British Journal of Anaesthetic & Recovery Nursing
Vol. 9(1), 14–16
doi: 10.1017/S1742645608000016

Conference Report

The Irish Anaesthetic and Recovery Nurses Association Annual Conference Report, October 2007, Waterford, Ireland

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BJARN Editor

Waterford, Southern Ireland, was the destination of the 2007 annual conference of the Irish Anaesthetic and Recovery Nurses Association. Representing England were myself and Manda Dunne, BARNA Chair. Once again we were made to feel very welcome and enjoyed a range of interesting lectures and exhibitions. This year we were lucky to meet the Irish Minister for Health, Mary Harney, who had just announced some unwelcome changes to a number of large hospitals. This communication will feature a short review regarding some of the presentations and lectures attended.

MRSA and the Anaesthetic Environment

Robert Cunney

Consultant Microbiologist, Children's University Hospital, Dublin, Ireland; Consultant Microbiologist, Health Protection Surveillance Centre, Dublin, Ireland

The prevalence of MRSA in Ireland is higher than most other European countries. MRSA is particularly relevant to surgical patients, as staphylococci are the most frequently identified cause of surgical site infection. While most infections caused by MRSA are relatively minor, it can cause devastating infection in some situations, particularly in the setting of implant surgery or in immunosuppressed patients. Transmission of MRSA can generally be prevented in the perioperative setting by adherence to routine infection control practice, particularly in relation to surveillance and screening, hand hygiene, environmental hygiene and antibiotic stewardship. While it is important to ensure that infection precautions are effectively applied, it is also important not to apply excessive precautions that may interfere with the effective running of the operating theatre suite. Many common practices, such as scheduling all patients colonised with MRSA at the end of an operating list, rigorous environmental decontamination of all surfaces following an

'MRSA-positive' surgical case, or leaving a theatre empty for an hour or more following such cases, are probably unnecessary, other than in exceptional circumstances. Good communication, adequate staffing levels and observance of routine transmission-based infection control precautions are of greater importance in preventing the transmission of MRSA.

This was an extremely clear and coherent lecture that heavily promoted screening, surveillance and hand hygiene in the theatre as the most effective weapons against MRSA. I was surprised to hear that environment has very little impact on infection rate, contrary to what the media reports. Dr. Cunney put to bed a few well-known myths by confirming our suspicions that patient shaving, showering and changing gowns prior to surgery are not backed up by current research and are not necessary for the control of MRSA. He also left us with food for thought regarding the scheduling of MRSA patients. It may feel logical to have these patients last on the surgical lists, but this maybe impinging on 'best care' practices by leaving the sickest patient till last.

The Physical Load of Peri-operative Nurses

Paul Meijsen

Peri-operative Nurse, General Hospital, Eindhoven, The Netherlands

This presentation discusses a large-scale study carried out in the operating wards of 16 Dutch hospitals exploring the physical strain among peri-operative nurses. The study design, tool and results are also discussed in relation to peri-operative nursing. The management of the physical strain of work in the operating room should be part and parcel of the professional skills of peri-operative nurses.

I found this a fascinating study, mainly for the reason that, as a recovery nurse, I had never really thought about the unique strain that peri-operative nurses are subjected to. As a profession we are naturally more concerned with the welfare of the individual on the operating table in front of us than we are with our own health and safety. The study found that the average peri-operative nurse stands stationary for more than 4 hours per shift and despite constant change and development within the operating environment, ergonomically nothing has changed. Instances of back, neck and shoulder pain are higher than that of the general public and 60% of those affected attributed it directly to their profession. It is apparent that sport and fitness out of work is not sufficient to reduce the damage being done.

Paul Meijsen Lectures at the Fontys University of Applied Sciences, Eindhoven, The Netherlands.

Legal Matters and the Peri-operative Environment

Brenda Daly

Lecturer in Law, Dublin City University, Dublin, Ireland

This presentation highlights the foremost legal issues that can arise in the peri-operative environment. Particular emphasis is placed on the current laws and legislation pertaining to issues of peri-operative consent. Informed consent is recognised as an important legal and ethical principle in health care. Issues such as patient's capacities to give informed consent are outlined, since difficulties arise in the health

https://doi.org/10.1017/S1742645608000016 Published online by Cambridge University Press

care setting where the patient is incompetent and unable to consent to, or refuse medical treatment. The introduction of the Mental Health Act 2001 provides some guidance to the treatment of incompetent patients and provides greater safeguards than those that existed previously. This presentation also discusses the pragmatic impact that these changes should have for anaesthetic and recovery nurses. Brenda's doctoral research examined the issue of legal accountability of the medical profession.

This lecture was condensed well considering the large scope of this subject. I am always amazed by how clear-cut one thinks the law surrounding this subject is, until you hear some of the real-life stories regarding patient consent and the peri-operative environment. Informed consent is increasingly appearing in medical negligence cases, with clerks examining three elements needed to ensure rightful consent. The first is the amount of information supplied, as some individuals may require more than others. Does the amount given equate the amount needed? The second is the patient's capacity to understand. This is vital and sometimes difficult to assess as the individual may not have the capability to comprehend the information given. And the third is the patient's willingness to undergo the procedure. Can you be sure manipulation or coercion has not been used?

It can be hard for any medical professional to accept that an individual does not want to receive treatment, but we must remember that the law states that if of sound mind, patients have the right to refuse a procedure even if the outcome will lead to death. This lecture brought home to me the importance of advocacy and our obligations to the patient. After all, we have the most contact with the peri-operative patient and can get a clear idea of their true wishes, and relay it to the surgical/anaesthetic team.

This was a fantastic one-day conference with a good range of subjects. It was somewhat overshadowed, as a few days previously Mary Harney, Minister for Health, had announced the closure of a large Accident and Emergency in Ennis, with a consultant-led service and limited hours of operation to be left in its place. It was also confirmed that 30 agency nurses from one hospital will not have their contracts renewed. The Minister did get a chance to address the conference delegates and reinforced the notion of 'slow change', using the analogy of a one hundred and thirty thousand strong cruise liner. 'The cruise ship cannot be flipped round immediately; it has to be done slowly with precision'.

Leaders of local hospitals meet Minister for Health, Mary Harney.

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