

Operating Room Nurses'
Standards of Perioperative Nursing Practice:
An Analysis of Use in Practice

by
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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

During the last twelve years, the Association of Operating Room Nurses (AORN) in collaboration with the American Nurses Association (ANA) has developed and revised standards that operationalize the nursing process to the operating room setting and help define what AORN calls perioperative nursing practice. Assuming that the use of nursing process would enhance individualized patient care during surgical intervention and contribute to positive patient outcomes, plus the implied legal accountability inherent in published standards, one would expect perioperative nurses to be using these standards to guide their clinical practice.

However, in several clinical settings in the state of Oregon, the author has noticed discrepancy between standards and practice. The author knows of only a few operating rooms represented in AORN chapters in the mid-Willamette valley and the Portland metropolitan area where nurses are making an effort to become familiar with nursing diagnosis and its role in nursing process, and only one where nurses are attempting to document their nursing by written careplans.

Why, after twelve years, does such a discrepancy remain between standards and practice? If AORN's

standards are not being used as a framework for perioperative nursing, what are nurses using instead to guide clinical practice?

REVIEW OF THE LITERATURE

In reviewing the literature, two types of information were sought: concepts that form the contextual setting of the problem and studies relevant to perioperative standards. Three concepts relevant to the contextual setting of the problem will be reviewed: nursing process, perioperative nursing practice, and AORN standards.

CONCEPTS AND DEFINITIONS

Nursing Process

The concept of nursing process has developed during the evolution of nursing from art to science, vocation to profession. By documenting her approach to nursing care, Florence Nightingale (1967) established the groundwork for a systematic approach to problem solving that was to become the nursing process.

Abdellah (1960) applied the scientific problem solving technique to the nursing process: observe the facts, develop assumptions, initiate actions, and evaluate results. She theorized that, by using this systematic approach, nurses performing specific actions could predict particular results.

Although relatively untested, nursing process is a model of nursing care that has become part of the prevailing nursing ethos. It is sanctioned by the American Nurses's Association Standards; it serves as the foundation for most nursing school curricula; it serves as one dimension of the "Test Plan" for Registered Nurse State Board Test Pool Examination; and it has become important to the Joint Commission on Accreditation of Hospitals as an indicator of quality nursing care.

For the purposes of this study, the nursing process will be defined as a scientific method to systematically assess patient problems, plan appropriate nursing interventions, implement the plan, and evaluate the effectiveness of the nursing care provided.

Perioperative Nursing Practice

In 1975, in response to members' growing self-awareness and a commitment to the necessity of the registered nurse in the circulator role, AORN initiated Project 25 to define the role of nurses in the operating room ("Delegates approve statements,"1975). Project 25's report was presented at the 1978 AORN Congress.

The Task Force labelled nursing in the operating room the perioperative role and defined it as "a

comprehensive practice encompassing the patient's surgical experience from the preoperative, through the intraoperative, and into the postoperative period...with primary emphasis on the intraoperative period and responsibility for preoperative assessment and postoperative evaluation....Nursing in the operating room provides continuity of care designed to meet individual needs through the nursing process [italics added]" (AORN's Project 25 Task Force, 1978, 1162).

In the early 1980s, an AORN Nursing Practices Committee was charged with updating the definition of nursing in the operating room. The definition of practice remained the same, but the definition of excellence in practice changed. Whereas perioperative nursing excellence had been linked to specific locations for nurse-patient interactions, the philosophy now states "Excellence can be demonstrated in any geographical location in which the perioperative nurse comes in contact with the patient" (AORN Nursing Practices Committee, 1985, 194). Since the individual practitioner may not control where care must be delivered, this seems to reflect an attempt by the committee to deal with the realities of practice.

Standards of Perioperative Nursing Practice

AORN and ANA (1983) define a standard as "an

authoritative statement enunciated and promulgated by the profession by which the quality of practice can be judged" (11:2-1). They maintain that nursing as a profession has the obligation to define nursing, establish the scope of nursing practice, and set standards as a means of assuring quality service to the public.

The Association of Operating Room Nurses has published three types of standards: structural, process, and outcome. Quality care for the surgical patient is the common goal, but each has a different approach to the definition and measurement of quality.

Structural standards imply that if the proper framework, or structure, is provided for the delivery of nursing care, quality care will result. The structural standards that AORN has generated are entitled Standards of Administrative Nursing Practice: Operating Room (1982).

Process standards prescribe nursing actions toward the goal of positive patient outcomes, and the assumption is that if certain nursing activities occur, this goal will be achieved. It is this type of standard which was of concern to the present study. Throughout the remainder of this paper, unless specified otherwise, the term standards will refer to process standards.

Outcome standards concern what has happened to the patient as a result of care received. If certain positive outcomes are achieved, these standards imply that quality nursing care accounts for at least part of the positive effect. Patient Outcome Standards for Perioperative Nursing are the newest standards from AORN (1984).

Process Standards

The first process standards for operating room nursing, Standards of Nursing Practice: Operating Room were the result of a 1975 collaboration between AORN and the American Nurses Association (ANA). Like those of ANA, AORN's standards are based on the nursing process model. They consist of seven standard statements that reflect the nursing process and prescribe actions to be performed by the nurse providing care to the surgical patient. Each standard includes a list of assessment factors that are intended to help nurses evaluate whether they are meeting the standard.

The first standard addresses the collection of data for making a patient assessment. The second involves the creation of nursing diagnoses from the data. Standards three and four focus on the development of the nursing care plan, specifically the creation of the patient care goals and prescription of

nursing actions needed to reach those goals. The fifth standard concerns implementation of the plan, and the sixth, evaluation. The final standard involves a reevaluation of the entire process in keeping with the cyclical nature of nursing process.

In 1982, the AORN Committee on Nursing Practices (1982) identified how process standards define professional accountability for nurses in the operating room. They stated that standards provide a common vocabulary with other nursing specialties by means of nursing process. Documentation, an essential part of the standards, contributes to continuity of patient care and verifies that nursing care is being provided behind the "double doors" of the operating room. The Committee viewed documentation as an essential component in validating the role of the professional nurse for intraoperative care of the surgical patient.

Being self-regulating is also a part of professional accountability. Quality assurance, evaluation of staff performance, and program evaluation are meaningless without standards against which to evaluate them. AORN standards define quality within the context of perioperative practice.

Standards are also used by the public to evaluate whether perioperative nurses are fulfilling their

obligation to society. There is a growing tendency for the courts to look to national standard-setting medical and nursing organizations for objective guidelines and criteria that exemplify quality patient care (Regan, 1981).

The Committee on Nursing Practice stated further that the standards, "as a set of guidelines for nursing care" (1982, 371), simplify collecting and analyzing data about the care perioperative nurses give by providing a standardized approach to patient care. In this way, standards provide a foundation for research.

AORN and ANA collaborated again in 1982 to revise the AORN standards. The goal was to eliminate ambiguities and make the standards more useful in daily practice. The revision, Standards of Perioperative Nursing Practice (AORN, 1983), contain the same seven standards, with interpretive statements added to each standard to explain it and provide definitions of terms and actions necessary to achieve the standard. The assessment factors were also retitled criteria. (See Appendix A.)

In 1983, at the time of publication of the standards, the Committee on Nursing Practices stated that because a standard is the minimal level of

performance required, achievement of each standard is mandatory. The addition of criteria was intended to make achievement of standards easier. Criteria, as introduced, were to be tools for measuring to what degree each standard had been met. The role of criteria was to define vital pieces of the whole.

In the AORN Journal article which introduced the revised standards (Committee on Nursing Practices, 1982), the Committee stated that the criteria were meant to suggest, recommend, and stipulate. It was not and still is not clear, however, which criteria, if any, are relative or suggestive, and which are absolute or mandatory. As a result, addition of criteria to the standards seems to have made the evaluation of performance more difficult.

In an opinion published about the same time, Charles M. Chambers (1983), General Counsel of the Council on Postsecondary Accreditation explained the relationship and differences between standards and criteria in the context of measuring quality. He maintains that standards are absolutely correct specifications of some desired quality; whereas criteria are merely derived from, related to, or based upon corresponding standards. If something fails to meet a standard, it is considered unacceptable. However, if something fails to meet a criterion, it

may or may not be acceptable: One just does not know.

Chambers states that this ambiguity derives from the fact that alternative ways may exist to meet the standard other than those specified through the criteria.

Chambers (1983) also discusses several approaches to setting standards. One approach involves specifying in some detail each desirable feature, component, or ingredient of whatever is being considered. He gives the example of military procurement standards for toothpaste. Although perfect according to the standards, the green tubes with the twelve digit stock number gather dust while the post exchange does a brisk business in Crest and Pepsodent.

AORN's process standards seem to fit this standard setting approach, in that they describe and prescribe specific nursing activities, based on nursing process, to attain quality nursing care for surgical patients. The implicit goal is certainly quality, but the explicit goal of these standards is to standardize the approach to patient care by prescribing the nursing activities specified in the nursing process model.

RESEARCH ON PERIOPERATIVE STANDARDS

Use of Nursing Process

Information regarding the use of nursing process by nurses in the operating room was an incidental finding of a study that was a collaborative effort between AORN and the Western Interstate Commission for Higher Education (WICHE) (Lindeman, C. A., Enloe, C. H., Funderburk, L., Grundemann, B., Harmon, M., Kneedler, J., Nolan, M., Van Poole, M., 1978). The study explored the relationship between operating room nursing activities and patient outcomes, with the long-range goal of developing a tool consisting of patient outcomes that would serve as indicators of quality care.

The researchers developed a list of ten nursing activities as variables for their data collection tool: preoperative teaching; psychological support; counts; maintain efficient, effective, and safe intraoperative environment; communication of intraoperative information; and postoperative evaluation visit. The postoperative evaluation visit was defined as "actions of OR personnel and patient to determine the effectiveness of care provided by nurses during the preoperative, intraoperative, and immediate postoperative phases and to determine patient satisfaction and whether patient's expectations were

congruent with the care he received" (Lindeman, et al, 1978, 210). After initial testing of the tool, the postoperative evaluation visit was eliminated because it did not occur frequently enough to be useful in the study. This finding implies that nurses were failing to complete the last step of the nursing process.

The researchers in the above study had assumed that some nursing activities would be performed in some operating rooms and not in others; however, they found little variance between practice in the hospitals studied. Results of the study indicated that hospital size and the surgical patient's preoperative status had more effect on postoperative outcomes than did nursing activities performed in the operating room.

A telephone survey reported on the use of the assessment and evaluation portions of nursing process by perioperative nurses. Four hundred forty-three operating supervisors, were asked two questions: "Do your registered nurses do any kind of patient assessment preoperatively?" and "Do your registered nurses do any kind of postoperative assessment?" Two hundred seventy-three indicated that nurses did do preoperative assessments and 99 gave negative responses. With regard to postoperative assessments,

188 respondents gave affirmative responses with 182 negative.

Although the surveyors were AORN past presidents, board members, and national committee chairpersons; the issue of social influence on responses was not addressed. No demographic information was given on the sample surveyed. And since the terms preoperative assessment and postoperative assessment were not defined by the surveyors prior to asking their questions, it is unknown how the questions were interpreted.

Compliance with AORN Standards of Practice

The AORN Standards of Nursing Practice Committee conducted a survey in 1980 (Committee on Nursing Practices, 1981) that served as a basis for standards revision. Questionnaires were sent to 25% of those who attended the AORN Congress in 1980. Of the 1,468 surveyed, 385 (26%) responded.

Results indicated that 96% of the respondents said they were doing what they considered to be preoperative assessment. Typically, this assessment was done in the surgical suite or holding area; however, 49% of the nurses were also going to patient units, and 3% were assessing patients in the physician's office or clinic. Most of the respondents reported they "usually" (47%) or "sometimes" (34%) did

a care plan; however, 77% of them indicated the plan was mostly a mental process. Only 10% said their plan was usually in writing.

When asked if they evaluated the care plan, 32% responded that they "sometimes" did, and 51% said they "usually" did. The Committee traced the failure to evaluate to the general lack of a written plan.

Since questionnaires were sent only to active AORN participants, it may not be representative of all nurses practicing in the operating room. And although the study was based on AORN's process standards (1975), the report of the findings did not address deriving nursing diagnoses, setting patient goals, or reassessing the plan.

The 1980 survey did identify areas in which perioperative nurses were having difficulty with the standards. These areas were:

- understanding the terminology in the standards
- difficulty in formulating nursing diagnoses
- difficulty differentiating between patient and nursing goals
- failure to write nursing care plans
- failure to evaluate nursing care
- inadequate documentation of nursing activities

No surveys on compliance have been reported since the revised Standards of Perioperative Nursing Practice were published in 1982. Experience suggests that the difficulties documented in the 1980 survey persist.

CONCEPTUAL FRAMEWORK

AORN has invested heavily in nursing process as the model for patient care in the operating room. Nursing process is "the heart and core of the perioperative role" (AORN, 1983, 11:2-2) and AORN's process standards are nursing process operationalized within the operating room context.

In the light of the difficulties experienced in using the standards, however, one must examine the assumption that nursing process ensures quality nursing care. Nursing process, a method of unknown effect, is being applied in a fashion analogous to a theory (Openshaw, 1984).

Openshaw reminds us that there is little evidence in nursing's body of knowledge to suggest that there are functional relationships between nursing activities and specific, predictable outcomes. In fact, she warns that investing too heavily in the nursing process model can block identification of alternative nursing activities that would result in adequate outcomes (1984). Although nursing process is useful, it is not necessarily the only way to approach patient care.

AORN's Standards of Perioperative Practice can be considered a theory, in that they were created as a framework to meet a specific goal. Dickoff, James,

Wiedenbach (1968) define a theory as a conceptual framework to some purpose. They stated that theory is neither a useless fairy tale nor an absolute picture of reality but is "an invention of concepts in interrelation" (p. 430) that is continually subjected to comparison with reality to determine if the invention is adequate for the purpose it was designed to serve.

In other words, a theory is a tool that is invented or created to fulfill a specific need or meet a particular goal. As the tool is used, there is a dynamic interplay between it and the perceived realities of the situation. If there are continual incongruities between the tool and reality, and the tool is not adjusted or adapted, it will become dysfunctional; i.e., it will no longer accomplish the job it was created to do.

Because nursing practice in the operating room is complex, ambiguous, and multiplistic, to approach patient care utilizing a single nursing model may be simplistic. Therefore, standards based only on nursing process may not be adequate to guide all professional nursing activity.

AORN's standards were written with the intent to guide nursing practice. Consequently, they can be viewed as a normative or prescriptive theory.

Dickhoff, James, and Wiedenbach (1968) suggest that prescriptive theory can be tested in three areas: coherency, feasibility, and palatability. Coherency means, does the theory work? Do the steps prescribed reach the goal the theory is striving to achieve? Feasibility concerns activities that are required to reach the goal. Must some activities that are valued be subordinated to perform the activities prescribed by the theory? What are the costs involved in performing the prescribed activities, not only in economic terms, but in time, energy, and opportunities that are lost? Palatability has to do with how nurses view the activities required by the theory. Are there steps or actions that the theory prescribes that are considered repugnant or trivial?

To summarize, if there is a discrepancy between practice and AORN process standards, there may be several explanations for this incongruity. Nurses may not be familiar with the standards, or they still may be having difficulty understanding them. On the other hand, they may be purposefully deviating from the standards. This could be occurring if the standards do not serve nurses as a viable guide for practice. Nurses may view the standards as unrealistic and unattainable (feasibility). They may dislike performing certain activities prescribed in the

standards or dislike the consequences of using them (palatability).

The present study evaluated the feasibility and palatability of AORN's Standards of Perioperative Nursing Practice. However, it was beyond the scope of this study to test the standards for coherency.

Perioperative nurses are not the only clinical specialty to have standards based on the nursing process model, nor are we the only specialty having difficulty implementing them in practice settings. A better understanding of why standards are not being utilized by nurses within our clinical setting may have implications for other nursing specialties as well.

RESEARCH QUESTIONS

To what extent do AORN's Standards of Perioperative Nursing Practice serve as a framework/guide for perioperative nursing in Oregon?

1. Are perioperative nurses in Oregon familiar with AORN's Standards of Perioperative Nursing Practice?
2. Are perioperative nurses in Oregon having difficulty understanding AORN's Standards of Perioperative Nursing Practice?
3. Do AORN's Standards of Perioperative Nursing Practice provide a sufficient guide for

perioperative nursing practice?

- A. Are there components of perioperative nursing practice that are not covered by the standards?
- B. Are perioperative nurses using alternative guides to practice in place of or as supplements to AORN standards?
- C. Do perioperative nurses in Oregon consider AORN standards feasible?
- D. Do perioperative nurses in Oregon consider AORN standards palatable?

CHAPTER II

METHODS

Description of the Study

This study was a non-experimental design which examined the extent to which AORN's Standards of Perioperative Nursing Practice are used by nurses as a guide for practice and investigated the "real-life" efficacy of these standards. In addition, the study attempted to determine nurses' degree of familiarity and level of understanding of the standards.

Data were collected from operating room supervisors and staff nurses in several locations throughout the state. A structured interview format was used.

Sample and Subjects

The sampling unit was operating rooms in the state of Oregon, and nurses practicing within them were the subjects used for data collection. Five operating rooms were selected from Joint Commission of Hospital Accreditation (JCAH) approved health care facilities with 150 or more beds. The sample size was limited in an attempt to gather data more thoroughly within the time constraints of the study period.

Nursing process is used by JCAH as an indicator of quality nursing care. It was reasoned, therefore, that hospitals approved by this accrediting body would

be more likely to use this model to guide practice in the operating room. Size of health care facility was also made a criterion for selection of the sample. Availability of large numbers of nursing staff was required to facilitate data collection.

The sampling units selected represent four of Oregon's five geographic regions, as defined by the Oregon State Board of Health. (See Appendix B.) The Portland metropolitan area was represented by two operating rooms, since the majority of health care facilities 150 beds and over are located in this geographical area. The southern, central, and mid-Willamette areas of Oregon were represented by one operating room each. No health care facilities in the eastern geographic area of Oregon satisfied the criteria for inclusion in the study.

Structured interviews were conducted with two levels of nursing personnel within each of the five operating rooms: supervisory and staff. Supervisory personnel was defined as nurses who have patient contact, but are not routinely assigned to staff an entire operative procedure. Nurses hired for facilitator roles, i.e.; charge nurses, head nurses, and staff development, were considered supervisory staff.

The director of each of the five operating rooms

selected as sampling units received a letter with a response card enclosed recruiting participation in the study (Appendices C and D). To allow directors greatest flexibility to respond to time and staffing constraints, they selected the nurses who were interviewed.

Variables and Assumptions

A structured interview was designed to collect data that will answer the research questions. There were three variables of interest to the study. The first, familiarity, is the degree to which nurses are familiar with the standards. The second, understanding, is the extent to which nurses understand the intent and terminology of the standards and criteria. The final variable, adequacy, is a measure of the efficiency of the standards as a guide to practice.

The first two variables were derived from a very basic assumption. If nurses do not know and understand the standards and their criteria, they are unlikely to use them in practice.

The variable adequacy grew out of four assumptions. The first assumption is: The extent to which standards are utilized is a measure of their adequacy to guide practice. Second, to guide practice, a model, in this case, the standards, should

be comprehensive enough to cover all components of practice.

The third assumption is that the standards, as normative theory, undergo continual testing at the practice level. Nurses familiar with the standards may view them with distaste or distrust because of the incongruities between the standards and their own perceptions of reality; which leads to the final assumption. Nurses who perceive AORN's standards as infeasible and/or unpalatable will demonstrate use of alternative standards to guide their nursing activities.

Development of the Data Collection Instrument

Prototype and Pilot Testing

Since no instrument could be found that measured the variables of interest to the present study, one was developed by the researcher. After pilot testing with a small sample, the data collection instrument was altered to make it more efficient and improve validity.

The Revised Interview Format

The revised interview consists of four sections. In the first section, subjects were asked to recall and describe two cases from their own practice, one in which they thought they took "very good care" of the patient and another where they were not satisfied with

their own performance. This approach was used to evoke the widest range of responses and to provide information regarding variations within the daily practice of the individual practitioner. These "best" case/"worst" case scenarios provided the subjects with a reference base for the remainder of the interview (See Appendix E).

In the second section, the subjects were asked whether they were familiar with AORN Standards of Perioperative Nursing Practice and whether they used them. In addition, they were asked to describe how they used them and to specify the purposes they believe standards should serve.

In the third part of the interview, researcher and subject reviewed the standards together. For each standard and criterion the subjects were asked two questions: "Did you use this standard/criterion to guide your practice during your 'best' case?", and "Did you use this standard/criterion to guide your practice during your 'worst' case?".

For data collection and analysis, "No's" were divided into seven explanation categories:

- (No:1) The nurse is not familiar with the standard/criterion, i.e., does not know about it,
- (No:2) the nurse does not understand the terminology or intent of the standard/criterion,
- (No:3) the standard/criterion is not considered relevant to the situation, i.e., not applicable,

- (No:4) the standard/criterion is not considered feasible, i.e., realistic,
- (No:5) the standard/criterion is not considered palatable, i.e., desirable,
- (No:6) some other guide to practice is considered more appropriate in this situation, and
- (No:7) other.

When subjects used such terms as "relevant", "feasible", and "unrealistic", they were asked to explain and define them.

Each standard and criterion was on a separate page of the data collection instrument. Subjects' explanations regarding "No" responses were recorded in a comments section at the bottom of each page.

During the final part of the interview, subjects were asked to again consider the standards as a whole. This section served as a summary and allowed the subjects to make generalizations regarding the standards and their overall use in practice.

At the conclusion of the interview, the researcher asked general and personal information about the subjects. This information included: title at work, years of operating room experience, age and membership in AORN.

Data Collection Procedure

After consent to participate in the study was obtained, specific appointments for data collection interviews were made by telephone. To insure privacy, arrangements for a room in which to conduct the

interviews were also be made during this call.

Although recording of data was primarily done by notation of subjects' responses and rationale directly onto each data collection instrument, the interviews were also tape recorded. Prior to beginning the interview, the subjects were informed about the recording. No one objected.

The structured interview was read by the researcher to control for variations in presentation. However, many responses, especially in section three, required the researcher to ask questions that related to the specific scenarios the subjects had described.

It is recognized that superimposing personal bias is a danger inherent in this method of data collection. The researcher anticipated that her opinions and interpretations might be solicited during the interview process and predetermined that subjects' responses would be recorded before any discussion.

Protection of Human Subjects

Since data collection did not involve direct patient contact, human subjects were protected by maintaining confidentiality regarding source of data. Participants in the study were assured that all names would be kept confidential and findings would be reported only in terms of the aggregate.

CHAPTER III

RESULTS

The Subjects

Two of the ten subjects interviewed were male. Age of subjects ranged from 29 to 59 with a mean age of 42.7 years. Years of nursing in the operating room ranged from 6 to 22 with a mean of 13.1 years. All subjects were members of AORN.

General Data Organization

After the data had been collected, they were organized into a more visual format. Responses from section three of the interview were compiled onto two worksheets per subject: "best" case and "worst" case (Appendix F). Data from these worksheets were pooled into two indices that listed each standard and criterion and recorded each subject's response by response category. Table 1 in Appendix G illustrates what these indices were like, with the exception that specific subject codes have been replaced by the total number of subjects in each response category.

By using the data indices, the researcher was able to extract subjects' explanations of "No" responses from the 10 data collection instruments. These specific response explanations were then subjected to content analysis for commonalities.

The data indices were also useful for

identifying standards and criteria that were particularly problematic for the subjects interviewed. By having the data in a more visual format, it was easier to see trends and make generalizations.

The results of the study will be presented in two parts. The first part will report on each of the seven standards in terms of understanding, feasibility, and palatability. The second will address the research questions.

Description of the Findings

Standard I:

"THE COLLECTION OF DATA ABOUT THE HEALTH STATUS OF THE INDIVIDUAL IS SYSTEMATIC AND CONTINUOUS. THE DATA ARE RETRIEVABLE AND COMMUNICATED TO APPROPRIATE PERSONS."

Understanding

Only two subjects had difficulty understanding this standard or its extant criteria. One seemed confused by "physiological responses" in criteria 1b; and the other subject wondered if criteria 3, "Health data is reported and recorded," meant she was supposed to record health status data that could be found elsewhere in the patient's record.

Feasibility

Seven of the ten subjects found parts of Standard I infeasible to use as guides to practice in the case scenarios they had described. The most common

rationale cited was that the patient was unconscious or sedated, followed by a lack of time due to the emergent nature of the case. The raw data regarding criteria and subjects' rationale are found in Table 2 in the appendices.

During content analysis, the researcher found that subjects felt two types of time constraints: those due to emergency situations and those inherent in the operating room environment. These were labeled time-emergency and time-system.

Palatability

Only three subjects found parts of Standard I unpalatable. One subject thought that knowing "previous responses to illness, to hospitalization, and to surgery" was unnecessary for planning intraoperative care. One stated she does not record health status data that can be found elsewhere in the patient's chart because she does not believe in duplication of effort. The third claimed that recording health status data (I:3) was not a useful activity.

Subjects' perceptions of palatability of the individual standards and extant criteria are presented completely in a figure in Appendix G. This figure depicts the number of subjects who responded "No, I did not use that standard/criterion because I didn't

consider that activity or its consequences to be desirable." None of the subjects viewed the standard itself as unpalatable. Three criteria regarding the collection of specific health status data were the least desirable: cultural and spiritual information; the individual's understanding, expectations, and perceptions regarding the surgical experience; and information regarding previous responses to surgical interventions.

Standard II:

"NURSING DIAGNOSES ARE DERIVED FROM HEALTH STATUS DATA."

Understanding

Nine of the ten subjects misunderstood at least part of Standard II. Content analysis of the comments revealed that the subjects had problems with two types of understanding: process and terminology.

Terminology problems included semantic difficulties and interpretation of the meaning, i.e., intent of the standards. In addition, some subjects had problems understanding standards and criteria that required a knowledge of process. For example, one subject put it like this: "I simply don't understand the process of nursing diagnosis."

Even though subjects read the interpretive statement which accompanies each standard statement,

many had trouble equating a patient problem or potential problem with nursing diagnosis. One subject, even in response to further questioning, was unable to identify the diagnosis step in his decision-making process: He skipped from assessment to supplies and equipment he needed to collect.

Although two subjects had difficulty understanding the nursing diagnosis process, seven had problems with terminology. The terms with which subjects seemed to have the most difficulty were "current scientific knowledge" in criteria 2 (4 subjects) and "congruent" in criteria 3 (3 subjects).

Feasibility

As in Standard I, the number of subjects who stated they did not use Standard II and its extant criteria to guide practice is greater for the "worst" case than "best" case scenarios. As illustrated in Table 3 (Appendix G) more criteria were considered infeasible in "worst" case scenarios than in "best" case.

Palatability

The subjects who responded in this category were very clear why recording nursing diagnoses was not desirable in their practice. One subject said, "I already do nursing diagnoses in my head. Writing them would be a waste of time."

One subject viewed criterion 3, "nursing diagnoses are congruent with the diagnoses of other health professionals," as counterproductive. She said, "This boxes you in. Your diagnoses should add to a more complete picture of the patient."

Another subject said, "The floor already does nursing diagnosis, and they pass along to us information about special patient problems." She implied that writing nursing diagnoses would not be desirable because it would involve duplication of effort.

Standard III:

"THE PLAN OF NURSING CARE INCLUDES GOALS DERIVED FROM THE NURSING DIAGNOSES."

Understanding

Seven out of ten subjects had difficulties understanding Standard III. One subject's misunderstanding of the process of nursing diagnosis effected her understanding of goal-setting (III).

Criterion 2, "The individual's present and potential physical capabilities and behavioral patterns are congruent with goals," presented quite a mixture of terminology and process difficulties. One subject wondered who the "individual" might be, and several subjects did not know what the word "congruent" meant. Two subjects had difficulty

interpreting "present and potential physical capabilities and behavioral patterns." Three subjects did not understand the process of goal-setting.

Two subjects did not understand "measurable criteria" in criterion 3, and one misunderstood "appropriate persons" in criterion 5. "Time estimate for attainment" (III:6) was difficult for one subject to understand.

Feasibility

Time-system was the most frequently cited rationale for not using criteria to guide practice, with only one additional citation for "worst" case than in "best" case scenarios. Table 4 shows how eight subjects' responses were distributed among the criteria in Standard III.

One subject said, "I might identify a goal, but where would I write it down? Our forms don't lend themselves to this." Another said, "I can see where writing goals would be useful, but it's feasible only if this [activity] can be made to fit the present time available."

Palatability

Five subjects viewed portions of Standard III as undesirable. Four of the five did not object to setting patient care goals, in fact they were doing it. What they did object to was writing goals.

Several said, "Writing goals would not change how I already care for patients." In fact, two subjects said that writing goals would take time that could be utilized to take care of the patient: "I only have so much time with a patient. If I have to choose whether to take care of my patient or write about it, writing is definitely second choice."

Standard IV:

"THE PLAN FOR NURSING CARE PRESCRIBES NURSING ACTIONS TO ACHIEVE THE GOALS."

Understanding

Six subjects had trouble understanding parts of this standard. Four subjects did not know how to interpret "current scientific knowledge" (IV:1). In Criterion 3, four subjects found "individual" and "significant others" difficult to understand, and one subject wondered how much of her plan would be appropriate to share with the "individual."

Feasibility

Table 5 (Appendix G) summarizes subjects' opinions regarding Standard IV's feasibility. Time-system and Scrub role were the most frequently cited reasons for not utilizing criteria within this standard.

Criteria 3 and 4 specified that the plan be written, and these criteria were considered

infeasible. One nurse said, "I document what was done for the patient, not what I plan to do. I don't have time to do both." Another said, "It's not feasible to write all the nursing actions: You'd be writing all the time you were supposed to be taking care of the patient."

Although the nurses sampled did not use these criteria to guide practice, not all their comments were negative. One nurse said, "Having a written plan would give more depth to my role. In a way, it would validate my expertise." Another stated that having written care plans would make the staff more aware of what they do. This subject thought standardized nursing care plans would not only assist in patient care activities but would communicate that nursing was taking place intraoperatively.

Palatability

The criteria that subjects viewed as infeasible were also viewed as undesirable. Two subjects stated that specifying parts of the plan ahead of time (4b, c) was counterproductive, in that it would reduce flexibility. One subject stated that even if time and staff were available to write care plans, she probably would not do it unless the hospital required it, since she could see no purpose for this activity. Another nurse viewed criterion 4 as "a little insulting." "I

am already doing that in my head. Writing it down would just be a waste of time."

One subject said, "Cerebral care plans are quicker and more flexible, but we might forget something." He was sure that with more education and practice he could do care plans, but he felt promoting change in this clinical setting would be difficult.

Standard V:

"THE PLAN FOR NURSING CARE IS IMPLEMENTED."

Understanding

None of the ten subjects understood the first criterion in Standard V. This criterion is about accountability. Nursing performance can be evaluated by comparing the written plan to three indicators: documentation of what was done for the patient, observation of nursing practice, and what the patient or the patient's significant others say was done. A written plan is required, however, in order for perioperative nurses to demonstrate accountability.

There were two things about criterion 1 that seemed to confuse the subjects: the word "documented," and "confirmation by the individual or significant others." The criterion might be clearer if it read "Nursing actions specified in the plan are performed and demonstrated" instead of "documented." One subject asked, "How can you document by observing?"

As the criterion is written, confirmation by the patient or significant others is not an optional way to demonstrate accountability: It does not read "and/or confirmation by the individual...". Several subjects wondered how a sedated or anesthetized patient could confirm that the nurse acted according to plan.

Feasibility

Five subjects considered criterion 1 infeasible: They did not have time to write a plan of care against which nursing activities could be evaluated. One subject also stated that at his facility, most patients and significant others are not made privy to the nurse's plan so would not be capable of evaluating whether the nurse performed according to plan.

The second criterion, "Nursing actions and patient outcomes are communicated to others as appropriate," was not feasible to the subject performing in the scrub role. He said, "Nursing process is possible in the scrub role, but not this activity."

Palatability

One subject considered criterion 1 an undesirable activity. The responses in this category reflected the perception that making written care plans takes time and the subjects' preference to use the limited

time available for purposes other than "charting."

Standard VI:

"THE PLAN FOR NURSING CARE IS EVALUATED."

Understanding:

Four subjects demonstrated lack of understanding of components of this standard. Even though subjects read the interpretive statements, two misunderstood the evaluation process. One did not understand that evaluation is a continuous nursing activity. He said, "We do get feedback via incident reports. And surgeons sometimes tell us how the patient did post-op...". Another subject equated evaluation with post-operative visits, which she felt are no longer feasible since patients are recovered and discharged so rapidly.

Three subjects had difficulty with criterion 1. One did not know how to interpret "degree of goal attainment," and one nurse said she had thought goals and patient outcomes were the same thing. The term, "significant others," puzzled one subject.

Feasibility

In response to the standard statement, one subject stated that a written record of nursing evaluation was not feasible because of the time this activity requires. Two subjects also gave this rationale for the first criterion. Four subjects

viewed criterion 2 infeasible for the following reasons: no time, documentation format problems, not possible in the scrub role, and results of nursing actions were not known to the nurse.

Palatability

Several nurses objected to what they considered "bragging." Said one subject, "I don't usually go about saying 'I did my job.'" Another nurse did not think communicating goal achievement was expected or necessary to be considered professional.

Standard VII:

"REASSESSMENT OF THE INDIVIDUAL, RECONSIDERATION OF NURSING DIAGNOSIS, RESETTING OF GOALS, AND MODIFICATION AND IMPLEMENTATION OF THE NURSING CARE PLAN ARE A CONTINUOUS PROCESS."

Understanding

Only two nurses had any difficulty with this standard and its extant criteria. Unfamiliarity with nursing process as a whole affected one subject's understanding of this standard. The other had trouble understanding how observation can be documentation.

Feasibility

Criterion 1 was considered infeasible by five subjects for their "best" case scenarios and six subjects for their "worst" case scenarios. One subject's unfamiliarity with nursing process affected

her view of feasibility for both case scenarios. All the other subjects attributed infeasibility to lack of time.

Several subjects identified the process of updating surgeons' preference cards and case cart requisitions as modification of the nursing care plan. Surgeons often announce changes in suture and instrumentation preferences during the procedure, and if these changes are noted on the preference cards or case requisitions, the next nurse will be better prepared to meet the surgeons'; i.e., patients', needs.

Palatability

There were no responses in this category for Standard VII. Evidently, all subjects considered this standard and its extant criteria desirable.

Analysis of the Findings

Research Question 1:

"Are perioperative nurses in Oregon familiar with AORN's Standards of Perioperative Nursing Practice?"

Data collected in sections two and three of the structured interview answers the question regarding nurses' familiarity with the standards. The familiarity of interest to this study is conceptual, which means that the subjects have read the standards, know what they look like, what they are about, and how they were derived.

Familiarity was determined by reviewing subjects' stated response to the question "Are you familiar with AORN's Standards of Perioperative Nursing Practice?" to the uses they claim to make of them. The researcher expected those subjects who stated that they were familiar with the standards to list uses that reflect the nursing process or correspond with those identified by AORN's Committee on Nursing Practices: accountability, quality assurance, communication, evaluation of staff performance, legal implications, and research.

Nine out of ten subjects stated they were familiar with AORN Standards of Perioperative Nursing Practice, and eight of ten claimed they used the standards in their practice. However, when subjects' stated use of the standards were compared to the list of potential uses generated by AORN's Nursing Practices Committee and evaluated for evidences of nursing process, only three subjects demonstrated familiarity. Four of the ten subjects seemed to confuse the standards with AORN Recommended Practices, which are frequently revised and intended to serve as goals and guidelines for departmental policy and procedure. Responses of four subjects demonstrated consistency between stated familiarity and demonstrated familiarity.

The researcher also found that several subjects were confusing the standards with perioperative role. They would say at the beginning of the interview, "Well, you're really interviewing the wrong people here. We don't do preop. and postop. visits."

A possible response to the interview question, "Did you use this standard/criterion to guide practice...?" might have been, "No, I did not know about it." Responses of this sort were coded No:1, Not Familiar. Standards and criteria not utilized for this reason were identified by subject from the pooled data in the data index and evaluated in terms of frequency of response. As shown in Table 1, Appendix G, none of the subjects used lack of familiarity as a reason for not utilizing AORN's standards and extant criteria.

Research Question 2:

"Are perioperative nurses in Oregon having difficulty understanding AORN's Standards of Perioperative Nursing Practice?"

Data on subjects' understanding of the terminology and intent of the standards were derived from section three of the structured interview. If a subject stated they did not use the standard or criterion because they did not understand it or if they obviously had difficulty interpreting it during

the interview, the No:2, Not Understood was circled. The researcher asked further questions to determine what it is about the standard/criterion that the subject did not understand, and these responses were noted in the comments section.

All standards and criteria that received No:2 responses were identified by subject from the pooled data in the data indices (Table 2, Appendix G). Content analysis was done on the specific problems the subjects had had with the standards.

Subjects showed consistency in response between "best" case and "worst" case scenarios. If subjects did not use a standard/criterion in their "best" case scenarios, it was not used for their "worst" case either. Therefore, the two cases were combined for analysis.

The seven standards and their extant criteria add up to 88 items, and the nurses in the study misunderstood 23 of those. Of ten subjects, nine found an average number of seven standards/criteria difficult to understand.

Subjects had difficulty understanding both terminology within the standards and nursing process, from which the standards are derived. Combined "best" case/"worst" case responses totaled 142, 74 (52%) were due to terminology and 68 (48%) were due to

misunderstanding of process.

Research Question 3:

"Do AORN's Standards of Perioperative Nursing Practice provide a sufficient guide for perioperative nursing practice?"

- A. Are there components of perioperative nursing practice that are not covered by the standards?"

This question is based on the assumption that if standards do not provide guidance for all areas of a nurse's practice, he/she will not find them useful. In examining the scenarios, the researcher looked for terms that seemed to typify the situation and for what the nurses perceived as making that case "best" or "worst." These became the descriptors for components of practice that the subjects perceived as valuable. Table 6 compares these components to the components of practice delineated in the standards: assessment, diagnosis, planning, goal-setting, implementation of the plan, reassessment of the individual, and reevaluation of the plan. Congruency between the two lists provided a measure of the adequacy of the standards to guide practice; that is, the more congruent, the more adequate.

Content analysis of notes taken during subjects' descriptions of case scenarios revealed some

Components of Practice as Identified from Subjects' ScenariosCompared to Components as Delineated in the Standards

<u>Subject</u>	<u>"Best" Case</u>	<u>"Worst" Case</u>	<u>Standards</u>
1	Emergency - Prepared	Not Prepared	Assessment Planning
2	Teamwork	Rushed - Lack of Connection with Pt.	
3	Anticipating well - Plan	Not Prepared	Assessment Planning
4	Emergency - High Touch Intervention	Rushed - Did Not Meet Own Standards	Assessment Planning Implementation Evaluation
5	Emergency - High Touch Intervention	Rushed - Did Not Meet Own Standards	Assessment Planning Implementation Evaluation
6	Emergency - Teamwork	Rushed - Ethical Dilemma	
7	Effective Pt. Intervention	Equipment Failure	Assessment Planning Implementaion Evaluation
8	Anticipating - Plan	Rushed - Did Not Meet Own Standards	Assessment Planning
9	Emergency - Teamwork	Emergency - Rushed - Lack of Plan	
10	Emergency - Teamwork	Ethical Dilemma	

surprising commonalities. Interestingly, six of the ten "best" case scenarios were emergency situations.

Teamwork seemed to typify four of the ten "best" case scenarios. For example, one subject described how every member of the surgical team knew exactly what to do in the emergency situation. Roles were well-defined and everything "clicked." He tried to express the feeling of calm that was in the room and how satisfying it was to him personally, knowing that he had anticipated both surgeon's and anesthesiologist's needs.

Prepared: Had plan typified three subjects' experiences. One subject described all the steps she went through to prepare the operating room for a "craniotomy patient;" including turning up the temperature in the room so he would not get hypothermic during the skin prep, having extra fluids and blood available for the anesthesiologist, and making sure all the supplies specified on the surgeon's preference care were in the room. Her goal was that all the "hustle and bustle" would be completed before the patient came in the room so she could stay right by his side until induction was completed.

High-touch patient intervention typified three other subjects' experiences. One nurse described a

case where a young woman had received a traumatic injury to her hand, including the amputation of the tip of one finger. The patient was very anxious and upset. The nurse assessed the patient's maturity level, identified the first stages of the grieving process, and planned several nursing interventions to provide the patient with some coping strategies.

An even more interesting commonality emerged during content analysis of the "worst" case scenarios. In eight of the ten, the subjects had felt rushed at the beginning of the case. In contrast to the "best" cases, however, only one "worst" case scenario was an emergency.

Because of time pressures inherent in their everyday work environment, three of those eight nurses felt they had not met their own personal standards. Three others stated they were unprepared for the cases. One nurse particularly mentioned her "lack of connection" with the patient. "When I don't get a chance to assess the patient or at least establish some sort of rapport, I find I am doing tasks instead of taking care of the patient."

The two "worst" cases that seemed unrelated to time can be described as an ethical dilemma and an equipment failure. One nurse described how uncomfortable he felt when the surgeon and

anesthesiologist instructed him to cease cardiac compressions in a code situation. The patient was an elderly, arthritic woman who had been added on to the end of the day's surgery schedule for a tracheostomy. He had taken special care to pad and prop her so she would be as comfortable as possible, and although she could not speak because she was intubated, she communicated her appreciation of his efforts. Upon induction of anesthesia, she arrested, and the nurse felt the physicians "gave up" too soon.

The equipment failure involved an operative microscope. The nurse had identified a potential problem and called the company representative for a replacement part. However, the replacement turned out to be worse than the part she had had already, and a surgery had to be cancelled.

When these cases are compared with the descriptors or components of practice as delineated in AORN standards, assessment and planning are fairly well represented. In the High-touch patient intervention scenarios, one can infer that assessment, planning, implementation, and reassessment took place. In all of the rushed, "worst" case scenarios, one can also infer that the subjects felt time pressures inhibited assessment planning, and implementation.

What the standards do not include are

interpersonal relationships with the other members of the surgical team or the teamwork that was the essence of four of the ten "best" cases. Likewise, the standards do not address either the technical or the ethical aspects of perioperative nursing practice.

Although the researcher had not previously considered time management a component of practice, it was clearly identified as an area of major concern by subjects in the present study. The economics-driven push for productivity is being felt at the practice level. Unfortunately, the standards do not help nurses deal with time constraints. Indeed, as will be noted later, nurses perceive implementation of standards as time consuming.

Another method used to examine components of practice was to compare how subjects said they used standards to how they felt standards should be used. This information is displayed in Table 7. A third column has been added listing the purposes for the standards that AORN's Nursing Practices Committee has identified. Purposes that match across all three columns are: defines quality, defines nursing (accountability), tool for evaluating nurse performance, and promotes scientific knowledge base for practice (research).

Five subjects, 50% of the sample, stated that

Comparison of Subjects' Stated Use, Proposed Uses, and AORN'sProposed Purposes of Standards of Perioperative Nursing Practice

<u>Subjects' Stated Uses</u>	<u>Subjects' Proposed Uses</u>	<u>AORN's Proposed Purposes</u>
1. Defines quality for nursing in OR: a. baseline b. optimum=goal	1. Defines quality for nursing in OR: a. baseline b. optimum=goal	1. Quality assurance
2. Defines nursing in OR, describes use of nursing process in perioperative setting.	2. Defines nursing in OR	2.
3. Tool for evaluating nurse performance	3. Tool for evaluating nurse performance	3. Evaluation of staff performance
4. Promotes scientific knowledge base for practice	4. Promotes scientific knowledge base for practice	4. Research
5. Provides specific guidelines for care delivery: a. identification of patient b. assessment of patient 1. physical/psychological 2. patient's understanding of surgical experience c. making individualized plans to meet needs of the patient as well as surgeon, anesthesiologist. d. charting	5. Provides specific guidelines for care delivery: a. assessment of patient b. psychological support of the patient	5.
6.	6. Stipulates legal accountability	6. Legal implications
7.	7. Standardizes care	7.
8.	8.	8. Communication
9.	9.	9. Accountability in practice

standardizing care is a desirable use for standards. However, none of them utilized standards for this purpose. A more serious problem was that the majority of the stated uses (67%) involved providing specific guidelines. Although this concept matches an entry in the Proposed Uses column, this use more nearly matches the purpose of AORN Recommended Practices.

Component to component, the first two columns match fairly well, in that four out of five purposes in the first column match four out of seven in the second. However, the fact that 67% of subjects' stated uses had to do with providing specific guidelines supports the conclusion of the previous section: Nurses are not familiar with AORN standards.

Research Question 3 (Continued):

B. "Are perioperative nurses using alternative guides to practice in place of or as supplements to AORN standards?"

This portion of Question 3 concerns identifying standards and criteria that nurses are using instead of or in addition to those of AORN. It is based on the assumption that nurses use internal and/or external standards to guide nursing activities.

Data for this question were gathered in section three. It was anticipated that some subjects might state that they did not use AORN's standards/criteria

because they were already using something more appropriate as a guide for practice. These responses were coded No:6.

Standards and criteria receiving No:6 responses were identified by using the data indices, and the subjects' rationale for their responses were compiled.

Eight subjects chose not to use AORN's standards because they were using something else to guide their nursing activities. Because responses were consistent between "best" and "worst" cases, the data were combined for analysis. Content analysis revealed six other guides to practice. As can be seen in Table 8, departmental procedures was the most commonly cited alternative guide to practice. The second most commonly cited guide was departmental policies.

Research Question 3 (Continued):

C. "Do perioperative nurses in Oregon consider AORN standards feasible?"

Feasibility concerns the possibility of implementing the standards in practice. In the present study, 20 case scenarios were reviewed to identify subjects' practice constraints with respect to feasibility of implementing standards.

Data on feasibility were collected in section 3 of the interview. Subjects who did not use the standard/criterion because they considered it

Alternative Guides to Practice Used by Subjects During Case Scenarios

<u>Alternative Guides</u>	<u># of Times Cited</u>	<u>% of Total</u>
Departmental Procedures	50	45%
Updated Surgeons' Preference Cards	46	42%
AORN Recommended Practices	8	7%
Departmental Policies	2	2%
Departmental/Hospital Standards	2	2%
Quality Assurance Standards	2	2%
	<hr/>	<hr/>
56 responses x 2	110	100%
("Best"/"Worst" combined)		

infeasible or unrealistic (No:4 responses) were asked to elaborate on their decisions, and these data were recorded in the comments sections of the data collection instruments. The data indices (Table 1, Appendix G) identified which standards and criteria were considered infeasible by which subjects, and the data collection instruments were reviewed for the rationale.

As was expected, more subjects gave No:4 responses for "worst" case than for "best" case scenarios. In addition, subjects had more reasons for those responses in "worst" case scenarios.

Content analysis of comments recorded during subjects' elaboration on No:4 responses revealed 12 different major reasons for not utilizing standards and criteria. These reasons along with the number of times each was cited are found in Table 9.

The following example is typical of the subjects' perceptions regarding feasibility of standards. Regarding Standard II, "NURSING DIAGNOSES ARE DERIVED FROM HEALTH STATUS DATA," one subject said, "I maintain a certain level of care for all my patients. I individualize my standard care [plan] only if I identify a special patient problem. Writing it down wouldn't change the way I nurse, it would just take longer."

Reasons Subjects Gave for Considering AORN Standards
of Perioperative Nursing Practice Infeasible

"Best" Case

<u>Reasons</u>	<u># of Times Cited</u>	<u>% of Total</u>
Time - System	60	57%
Scrub role	11	10%
Documentation format problem	9	8%
Time - Emergency	7	7%
Nurse did not know how	7	7%
Patient unconscious/sedated	6	6%
Not role	2	2%
Privacy problem	1	1%
Nurse uncomfortable with activity	1	1%
"Individual/significant others" not privy to plan	1	1%
	<hr/>	<hr/>
	106	100%

(Table continues)

"Worst" Case

Time - System	76	61%
Scrub role	16	13%
Documentation format problem	9	7%
Nurse did not know how	7	6%
Time - Emergency	5	4%
Patient could not verbalize	3	2%
Nurse uncomfortable with activity	3	2%
Privacy problem	2	2%
Not role	1	1%
"Individual/significant others" not privy to plan	1	1%
Equipment failure	1	1%
	<hr/>	<hr/>
	124	100%

Nurses identified time constraints as the greatest deterrent to use of standards, with 57% of "best" case and 62% of "worst" case responses falling in this category. Again, these time constraints were not associated with emergency cases, but with the normal, everyday push for speed and productivity. One subject said, "I hate it when the anesthesiologist says, 'I've got the chart: You take the kid.' I never catch up!"

The documentation format problems that were identified by the subjects were also associated with time constraints. Several subjects intimated that if there was a form that allowed them to quickly and efficiently record their use of nursing process, they would be more apt to use those parts of the standards that prescribe documentation activity.

In two of the 20 case scenarios, one "best" and one "worst," subjects had functioned in the scrub role. Both these subjects had not consciously considered AORN standards as a guide to nursing practice in this role. However, they did use nursing process: they collected information regarding the patient's physical status, planned and collected instrumentation and supplies to meet specific needs, implemented and adapted the plan during the surgical procedure, and evaluated the adequacy of the plan

against the actual needs of the case, and revised the plan by making appropriate changes on the surgeon's procedure preference cards or case cart requisitions. Other than updating preference cards or case cart requisitions, which was done retrospectively, the nurses functioning in the scrub role could not identify use of any AORN standards or criteria which prescribed documentation of nursing process.

Question 3 (Continued):

D. "Do perioperative nurses in Oregon consider AORN standards palatable?"

Palatability concerns whether nurses see disadvantages in performing nursing activities as prescribed by the model. Did the subjects choose not to use a standard/criterion because a prescribed activity was repugnant or resulted in an undesirable outcome? Subjects' responses were also analyzed to identify costs involved in performing according to the model in terms of opportunities lost or valued activities that must be subordinated.

No:5 responses in section 3 of the data collection instrument reflect subjects' perceptions regarding desirability of performing as specified in the standards. The data indices were used again to pinpoint No:5 responses. The comments of these specific subjects were pooled and subjected to content

Reasons Subjects Gave for Considering AORN Standards
of Perioperative Nursing Practice Unpalatable

"Best" Case

<u>Reasons</u>	<u># of Times Cited</u>	<u>% of Total</u>
Unnecessary activity	15	29%
Would not change practice 5	11	21%
Would not improve practice 6		
Activity costs time with patient	9	17%
Not useful in practice	6	12%
Counterproductive	5	10%
Would not change patient outcomes	2	4%
Duplication of effort	2	4%
Requires too much paperwork	1	1.5%
Waste of time	1	1.5%
	<hr/>	<hr/>
	52	100%

"Worst" Case

Unnecessary activity	13	27%
Would not change practice 10	13	27%
Would not improve practice 3		
Costs time with the patient	9	18%
Not useful in practice	5	10%
Counterproductive	5	10%
Duplication of effort	2	4%
Requires too much paperwork	1	2%
Waste of time	1	2%
	<hr/>	<hr/>
	49	100%

analysis for common themes.

Eight subjects gave 52 reasons in the "best" case and 49 in the "worst" case for considering certain standards and criteria unpalatable. As illustrated in Table 10, the leading reason subjects gave was that using these standards/criteria caused or resulted in unnecessary activity. If subjects could see no inherent or resulting value in an activity prescribed by a standard or criteria, they were not apt to use them to guide practice. This applied particularly to recording and documenting. One nurse said, "I am being asked to prove that I am doing my job. I'm doing it [the standard], but I resent having to write it down. It costs me time from my patient, and it costs the hospital money for my time."

Tallying the total times subjects used the extant criteria within each standard provided a final measure of feasibility and palatability. This was done on special worksheets which are presented as Tables 11 and 12 in Appendix G.

Data illustrated in this table indicate that subjects used the first standard (collecting health status data) most frequently in both "best" and "worst" case scenarios. Extant criteria within Standards III (goal-setting) and IV (prescribing nursing actions) were used the least.

nursing actions) were used the least.

General Research Question:

"To what extent do AORN's Standards of Perioperative Nursing Practice serve as a framework/guide for perioperative nursing in Oregon?"

The extent to which perioperative nurses in Oregon utilize AORN's standards to guide clinical activities was answered by tallying the "Yes" responses to the question, "Did you use this standard/criterion to guide your practice...?" Frequency and pattern of response were identified by the data indices and percentages were computed from which inferences were made regarding nurses' overall use of the standards.

When "Yes" responses were tallied for all ten subjects (Table 1, Appendix G) there were 203 out of a possible 455 (45%) for "best" case and 186 out of a possible 454 (41%) for "worst" case. Some subjects gave more than one response for each standard/criterion. The nurses in this sample used less than half of AORN's standards and extant criteria to guide their practice in the 20 case scenarios they described. Because daily practice probably falls somewhere between the "best" case/"worst" case extremes, one could infer that standards are being

utilized approximately 43% of the time by these subjects.

If one examines use of standards separately from use of extant criteria, it becomes evident that nurses are using the components of nursing process. The ten nurses in the sample used AORN's seven standard statements 81% of the time in the "best" case scenarios and 71% of the time in the "worst," for an average use of 76%. AORN's extant criteria were not nearly so useful as guides to practice. The study subjects utilized the criteria within the standards only 40% of the time in the "best" case examples and 38% in their "worst," for an average use of 39%.

Table 13 summarizes the subjects' use of AORN's standards to guide their practice during the case scenarios. All standards and criteria equaled 44 items. Ten subjects multiplied by 44 equals 440; however, subjects often gave more than one response per standard/criteion. Percentages were computed by dividing number of responses per response category by the total number of responses. As the table illustrates, there was not a significant difference between "best" case and "worst" case in terms of subjects' use of standards.

Number of Subjects Using or Not Using the Standards for
Their "Best" and "Worst" Cases

(N) = 10

	<u>"Best" Case</u>		<u>"Worst" Case</u>	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
<u>Used</u>	203	45%	186	41%
<u>Did Not Use</u> <u>Because:</u>				
Not Familiar	0	0%	0	0%
Not Understood	66	15%	66	15%
Not Relevant	0	0%	4	1%
Not Feasible	104	23%	117	26%
Not Palatable	44	10%	41	9%
Something Else More Appropriate	28	6%	28	6%
Other	10	2%	12	3%
	—	—	—	—
	455	100%	454	100%

CHAPTER IV

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Conclusions and Implications

This study revealed what seem to be three types of competing standards. The first two types are what the nurses in the study actually seemed to be utilizing to guide their practice: individual; i.e., idiosyncratic, and organizational; i.e., bureaucratic. These standards can be illustrated by the nurse who said, "My job is defined by policy and procedure and my own personal standards. I am there for the patient, anesthesiologist, scrub, and surgeon...I just want to feel that when I go to the recovery room that I have done a good job."

The third type is professional standards, which in the present study are AORN Standards of Perioperative Nursing Practice. The study findings show that many of the standards and extant criteria were considered by the nurses in the sample to be infeasible and unpalatable.

One of the assumptions guiding data collection was that if the standards were not perceived as an adequate guide to practice, nurses would use something else. The study findings support this assumption, in that subjects utilized internal and external standards instead of or in addition to AORN's process standards.

Practicing nursing according to individual or idiosyncratic standards seemed to yield intrinsic rewards; i.e., the satisfaction of a job well done. The nurse who said, "All I want to do is to know when I take the patient to the recovery room that I have done a good job," exemplifies this. On the other hand, nurses seemed to suffer anguish if they did not "live up to" these internal standards; i.e., the two subjects whose "worst" case was typified by not being able to practice according to their own personal standards.

Organizational or bureaucratic standards were the most commonly used standards that the study subjects used instead of or in addition to AORN's Standards of Perioperative Nursing Practice. While there may not be frequent rewards associated with practicing according to bureaucratic standards, the organization certainly has the power to punish. The nurse who said that she would not do nursing care plans unless the hospital required it illustrates practice under this type of standard.

Professional standards, or in this case, AORN Standards of Perioperative Nursing Practice, are competing at the practice level with these two types of standards. However, professional standards carry neither reward nor punishment for those nurses who

utilize them to guide their nursing activities. Indeed, nursing activities prescribed by this model often compete with valued components of practice as identified by the subjects of this study.

Not included in AORN standards are three components of practice identified in the subjects' 20 case scenarios. The subjects of this study value personal relationships, not only with the patient, but with the other members of the surgical team. The technical aspects of their perioperative practice were important to them, and time management was also clearly identified as a component of perioperative practice. In examining these valued components, one can begin to understand why organizational or bureaucratic standards are so important to nurses in the operating room: All three of these components are heavily influenced by the system or environment within which perioperative practice occurs.

Nursing process is concerned with the nurse/patient dyad, and although "patient contact" was an important factor in many of the "best" case scenarios, nurses in the present study also delivered care and affected patient outcomes by other methods. They "nursed" the surgeon, the anesthesiologist, the scrub nurse (if they were practicing in the circulating role), and even the equipment to enable

care to be delivered and ensure a positive surgical outcome. These other methods or care delivery pathways are not valued by or even necessarily identified with traditional nursing.

Basing perioperative nursing standards on nursing process has helped gain recognition for operating room nursing among our peers, but the standards have been difficult to implement at the practice level because of these competing values and standards. One study subject said, "It seems like the standards are taking operating room nursing and retrofitting it to nursing process." Although nursing process is useful, it simply does not fit the complex, ambiguous, and multiplistic nursing that takes place in the operating room.

Other nursing specialties have also had difficulty "fitting in" with nursing process. Nursing administration "nurses" systems to affect patient care, and community health care nursing is often more concerned with aggregate populations than individuals.

These care delivery methods are very familiar to nurses in the operating room. Perioperative nursing now has the exciting opportunity to enrich the entire nursing profession by incorporating into standards of practice values and components that are as pertinent and dynamic as the nurse/patient dyad.

Limitations and Recommendations

Although 20 cases were examined, 10 subjects is a small sample size upon which to base generalizations. It would be helpful to replicate this study in another geographic area of the United States, perhaps on the East coast.

There were aspects of the data collection instrument that provided problems during data analysis. Some criteria contained more than one element. For example, Standard I, criterion 3 states "Health data are recorded and communicated." Although many subjects said they communicated health data, the researcher had no mechanism to reflect this. The instrument should have handled recorded and communicated separately.

Collecting data on alternative guides to practice was more of a methodological problem than was expected. Subjects seemed to find it difficult to consciously recognize what they were using to guide practice. Although no subjects identified internal standards as a more appropriate guide than AORN standards (No:6), their comments and the descriptions of scenario cases indicate that personal standards were utilized much more frequently than data suggests.

Only a few subjects were very negative regarding AORN standards. Most seemed more frustrated and

discouraged by attempts to implement them at the practice level. The documentation of nursing process, for the most part, was considered by these subjects to be desirable but not feasible. Several subjects suggested a flow sheet, checklist, or some other form of streamlined documentation that would allow nursing process within the operating room to be more visible and contribute to continuity of care. Standardized nursing care plans were suggested by several as a possible mechanism for implementing standards within their clinical settings. However, the subjects in this study seemed overwhelmed by the perceived complexity of the project.

There are several implications for further education of nurses within the operating room. Nursing diagnosis and goal-setting were activities that intimidated most subjects. Familiarization with the activities that nursing process prescribes is necessary to enable nurses to implement the standards.

Finally, the researcher found several nurses resentful of, as they called it, "having to prove" they were nursing. The nursing profession has an obligation to be accountable for practice. In this age of consumer sophistication, it is at best naive to assume that documentation of practice within the operating room need only reflect what nurses did, not

why they did it. For nurses having to justify their presence in a milieu that is viewed as primarily technical, accountability becomes extremely relevant.

AORN Standards of Perioperative Nursing Practice are a tool that has not been fully exploited by those for whom it was designed. The reason for this under-utilization is that nursing process is not an efficient guide to practice for nurses who provide other than direct patient care. However, the framework and much potential exist for the creation of a dynamic model for nursing practice.

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APPENDIX A

The Association of Operating Room Nurses
Standards of Perioperative Nursing Practice

Standards of Perioperative Nursing Practice

These standards were approved by the Executive Committee of the American Nurses' Association Division on Medical-Surgical Nursing Practice and the Board of Directors of the Association of Operating Room Nurses. These standards are copyrighted by and used with permission of the American Nurses' Association. They are a revision of the *Standards of Nursing Practice: OR*, first printed in 1975.

Introduction

As the professional society for nursing in the United States, the American Nurses' Association is responsible for defining nursing, for establishing the scope of nursing practice, and for setting standards of nursing practice as a means of assuring the quality of the services nurses offer to the public.¹ A standard is an authoritative statement enunciated and promulgated by the profession by which the quality of practice can be judged.

The American Nurses' Association published *Standards of Nursing Practice* in 1973, and in 1974 published *Standards of Medical-Surgical Nursing Practice*, which had been developed by the ANA Division on Medical-Surgical Nursing Practice. Medical-surgical nursing is the nursing care of adults with known or predicted physiological alterations, with trauma, or with disability. Medical-surgical nursing practice includes the care and treatment necessary to provide comfort; to assist individuals in the promotion and maintenance of health and the prevention, detection, and treatment of illness; to promote restoration to the highest possible productive capacities; and to assist with a peaceful death.²

The *Standards of Medical-Surgical Nursing Practice* are expressed in terms of the nursing process, which includes assessment, planning, implementation, and evaluation. Because of the breadth of the scope of medical-surgical nursing practice, adaptation of the standards to several areas within medical-surgical nursing will assist nurses in evaluation of their practice.

A joint committee of the Executive Committee of the ANA Division on Medical-Surgical Nursing Practice and the Association of Operating Room Nurses determined that standards of care for individuals who are experiencing surgical intervention in the operating room would provide a means for

assuring the quality of nursing care received by these individuals.

Since publication of *Standards of Nursing Practice: Operating Room* in 1975, AORN has provided for its membership a variety of programs and activities to assist nurses in the operating room to be aware of and to use these standards to evaluate their professional practice. Recognizing that changes in practice and societal values would necessitate periodic changes, AORN collected data from operating room nurses in practice during this time to determine the applicability and usefulness of the language and format of the standards. This revision incorporates the feedback from these operating room nurses. Several changes have also been made in the format of the standards.

The standards of nursing practice for care of individuals who are experiencing surgical intervention were jointly reviewed and expanded in 1981 by the Executive Committee of the ANA Division on Medical-Surgical Nursing Practice and the Association of Operating Room Nurses. Publication of these revised standards is part of the continuing work of the nursing profession to assure the quality of nursing practice.

Notes

1. American Nurses' Association. *Nursing: A Social Policy Statement*. (Kansas City, Mo.: the Association, 1980).
2. American Nurses' Association. *A Statement on the Scope of Medical-Surgical Nursing Practice*. Kansas City, Mo.: the Association, 1980.

Standards of Perioperative Nursing Practice

These standards relate to the practice of nursing in the perioperative period, in which the focus of practice is on the individual experiencing surgical intervention. The dimensions of this practice range from preoperative assessment and planning in the home or clinic, on the care unit, or in the holding area of the operating room suite; to intraoperative intervention; and to postoperative evaluation and documentation in the operating room and post-anesthesia area, on the care unit, and/or in the home or clinic. In planning nursing interventions in the perioperative period, nurses must take into account related physiological, social, and behavioral problems resulting from or affecting the individual's re-

sponse and/or adaptation to the surgical intervention. The practice of nursing in the perioperative period occurs in a milieu in which basic life-sustaining needs are of the highest priority, and is predicated upon medical-surgical nursing principles. It is a practice designed to meet individual needs through the nursing process, ensuring continuity of care through the individual's surgical experience.

The format for each of the seven standards statements reflects the nursing process and states explicitly what is to be performed by the nurse providing care to the surgical patient. The interpretive statements provide definitions of terms and actions and also provide guidelines to the process involved in achieving the standards. The criteria are written in measurable terms so the operating room nurse can measure to what degree each standard has been met.

The Standards of Perioperative Nursing Practice are based on the nursing process, the heart and core of the perioperative role. They are written as a guide for the operating room nurse to provide quality care to the patient receiving surgical intervention through use of the nursing process. They also provide a means to measure the quality of that care.

Standard I

THE COLLECTION OF DATA ABOUT THE HEALTH STATUS OF THE INDIVIDUAL IS SYSTEMATIC AND CONTINUOUS. THE DATA ARE RETRIEVABLE AND COMMUNICATED TO APPROPRIATE PERSONS.

Interpretive Statement

The fundamental step of the nursing process is initiated by the operating room nurse after the individual consents to have surgical intervention. The initial collection of data may occur in a variety of settings, such as the surgical suite, the care unit, or the home or clinic. Data collection may be accomplished through diverse means, such as interview, review of records, assessment, or consultation among members of the health care team. It is a progressive and orderly process that requires the operating room nurse to possess skills necessary to gather meaningful and pertinent data relative to the surgical intervention. Priority of data collection is determined by the immediate health care problems

or needs of the patient.

Criteria

1. Health data collected is relative to the planned surgical intervention and includes, but is not limited to, the following:
 - a. Current medical diagnosis and therapy
 - b. Physical status and physiological responses
 - c. Psychosocial status of the patient
 - d. Cultural and spiritual information
 - e. The individual's understanding, perceptions, and expectations of the surgical procedure
 - f. Previous responses to illness, to hospitalization, and to surgery
 - g. Results of diagnostic studies.
2. Health data is collected by a variety of methods.
3. Health data is reported and recorded.

Standard II

NURSING DIAGNOSES ARE DERIVED FROM HEALTH STATUS DATA.

Interpretive Statement

The nursing diagnoses are judgments the operating room nurse makes based on the analysis and interpretations of data about the individual's problems and needs and health status. The nursing diagnoses are concise statements about the individual's health status and problems amenable to nursing intervention.

Criteria

1. Current health status deviations and/or problems are identified.
2. Current scientific knowledge supports the nursing diagnoses.
3. The nursing diagnoses are congruent with the diagnoses of other health professionals.
4. The nursing diagnoses are recorded and communicated.

Standard III

THE PLAN OF NURSING CARE INCLUDES GOALS DERIVED FROM THE NURSING DIAGNOSES.

Interpretive Statement

Goals for care are derived from the nursing diagnoses and are mutually formulated with the indi-

vidual, significant others, and other health personnel. The goals developed must be attainable through available human and material resources. Goals direct the nursing actions to correct, alter, or maintain the nursing diagnoses. Areas for the operating room nurse to consider when formulating goals for individuals experiencing surgical intervention should include, but are not limited to, the following:

- Absence of infection
- Maintenance of skin integrity
- Absence of adverse effects due to proper use of safety measures related to positioning, extraneous objects, and chemical, physical, and electrical hazards
- Maintenance of fluid and electrolyte balance
- Knowledge of the patient and significant others of the physiological and psychological responses to surgical intervention
- Participation of the individual and significant others in the rehabilitation process.

Criteria

1. Goals are clearly written as statements of outcomes.
2. The individual's present and potential physical capabilities and behavioral patterns are congruent with goals.
3. Measurable criteria for determining the attainment of the goals as a result of nursing actions are included in the goal statement.
4. Goals are prioritized.
5. Goals are recorded and communicated to appropriate persons.
6. Goals include a time estimate for attainment.

Standard IV

THE PLAN FOR NURSING CARE PRESCRIBES NURSING ACTIONS TO ACHIEVE THE GOALS.

Interpretive Statement

The goals for the nursing care become the guide for the nursing actions necessary to achieve the identified outcomes. Priorities for the provision of nursing care are established by the operating room nurse in collaboration with the individual, significant others, and members of the health care team. The plan reflects preoperative assessment, priorities for nursing action, and a logical sequence of nurs-

ing activities to attain the goals. The plan is developed with and communicated to the individual, significant others, and health care personnel as appropriate. The plan reflects consideration of the individual's rights and desires. The plan specifies nursing activities performed in the perioperative period. Examples of nursing activities performed might include, but are not limited to, the following:

- Assurance of information and supportive preoperative teaching specifically related to the surgical intervention and the operating room nursing care
- Identification of the individual
- Verification of the surgical site
- Verification of operative consent and procedure and reports of essential diagnostic procedures
- Positioning according to physiological principles
- Adherence to principles of asepsis
- Assurance of appropriate and properly functioning equipment and supplies for the individual
- Provision for comfort measures and supportive care to the individual
- Environmental monitoring and safety
- Psychological and physiological monitoring of the individual
- Evaluation of outcomes in relation to the identified nursing activities
- Communication of intraoperative information to significant others and members of the health care team.

Criteria

1. Current scientific knowledge supports the plan.
2. Human and material resources are available to implement the plan.
3. The plan is written and communicated to the individual, significant others, and other appropriate members of the health care team.
4. The plan specifies the following:
 - a. Nursing actions necessary to achieve the goals
 - b. Priority of nursing action
 - c. A logical sequencing of nursing actions
 - d. How the nursing actions are to be performed
 - e. When the nursing actions are to be performed
 - f. Where the nursing actions are to be performed
 - g. Who is to perform the nursing actions.

Standard V
THE PLAN FOR NURSING CARE IS IMPLEMENTED.

Interpretive Statement

The nursing actions performed are consistent with the plan and provide continuity of nursing care in the preoperative, intraoperative, and postoperative periods. The nursing actions are performed with safety, skill, efficiency, and effectiveness.

Scientific principles provide the basis for nursing actions. All care provided reflects the rights and desires of the individual and significant others. The nursing interventions and outcomes are documented through permanent written records, with subsequent oral or written reports to other health care providers when appropriate.

Criteria

1. Nursing actions specified in the plan are performed and documented by means of the following:
 - a. Written records
 - b. Observations of nursing practice
 - c. Confirmation by the individual or significant others.
2. Nursing actions and patient outcomes are communicated to others as appropriate.

Standard VI
THE PLAN FOR NURSING CARE IS EVALUATED.

Interpretive Statement

Evaluation is a process the operating room nurse uses to determine the degree of goal attainment. The evaluation is continuous and is based on the nurse's observations and the individual's responses to the nursing interventions. The operating room nurse reviews each of the formulated goals to determine the results of the individual's care. The results of the nursing actions are then compared to the desired goals to determine the degree of goal attainment. The individual, significant others, and health personnel contribute to the evaluation of

goal attainment. The data collected from these sources reflect the outcomes of nursing activities.

Criteria

1. The degree of goal achievement is communicated by the operating room nurse to the individual, significant others, and health personnel.
2. The results of nursing actions are documented by written records, observations of nursing practice, and/or confirmation by the individual or significant others.

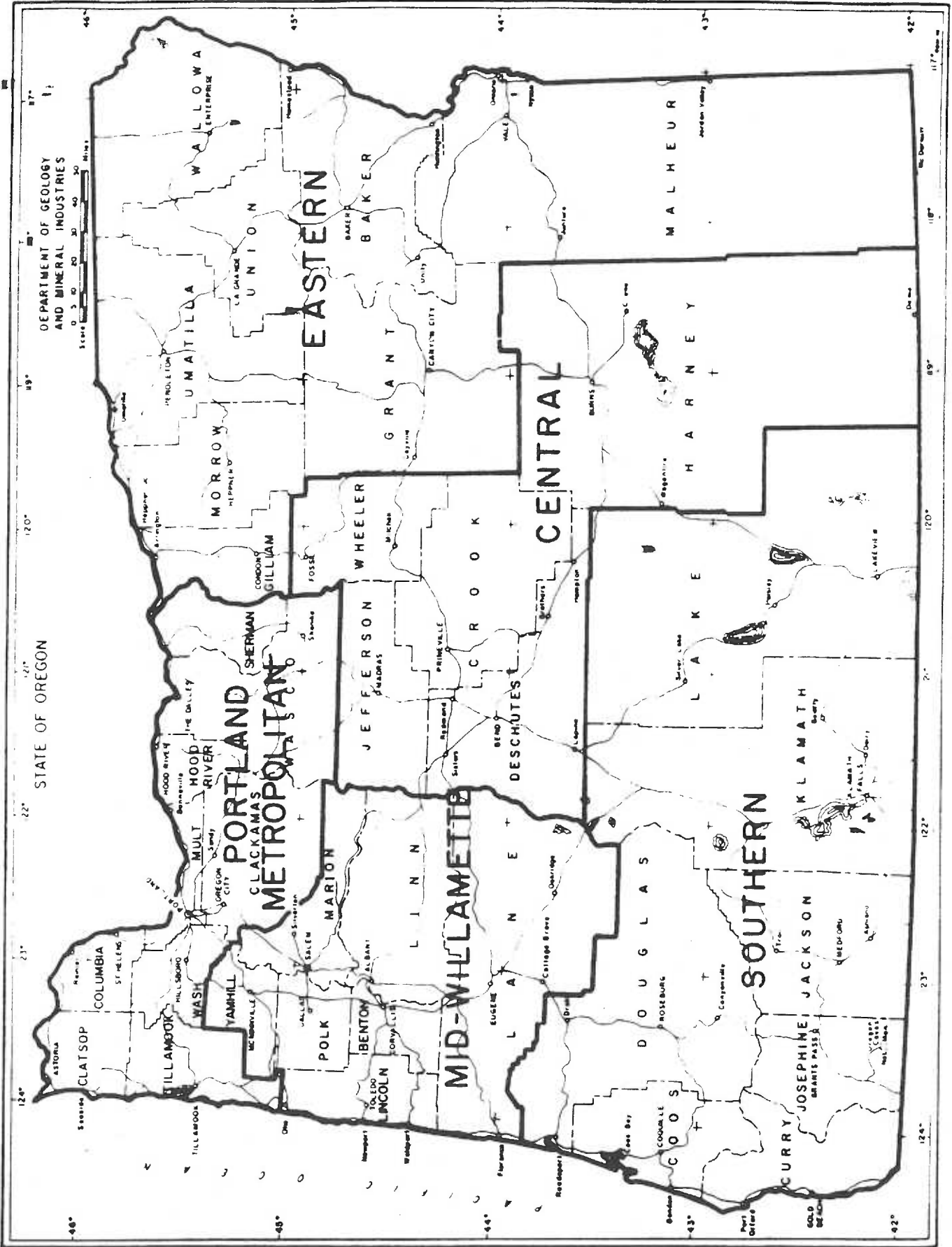
Standard VII
REASSESSMENT OF THE INDIVIDUAL, RECONSIDERATION OF NURSING DIAGNOSIS, RESETTING OF GOALS, AND MODIFICATION AND IMPLEMENTATION OF THE NURSING CARE PLAN ARE A CONTINUOUS PROCESS.

Interpretive Statement

Reassessment allows the operating room nurse to critically examine the total process from which the planned and delivered nursing interventions are derived. Implementation of the nursing process establishes a feedback to the nurse that facilitates the review of individual professional practice. The steps of the nursing process are taken concurrently and recurrently. New data and/or the degree of goal achievement are assessed and used to reconsider the nursing diagnoses, goals for individual, and plan of care. Reassessment allows the dynamics of nursing to operate in an open system whereby modification of the plan of care can be made as changes occur in the individual's internal and external environment.

Criteria

1. Review or revision of the plan of care is documented by written records, observations of patient responses, and the perception of the individual or significant others.
2. Status of the plan of care is communicated to appropriate others.



THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225 7700

Community Health Care Systems

Letter Requesting Participation
present date

Name of OR Director
Title
Hospital Name
Address

Name of OR Director:

I am a graduate student in nursing at Oregon Health Sciences University in Portland. To complete the requirements for a Masters in Nursing, I am studying to what extent perioperative nurses in Oregon are using AORN's Standards of Perioperative Nursing Practice to guide their patient care activities. Your operating room has been selected to be one of five in the state where data will be collected.

I would like permission to conduct two interviews with members of your staff: a supervisor and a staff nurse of your choice. I am defining "supervisor" as a nurse in a facilitory role who has patient contact but is not normally assigned to staff a room for the duration of a case. Each interview will take approximately one hour.

The Association of Operating Room Nurses has endorsed this study and is funding it. Findings will be used during the next revision of AORN's process standards.

Hospital and interview subjects' names will be held confidential. Results of the study will be presented in the aggregate only.

I hope you will consent to represent your area of Oregon in this study. To maintain quality within present economic constraints, perioperative nurses need standards that are efficient and useful guides for practice.

I have been invited to present preliminary findings during a poster session at AORN Congress, Thursday, April 9, so I have little time. I would appreciate hearing from you very soon.

I will call you to make specific arrangements for the interviews. Thank you in advance for your support.

Sincerely,

Dora Sue Redford, RN, BS

If you have questions, you may call me @ 687-6000. My advisor, Marie Berger, RN, PhD, is also available @ 225-7709.



RSVP Card



THE OREGON HEALTH SCIENCES UNIVERSITY

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201

- Yes, I will participate in the study on use of standards by perioperative nurses in Oregon. I understand data sources will be kept confidential and that I will receive a complimentary copy of the completed study.
- No, I would rather not participate.

 X

APPENDIX E
Structured Interview
Data Collection Instrument

STRUCTURED INTERVIEW

DATA COLLECTION WORKSHEETS

INTRODUCTION:

This interview is designed to help me learn about your practice in the operating room. I am particularly interested in what guides your nursing activities, or how you decide what to do for your patients.

SECTION I:

I would like to begin by having you remember and describe a couple of specific cases from your experience. First, I'd like you to think about and describe everything you can remember about a case where you were pleased with your performance as a nurse. This would be a case where you think you took very good care of the patient. Tell me all the details you can remember, including your feelings, from the moment you began preparing for the case until your last contact with that patient.

Now, I'd like you to remember a case where you felt you gave less than satisfactory care, a case where you were not satisfied with your own performance. Try to relate all the details you can remember, including how you felt during and after the case.

DATA COLLECTION WORKSHEET 2

SECTION II:

A. Are you familiar with AORN's Standards of Perioperative Nursing Practice?

_____ Yes (continue to B.)

_____ No (skip to D.)

B. Do you use them in your practice?

_____ Yes (continue to C.)

_____ No (skip to D.)

C. How do you use them? For what purpose or purposes do you use them?
(continue to D.)

D. What purposes do you feel standards should fulfill? What good are standards?

DATA COLLECTION WORKSHEET 3

SECTION III:

This last question is quite comprehensive. We'll go through AORN's standards point by point and review each standard and criterion. What I will want to know is if you used each standard and criterion, either consciously or subconsciously, to guide your nursing activities in the two case examples you just described. If the standard or criterion was not used, we will discuss the cases further so I can get a pretty complete picture of why not. Some of the things I will be looking for are: when are the standards useful and when aren't they, are there things about the standards that nurses don't like, and if standards are not being used to guide practice, what do nurses use? I also will be interested in if the standards are familiar and understandable.

AORN is also interested in the answers to these questions. In fact, they have endorsed and funded this study. Your responses will be used during the next revision of the standards.

So, follow along on your copy. I will read each standard and criterion out loud. Go ahead and skim the interpretive statements for each standard. Then I will ask two questions for each standard and criterion: "Did you use this standard/criterion to guide your practice during your 'best case' example?" and "Did you use this standard/criterion to guide your practice during your 'worst case' example?"

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 4

CODES

Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something else more appropriate

7 = other

STANDARD/CRITERIONYES (check)NO (circle)

Standard 1

THE COLLECTION OF DATA ABOUT THE HEALTH STATUS OF THE INDIVIDUAL IS SYSTEMATIC AND CONTINUOUS. THE DATA ARE RETRIEVABLE AND COMMUNICATED TO APPROPRIATE PERSONS.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 5

CODES

Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something else more appropriate

7 = other

STANDARD/CRITERION	YES (check)	YES (circle)							
Criteria									
1. Health data collected is relative to the planned surgical intervention and includes, but is not limited to, the following:	#1) a. _____	#1) a.	1	2	3	4	5	6	7
a. Current medical diagnosis and therapy	b. _____	b.	1	2	3	4	5	6	7
b. Physical status and physiological responses	c. _____	c.	1	2	3	4	5	6	7
c. Psychosocial status of the patient	d. _____	d.	1	2	3	4	5	6	7
d. Cultural and spiritual information	e. _____	e.	1	2	3	4	5	6	7
e. The individual's understanding, perceptions, and expectations of the surgical procedure	f. _____	f.	1	2	3	4	5	6	7
f. Previous responses to illness, to hospitalization, and to surgery	g. _____	g.	1	2	3	4	5	6	7
g. Results of diagnostic studies.									
	#2) a. _____	#2) a.	1	2	3	4	5	6	7
	b. _____	b.	1	2	3	4	5	6	7
	c. _____	c.	1	2	3	4	5	6	7
	d. _____	d.	1	2	3	4	5	6	7
	e. _____	e.	1	2	3	4	5	6	7
	f. _____	f.	1	2	3	4	5	6	7
	g. _____	g.	1	2	3	4	5	6	7

COMMENTS:

88
facility code _____

subject code _____

DATA COLLECTION WORKSHEET 6

CODES

Case Codes

#1 = 'best' case
#2 = 'worst' case

'No' Codes

1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something else more appropriate
7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

2. Health data is collected by a variety of methods.

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 7

 CODES
Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something else more appropriate

7 = other

 STANDARD/CRITERION
YES (check)NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

3. Health data is reported and recorded.

#2) _____

#2) 1 2 3 4 5 6 7

 COMMENTS:

90
facility code _____

subject code _____

DATA COLLECTION WORKSHEET 8

CODES

Case Codes

#1 = 'best' case
#2 = 'worst' case

'No' Codes

1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something else more appropriate
7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

Standard II

NURSING DIAGNOSES ARE DERIVED FROM
HEALTH STATUS DATA.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 9

CODES

Case Codes

#1) _____
 #2) _____

'No' Codes

- 1 = not familiar
- 2 = not understood
- 3 = not relevant
- 4 = not feasible
- 5 = not desirable
- 6 = something else more appropriate
- 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

Criteria

1. Current health status deviations and/or problems are identified.

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 10

CODES

Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something more appropriate

7 = other

STANDARD/CRITERION

YES (check)NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

2. Current scientific knowledge supports the nursing diagnoses.

COMMENTS:

DATA COLLECTION WORKSHEET 11

CODES

Case Codes
#1 = 'best' case
#2 = 'worst' case

'No' Codes
1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

3. The nursing diagnoses are congruent with the diagnoses of other health professionals.

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 12

 CODES
Case Codes#1 = 'best' case
#2 = 'worst' case'No' Codes1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

STANDARD/CRITERION

YES (check)NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

4. The nursing diagnoses are recorded and communicated.

 COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 13

 CODES
Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something more appropriate

7 = other

 STANDARD/CRITERION
YES (check)NO (circle)**Standard III**
 THE PLAN OF NURSING CARE INCLUDES
 GOALS DERIVED FROM THE NURSING DIAG-
 NOSES.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

 COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 14

 CODES
Case Codes#1 = 'best' case
#2 = 'worst' case'No' Codes1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

 STANDARD/CRITERION
YES (check)NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

Criteria

1. Goals are clearly written as statements of outcomes.

 COMMENTS:

DATA COLLECTION WORKSHEET 15

CODES

Case Codes

- #1 = 'best' case
- #2 = 'worst' case

'No' Codes

- 1 = not familiar
- 2 = not understood
- 3 = not relevant
- 4 = not feasible
- 5 = not desirable
- 6 = something more appropriate
- 7 = other

STANDARD/CRITERION	<u>YES</u> (check)	<u>NO</u> (circle)							
	#1) _____	#1)	1	2	3	4	5	6	7
2. The individual's present and potential physical capabilities and behavioral patterns are congruent with goals.	#2) _____	#2)	1	2	3	4	5	6	7

COMMENTS:

DATA COLLECTION WORKSHEET 16

CODES

Case Codes

#1 = 'best' case
 #2 = 'worst' case

'No' Codes

1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

3. Measurable criteria for determining the attainment of the goals as a result of nursing actions are included in the goal statement.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 17

 CODES
Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something more appropriate

7 = other

STANDARD/CRITERION	<u>YES</u> (check)	<u>NO</u> (circle)
	#1) _____	#1) 1 2 3 4 5 6 7
4. Goals are prioritized.	#2) _____	#2) 1 2 3 4 5 6 7

 COMMENTS:

100
facility code _____

subject code _____

DATA COLLECTION WORKSHEET 18

CODES

Case Codes
#1 = 'best' case
#2 = 'worst' case

'No' Codes
1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

5. Goals are recorded and communicated to appropriate persons.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

101
facility code _____

subject code _____

DATA COLLECTION WORKSHEET 19

CODES

Case Codes

#1 = 'best' case
#2 = 'worst' case

'No' Codes

1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

6. Goals include a time estimate for attainment.

COMMENTS:

DATA COLLECTION WORKSHEET 20

CODES

Case Codes

#1 = 'best' case
 #2 = 'worst' case

'No' Codes

1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

Standard IV

THE PLAN FOR NURSING CARE PRESCRIBES
 NURSING ACTIONS TO ACHIEVE THE GOALS.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

DATA COLLECTION WORKSHEET 21

<u>Case Codes</u>	CODES	<u>'No' Codes</u>
#1 = 'best' case		1 = not familiar
#2 = 'worst' case		2 = not understood
		3 = not relevant
		4 = not feasible
		5 = not desirable
		6 = something more appropriate
		7 = other

<u>STANDARD/CRITERION</u>	<u>YES</u> (check)		<u>NO</u> (circle)						
Criteria	#1) _____	#1)	1	2	3	4	5	6	7
1. Current scientific knowledge supports the plan.	#2) _____	#2)	1	2	3	4	5	6	7

COMMENTS:

DATA COLLECTION WORKSHEET 22

<u>Case Codes</u>	CODES	<u>'No' Codes</u>
#1 = 'best' case		1 = not familiar
#2 = 'worst' case		2 = not understood
		3 = not relevant
		4 = not feasible
		5 = not desirable
		6 = something more appropriate
		7 = other

<u>STANDARD/CRITERION</u>	<u>YES</u> (check)		<u>NO</u> (circle)					
	#1) _____		#1) 1 2 3 4 5 6 7					
2. Human and material resources are available to implement the plan.	#2) _____		#2) 1 2 3 4 5 6 7					

COMMENTS:

DATA COLLECTION WORKSHEET 23

CODES

Case Codes
 #1 = 'best' case
 #2 = 'worst' case

'No' Codes
 1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

3. The plan is written and communicated to the individual, significant others, and other appropriate members of the health care team.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS :

DATA COLLECTION WORKSHEET 24

CODES

Case Codes
#1 = 'best' case
#2 = 'worst' case

'No' Codes
1 = not familiar
2 = not understood
3 = not relevant
4 = not feasible
5 = not desirable
6 = something more appropriate
7 = other

STANDARD/CRITERION	YES (check)	NO (circle)							
	#1)a. _____	#1)a.	1	2	3	4	5	6	7
	b. _____	b.	1	2	3	4	5	6	7
	c. _____	c.	1	2	3	4	5	6	7
4. The plan specifies the following:	d. _____	d.	1	2	3	4	5	6	7
a. Nursing actions necessary to achieve the goals	e. _____	e.	1	2	3	4	5	6	7
b. Priority of nursing action	f. _____	f.	1	2	3	4	5	6	7
c. A logical sequencing of nursing actions	g. _____	g.	1	2	3	4	5	6	7
d. How the nursing actions are to be performed									
e. When the nursing actions are to be performed	#2)a. _____	#2)a.	1	2	3	4	5	6	7
f. Where the nursing actions are to be performed	b. _____	b.	1	2	3	4	5	6	7
g. Who is to perform the nursing actions.	c. _____	c.	1	2	3	4	5	6	7
	d. _____	d.	1	2	3	4	5	6	7
	e. _____	e.	1	2	3	4	5	6	7
	f. _____	f.	1	2	3	4	5	6	7
	g. _____	g.	1	2	3	4	5	6	7

COMMENTS:

DATA COLLECTION WORKSHEET 25

CODES

Case Codes

- #1 = 'best' case
- #2 = 'worst' case

'No' Codes

- 1 = not familiar
- 2 = not understood
- 3 = not relevant
- 4 = not feasible
- 5 = not desirable
- 6 = something more appropriate
- 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

Standard V
 THE PLAN FOR NURSING CARE IS IM-
 PLEMENTED. _____

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
V	10	1a	0
		b	1
		c	0
		2	9
		<hr/> 10 of a possible 40 = 25%	
VI	6	1	1
		2	5
		<hr/> 6 of a possible 20 = 30%	
VII	9	1	4
		2	10
		<hr/> 14 of a possible 20 = 70%	

Feasibility and Palatability of AORN Standards
of Perioperative Nursing Practice, "Worst" Case

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
I	9	1a	9
		b	8
		c	6
		d	2
		e	6
		f	6
		g	8
		2	9
		3	6
II	6	1	7
		2	6
		3	1
		4	0
III	6	1	0
		2	3
		3	0
		4	7
		5	0
		6	2
IV	9	1	6
		2	9
		3	1
		4a	2
		b	1
		c	1
		d	1
		e	0
		f	0
		g	1
			<hr/> 22 of a possible 100 = 22%

(Table continues)

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
V	7	1a	0
		b	1
		c	0
		2	9
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 10 of a possible 40 = 25%	
VI	5	1	1
		2	5
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 6 of a possible 20 = 30%	
VII	8	1	3
		2	9
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 12 of a possible 20 = 60%	

Frequency with which Standards and Criteria were Viewed Unpalatable

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
I		+								
la		*								
b										
c										
d										
e										
f										
g										
2										
3										
II										
1										
2										
3		*								
4										

S/C = Standard/Criterion

* = "Best" case

= = "Worst" case

(Table continues)

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
III	***** +++++									
1	+++++									
2										
3	* +++++									
4	***** +									
5	***** +++++									
6	***** +++++									
IV										
1										
2	+									
3	***** +++++									
4a	***** +++++									
b	***** +++++									
c	***** +++++									
d	* +									

S/C = Standard/Criterion

* = "Best" case

+ = "Worst" case

(Table continues)

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
e	*									
	+++++									
f										
	+++++	+++++								
g										
	+									
V										
	+++++									
1a	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
b	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
c	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
2	*									
	+									
VI	*									
	+++++									
1	*+*+*+*									
	+++++									
2	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
VII										
	+									
1	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
2										
	+									

S/C = Standard/Criterion

* = "Best" case

+ = "Worst" case

DATA COLLECTION WORKSHEET 26

CODES

Case Codes
 #1 = 'best' case
 #2 = 'worst' case

'No' Codes
 1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION	YES (check)	NO (circle)							
Criteria									
1. Nursing actions specified in the plan are performed and documented by means of the following:	#1)a. _____	#1)a.	1	2	3	4	5	6	7
a. Written records	b. _____	b.	1	2	3	4	5	6	7
b. Observations of nursing practice	c. _____	c.	1	2	3	4	5	6	7
c. Confirmation by the individual or significant others.	#2)a. _____	#2)a.	1	2	3	4	5	6	7
	b. _____	b.	1	2	3	4	5	6	7
	c. _____	c.	1	2	3	4	5	6	7

COMMENTS:

DATA COLLECTION WORKSHEET 27

CODES

Case Codes

- #1 = 'best' case
- #2 = 'worst' case

'No' Codes

- 1 = not familiar
- 2 = not understood
- 3 = not relevant
- 4 = not feasible
- 5 = not desirable
- 6 = something more appropriate
- 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

2. Nursing actions and patient outcomes are communicated to others as appropriate.

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

facility code _____

subject code _____

DATA COLLECTION WORKSHEET 28

 CODES

Case Codes

#1 = 'best' case

#2 = 'worst' case

'No' Codes

1 = not familiar

2 = not understood

3 = not relevant

4 = not feasible

5 = not desirable

6 = something more appropriate

7 = other

STANDARD/CRITERION

YES (check)NO (circle)

Standard VI

THE PLAN FOR NURSING CARE IS EVALUATED.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

 COMMENTS:

DATA COLLECTION WORKSHEET 29

CODES

Case Codes
 #1 = 'best' case
 #2 = 'worst' case

'No' Codes
 1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION	<u>YES</u> (check)	<u>NO</u> (circle)							
Criteria	#1) _____	#1)	1	2	3	4	5	6	7
1. The degree of goal achievement is communicated by the operating room nurse to the individual, significant others, and health personnel.	#2) _____	#2)	1	2	3	4	5	6	7

COMMENTS:

DATA COLLECTION WORKSHEET 30

<u>Case Codes</u>	<u>CODES</u>	<u>'No' Codes</u>
#1 = 'best' case		1 = not familiar
#2 = 'worst' case		2 = not understood
		3 = not relevant
		4 = not feasible
		5 = not desirable
		6 = something more appropriate
		7 = other

<u>STANDARD/CRITERION</u>	<u>YES (check)</u>	<u>NO (circle)</u>
	#1) _____	#1) 1 2 3 4 5 6 7
2. The results of nursing actions are documented by written records, observations of nursing practice, and/or confirmation by the individual or significant others.	#2) _____	#2) 1 2 3 4 5 6 7

COMMENTS :

DATA COLLECTION WORKSHEET 31

CODES

Case Codes
 #1 = 'best' case
 #2 = 'worst' case

'No' Codes
 1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

Standard VII
 REASSESSMENT OF THE INDIVIDUAL, RECON-
 sideration of nursing diagnosis, RESET-
 ting of goals, and modification and
 implementation of the nursing care
 plan are a continuous process.

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

COMMENTS:

DATA COLLECTION WORKSHEET 32

CODES

Case Codes
 #1 = 'best' case
 #2 = 'worst' case

'No' Codes
 1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

Criteria

Review or revision of the plan of care is documented by written records, observations of patient responses, and the perception of the individual or significant others.

COMMENTS:

DATA COLLECTION WORKSHEET 33

CODES

Case Codes

#1 = 'best' case
 #2 = 'worst' case

'No' Codes

1 = not familiar
 2 = not understood
 3 = not relevant
 4 = not feasible
 5 = not desirable
 6 = something more appropriate
 7 = other

STANDARD/CRITERION

YES (check)

NO (circle)

#1) _____

#1) 1 2 3 4 5 6 7

#2) _____

#2) 1 2 3 4 5 6 7

2. Status of the plan of care is communicated to appropriate others.

COMMENTS:

DATA COLLECTION WORKSHEET 34

SECTION IV:

In summary then:

- A. When would you say the standards are most useful to you in your practice?
- B. Can you think of any instances when you clearly would not use the standards?

APPENDIX F

Data Analysis Worksheet
 Responses of Individual Subjects
 Regarding Use of Standards/Criteria:
 Section III.

STANDARD/CRITERION	YES	NO: 1	2	3	4	5	6	7	
I.	
1a.	
b.	
c.	
d.	
e.	
f.	
g.	
2.	
3.	
II.	
1.	
2.	
3.	
4.	
III.	
1.	
2.	
3.	
4.	
5.	
6.	
IV.	
1.	
2.	
3.	
4a.	
b.	
c.	
d.	
e.	
f.	
g.	
V.	
1a.	
b.	
c.	
2.	
VI.	
1.	
2.	
VII.	
1.	
2.	
TOTALS:	_____	_____	_____	_____	_____	_____	_____	_____	
RATIOS:	() : 44	() : 44	() : 44	() : 44	() : 44	() : 44	() : 44	() : 44	
PERCENTAGES:	YES	NO:	1	2	3	4	5	6	7

APPENDIX G

Raw Data and Descriptive Tables

Number of Subjects Using or Not Using Specific Standards for "Best" Case(N) = 10

S/C	Used	Did Not Use						
		Not Familiar	Not Understood	Not Relevant	Not Feasible	Not Palatable	Something Else More Appropriate	Other
I	10							
1a	9				1			
b	9		1					
c	8				2			
d	5				4			
e	5				5			
f	4				5	1		
g	7				3			
2	10							
3	4		1		4	2		1
II	7		1		2	1		
1	10							
2	6		4					
3	1		7		1	1		
4			2		6	2		
III	6		1		2	1		
1					7	3		
2	3		7		1			
3			2		5	2	1	
4	7		1		1	1		
5			2		3	4		1
6	4		1		2	3		

(Table continues)

S/C	Used	Did Not Use							
		Not Familiar	Not Understood	Not Relevant	Not Feasible	Not Palatable	Something Else More Appropriate	Other	
IV	9					1			
1	6		4						
2	10								
3	1		4		5	3			
4a	2				5	2		1	
b	1		3		5	2		1	
c	1		3		5	2		1	
d	1				1		7	1	
e					1	2	6	1	
f						3	6	1	
g	1					1	7	1	
V	10								
1a			5		5	1			
b	1		5		4	1			
c			5		5	1			
2	9				1				
VI	6		2		1		1		
1	1		3		2	4			
2	5				4			1	
VII	9		1						
1	4		1		5				
2	10								
		203	0	66	0	104	44	28	10
		45%	0%	15%	0%	23%	10%	6%	2%

TOTAL = 455 (Subjects may respond more than once per S/C) (Table continues)

Number of Subjects Using or Not Using Specific Standards for "Worst" Case(N) = 10

S/C	Used	Did Not Use						
		Not Familiar	Not Understood	Not Relevant	Not Feasible	Not Palatable	Something Else More Appropriate	Other
I	9				1			
1a	9				1			
b	8		1		1			
c	6				4			
d	2			1	7			
e	6			1	3			
f	6				3			1
g	8				2			
2	9				1			
3	6		1		2	2		1
II	6		1	1	2	1		
1	7			1	2			
2	6		4					
3	1		7		1	1		
4			2		6	2		
III	6		1		3	1		
1					7	3		
2	3		7					
3			2		5	2	1	
4	7		1		1	1		
5			2		4	3		1
6	2		1		4	3		

(Table continues)

S/C	Used	Did Not Use							
		Not Familiar	Not Understood	Not Relevant	Not Feasible	Not Palatable	Something Else More Appropriate	Other	
IV	9					1			
1	6		4						
2	9				1				
3	1		4		6	2			
4a	2				5	2		1	
b	1		3		5	2		1	
c	1		3		5	2		1	
d	1				1		7	1	
e					1	2	6	1	
f						3	6	1	
g						1	7	1	
V	7				2			1	
1a			5		5	1			
b	1		5		4	1			
c			5		5	1			
2	9				1				
VI	5		2		2		1		
1	1		3		2	4			
2	3		1		6				
VII	8		1		1				
1	3		1		6				
2	9				1				
		186	0	66	4	117	41	28	12
		41%	0%	15%	1%	26%	9%	6%	3%

TOTAL = 454 (Subjects may respond more than once per S/C)

Perceived Feasibility of Standard I

"Best" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
I:1a	1	1	time-emergency	1
c	2	2	pt. unconscious/sedated	1
			time-system	1
d	5	5	pt. unconscious.sedated	1
			privacy problem	1
			time-emergency	1
			scrub role	1
e	5	5	pt. unconscious/sedated	2
			time-emergency	1
			scrub role	1
			too subjective to eval.	1
f	5	5	pt. unconscious/sedated	2
			time-emergency	1
			scrub role	1
			time-system	1
g	3	4	dx. studies not avail.-emergency	2
			time-system	1
			not role-holding area does this	1
I:3	4	5	documentation format problem	2
			time-system	1
			time-emergency	1
			scrub role	1
<hr/>	<hr/>	<hr/>		<hr/>
7	25	27		27

S/C = Standard/Criterion

(Table continues)

"Worst" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
I	1	1	time-system	1
I:1a	1	1	time-emergency	1
b	1	1	time-system	1
c	4	7	time-emergency	2
			privacy problem	1
			pt. could not verbalize	1
			time-system	2
d	7	9	time-emergency	1
			time-system	4
			nurse uncomfortable with eval.	2
			privacy problem	1
			pt. could not verbalize	1
e	3	3	time-emergency	1
			time-system	1
			pt. could not verbalize	1
f	3	3	time-system	3
g	2	3	time-system	2
			not role-holding area does this	1
I:2	1	1	scrub role	1
I:3	2	2	time-system	1
			documentation format problem	1
<hr/>	<hr/>	<hr/>		<hr/>
10	28	31		31

S/C = Standard/Criterion

Perceived Feasibility of Standard II"Best" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
II	2	2	don't know how to do nursing dx.	1
			time-system	1
II:3	1	1	don't know how to do nursing dx.	1
II:4	6	6	documentation format problem	3
			scrub role	1
			don't know how to do nursing dx.	2
<hr/>	<hr/>	<hr/>		<hr/>
3	9	9		9

"Worst" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
II	2	2	time-system	1
			don't know how to do nursing dx.	1
II:1	2	2	time-system	1
			scrub role	1
II:3	1	1	don't know how to do nursing dx.	1
II:4	6	6	documentation format problem	3
			time-system	1
			don't know how to do nursing dx.	2
<hr/>	<hr/>	<hr/>		<hr/>
4	11	11		11

Perceived Feasibility of Standard III

"Best" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
III	3	3	time-system	1
			scrub role	1
			documentation format problem	1
III:1	7	7	time-system	5
			scrub role	1
			don't know how to do nursing dx.	1
III:3	5	5	time-system	3
			don't know how to write	
			measurable criteria	1
			scrub role	1
III:4	1	1	time-system	1
III:5	4	5	time-system	2
			documentation format problem	2
			scrub role	1
III:6	4	4	time-system	3
			scrub role	1
<hr/>	<hr/>	<hr/>		<hr/>
6	24	25		25

(Table continues)

"Worst" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
III	3	3	time-system	1
			scrub role	1
			documentation format problem	1
III:1	7	7	time-system	5
			scrub role	1
			don't know how to write goals	1
III:3	5	5	time-system	3
			don't know how to write	
			measurable criteria	1
			scrub role	1
III:4	1	1	time-system	1
III:5	4	5	time-system	2
			documentation format problem	2
			scrub role	1
III:6	4	4	time-system	3
			scrub role	1
<hr/>	<hr/>	<hr/>		<hr/>
6	24	25		25

Perceived Feasibility of Standard IV

"Best" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
IV:3	5	5	time-system	5
IV:4a	5	5	time-system	4
			scrub role	1
4b	5	5	time-system	4
			scrub role	1
4c	5	5	time-system	4
			scrub role	1
4d	1	1	time-system	1
4e	1	1	time-system	1
<hr/>	<hr/>	<hr/>		<hr/>
6	22	22		22

(Table continues)

"Worst" Case

<u>S/C</u>	<u># Subjects</u>	<u># Responses</u>	<u>Rationale</u>	<u># Responses/Rationale</u>
IV:2	1	1	equipment failure	1
IV:3	6	6	time-system	5
			scrub role	1
IV:4a	5	5	time-system	4
			scrub role	1
4b	5	5	time-system	4
			scrub role	1
4c	5	5	time-system	4
			scrub role	1
4d	1	1	time-system	1
4e	1	1	time-system	1
<hr/>	<hr/>	<hr/>		<hr/>
7	24	24		24

Feasibility and Palatability of AORN Standards
of Perioperative Nursing Practice, "Best" Case

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
I	10		
		1a	9
		b	9
		c	8
		d	5
		e	5
		f	4
		g	7
		2	10
		3	4
			<hr/> 61 of possible 90 = 68%
II	7		
		1	10
		2	6
		3	1
		4	0
			<hr/> 17 of possible 40 = 43%
III	7		
		1	0
		2	3
		3	0
		4	0
		5	0
		6	4
			<hr/> 14 of possible 60 = 23%
IV	9		
		1	6
		2	10
		3	1
		4a	2
		b	1
		c	1
		d	1
		e	0
		f	0
		g	1
			<hr/> 23 of possible 100 = 23%

(Table continues)

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
V	10	1a	0
		b	1
		c	0
		2	9
			<hr/> 10 of a possible 40 = 25%
VI	6	1	1
		2	5
			<hr/> 6 of a possible 20 = 30%
VII	9	1	4
		2	10
			<hr/> 14 of a possible 20 = 70%

Feasibility and Palatability of AORN Standards
of Perioperative Nursing Practice, "Worst" Case

Standard # x's Used Criterion # x's Used

I 9

1a	9
b	8
c	6
d	2
e	6
f	6
g	8
2	9
3	6

$\overline{60}$ of a possible 90 = 67%

II 6

1	7
2	6
3	1
4	0

$\overline{14}$ of a possible 40 = 35%

III 6

1	0
2	3
3	0
4	7
5	0
6	2

$\overline{12}$ of a possible 60 = 20%

IV 9

1	6
2	9
3	1
4a	2
b	1
c	1
d	1
e	0
f	0
g	1

$\overline{22}$ of a possible 100 = 22%

(Table continues)

<u>Standard</u>	<u># x's Used</u>	<u>Criterion</u>	<u># x's Used</u>
V	7	1a	0
		b	1
		c	0
		2	9
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 10 of a possible 40 = 25%	
VI	5	1	1
		2	5
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 6 of a possible 20 = 30%	
VII	8	1	3
		2	9
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> 12 of a possible 20 = 60%	

Frequency with which Standards and Criteria were Viewed Unpalatable

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
I										
	+									
1a	*									
	+									
b										
	+									
c	*****									
	+++++									
d	*****									
	+++++									
e	*****									
	+++++									
f	*****									
	+++++									
g	*****									
	+++++									
2										
	+									
3	*****									
	+++++									
II	*****									
	+++++									
1										
	+++++									
2										
3	*									
	+									
4	*****									
	+++++									

S/C = Standard/Criterion

* = "Best" case

= = "Worst" case

(Table continues)

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
III	***** +++++									
1	+++++									
2										
3	* +++++									
4	***** +									
5	***** +++++									
6	***** +++++									
IV										
1										
2	+									
3	***** +++++									
4a	***** +++++									
b	***** +++++									
c	***** +++++									
d	* +									

S/C = Standard/Criterion

* = "Best" case

+ = "Worst" case

(Table continues)

S/C	Number of Subjects									
	1	2	3	4	5	6	7	8	9	10
e	*									
	+++++									
f										
	+++++	+++++								
g										
	+									
V										
	+++++									
1a	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
b	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
c	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
2	*									
	+									
VI	*									
	+++++									
1	*+*+*+*+*+*+*+*+*+*									
	+++++									
2	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
VII										
	+									
1	*+*+*+*+*+*+*+*+*+*									
	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++	+++++
2										
	+									

S/C = Standard/Criterion

* = "Best" case

+ = "Worst" case

AN ABSTRACT OF THE THESIS OF

DORA SUE REDFORD

For the MASTER OF SCIENCE

Date of Receiving this Degree: June 12, 1987

Title: OPERATING ROOM NURSES' STANDARDS OF
PERIOPERATIVE NURSING PRACTICE: AN ANALYSIS OF USE
IN PRACTICE

APPROVED: .

 Marie Berger, R.N., Ph.D., Thesis Advisor

This was a descriptive study which examined the extent to which the Association of Operating Room Nurses Standards of Perioperative Nursing Practice are used by nurses as a guide to nursing activities in the operating room. The study investigated the "real-life" efficacy of the standards, which are derived from the nursing process model. In addition, it attempted to determine nurses' degree of familiarity and level of understanding of the standards.

Data were collected from ten operating room supervisors and staff nurses in five JCAH approved hospitals of over 150 beds. Four of the five geographical areas of the state of Oregon were represented. A structured interview format was used.

The subjects had difficulty utilizing the standards and extant criteria because of frequent misunderstandings both of terminology within the standards and nursing process. They did not use

standards and criteria that prescribed documentation of nursing process. The most frequent deterrents were lack of time due to systems problems within the OR, the scrub role, documentation format problems, and lack of evidence that documenting nursing process will improve patient outcomes.

An analysis of the data revealed that the subjects were using three sets of competing standards: personal, organizational, and professional. Personal standards seemed to yield intrinsic rewards, organizational held power to punish, but professional standards carried neither reward or punishment. The nurses in the study primarily utilized departmental procedures and surgeons' preference cards (organizational standards) to guide practice instead of or in addition to AORN standards.

Although the subjects valued the nurse-patient dyad, which is the heart of nursing process, they also valued interpersonal relationships among the surgical team members and the technical aspects of their practice. These components are not included in the AORN standards.

Perioperative nurses effect patient outcomes not only through direct patient contact but by "nursing" other members of the surgical team, the environment, and even equipment. Other nursing specialties, such

as nursing administration and community health care nurses, also nurse systems and aggregate populations. Nursing process is an imperfect model for practice that is so complex, ambiguous, and multiplistic, but the framework and potential exist for a model that is as dynamic and relevant as nursing itself.