

Would you like to go to the Hip and Knee Arthroplasty course for perioperative practitioners in Cardiff on 24th/25th November? The course is aimed at D/E/MTO3/4 staff working in Orthopaedic practice. Please complete the form below or call Mary Burke on Tel: +44 01382 496277. The cost of the two day course will be £150 or £75 for one day.

## Feedback from study days:

"Thoroughly enjoyed the day and have learnt new things and will take some points back to my department"

**"Very well run and informative study day"**

"Enjoyed discussion groups. It was good to realise that other hospitals have the same problems as ourselves"

Name

Hospital address

Post Code

Tel No

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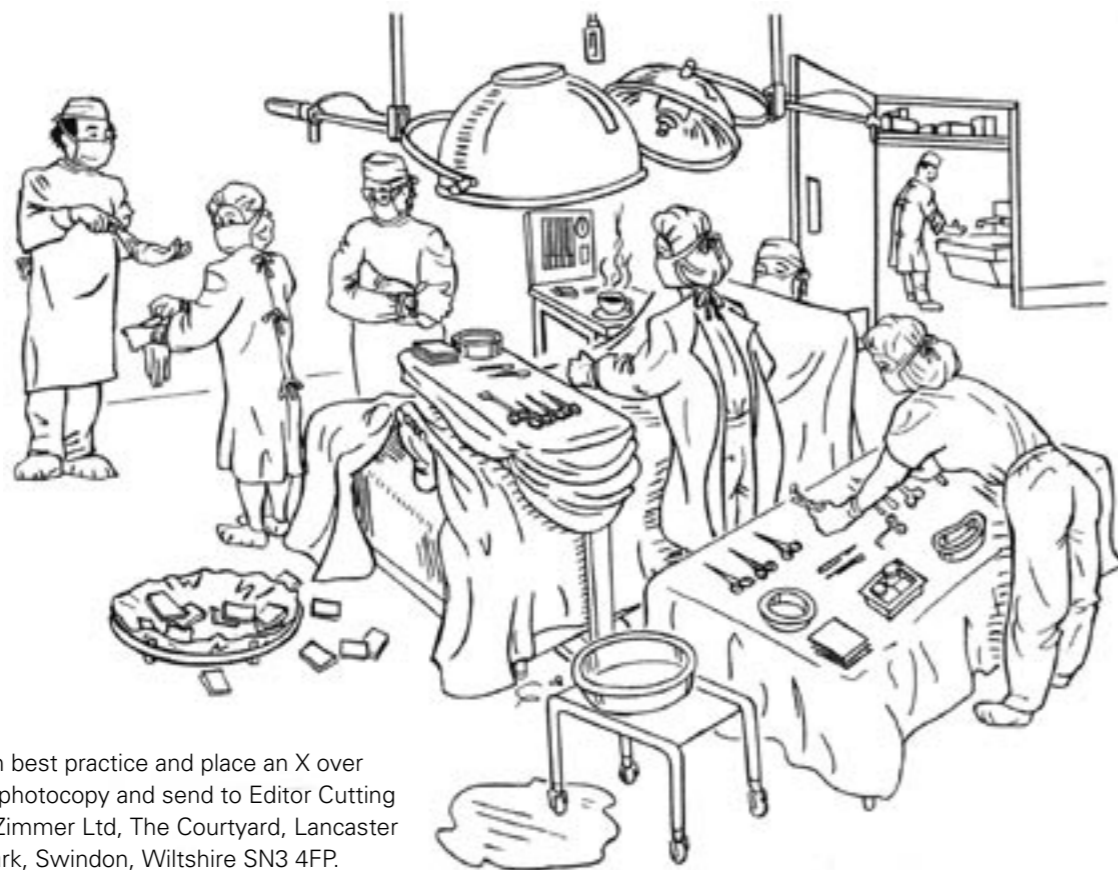
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## WIN £50!

The winner will be drawn from those with the equal most practice errors identified if there is no clear winner.



Find at least 12 breaks in best practice and place an X over the spot then cut out or photocopy and send to Editor Cutting Edge, c/o Sue Gregg at Zimmer Ltd, The Courtyard, Lancaster Place, South Marston Park, Swindon, Wiltshire SN3 4FP.

The views expressed in this publication are not necessarily those of Zimmer Ltd UK.



If there is anything you would like to say, e-mail us at: [editorcuttingedge@mac.com](mailto:editorcuttingedge@mac.com)

**Page 02** Bone plating made simpler and quicker



In the last edition we were informed by the National Patient Agency of the work that they have been doing on reducing the risk of Wrong Site Surgery. I promised you that as soon as any solutions had been developed by the NPSA you would be informed given that the largest incidence rate is reported to be from Orthopaedic surgery.

Clive Tomsett, Assistant Director at NPSA recently presented at a perioperative conference and although the report (England) has yet to be published, some outcomes have been addressed in the US and Clive has suggested that in the interim we might look at some of their solutions on the Internet. The following documents are interesting: <http://www.jcaho.org> Joint Commission on accreditation of healthcare Organisation, "A follow-up review of wrong site surgery. Sentinel events Alerts numbers 6 and 24.

Clive stated that what is most common and significant from the factors identified is communication breakdown between the surgical team members and the patient and their family in the majority of wrong site surgery cases.

The centre spread in this issue is very close to my heart. I adopted a Ugandan daughter in 1979 and through the connections with her family and subsequent frequent visits have been closely involved in the development of perioperative nurse education

across East Africa. You too could be involved. Read more about it inside!

Have you ever thought about the working life of a medical representative? As we work more and more closely with our industry partners, it is important that we recognise the work that they do to support healthcare and education. We have a short article in this edition.

And don't forget to contact us if there are any specific issues that you would like to read

more about in future editions. Email me at: [editorcuttingedge@mac.com](mailto:editorcuttingedge@mac.com) with your suggestions



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Sharing with our perioperative colleagues across the world

# the African experience...

## The seed

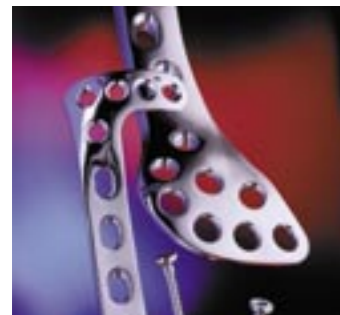
Back in 1977, I was on a late shift in Neuro theatres and missed a church Council meeting. The following morning I had a call to say that I had been 'volunteered' to host a Ugandan Bishop from our link diocese. The week went well and we were asked if we would give a home to and educate the eldest child of 13 children, Maureen, who had shown great academic promise which would be unfulfilled since the ousting of almost all the educators

in the Amin regime. During the civil war, Maureen, then very young had carried her young baby brother to safety in the Ruwenzori Mountains bordering Ruanda. The Bishop and his wife had six of their own children and seven orphans in their home and needed help. A long story later, too long for this telling and with the help of the Home Office, Lambeth Palace, Terry Waite, Cliff Richard and a host of others, Maureen became part of our young family. Suddenly we had three daughters and even

a female cat, so my husband felt completely outnumbered. I got a male cat to redress the balance.

On a holiday visit to Maureen's home in south-west Uganda, I made a point to visit and take gifts to the operating theatres both in her home town of Mbarara and in Kampala at the University Hospital, Mulago. It was on that occasion, that Professor Francis Omaswa, then a cardiac surgeon and now director-General for Health in Uganda asked if I, as

National Secretary of the National Association of Theatre Nurses, could help update the country's perioperative education which had not been addressed since independence from Britain. Kate Woodhead was National Chair of NATN at the time and as she also had links with Africa, agreed to help. Two years after this visit, a three-visit plan we had developed was implemented in agreement with the Ugandan and subsequently other East African Departments of Health.



## Bone plating made simpler and quicker

I think we have all been there; you're scrubbed for what you think is going to be a routine bone plating procedure that turns into something of a nightmare because the surgeon spends ages struggling, trying to contour the plate adequately to the bone. Finally the plate goes on, fitting where it touches. Let's face it bending a piece of steel to fit something as knobbly as a distal humerus isn't easy!

Well, that's something of the past in our hospital since we started buying Peri-Articular plates from Zimmer. These are a range of plates for different fracture situations which are pre-contoured and made to fit like a glove over the bone without the need for bending.

To be honest, I was pretty sceptical at first, and for our first few procedures I kept the plate benders close at hand, but I can truly say that we have not needed them once as yet. I am told the secret of the close fit is achieved by making the plate thin around the joint so it auto contours as the screws tighten the plate to the bone and making it thicker along the shaft where the strength is needed. Even the screws are low profile and fit flush with the plate.

To be fair, the plates are a little more expensive but in our theatres we are sure that they save money as the job gets done quicker and the final fit is so much better.

**Sr Kim Good**  
Royal Oldham Hospital

## Now available in the Zimmer Periarticular range:

- Distal posterior lateral humeral plate,
- Distal medial Humeral plate,
- Proximal dorsal ulnar plate,
- Distal dorsal T radial plate,
- Distal dorsal delta radial plate,
- Distal volar radial plate - lateral column,
- Distal volar ulnar radial plate - Medial column,
- Distal lateral femoral plate,
- Distal medial femoral plate,
- Proximal medial tibial plate 3.5mm & 4.5mm,
- Proximal lateral tibial plate 3.5mm & 4.5mm,
- Distal lateral tibial plate
- Distal medial tibial plate



# Sharing with our perioperative colleagues across the world

## the African experience... (ctd)

### The Plant

**Uganda** – In April 2001 we made our first visit to Uganda to share with 52 nurses from all parts of the country a theoretical perioperative educational programme that included standards of practice, risk management and change management issues. On our second visit in 2002 we met up in different parts of the country with most of the 52 delegates from 2001 and took with them as gifts – nurses' scissors, eye protection (it is thought that 1 in 3 Ugandans are HIV positive) and surgical instruments. At the hospitals we visited, we undertook a clinical audit of each theatre area and the results were fed back to the staff and the Ugandan Department of Health. Resources are scarce and money often runs out by the tenth day in each fiscal

month. We met nurses who had to wash all the laundry and spend many hours ironing drapes and masks. One nurse, whose hospital was in a remote rural area on the border with Rwanda had had no electricity for months, because the £400 replacement battery could not be afforded. On this visit time was spent reinforcing the theoretical teaching from the previous year and also covered topics such as infection control and managing challenging people.

With the support of the Ministry of Health and building on the work already achieved, we were now focused on developing leaders for the future and Ugandan nurses joined our leadership programme in Zambia.



**Zambia** – The objective was to bring to them both the theoretical and practical knowledge working within the resources of the system in place. During the first visit, topics covered in the theoretical course included documentation, safety of patients and staff, microbiology and infection control as well as developing nursing attitudes to patient care in the operating theatre. The second visit in 2003 reinforced some of the earlier messages as well as undertaking clinical audits at the hospitals in different parts of Zambia.

The 2004 visit included a leadership programme for a small number of delegates, chosen from previous students, to develop the knowledge and practice that is being shared from the UK. This programme was led by Kate Woodhead and Debbie Lee, who is a former UK Department of Health Nursing Officer in Critical Care. This also enabled potential leaders from the perioperative environment to develop their leadership, mentoring

and professional practice. In conjunction with the leadership programme, the theatre curriculum was brought up to date at the University Teaching Hospital Theatre School of Nursing and IT skills were taught to the staff at the University Theatre School. This part of the programme was led by myself and Jane Reid, Vice Chair of NATN and an Academic at Bournemouth University. Both were a huge success.

**Kenya 2003 and 2004** A first theory-based course was run successfully for 50 delegates in Nairobi in autumn 2003 and will be followed by a second clinical audit programme in Nairobi, Mombassa and Nkuru in autumn 2004 along the lines of the work done to date in previous East African visits. Discussions have also taken place with the Aga Khan University towards developing a Master's module for perioperative nurses.

The education to date for all countries has been designed as such;

**Part A** – Update basic skills and knowledge

**Part B** - Review implementation of change and benchmark theatre practice

**Part C** - Provide capacity building leadership programme for potential and actual leaders of Operating Theatres

**The fruit** – future work – We have been asked to help in other countries, mainly in East Africa, which makes sense as the people are in the main English-speaking and our skills are not sufficiently multi-lingual to deliver theoretical lectures. I am trying to learn Swahili, but English will remain the language of choice for a long time yet. We recognised that we could not sustain rapid growth without the help of others who were sufficiently able to adapt their practice for the situations

we work in. To this end we decided to gain charitable status and enlarge our volunteer base and distributed fliers at NATN Congress in 2003 as well as mentioning volunteering whenever we are asked to deliver a talk on our work.

**Volunteers** – We now have a database of 14 volunteers who would like to assist us in the support for our African colleagues. Thanks to all of you for volunteering. We used one of our volunteers, Debbie Lee, as you will see from the leadership programme this year delivered in the Copper Belt, Zambia. Given our small resources, it is not possible to use our volunteers as soon as they contact us. We have at the moment a three year model for each country which requests our assistance and are very conscious of our responsibilities for personal safety and security on their visits, so have mapped out a method in which all new volunteers will be accompanied by an

experienced member for their first two visits. This in turn bring limitations as the experts have to earn a living and undertake their volunteer work in annual leave so can't be away all the time, no matter how attractive that might seem. Each volunteer will be interviewed and fully briefed if accepted to the 'team'. We use the Foreign Office and VSO advice to ensure that we do not risk our safety and security on visits. So if you haven't heard from us yet, it is not because we don't need or want your skills and expertise!

**Awards** – We are delighted that Molnlycke has created an award that will be given each year to an individual who puts their self forward and meets the essential criteria. The award is for the winning individual to be part of the FoAN team on a selected African visit appropriate to their skills. Lesley and Kate will be part of the judging panel.

**Fundraising** – Donations are vital to us being able to achieve the valuable work that we do. Our African colleagues are the most diligent learners we have worked with and deserve our help. Financial donations can be made to "Friends of African Nursing" either through Lesley or Kate with initial contact made by email to: [lesleyfudge@blueyonder.co.uk](mailto:lesleyfudge@blueyonder.co.uk) or [kate@periop.fsnet.co.uk](mailto:kate@periop.fsnet.co.uk)

Donations of equipment are desperately needed. Operating tables with standard hydraulics, resuscitaires, instruments, trolleys, theatre linen, scrub suits, gowns, trauma plates and screws and any usable equipment accompanied by user manuals would be of enormous value.

There is however, a however! We have very limited funds and getting equipment to Africa is a very expensive business, so if there are manufacturers who regularly ship containers to East Africa and have room for additions and could arrange delivery at the other end, we'd love to hear from you. Really, we would!

We take current and recently published perioperative books, instruments, eye protection and other very practical items with us and although very lucky with the kind people at the airports, have fallen foul on an off day and been charged ridiculous excess baggage charges. We will not take that risk again and would be very grateful if anyone has good contacts with very cost-effective (free) shippers. Once we have achieved charitable status this may become easier but any help would be useful until then

And Maureen? She did very well. She was the first African to gain BSc RGN qualification at King's College, trained in HIV and midwifery and has a fourteen year old son, my African grandson, Agaba.



The tragedy of AIDS – Main street, Kampala



Please contact us if you can help in any way, no matter how small – or big!

# Nurse to rep and back again:

# A reflection

Sam Halliwell

A year ago I made a big career move which many called me mad for making. Over the past year I have moved from a very successful sales career with the largest orthopaedic company in the world to return to a career in nursing. I am pleased to say not everyone thinks I'm "mad" and during the year I have also received many compliments such as "kind", "caring" and "brave".

There is nothing unusual about making the move from nursing to medical selling, in fact my advice as an ex-nurse was sought on a number of occasions by nurses thinking of making the jump. So why then have I decided to return to nursing? A question I have asked myself many times, especially on a Sunday morning whilst cleaning a patient's dentures!

My decision was very difficult. Many see sales as glamorous and it can be! I was very privileged to travel to so many wonderful places, rode a camel in Dubai under a wonderful sunset, swam with turtles in Barbados and dined in Michelin starred restaurants. More importantly, I saw and learnt so much about orthopaedics. I worked with so many respected surgeons and professional staff. The working relationships I made with consultants, nurses and hospital management made my job really enjoyable; I miss so many of them still. Working at the forefront of

orthopaedics was exciting and very challenging. Sales is also competitive and I am pleased to say I was successful, achieving runner-up to top salesperson of the year.

Why return to nursing then? It's not glamorous and hopefully not too competitive, it doesn't pay as well as my previous position. The decision was purely personal and by returning to nursing, allowed me to be myself.

I am frequently asked has nursing changed since I last nursed in the early 1990's at Westminster Hospital in London. The answer is yes and no. The role of the nurse has developed immensely and there is far more responsibility. Patients are far more aware of their rights and their knowledge has improved drastically. Basic nursing care is still the same, patients still need to feel cared for. I do feel it's all down to trust – patients are not as trusting as they were. I feel the media has damaged the NHS's



credibility. Staff shortages are also more apparent and it is difficult sometimes to cope.

I do feel I have made the right decision in returning to nursing. I get so much from my work, a complete feeling of satisfaction. I have found I have more compassion and patience than I ever believed possible. If I can make a difference it's been worthwhile.

My advice to those looking to move into sales from nursing is go for it if that's what you want. Sales can be a wonderful challenge, it is not always glamorous and you only swim with turtles if you have given your all; 110% effort is what is required if you want to make it. But then is that not true of anything that is worthwhile? You only get back what you put in, as I am finding out, especially on Sunday mornings.

So am I mad? I will let you decide.


# Signs, Symbols and batch recording...

Signs and Symbols on packaging are a safeguard and also can be used for controlling and ordering stock, just like the supermarkets if used to their best effect. They assure sterility and the methods used, manufacturing dates, expiry dates and CE marking. They can also inform the staff as to whether there are any special instructions needed for the use of the product. You could run a quiz or test with colleagues to see if they know what they all mean and their importance, so, here are a selection of examples of signs and symbols frequently used on product packaging for information.

For example look at the many symbols and bar codes on the following two product packages, do you know what they all mean?



DATE OF MANUFACTURE



1999-12

USE BY DATE



2002-06-30

BATCH CODE

LOT ABC 1234

Synonyms for this are:

- Lot number
- Batch Number

ATTENTION, SEE INSTRUCTIONS FOR USE



"The factory symbol with a date beneath or alongside shows when the product was made. This can be really useful information to ensure that you aren't being sold old stock with short shelf life. Have a check on the shelves of your stock and just see when it was made and also have a look as new stock arrives just to see how old it is. Now some products have long shelf lives so the next symbol is as important as this one to understand"

"The egg-timer will show you just how much shelf life is left on the product and will help with your stock rotation, just like the supermarkets, always making sure that the oldest product is used first and that nothing goes out of date. This is the same as an expiry date. But are you like me and always get my milk from the back of the shelf to get the container with the longest shelf life! Not the way to do good stock rotation at work though"

"Batch codes are on labels for two main reasons; one is so that you can track the product to a patient should there be any unfortunate events in the future and we have all heard of failed implants and the like where we have had to investigate which patient had them implanted and; the other is for the manufacturer to be able to track a product back to its manufacture as all the components such as the steel supplier, the grade of product, the others manufactured at the same time etc can be traced. If a product needs to be tracked, the reason for product failure can be complex to discover and behind these batch or lot numbers a lot of information is stored"

"The exclamation mark has always meant that we had to take special care or pay extra attention and this is no different than when we see this sign when driving. It means that there is something more that needs to be understood before proceeding and in many cases this means that there are special instructions for the use of the product. Make sure that you do use the instructions as advised, as product indemnity may be lost if you don't use products as advised by the manufacturers and the patient may be put at risk"

STERILE

STERILE		
STERILE	EO	Method of sterilisation: ethylene oxide
STERILE	R	Method of sterilisation: irradiation
STERILE		Method of sterilisation: steamer dry heat

"The method of sterilisation used for the product should be clearly visible on the labelling. Gamma irradiation may be indicated with a red dot. If the dot is not red, it may not be sterile and should not be used. Equally, if there is no indication of the method of sterilisation used, a check should be made with the supplier as some products are delivered unsterile. Although this should be clearly stated, checking is the safe option"

CE markings on labels are mandatory and mean that the manufacturer has stated that their product meets all the requirements set down for sale and use.

Hopefully you now have a better idea of all the tiny symbols on the packaging, any more and we'll need a microscope to read them. Ah, well there lies another tale. There is a European standard for labelling and one of the requirements in the standard is the font size of the text. Sad if you have a tiny product, the packaging will probably be much bigger than required to get all the information legible for you. Now there lies another tale, the government requirements for the management and reduction of waste. There seems to be a need for a bit of joined up thinking somewhere! I do hope that you enjoy reading labels in future.