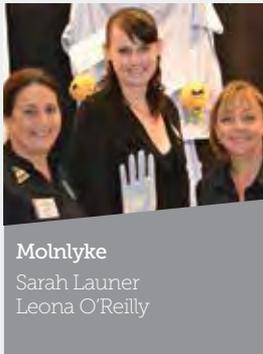
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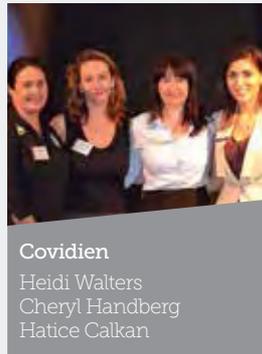
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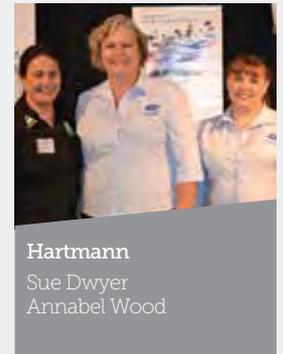
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ACORN would like to congratulate **Kim Shimmin**, newly retired after working with Covidien for 25years.

ACORN wishes to acknowledge our corporate members

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AUSTRALIAN COLLEGE OF OPERATING ROOM NURSES LTD

ACN: 071 142 768

MINUTES OF THE SIXTEENTH ANNUAL GENERAL MEETING OF THE COMPANY held on, Wednesday 23rd May 2012 at 2:00pm CST at the Darwin Convention and Exhibition Centre, Stokes Hill Road Darwin NT 0800

ACORN President Ms Victoria Warwick welcomed everyone to the meeting and declared the meeting of the Sixteenth Annual General Meeting of the Australian College of Operating Room Nurses Limited open.

Ms Warwick recognised the Past Presidents, Fellows, and Life Members attending the meeting.

Ms Warwick introduced the ACORN Director's present.

Ms Warwick advised that Mr Steve Fimmano from BDO Kendalls, ACORN's Financial Advisor had been requested to attend the meeting.

82 members attended the meeting and 4 Non Members

Apologies were received from Ms Phyllis Davis, Yvonne Van Netton, Rachel Foster, Mr K Soon, Mr Vahid Humphrey and Mr S Fimmano.

PROXY INSTRUMENTS

There was no proxy vote received.

MINUTES OF THE ANNUAL GENERAL MEETING OF ACORN held on Wednesday 15th July 2011 at the Launceston Country Club and Casino, Country Club Avenue, Prospect Hill TAS 7250 were reproduced in the journal and circulated at the meeting.

Mr Robert McCann put the motion, which was seconded by Ms Avril Brown;

'That the minutes as circulated and tabled at this meeting are a true and correct record of the Annual General Meeting of the Australian College of Operating Room Nurses Limited held in Tasmania.'

The motion was carried by a show of hands.

BUSINESS ARISING FROM THE MINUTES

NIL.

REPORTS

President: Victoria Warwick

Ms Victoria Warwick provided a verbal overview of her President's Report as tabled in the ACORN 2011 Annual Report.

Ms Patricia Nicholson put the motion, which was seconded by Ms Lillian Blair:

'That the President's Report as circulated and read be accepted.'

The motion was carried by a show of hands.

Honorary Secretary: Tracy Kerle

Ms Kerle provided a list of correspondence, which was tabled for perusal.

Ms Tracy Kerle put the motion, which was seconded by Ms Lillian Blair:

'That the correspondence as listed and tabled be received and accepted.'

The motion was carried by a show of hands.

Honorary Treasurer: Robert McCann

Mr McCann provided a verbal overview of the financial situation as printed in the Annual Report.

Editor: Pauline Walker

Ms Pauline Walker outlined the Editors Report as tabled

Mr Robert McCann put the motion, which was seconded by Ms Carollyn Williams:

'That the Editor's Annual Report as read and tabled be accepted.'

The motion was carried by a show of hands.

BUSINESS OF WHICH DUE NOTICE HAS BEEN GIVEN

Mr Robert McCann put the resolutions on behalf of the Board of Directors:

1. To consider, and if thought fit, adopt the balance sheet of the Company as at 31st December 2011 and the income statement for the year ended 31st December 2011, the Director's Declaration and the Independent Audit Report.

Seconded: Ms Cheryl Winter

Resolution 1 was carried by a show of hands.

2. To resolve, in accordance with Article 91.1 to re-appoint Mr Ken E. K. Soon, of 18 Brooker Street, Glenunga SA 5064 as the Company's Auditor.

Seconded: Ms Kim Hepper

Resolution 2 was carried by a show of hands.

The President formally recorded the members of the 2012 ACORN Board:

New South Wales: Tracy Kerle - Director, Jeremy Duff - Representative
Northern Territory: Rosemary Gaston - Director, Sharon Harding - Representative
Queensland: Ruth Melville - Director, Joy Jensen - Representative
South Australia: Robert McCann - Director, Lyell Brougham - Representative
Tasmania: Avril Brown - Director, Elissa Shaw - Representative
Victoria: Angela Hand - Director, Carollyn Williams - Representative
Western Australia: Catherine Scott - Director, Geraldine Keogh - Representative

NEXT ANNUAL GENERAL MEETING

The Sebel Albert Park 65 Queens Road Albert Park VIC 3004.
Time and date TBC.

Meeting closed at 2:30pm CST

AUSTRALIAN COLLEGE OF OPERATING ROOM NURSES LTD

ACN: 071 142 768

Notice is hereby given that the Annual General Meeting of the Company will be held at The Pullman Albert (previously The Sebel), Park 65 Queens Road Albert Park VIC 3004 at 2:00pm

AGENDA

1. Presidents Opening Remarks
2. Attendance
3. Apologies
4. Confirmation of Minutes of 16th Annual General Meeting
5. Business arising from the Minutes
6. Correspondence
7. Receive Annual Report
8. Receive Financial Report for 2012 and Report of the Auditor
 - 8.1 Resolution 1: To consider, and if thought fit, adopt the balance sheet of the Company as at 31st December 2012 and the income statement for the year ended 31st December 2012, the Director's Declaration and the Independent Audit Report.
 - 8.2 Appoint Auditors for 2013
Resolution 2: To resolve, in accordance with Article 91.1 to re-appoint Mr Ken E. K. Soon of 18 Brooker Street, Glenunga SA 6064, as the Company's Auditor.
9. Editors Report
10. Special business
11. Notification of Appointment of Directors for 2012/13
12. Date and time of next meeting
13. Meeting closure

Dated this

BY ORDER of the Board

Carollyn Williams,
Honorary Secretary

Australian College of Operating Room Nurses Limited

ACN: 071 142 768

Representing Perioperative Nursing

M: PO Box 899 Lyndoch SA 5351

T: 1300 781 924 F: 1300 781 934 E: acorncompany@senet.com.au

Proxy Voting Form

Please return to ACORN by mail or facsimile not less than 24 hours prior to the meeting.

I, of

being a member of the above named company, and a member of the
(Name of Local Association)

appoint of

or, in his or her absence, of

as my proxy to vote for me on my behalf at the annual general meeting of the company to be held on 8th August 2013 at 2:00pm Victorian time and at any adjournment of that meeting.

This form is to be used in favour or against each resolution. Please circle the appropriate action.

Resolution No 1 in favour against

Resolution No 2 in favour against

Signed: Date:

Financial Member of
(Local Association)

The following notes are cited from the Articles of Association of the Company.

PART 8 - PROXIES

39. Appointment of Proxy

39.1 A member may appoint one proxy. A proxy must be a member.

40. Deposit of Proxy and Attorney Instrument

40.1 An instrument appointing a proxy may not be treated as valid unless the instrument, and the power of attorney or other authority (if any) under which the instrument is signed or proof of the power or authority to the satisfaction of the Council is or are deposited at the registered office of the Company or at any other place specified for that purpose in the notice convening the meeting not less than 24 hours before the time for the holding of the meeting or adjourned meeting as the case may be at which the person named in the instrument proposes to vote.

40.2 For the purpose of **article 40.1** it is sufficient if the proxy is received at the registered office of the Company by facsimile transmission or by similar means of communication in a reasonably legible form. If the proxy is required to be accompanied by other documents then these documents may also be received at the registered office by facsimile transmission.

41. Proxy Instrument to be in Writing

41.1 An instrument appointing a proxy must be in writing under the hand of the appointor or of the appointor's attorney duly authorised in writing.

42. Form of Proxy

42.1 The instrument of proxy must be in the form determined by the Council but the form must:

- (1) enable the member to specify the manner in which the proxy must vote in respect of a particular transaction; and
- (2) leave a blank for the member to fill in the name of the person primarily appointed as proxy.

42.2 The form may provide that if the member leaves it blank as to the person primarily appointed as proxy or if the person or persons named as proxy fails or fail to attend, the chairman of the meeting is appointed proxy.

42.3 Despite **article 42.1** an instrument appointing a proxy may be in the following form or in a form that is as similar to the following form as the circumstances allow (overleaf).

43. Effect of Proxy Instrument

43.1 An instrument appointing a proxy is deemed to confer authority to demand or join in demanding a poll.

43.2 If a proxy is only for a single meeting it may be used at any postponement or adjournment of that meeting, unless the proxy states otherwise.

43.3 A proxy may be revoked at any time by notice in writing to the Company.

44. Voting Rights of Proxies and Attorneys

44.1 An instrument appointing a proxy may specify the manner in which the proxy is to vote in respect of a particular resolution and, where an instrument of proxy so provides, the proxy is not entitled to vote on the resolution except as specified in the instrument.

44.2 A vote given in accordance with the terms of an instrument of proxy or of a power of attorney is valid despite:

- (1) the previous death or unsoundness of mind of the principal; or
- (2) the revocation of the instrument (or of the authority under which the instrument was executed) or of the power;

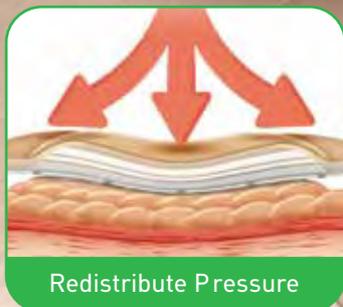
if the Company has not received written notification of the death, unsoundness of mind or revocation at the registered office of the Company before the commencement of the meeting or adjourned meeting at which the instrument is used or the power is exercised.

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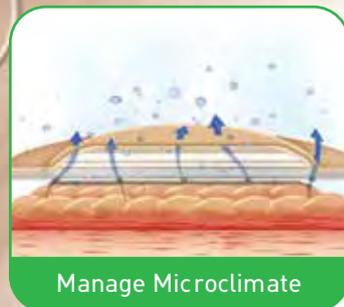
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Research Corner



Knowledge translation: The missing link to improving the quality of health care

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Abstract

The importance of transferring knowledge from research into health care policy and practice is widely recognised. A major problem, however, is the complexity of the process which policy makers, managers, clinicians and researchers struggle with. This can result in research findings not being used, with subsequent wasted resources and the inability to provide treatments to those who need them. Through knowledge translation and collaboration between researchers and users of research, we can position the way to address the problem of the underutilisation of research findings, which leads to quality and safety in patient care. This article presents a discussion about the translation of knowledge into practice.

Keywords: Knowledge transfer, knowledge translation, patient safety, quality care.

Introduction

Today in our fast-paced, changing world we cannot pick up a newspaper, listen to the radio or watch the television news without facing reminders of the challenges to health care and the poor state of the health systems. At the same time, within Australia and globally, billions of dollars are spent each year in both the public and private health sectors on biomedical, clinical, and health services research; continuing health care professional education; and patient safety and risk management. Despite this, transferring health care research into practice and policy is a complex process which policy makers, managers and researchers struggle to do. Failing to do so, however, results in health inequities, wasted resources and the inability to provide treatments to those who need them^{1,2}. Accordingly, health care professionals are unable to provide the level of care to which they aspire³. This article presents a discussion about the translation of knowledge into practice.

We are all aware that an important part of contemporary health care practice is the expectation that all professionals practise in a manner which, at best, embraces the integration of the best available evidence into their everyday encounters with patients and, at least, that the care they give is of the highest quality, is safe and causes no harm to patients. Most perioperative nurses will be familiar with systematic reviews, evidence-based guidelines and standards of practice (policies or practice protocols) that inform their practice. The evidence-based movement has focused on identifying, appraising and providing the best available evidence to all health professionals. However, the provision of evidence alone

is not sufficient to change what we do in practice⁴. Hence there is a gap between what is known and what gets done in practice. This gap, the 'know-do' gap, between available knowledge and its application in policy and practice is not new, but systematic approaches to address it are urgently needed⁵.

Although the importance of transferring knowledge from research into health care policy and practice is widely recognised, a major cause for failure is the time taken to transfer research findings into practice. This process has been described as slow and haphazard and may take up to two decades to transfer research findings to directly improve patient care^{1,2,3}. Caplan⁶ proposes that a reason for this is decision makers, managers and clinicians come from different worlds to researchers. Whilst researchers may revere theories and concepts, decision makers, managers and clinicians want evidence which is relevant and easy to understand. Furthermore, reviews of research implementation have highlighted that researchers do not always pay attention to the theoretical underpinnings of their work, nor provide sufficient contextual details for an assessment of transferability⁷. Given these issues, it is important that researchers and decision makers and other members of the health team collaborate to drive the translation, transfer and implementation of health research evidence into everyday practice.

Adding to these issues is the debate on what constitutes best available evidence, how to harness it in policy and practice, and whether it is sufficient to bring about sustainable change in adaptive complex social settings⁸. Furthermore, Pablos-Mendez *et al.*⁹ propose the definition of knowledge is sometimes used interchangeably with that of information or evidence. It has been argued that information or evidence is explicit and factual, while knowledge results from the integration of information or evidence with belief and context. This implies that while information or evidence can flow easily, knowledge is embedded in people and their understanding¹⁰. It is also suggested that the perception of knowledge differs according to culture, as ultimately it is knowledge that drives people to act¹¹. Nevertheless, the impact of the gap and the transfer of knowledge to practice and policy result in poor-quality care, with patients failing to benefit optimally from advances in health care and being exposed to unnecessary risks of iatrogenic harms⁹.

Faced with a future population with chronic, complex health conditions, a large proportion of which will be seniors, combined with the opportunities offered by new technologies, clinicians, managers and policy makers are looking to (or are expected to



look to) research-derived knowledge as one critical source of evidence in their decision-making processes¹². To improve the quality and efficiency of health care and patient safety, the importance of practice development and knowledge transfer through research is, therefore, essential. Not surprisingly, attempts have been made to reduce this gap. These have included educational strategies to alter clinician behaviour and organisational and administrative interventions. Nurse researchers are doing an exceptional job in making discoveries and generating new knowledge that has the potential to improve the health of individuals and strengthen the health care system and economy, but unless this knowledge is actually translated into action, these benefits will not be realised¹³.

Many health care settings are now actively working to transfer research into practice using the steps of evidence-based practice models. Throughout the decades, though, the most significant barriers to successful changes in practice happens in the final phase: adopting (institutionalising) the change in practice¹⁴. Recognition of this issue has created interest in knowledge translation (KT), which is defined as the method for closing the gap from knowledge to practice, that is research findings need to be translated from knowledge to action in order to decrease the gap between what we know and what we do¹⁵. KT is further defined by the World Health Organization¹⁶ as “the synthesis, exchange and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and advancing people’s health” (page 2). In order to move successfully from *knowing to doing*, the breadth and depth of skills, knowledge and competencies are needed.

Ensuring that knowledge to practice occurs is complex and challenging. In the past the transfer of new knowledge into practice was the responsibility of the research users, such as the policy makers, health care managers and clinicians. KT conversely involves active collaboration between the researcher and the research users in all parts of the research process, including working together on the research questions, methodology, data collection, interpretation of the findings, and dissemination and implementation of the findings¹⁷. To achieve this, appropriate relationships must be cultivated, following which there is the expectation that all the stakeholders exchange knowledge to understand what the evidence is, how it can be appraised, and how it can be adapted to be used in the local context; hence resulting in action. The general assumption, therefore, is that collaborative research will engage, from its early stages, the so-called “knowledge user” (the clinician) and address questions that are of concern to them¹⁷.

Currently, however, there have been no clear directions to help health care researchers, clinicians, or managers make decisions about what implementation strategies to use, in which contexts, and with what groups of stakeholders. Beyond research and the various sources of useful knowledge, the key challenge lies in understanding the steps and processes involved in decision making and implementation. These are complex and influenced by many factors including the user’s context, the presence (or lack) of an enabling environment, perceived relevance and type of knowledge in question. In order to bridge the know-do gap, we need to better

understand the means by which knowledge is translated into action⁹.

Lavis *et al.*¹⁸ (p. 222) propose the following five questions to provide an organising framework as a means for knowledge to be translated into action.

What should be translated to decision makers, such as clinicians, or managers (the message)?

To whom should research knowledge be translated (the target audience)?

By whom should research knowledge be translated (the messenger)?

How should research knowledge be translated (the knowledge-transfer processes and supporting communications infrastructure)?

With what effect should research knowledge be translated (evaluation)?

By using these questions as a framework, opportunities for improvement in research organisations can be found in the differences between the answers suggested by our understanding of the research literature and those provided by research organisations’ decision makers asked to describe what they do¹⁸ (p. 245).

KT is about turning knowledge into action and encompasses the processes of both knowledge creation and knowledge application. As a consequence, KT subsumes and builds on continuing education and professional development. Opportunities in continuing education is, therefore, based on the best available knowledge, whether in the form of knowledge tools (for example, practice guidelines), knowledge syntheses or primary knowledge inquiries. Strategies and skills shown to be effective at translating knowledge is also essential.

What does this mean for perioperative nurses as researchers and knowledge-users? Well, there is much for us to consider before becoming involved in a research project as actionable outcomes may not be forthcoming. Thousands of nursing and medical research articles are published every year, but how many of these findings are put into practice? However, as suggested by Straus, Tetroe and Graham¹⁹, we must be cautious of the assumption that all knowledge must be translated. We need to ensure instead that a mature and valid base of evidence exists. The realities of health care systems are that we cannot do everything and thus we must work with stakeholders (including patients and the public, clinicians and policy makers) to establish an explicit process for prioritising activities related to knowledge translation. When research gaps are identified through synthesis, the appropriate people need to be involved from the beginning in order to conduct applied, collaborative, interdisciplinary research. Through KT and active collaboration between researchers and users of research, we can position the way to address the problem of the underutilisation of research findings, which leads to quality and safety in patient care¹⁵.

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The effectiveness of the *Surgical Safety Checklist* as a means of communication in the operating room

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Huaqiong Zhou • School of Nursing and Midwifery, Curtin University, Perth, WA

Abstract

This paper reports an integrative research review (IRR) on the effectiveness of implementing the *Surgical Safety Checklist* (SSC) as a means of communication in the operating room. A total of 11 studies conducted in 2012 were included in this review. Two main themes with subthemes emerged from the analysis. The first theme is *Administration of the SSC* with two subthemes: *Compliance rate with the SSC* and *Completion of the SSC*. The second theme was titled *Outcomes of implementing the SSC* with a subsequent four subthemes arising: *Verification of information, Mortality and complications, Adverse events, and Incidents*. This IRR revealed that implementation of the SSC had consistent positive outcomes in the reduction of preventable harm to patients undergoing surgeries. It is, however, recommended that further training in utilising the SSC and strategies is needed to ensure full compliance and completion rate with the SSC.

Keywords: *Surgical Safety Checklist*, communication, operating room, integrative research review.

Introduction

Effective communication within the surgical team is critical for patient safety in the perioperative environment¹. Recently there has been a great amount of interest in medical errors that occur because of poor and ineffective communication which has been reported as one of the leading causes of critical incidents in health care facilities^{2,3}, resulting in patient harm and death^{4,5}. Establishing effective communication within health care practices has become a national and international policy imperative⁵⁻⁷. This is especially posited as a crucial element to safety and quality of patients undergoing surgery⁸⁻¹². Surgery has been considered, by some, as an unsafe industry, with a fatal adverse event rate (catastrophic events per exposure) of 1 per 10,000 and the rate of serious complications following surgery at 1 per 100 exposures¹³. More than half of the adverse events and complications are related to surgical procedures that are suggested to be preventable with effective communication between surgeons, nurses and anaesthesiologists¹⁴⁻¹⁶.

One way to foster effective communication, within the surgical team within the operating room (OR) is through the use of a surgical safety checklist. The World Health Organization (WHO) developed a 19-item *Surgical Safety Checklist* (SSC)² which is divided into three stages:

1. Sign in before induction of anaesthesia.
2. Time out before skin incision.
3. Sign out (before the patient leaves OR)².

The SSC has been widely adopted and is now in practice as a patient safety tool globally and nationally. The use of the tool also reinforces and improves teamwork between clinical disciplines². Additionally, the implementation of the SSC has been associated with improved verification of patients' identity, written consent, and operation procedure^{17,18}, including decreases in mortality rates, complications, adverse events, and incidents^{16,19-21}.

The SCC, however, has not been without its critics and, conversely, Calland *et al.*²² claim there are no differences detected in patient outcomes, case times or technical proficiency with the use of the SSC. As a result of the inconsistent evaluation findings, there is a need to conduct a critical analysis of recent literature on the effectiveness of the SSC by applying a robust methodology such as an integrative research review (IRR).

The IRR approach allows for the simultaneous inclusion of diverse methodologies, such as experimental and non-experimental research, in order to fully understand a phenomenon of concern^{23,24}; as a consequence it has a greater role in evidence-based practice for nursing. It is a distinctive form of research that generates new knowledge about the topic through reviewing, critiquing, and synthesising representative literature in an integrated way, such that new frameworks and perspectives on the topic are generated²³⁻²⁷.

Aim

The aim of this paper is to report an IRR on the most recent research evidence related to effectiveness of implementing the SSC as a means of communication in the OR. The findings are deemed to be relevant for health personnel working in the perioperative environment to achieve safe and quality practice.

Study design

The IRR was carried out for the year 2012 to address the aim of the study. The process of the IRR was guided by the method used by Whittmore and Knafel²³, which suggests five procedures to ensure synthesising research evidence. The five procedures include problem identification, literature search, data evaluation, data analysis, and presentation.

Problem identification

There are inconsistent findings from the literature on the effectiveness of implementation of the SSC.

Literature search — inclusion criteria

The following four criteria were used for considering studies to be included in this IRR.

1. Types of studies

All published experimental studies, non-experimental studies, qualitative studies, and systematic reviews related to the SSC were included. Audits and quality projects were excluded²⁷, as well as discussion papers.

2. Types of settings and participants

The participants included health personnel, working in the OR setting/s, involved with patients who underwent surgical interventions.

3. Types of interventions/phenomena

This included studies that examined or explored the effectiveness of using SSC.

4. Types of outcomes

The reported outcomes following the use of the SSC included compliance, completion, mortality, morbidity, incidents and surgical performance.

Search methods

The literature search sought to identify published studies in English for the year 2012 that related to the usage of the SSC in the OR. The databases searched for this review included CINAHL, Embase, MEDLINE, ProQuest, PsycINFO, PubMed, and the Cochrane Library (CENTRAL). In addition, the reference lists in the identified articles were searched for additional studies. The search terms were limited to “operating room”/“operating theatre”/“operating suite”; “World Health Organization Surgical Safety Checklist”/“World Health Organisation Surgical Safety Checklist”; “surgical safety checklist”/“surgical checklist”/“checklist”; “handover”; and “communication”.

Data evaluation

A total of 4,306 papers were identified through the combined electronic searches. Titles and abstracts were appraised that were aligned with the aim of the IRR (n=4,207 excluded). The remaining 99 were reviewed for full texts, resulting in a further 59 being excluded. The process of exclusion was relatively straightforward and only a handful of studies warranted discussion between the reviewers to reach consensus as to whether they met the inclusion criteria. Forty studies were identified in the use of SSC in the OR for the search period and a total of 11 research studies published in 2012 were critically analysed.

Quality appraisal

The quality of the 11 articles was independently appraised by the authors. The appraisal included identifying clear aims/objective; checking that the study design was adequately described; ensuring the results were clear; and finally making sure the discussion did not draw conclusions beyond the limits of the study. No further studies were excluded on the basis of quality.

Data analysis

Data extraction and synthesis

Extracted data were initially compared item-by-item. Items were then coded and grouped together with similar data²⁷. As patterns started to emerge, the data was grouped into two main themes and seven subthemes. The two themes provided the framework to organise the literature and compare the studies systematically. Discrepancies about data that comprised the themes were resolved by seeking the original context for the data in the respective papers.

Presentation of the results

Study demographics

The 11 studies included in the IRR were conducted in several countries: the Netherlands (n=2), the USA (n=2), Ireland (n=2), and one from France, Germany, Spain, Switzerland, and Thailand. The research designs employed in these studies included descriptive non-experimental research (n=9), systematic reviews (n=1), and mixed methods using semi-structured interviews and surveys (n=1).

Themes

Two main themes emerged from the included 11 studies. The first theme is *Administration of the SSC* with two subthemes: *Compliance rate with the SSC* and *Completion of the SSC*. The second was titled *Outcomes of implementing the SSC* with a subsequent four subthemes arising: *Verification of information*, *Mortality and complications*, *Adverse events*, and *Incidents*. The main themes and subthemes are presented in Table 1.

Theme 1: Administration of the SSC

Administration of the SSC emerged as the main theme in six of the included 14 articles. Appropriate application of the WHO SSC involves verification of the listed items by various OR team members

Table 1. Main themes and subthemes

Main themes	Subthemes	Studies emerged from
1. Administration of the SSC	1.1 Compliance rate with the SSC	Borchard <i>et al.</i> (2012) ³⁰ Fourcade <i>et al.</i> (2012) ³¹ Kasatpibal <i>et al.</i> (2012) ³² Nugent <i>et al.</i> (2012) ³³
	1.2 Completion of the SSC	Bliss <i>et al.</i> (2012) ²¹ Fourcade <i>et al.</i> (2012) ³¹ Levy <i>et al.</i> (2012) ³⁴
2. Outcomes of Implementing the SSC	2.1 Verification of information	Böhmer <i>et al.</i> (2012) ³⁵ Kasatpibal <i>et al.</i> (2012) ³²
	2.2 Mortality and complications	Böhmer <i>et al.</i> (2012) ³⁵ Borchard <i>et al.</i> (2012) ³⁰ van Klei <i>et al.</i> (2012) ³⁷
	2.3 Adverse events	Bliss <i>et al.</i> (2012) ²¹ Fargen <i>et al.</i> (2012) ³⁸
	2.4 Incidents	da Silva-Freitas <i>et al.</i> (2012) ⁴⁰ de Vries <i>et al.</i> (2012) ⁴¹



and correct timing of domain administration². As previously mentioned, the WHO SSC was developed as a global guideline to promote patient safety in the OR and following operative procedures², the quality of the SSC administration, therefore, plays a critical role in preventing patient from harm following operative procedures^{28,29}.

Subtheme 1.1 Compliance rate with the SSC

Emerging from the main theme Administration of the SSC was the subtheme: *Compliance rate with the SSC*. This rate is calculated as the number of patients having SSC administered to operations divided by the total number of all patients undergoing surgery²⁹. A total of four studies reported the compliance rate with using the SSC, which varied from 12% to 100% (mean: 75% to 90.2%)³⁰⁻³³. Three studies reported compliance with the use of SSC specific in the stages of sign in and time out. For the sign in period, the compliance rate was 91.4%³²; the compliance rate was from 57% to 100% of the time out period^{30,33}.

Subtheme 1.2 Completion of the SCC

Completion of the SCC emerged as the second subtheme. A complete SCC is a checklist in which all items have been ticked; that is completeness rate is the percentage of completed items. Two studies reported completion rate of the SSC, 61%, and 97.26% respectively^{21,31}. More specifically, Levy *et al.*³⁴ discovered a large number of the SCC were incomplete of 142 paediatric surgical cases; among the 13 checklist items the average number of completed items was 4 (30.9%). The most commonly completed items were the "confirmation of patient name" and "the procedure" (99%), followed by the "time out" at the start of the checklist (97%); the rest of the items were completed in less than 60%³⁴. Overall, the findings demonstrated a lack of checklist completion reliability.

Theme 2: Outcomes of implementing the SSC

Digging deeper into the data, the *Outcomes of implementing the SSC* arose as the second main theme. This is aligned with the growing body of research evidence that examines the efficacy of the use of the SSC, by comparing surgical outcomes before and after the introduction of the checklist¹⁶⁻²². Outcomes reported in studies conducted during 2012 included verification of information; mortality and complications; adverse events; and incidents, which arose as the four subthemes.

Subtheme 2.1 Verification of information

The IRR found that the most confirmed items for *Verification of information* related to patients were "identity"³², "written consent"^{32,35}, "operative site"³², and "operation procedure"³². The other items verified with the SSC were "instruments", "sponges", "needle counts", "specimens with correct labelling", "identification of equipment-related problems"³². Knowledge of names and roles of the surgical team members were also found improved after the implementation of the SSC³². However, only 19.4% of the surgical sites were established and 64.4% essential imaging displayed³². Special attention was paid by two studies to whether it was verified through the SSC, that antibiotic prophylaxis for patients was given before the surgical incision. These reported that up to 71% of the cases were given antibiotic prophylaxis within an hour prior the incision^{32,35}.

Subtheme 2.2 Mortality and complications

Mortality and complications following surgical intervention emerged as the second subtheme and referred to the occurrence of any major complication, including death, during the period of postoperative hospitalisation, up to 30 days³⁶. In this IRR a retrospective cohort study³⁷ was identified, which included 25,513 adult patients undergoing non-day case surgery in a tertiary university hospital. Hospital administrative data and electronic patient records were used to obtain data. The result revealed a statically significant decrease in in-hospital mortality within 30 days after surgery after the introduction of the SSC (P=0.19)³⁷. In addition, Borchard *et al.*³⁰ conducted a systematic review of 22 studies on the impact of pre- and post-implementation of the SSC on mortality, and reported an odds ratio of 0.57 (95% CI 0.42–0.76) for the relative risk of mortality. An attitude survey also revealed that early communication by the participating anaesthesiologists and nurse anaesthetists regarding information about intraoperative complications had significantly improved³⁵. Additionally, Borchard *et al.*³⁰ reported an odds ratio of 0.63 (95% CI 0.58–0.67) for the relative risk of any complications associated with operations.

Subtheme 2.3 Adverse events

The third subtheme, *Adverse events* related to surgery, is an unanticipated outcome associated with operations involving "risk" to subjects that ultimately results in harm to the subject (impacts on subjects' morbidity and mortality) or others. Two studies reported a statistically significant reduction in overall adverse event rates after the SSC implementation (P value of 0.000 and 0.001, respectively)^{21,38}. Fargen *et al.*³⁸, in specific, surveyed nurses, radiation technologists, and physicians regarding near-miss adverse events following 71 procedures prior to implementation of the checklist and again 60 procedures for 4 weeks after using the checklist. The nine adverse events chosen by the author were "Pregnancy not addressed in woman of childbearing age"; "Wrong item opened at beginning of procedure"; "Creatinine not checked in patient 50+ or high risk"; "Heparin dose delayed or accidentally not given"; "Maximum contrast dose exceeded"; "Access obtained with wrong or no patient name in computer"; "Excessive radiation exposure to patient or staff"; and "Time delay due to poor communication"³⁸. The total number of adverse events was significantly lower post the checklist implementation (25 pre- versus 6 post)³⁸.

Subtheme 2.4 Incidents

Incidents as the fourth subtheme in this IRR include errors, preventable adverse events, and hazards associated with surgery as well as the wrong positioning of the patients and wrong settings and connections of the equipment³⁹. Two studies examined the incident rate after the introduction of the SSC. One reported a significant decrease in the patient safety incidents (P=0.01)⁴⁰. The other assessed the number, nature and timing of incidents intercepted by applying the SURgical PATient Safety System (SURPASS) checklist. One or more incidents were intercepted in 2562 checklists (40.6%) and the number of intercepted incidents was highest in the preoperative and postoperative stages⁴¹.

Discussion

This IRR aimed to examine the 2012 research evidence on the effectiveness of implementing the SSC in the OR settings. The findings of this IRR are discussed in the context of the two main themes.

Theme 1: Administration of the SSC

A wide range of compliance rate with the SSC (12–100%) reported in 2012 is consistent with two earlier studies demonstrating variation in compliance the SSC^{29,42}. Despite the importance of the 19 items of the SSC, none of the included studies of this IRR reported a 100% completion of the SSC, which is also evident in a study conducted by Paugam-Burtz *et al.*⁴³ in 2011. One contributing factor to these results is that not all health personnel were made aware of the checklist. For example, a survey revealed 93.8% of health respondents were aware of the existence of the WHO SSC and 88.8% reported knowing its objectives⁴⁴. It was also pointed out that more nurses were found than other personnel who knew the three stages of the SSC⁴⁴.

In addition, some health personnel reported that the SSC was difficult to introduce and implement³³ due to the introduction being time-consuming³³; taking long time to complete the SSC^{44,45}; and “concerns over gaining professional and social acceptance within the team”⁴⁶. Fourcade *et al.*³¹, therefore, explored the barriers to effective implementation of the SSC via interviewing surgeons, anaesthetists, nurses, senior nurses and quality managers. Eleven barriers were identified and included duplication of items within existing checklists; poor communication between surgeon and anaesthetist; time spent completing the checklist for no perceived benefit; lack of understanding and timing of item checks; ambiguity; unaccounted risks; and a time-honoured hierarchy³¹. It was suggested that the successful implementation of the SSC depended on the organisational and cultural factors within each centre³¹. In addition, proper training in using the SSC was reported as desirable by 84% of perioperative-related health personnel³³.

Theme 2: Outcomes of implementing the SSC

In contrast to an early study claiming no difference in patient outcomes on applying the SSC, the literature revealed consensus across all four subthemes from Theme 2, including reduction in mortality and complication rate following the surgical intervention; decrease in the adverse event and incidents related to surgery; and improved verification of information. Similarly, two studies observed a significant improvements in overall surgical procedures and patient outcomes after the introduction of the SSC ($P < 0.001$, $P < 0.05$, respectively)^{47,48}. This was also supported by Robb *et al.*⁴⁹ (2012) who found a significant reduction from converting laparoscopic cholecystectomy to open cholecystectomy after the SSC implementation ($P = 0.001$). It is recommended to apply the WHO SSC or adapt the SSC to suit the organisation worldwide.

Limitation of the review

This IRR presented a critically reviewed synthesis of research evidence on the efficacy of implementing SSC. However, the review is limited by the selected time frame for this IRR.

Conclusion

A total of 11 research articles in the year 2012 were reviewed by applying an integrative approach on the effectiveness of the use of SSC in the OR settings. Although there is no full compliance or completion of the SSC, this IRR revealed consistent positive outcomes in the reduction of preventable harm to patients undergoing surgeries after the implementation of the SSC.

Implication for practice

The WHO SSC has been revealed to be beneficial to both patients who undergone surgeries and OR-related health personnel so that the checklist should be continued globally^{38,43}. Further training in using the SSC and strategies is needed to ensure full compliance and completion rate with the SSC. Meanwhile, raising awareness of the SSC is also needed.

Implication for research

The majority of the studies employed non-experimental descriptive design (9/11, 81.8%). Rigorous research studies are therefore needed to examine the effectiveness of implementing the SSC in relation to patient outcomes.

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Robyn Williams

Well I can't believe it is my first report for the *ACORN Journal* as the President for 2013. The time has gone by so quickly! I am looking forward to the challenge that is ahead but I have big shoes to fill. Allanah has done a marvellous job over the last two years and I can only hope that I can follow in her footsteps.

The NSW OTA Executive has had a busy time working towards achieving our goals set down in our 2012 Strategic Plan. The membership and marketing team have been very busy developing our new website. They have been working with Fat Beehive modernising the look of the website, automating features such as membership renewals and online registration for our conference and the education/professional days. The layout is much more user-friendly and we have streamlined the members-only area. The new mission statement and banner has also been incorporated. We successfully launched the new website in March at our conference and it has been well received by our members. We would love to have you take a sneak peek at what we have done. Take the guided tour to show you what we have achieved. We have also moved into the new age of social media by launching our Facebook page, Twitter account, RSS feed and our first QR code. Congratulations to Brian, Lillian and the team for a job well done.

Our governance and finance group led by the one and only Dr Jed has been working on the development of a new constitution in line with the fair trading changes. This has been a very big project and in March 2013 our members reviewed this document and voted on adopting this at our AGM.

The education and research team has been active in organising many professional education days and, of course, our annual conference. The conference was a great success and our annual dinner was visited by many great stars of the stage and screen. We had a number of great speakers who gave our members lots to think about and a great discussion led by the chief nurse. I will be meeting with her in July to discuss issues relevant to perioperative nursing and also about our project that PIA is currently working on.

The professional issues and advocacy team has been working very hard on enhancing the profile of perioperative nursing and looking at our next big project. The team is about to profile perioperative nursing at the Australian College of Nursing 2013 Nursing and Health Expo in Sydney, NSW, on Sunday 23 June 2013 where we hope to inspire the delegates to undertake perioperative nursing as their career pathway. The team is also looking at an archive project to preserve our history for future perioperative nurses to experience.

One of the biggest things we embarked on was to modernise the NSW OTA logo. We enlisted the help of the members to vote on an assortment of options, which had been submitted by various designers in a competition we ran. The members voted on these at our AGM and you can now see our new logo on all our documents, merchandise and website.

That is all for now, but I look forward in the coming journals to be able to showcase the great work that our executive is undertaking.

Tracy Kearle, NSW OTA President

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Greetings to you all, as we head into winter, somewhat abruptly, after a magnificent autumn. Magnificent, not only for the beautiful autumn colours and that special quality of evening light that we are blessed with at this time of the year, but also because we had a rather splendid conference in April in Hobart.

The Hotel Grand Chancellor lived up to its name. It is a grand venue; very comfortable, with excellent food and meticulous attention to detail. Our *Elephant in the Room* theme proved to be an excellent choice, with all speakers weaving the theme through their presentations and our workshops, presenters, trade exhibition and dinner were all extremely well received. The Tasmanian business community provided support in many ways, and Covidien and Stenning & Co provided educational grants to the total value of \$2000. The conference report, written by our Conference Convener Julie French and many photographs, taken by Karen Madden, are available on the TORN website. [A small sample of the photographs are included here.](#)

By the end of the conference, it was clear to me that the perioperative nurses of the future need to fully engage in the care of their patients. That is not to say that we are actively uncaring, rather, we, as perioperative nurses, need to promote ourselves and behave as equals to other health professionals. I was reminded of the landmark report published in the United States in 2010, *The Future of Nursing: Leading Change, Advancing Health*¹, which included the following advice for nurses. We should practise to the full extent of our education and training, which should be high and seamlessly achievable through effective academic partnerships. Nurses should be equal partners with other health professionals in the redesign of all health services and we need to engage in improved data gathering and sharing to inform future workforce planning.

It is my personal belief that nurses are a caring community who often undervalue themselves, their ability and their contribution to best patient outcomes and society as a whole. This humility is rather endearing, and it could be argued that it comes with the territory of the profession, but it may be our downfall. Sometimes it all seems too hard, as we work, parent, study (again!) and juggle the multitude of hats that we wear on a regular basis, but unless we fit in the extra hat that represents professionalism and an equal playing field with our interprofessional colleagues, we are destined for groundhog day.

So I urge you all to become professionally active. This means joining and maintaining membership of your professional organisation; attending national and local association meetings and conferences; gaining postgraduate qualifications and using them in the workplace; supporting your perioperative colleagues at all times, welcoming learners to your workplace and arguing your point from a position of authority, to achieve better outcomes for yourselves and your patients.

The TORN Inc AGM is to be held on Saturday 27 July in Hobart. The venue is to be advised, on the TORN Inc website and via membership email, so please keep this date free and make an effort to attend. There are only minimal changes to the Constitution to be considered, so this shall very probably be a short AGM.

I was fortunate enough to attend the OTA Conference in Sydney and would like to thank the organisers for producing a wonderful event. Brian Julien (aka Captain Jack Sparrow) presented the new OTA website, which is a thing of beauty, to be admired by all who visit! I was unable to attend the NTPN Conference in Darwin; however, Roberta Johnson and Franya Cowlard attended and would like to thank the Territorians for their wonderful hospitality. Franya has special reasons to thank the NT, having sustained a substantial injury which resulted in the need to attend the conference in a wheelchair.

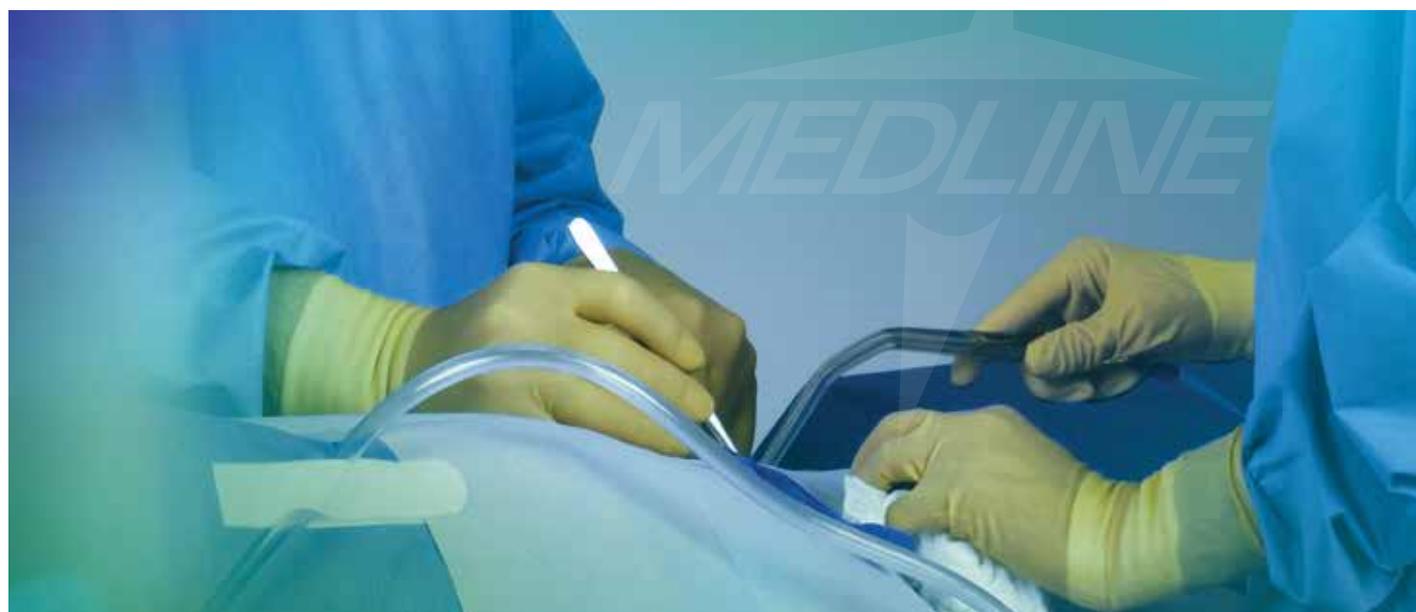
I could ramble on, but I shall not; I have reached my word count.

Best wishes for the coming season,

Avril Brown

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TBC

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Sharon Mewett, Gawler Hospital

Di Hockey, The Queen Elizabeth Hospital

Welcome to the SAPNA winter report. As I write this, Adelaide is in the grip of a mini heatwave so to speak! A number of us have just returned from the Northern Territory Perioperative Nurses conference, celebrating 21 years of the NTPN so the continuing heat is lovely, for a change. It was really fantastic to see such support for the NT conference. We were made very welcome and thoroughly enjoyed ourselves.

Back at home, SAPNA has had continued member and trade support for our Saturday morning education sessions. We had a plastic surgery focus on 25 May with specialty interest group meetings following the main meeting. Look out for the flyers for the next Saturday session on 24 August, a great way to network and log CPD time.

There is a lot of work going on around the implementation of the National Safety and Quality Health Service Standards. The standards are integral to the accreditation process, which some networks are working towards as the Standards determine how and against what an organisation's performance will be assessed. One Standard that comes to mind is S5: Patient identification and procedure matching with the three essential identifiers: full name, date of birth and MR number required to be checked whenever care is provided. This ensures patients correctly match their intended treatment. The use of a surgical team safety checklist seems to be causing a lot of controversy in several areas as to who is responsible for initiating the process. The most senior proceduralist in the theatre leads the completion of the checklist and all theatre staff must participate. S6: Clinical handover, where, at any change of care, the ISBAR format is being used for handover to support safe patient care. Through SAPNA we hope to help support those hospitals needing clarification with issues relating to these standards.

Our Enterprise Bargaining Agreement is currently still in the process of review and SAPNA is keen to work with the ANMF to see that the ACORN Standards continue to be met and appropriate skill mix and conditions remain.

Our updated constitution will soon be available on the website with changes passed at the November country study day.

The conference program is almost complete and is lining up to be a fantastic couple of days on Friday 18 and Saturday 19 October at the Westpac Centre AAMI Stadium. Make sure you mark your diary and come along. The theme is *Emergency — Be Prepared, Planning, Preparation and Performance*.

A reminder that memberships are again due for renewal in a month; memberships can be easily renewed online using our online payment system. Make sure you renew to get member rates for the conference in October. As always, please let SAPNA know any concerns you may have or how we may be able to help you in your professional practice.

Cathie Hashemi
SAPNA President

Northern Territory



**Wendy Rogers (Representative) &
Sharon Harding (Director)**



**Northern Territory
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The NTPN *Coming of Age* Conference, celebrating 21 years of the organisation, was held on 4 and 5 May at the Holiday Inn Esplanade. The conference was a huge success for the organisation, with 65 delegates and 23 health care exhibits. The conference was officially opened by Karen Parish, Chief Nursing Officer, from the Nursing and Midwifery Office of the Northern Territory and Ruth Melville, the ACORN President. VIPs included the above as well as Dr Christine Dennis, Executive Director of the Top End Hospital Network, who joined us for the Saturday morning session. Two Balinese nurses, Nyoman and Widi, from our sister hospital, Sanglah Hospital in Bali, also attended the conference. ACORN Executive Officer Stephen Born and the Editor-in-Chief Pauline Walker were also in attendance. All the local associations sent two members of their Executive to attend or nominated LA members as delegates — this was a show of national unity for the NTPN in the spirit of perioperative nursing.

As we turned 21, the NSW OTA kindly gave an engraved “Yard glass” to celebrate the momentous occasion. To date this is still yet to be christened!

There were speakers and presentations that highlighted and showcased the uniqueness the Territory has to offer. Topics included organ retrieval, the National Critical Care and Trauma Response Centre (NCCTRC), clinical redesign, electrosurgery safety and smoke plume, life and times of a surgical instrument, hand surgery, National Labelling Standard, laparoscopic banding, simulation training, working in third world medical facilities, Aboriginal culture and bush tucker. There was also a panel discussion and open forum with the very topical World Health Organization *Surgical Safety Checklist*. This session was well received and had active interaction from the delegates.

The closing sessions featured a presentation on the history of the NTPN from inception from Libby Webb and the conference closing as usual was a huge success with “Sharon Attenborough” making a guest appearance at the conference still in search of the “Genus Nursus Perioptus” commonly known as the perioperative nurse. She highlighted the evolution of the NTPN from mother ACORN giving birth to baby NTPN 21 years ago (Tanya Anderson), NTPN at 10 years of age (Wendy Rogers), NTPN at 21 years (Lisa Murphy) and finally what NTPN will grow into at 70 years of age (none other than Rose Gaston) who by the way drank from her catheter bag — this had the crowd in stitches. To finish the conference we had a big birthday cake with the croc logo and sparklers and we invited delegates to join us by the fountain courtyard for a complimentary glass of champagne — what better way to finish a conference! The conference was a wonderful opportunity for perioperative nurses to network and become reacquainted with old friends and to make new friends as well.

The social events were a highlight with the 21st birthday party. The theme for the dinner was “cocktail with sparkles”, held at the Mirambeena Travelodge Darwin. This was where the NTPN held its very first conference all those years ago. The dinner was held outside by the pool in a tropical setting and piñata was played well into the evening. The evening turned out to be very entertaining for all. Thank you to all the members of the conference committee who worked so tirelessly in planning the conference as well as behind the scenes to make it all happen! I hope that everyone who attended enjoyed a fabulous conference and we hope to see you all again in 2015!

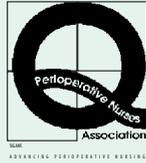
Cheers,

**Sharon Harding
NTPN President**

Queensland



**Joy Jensen (Director) &
Catherine Steel (Representative)**



**Perioperative Nurses
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There continues to be ongoing turmoil within the public health system that has seen disruption for many nurses and services while some private facilities appear to be expanding services. I feel that we should be supporting all nurses at this time. Over the last 40 years, PNAQ has continued to grow in profile, experience, professionalism and membership. We now have over 850 members Queensland-wide and we continue to grow each day. The collective knowledge of these members allows PNAQ to be a resource for educational and professional perioperative issues for its members and other associated perioperative committees. Recently the Executive committee commissioned professional assistance to update our website. Over the past years we have relied on the knowledge of committee members whose interest lay in this area and they have done a mammoth job, though with the growth of communication and information sharing being done online, professional assistance was deemed to be required. The web address remains www.pnaq.net.au and provides information for all the current events, upcoming events, links to other integral perioperative sites, past newsletters and branch contacts. Any feedback is also appreciated.

Part of our commitment to Advancing Perioperative Nursing is the PNAQ education days which provide contemporary information for both members and non-members. The next session is on 8 June at the Princess Alexander Hospital and looks at perioperative careers. I would encourage your attendance, not only to hear the speakers, but also for the networking opportunities that are fundamental to these days.

The state conference this year will be on 12 October, coinciding with National Perioperative Nurses' Day and will be held at the Australian Catholic University, Bayo. The organising committee, ably led by David Macklyn, is hard at work to provide an exceptional day (and night) for you. Please put a date claimer in your diaries. I look forward to seeing you there.

On a personal note, the last three to four months saw me on the 'other side' of nursing and I would like to thank everyone for their thoughts, good wishes and support whilst I was ill. I would like to acknowledge the PNAQ committee for their continued work and in particular Dr Brigid Gillespie for stepping back into the President's role at extremely short notice.

Regards,

**Kathy Flanigan
PNAQ President**

PNAQ INC CONFERENCE 2013



THE CUTTING

EDGE

12 October 2013

Australian Catholic University

Banyo | Brisbane | Queensland

For further information contact:

David Macklyn *PNAQ Conference Convenor*

Mob 0431 201 346 | thecuttingedge2013@pnaq.net.au

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Victoria



Leanne Mastin (Representative) & Carolyn Williams (Director)



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The VPNG conference committee is working hard preparing for the momentous occasion of the 50th State Conference in August this year. I invite all perioperative nurses to join us on the 8-9 August 2013 at the Pullman Albert Park (formerly the Sebel Hotel, Albert Park). The theme *Gold Standard: 50 Years of Perioperative Nursing Education* was chosen to highlight the incredible milestone of 50 years of perioperative education provided by VPNG and the programme is filled with diverse and stimulating topics. 'Complaints and notifications — case law relating to perioperative nurses' will be presented by Professor Mary Chiarella in a keynote address followed by a list of motivated speakers who will be providing an overview of present and future developments in the operating theatre. Dr Joy Don Baker, an invited guest from the University of Texas, presenting on 'Social Media' and 'Second Life'[®] (virtual environment) providing examples of providing continuing education in the virtual world is not to be missed.

The conference dinner will be on Thursday night with Steven Bradbury, OAM and Olympic gold medallist, providing dinner entertainment with Jelly Bean Jam, Sydney's number one party band providing the music. Delegates are invited to come dressed in 'black with a splash of gold' and join in the celebrations with friends and colleagues. With Gerry Gannon appointed MC for the evening, it promises to be a night filled with fun and entertainment. Places are limited, so please book early.

Education workshops will be presented by a number of the trade exhibitors during tea and lunchtime on both days, offering delegates the opportunity to complete CPD points while learning more about innovative medical products. This is a new initiative for VPNG, which we hope will not only provide education opportunities for the delegates but also increase the profile of the medical companies supporting VPNG. I encourage you all to attend the workshops during lunch.

A Pink Morning Tea, which will include a gold coin donation, will be hosted by VPNG on Friday following the panel of experts' presentations on breast cancer. All donations will be matched by VPNG with the proceeds to be donated to the Jane McGrath Foundation. Kathy McKenzie, a specialist communications and leadership trainer, will deliver the final session with 'Fire up Coaching: Igniting your potential', a session everyone should attend! With the ACORN Conference planned for Melbourne in 2014, VPNG will not be hosting a state conference next year, so I encourage all perioperative nurses to attend the VPNG *Gold Standard* celebrations this year. Further details about the programme are provided on the VPNG website at www.vpng.org.au.

The first education seminar this year was held at the ANF House in early March. Over 130 nurses attended the day, which included a range of presentations on safety, advances in endovascular surgery, anaesthetics and post-anaesthetic recovery unit. The positive response in the evaluations would indicate that offering this type of seminar is meeting the education needs of perioperative nurses.

In May VPNG hosted, for the first time, a one-day seminar at ANF House for perioperative managers in conjunction with the Women's Hospital. The line-up of topics included 'Attracting, recruiting and retaining quality staff and surgeons', 'Skills mix levels in the OR', 'Improving culture and morale in the operating theatre', 'Performance management' and 'Keeping motivated as a manager', presented by Charmayne Thompson, Operations Manager Perioperative Services and Matthew Bell, Nurse Unit Manager, both from the Royal Women's Hospital. Thirty managers attended the day and judging from the comments on Facebook, the day was a great success. We hope to continue providing education opportunities for perioperative managers in partnership with the Royal Women's Hospital.

Northern Territory Perioperative Nurses recently celebrated their coming of age and I attend the 21st birthday celebrations with Kerry Schroder, a VPNG committee member. There were a number of very interesting presentations over the two days, which made me reflect on the diverse issues the Northern Territory have to deal with when delivering patient care. On the Friday night we witnessed the beautiful sunset while attending a welcome at the Yacht Club and while venturing a little way onto the beach we were not game enough to get too close the edge of the water. It did not escape my notice the article I read the following morning about a 5m croc attack! The conference dinner promised to be different and we were not disappointed. Congratulations to Sharon Harding and to all the hard-working conference committee members on a great conference. On behalf of VPNG, I would like to congratulate NTPN on reaching their majority. I would like to make special mention of the members who have been a part of the group from its inception. Well done everyone! You certainly have a lot to be proud of and I was honoured to be present to witness this event. We wish you all every success in future ventures and look forward to working with you as a member state group of ACORN.

Until the next report, take care and I hope to see you all at the VPNG 50th State Conference in August.

Dr Pat Nicholson
VPNG President



VPNG Management Seminar Matthew Bell and Charmayne Thompson, Angela Hand gives thanks



VPNG Management Seminar Ali Kanatsios Charmayne Thompson and Tina Edgeworth



Metropolitan Seminar Beryl Young, Lee Hanson, Maria Merry and Helena Lau of Box Hill Hospital at lunch

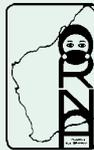


Metropolitan Seminar Larissa Jenkins, Sanja Visic, Bronwyn Hawkins, Sarah Aisbett from Knox Private

Western Australia



**Cath Scott (Director) &
Zaneta Smith (Representative)**



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information, flyers and registration forms, and hopefully links to the other associations and sites of interest. Let us know what you think.

Conference planning is going well with the registration forms and flyers finalised. If you haven't already received them, you will very soon. Caroline is still working on the speakers, but as always we will have a full programme to present over the day.

I would like to include an excerpt from Jacqui Smith's report about her attendance at the TORN Conference this year. Jacqui is a life member of ORNA WA and has been volunteering in Africa since her retirement from perioperative nursing. Jacqui presented a paper at our last conference on her contributions to the team performing obstetric fistula surgery in West Africa, transforming the lives of women who would otherwise be living the most horrendous life. It really was heartwarming to see photos of the faces of those women whose lives have been transformed.

"I was invited to present a paper at the TORN Conference in Hobart on 19–20 April 2013. It was a good opportunity to attend a fellow state conference and I am grateful for the sponsorship I received from both ORNA and TORN. The conference was presented on Friday afternoon and all day Saturday, with cocktails at the opening of the trade exhibition followed by dinner on Friday evening. There were approximately 90 delegates over the two days and 25 trade exhibitors. I could see the similarities with TORN that ORNA encounters and they are only having a one-day conference next year. They are having the dilemma with the trade exhibition of being very grateful for the support of the trade but the realistic problem of so few delegates. I would like to thank ORNA for their support in sponsoring my trip to Hobart as well as TORN for the accommodation in Hobart."

Jacqui's comments ring true in that the delegate and trade numbers are difficult to maintain. Companies can promote via education only. Remember when we used to leave conferences with bags full of goodies? Companies can't do this, so they need to use these events as educational forums. We are hoping at this year's conference to have the trade present short, sharp sessions during the exhibition times. Grace will keep us posted on this as we get closer to the conference.

In conclusion, I would like to let everyone know that the final two Standards which were in draft form in the 2012–13 ACORN Standards have been completed and anyone who purchased the Standards will receive the updated S19 and S20. If you have not received yours yet, you will be one of the members (who purchased at our last ORNA Conference) whose payment was not processed. Please let me know who you are and we will sort it out for you.

**Cath Scott
ORNA President**

Membership continues to grow at a slow but steady rate. We currently have 227 members. Those members who attended the study day and extraordinary meeting in March will be aware that we now have completed our financial auditing. The Executive committee is extremely grateful to Veronica Hill for her work in this regard.

You will recall I have been talking about a website for many months and Vicky has finally managed to complete the task. The site is built and should be live by the time you read this. The address is www.ornofwa.com. You will find membership forms, financial assistance

Coming events

23 June 2013

Australian College of Nursing (ACN) Nursing and Health Expo

Sydney Town Hall, George Street, NSW
<http://www.acn.edu.au/expos>
Phone 1800 061 660

9–14 July 2013

The 36th annual conference of the Australasian Society of Aesthetic Surgery

Port Douglas, QLD
<http://www.asapsevents.org/index.cfm?page=portdouglas>

20 July 2013

Zone 5 Professional education day

Murwillumbah, NSW
<http://www.ota.org.au/>

24–26 July 2013

INANE Conference

Cork, Ireland
www.nursingeditors-inane.org/

27 July 2013

Zone 7 Professional education day and AGM

Canberra, ACT
<http://www.ota.org.au/>

3 August 2013

Zone 1 Professional education day and AGM

Argenton, Newcastle, NSW
<http://www.ota.org.au/>

6–10 August 2013

Prostate Cancer World Congress & 14th Australasian Prostate Cancer Conference

South Wharf, Melbourne, VIC
info@prostatecancercongress.org.au
<http://www.prostatecancercongress.org.au/>

8–9 August 2013

VPNG's 50th State Conference & AGM

Gold Standard: 50 years of perioperative education
The Sebel, Albert Park, VIC
www.vpng.org.au

6 September 2013

Far Northern Branch (Queensland) Triennial Conference

What about us: the workforce sustainability
Pullman Reef Hotel Casino, Cairns, QLD
juliea_forster@health.qld.gov.au

19–21 September 2013

Wellington NZNO Perioperative Nurses Conference and Exhibition

The Dynamic face of Perioperative Nursing
The Langham Hotel, Auckland, New Zealand
<http://www.periop2013.co.nz>

26–29 September 2013

Australian Society of Anaesthetists National Scientific Congress 2013

Canberra, ACT
asa2013@sapmea.asn.au

2–4 October 2013

25th Annual Scientific Conference of the Obesity Surgery Society of Australia and New Zealand

Gold Coast, QLD
<http://ossanzconference.com.au/program>

6–9 October 2013

Annual Scientific Meeting of the Australian Orthopaedic Association

Darwin, NT
<http://asm.aoa.org.au/>

12 October 2013

PNAQ Annual Conference *The Cutting Edge*

Australia Catholic University, Banyo, Brisbane, QLD
<http://www.pnaq.net.au/index.html>

12–13 October 2013

Australian Day Surgery Nurses National Conference

Melbourne Convention Centre, VIC
www.adsna.info

13–16 October 2013

New Zealand Orthopaedic Association Annual Scientific Meeting 2013

Nelson, New Zealand
<http://asm2013.nzoa.org.nz/home>

17 October 2013

NSW Nurses and Midwives Association *Inspiration, Innovation and Education: Quality and Research in Nursing and Midwifery Practice*

Newcastle City Hall, Newcastle, NSW
www.nursingmidwiferyconference.com.au

23 October 2013

Transplant Nurses Association Conference

Darling Harbour, NSW
secretariat@tna.asn.au

18–19 October 2013

SAPNA Conference *Triple Zero Emergency — Be Prepared*

AAMI Stadium, West Lakes, SA
<http://www.sapna.org.au/index.php?id=6>

2–6 November 2013

RANZCO (College of Ophthalmologists) 2013 AGM and Scientific Congress

Hobart, TAS
<http://www.ranzco2013.com.au/information>

20–24 May 2014

ACORN National Conference *All for one and one for all. Achieving our common goals*

Convention and Exhibition Centre, Melbourne, VIC
<http://www.vpng.org.au/>

Eyes on the sun

Exposure to sunshine as a small child is crucial to the development of a healthy eye according to results of long-term myopia study conducted by University of Sydney researchers.

Their findings published this week in the American Academy of Ophthalmology's professional journal tables data showing children who spend more time outdoors were less likely to become short-sighted or myopic.

The researchers say that evidence suggests that small children under 6 years of age should spend at least 10hrs a week outdoors in the sunshine.

Orthoptist Professor Kathryn Rose, from the University's Health Sciences faculty says exposure to sunlight at a young age assists in the growth of a normal healthy eyeball preventing it from growing too fast or over-expanding and becoming oval or egg-shaped instead of round.

The Sydney Adolescent and Eye Study, a five year longitudinal follow-up study from the Sydney Myopia study, examined more than 2000 children from 55 primary and secondary schools for a number of risk factors linked with myopia.

Professor Rose says all children had a comprehensive eye examination. Accurate measurement of refractive errors (myopia, hyperopia and astigmatism) was conducted using an international standard regime of eye drops, similar to that adopted in WHO studies.

A detailed questionnaire gathered information on the children's ethnicity, general physical activities including hours spent in outdoor leisure such as cycling, outdoor sports, picnics or walking. Researchers also gathered data on near-sighted activities such as computer use and time taken watching television.

Amanda French PhD candidate and lead author says:

"The results show that the protective effect of time spent outdoors as a very small child persists even if a child is doing a lot of near work such as reading and studying."

While the results of the study showed television watching and computer use appear to have little effect on the development of refractive errors in the eye, children with one or both parents myopic had a greater likelihood of developing the condition but even for those children, time spent outdoors had a mitigating effect. Time spent in outdoor light also reduced the likelihood of myopia developing in children of all ethnicities.

French says prevention of myopia is important for future eye health as even low levels of the condition place you at higher risk of cataracts and glaucoma in adulthood.

"Promoting outdoor activity to parents and families, and including more outdoor pursuits in school curricula could be an important public health measure to avoid the development of myopia" says French.

Interviews: Amanda French e: Amanda.french@sydney.edu.au

Professor Kathryn Rose e: Kathryn.rose@sydney.edu.au

Media Contact: Victoria Hollick m: 0401 711 361

Sexy Stretch Marks Go Viral

A note from a husband to his wife encouraging her to embrace her stretch marks has caught the attention of thousands of facebookers worldwide. Accompanied by a photo of a mother with stretch marks labelled "mummy badges- HOT!" the note includes a list of things the husband admires about his wife, most notably her stretch marks after giving birth to four children.

"Nothing symbolises womanhood more than a tummy criss-crossed with those pale crescents of beauty." read the note.

The note which is part of a chapter from fitness authors Sharny and Julius' latest book "FITmum" shows the more sensitive side of the couple, who are best known for their hard approach to weight loss.

In the note, Julius tells his wife that "Real beauty in my opinion is a direct result of hard work, or sacrifice. Be it emotional or physical. Being born perfect is an amazing gift, but hard work leaves signs. Scars. None sexier than stretch marks."

The couple shared the note and image, in the hope of encouraging mums around the world to embrace their mummy badges!

"No bikie patch, no war wound or tattoo will ever come close to the perfect symbol of strength that a mummy badge has" says Julius.

The message is clearly hitting a sweet spot with mums across the globe. The couple who shared the post to their fans on facebook, have received a huge outburst of support, with the photo and note being shared across fitness and personal pages, thousands of times over the last 78 hours.

"I love this! Never look at your body with disgust because it doesn't look like an 18 year old cheerleader's. This is beautiful. Mummy badges J" said one sharer "This is amazing! Such pride and honour shown to the mother of his children" said another.

Julius first wrote the note after realising that his wife was uncomfortable with showing her body after the birth of her kids. Sharny says it helped her realise that her stretch marks weren't something to hide, but rather something to wear with pride.

"After my kids I would never wear a bikini or top that showed my stretch marks, because I thought that they were a sign that my body wasn't good enough. I could control my weight, but I couldn't control the marks, so my solution was to hide them at all costs. Julius' sweet letter really helped me realise that I was looking at them completely wrong. These were symbols that represent the best experiences of my life- giving birth to my children. Why shouldn't I wear them with pride?"

And mummy badges were born!



The full note can be found here: <http://sharnyandjulius.com/i-want-to-see-more-stretch-marks/>

Sharny and Julius' FITmum is now available to order from www.sharnyandjulius.com as an E-Book for \$19.95. Hard copies are available to pre order, and for a short time only, with every pre-order readers will receive the E-book free

For more information, images or to speak to Sharny and Julius please contact linda@marksonsparks.com or call 02 9213 2900

Stem cells from fat outperform those from bone marrow in fighting disease

Durham, NC – A new study appearing in the current issue of STEM CELLS Translational Medicine indicates that stem cells harvested from fat (adipose) are more potent than those collected from bone marrow in helping to modulate the body's immune system.

The finding could have significant implications in developing new stem-cell-based therapies, as adipose tissue-derived stem cells (AT-SCs) are far more plentiful in the body than those found in bone marrow and can be collected from waste material from liposuction procedures. Stem cells are considered potential therapies for a range of conditions, from enhancing skin graft survival to treating inflammatory bowel disease.

Researchers at the Leiden University Medical Center's Department of Immunohematology and Blood Transfusion in Leiden, The Netherlands, led by Helene Roelofs, Ph.D., conducted the study. They were seeking an alternative to bone marrow for stem cell therapies because of the low number of stem cells available in marrow and also because harvesting them involves an invasive procedure.

"Adipose tissue is an interesting alternative since it contains approximately a 500-fold higher frequency of stem cells and tissue collection is simple," Dr. Roelofs said.

"Moreover," Dr. Melief added, "400,000 liposuctions a year are performed in the U.S. alone, where the aspirated adipose tissue is regarded as waste and could be collected without any additional burden or risk for the donor."

For the study, the team used stem cells collected from the bone marrow and fat tissue of age-matched donors. They compared the cells' ability to regulate the immune system in vitro and found that the two performed similarly, although it took a smaller dose for the AT-SCs to achieve the same effect on the immune cells.

When it came to secreting cytokines — the cell signaling molecules that regulate the immune system — the AT-SCs also outperformed the bone marrow-derived cells.

"This all adds up to make AT-SC a good alternative to bone marrow stem cells for developing new therapies," Dr. Roelofs concluded.

"Cells from bone marrow and from fat were equivalent in terms of their potential to differentiate into multiple cell types," said Anthony Atala, M.D., editor of STEM CELLS Translational Medicine and director of Wake Forest Institute for Regenerative Medicine. "The fact that the cells from fat tissue seem to be more potent at

suppressing the immune system suggest their promise in clinical therapies."

The full article, "Adipose tissue-derived multipotent stromal cells have a higher immunomodulatory capacity than their bone marrow-derived counterparts," can be accessed at <http://www.stemcellstm.com>.

Flu shots boosted by exercise

Exercising at the time of having a flu shot may increase the success of vaccination according to University of Sydney researchers.

While having a flu vaccine is considered a great way to lessen your odds of catching the disease they don't work for everyone but Doctor Kate Edwards from the University's Faculty of Health Sciences, Exercise and Sport Science unit, believes exercise is the key to successful vaccination.

Being physically active has been found to improve immunity in general, but specifically doing some exercise immediately before or after a vaccination can boost vaccine response in particular says Doctor Edwards.

In a commentary published in this month's Human Vaccines & Immunotherapeutics and co-authored by vaccine guru, Professor Robert Booy also from the University of Sydney, Doctor Edwards advises that a bout of exercise can bring about profound changes in the immune system, such as increasing circulating cell numbers, with specific increases in certain subsets, and the release of immune messenger proteins by working muscle cells themselves.

With vaccine success rates sitting around fifty to seventy per cent, a large number of those vaccinated are receiving minimal benefit, which is often mentioned as a reason not to get the jab. People also avoid flu shots because of side effects like headaches and soreness.

But physical activity after a shot might not only make the vaccine work better, it might protect from some side effects as well. "We are almost certain that exercise can help vaccine response by activating parts of the immune system that means it's ready to respond when the vaccine is administered" says the lecturer at Health Sciences faculty.

Doctor Edwards cites a study conducted by scientists at the Iowa State University in the USA that showed mice who ran leisurely for about half an hour after vaccination showed maximum resistance to any side effects of the flu shot. Conversely the mice who were sedentary and the ones who indulged in extreme exercises succumbed to the side effects.

Doctor Edwards acknowledges that our bodies react in different ways and advises people not to overdo physical activity after a flu shot but engage in moderate activities such as cycling, or resistance exercise and avoid dehydration by drinking plenty of fluids.

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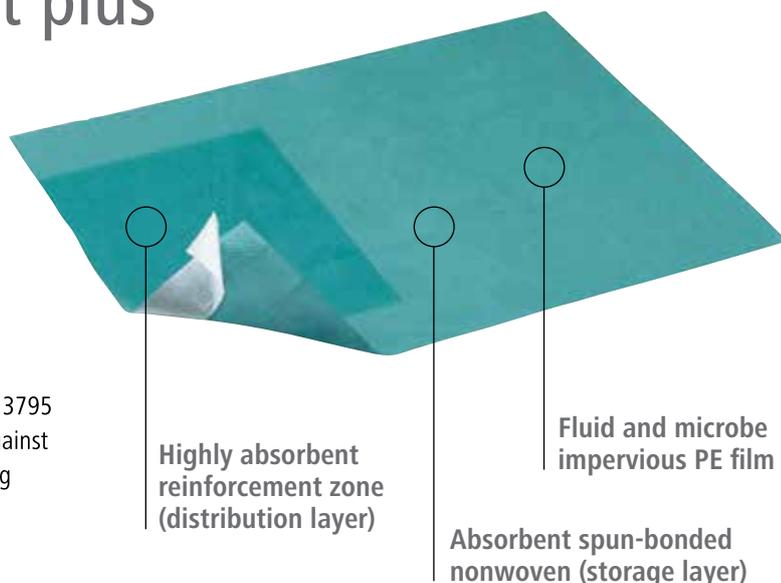
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