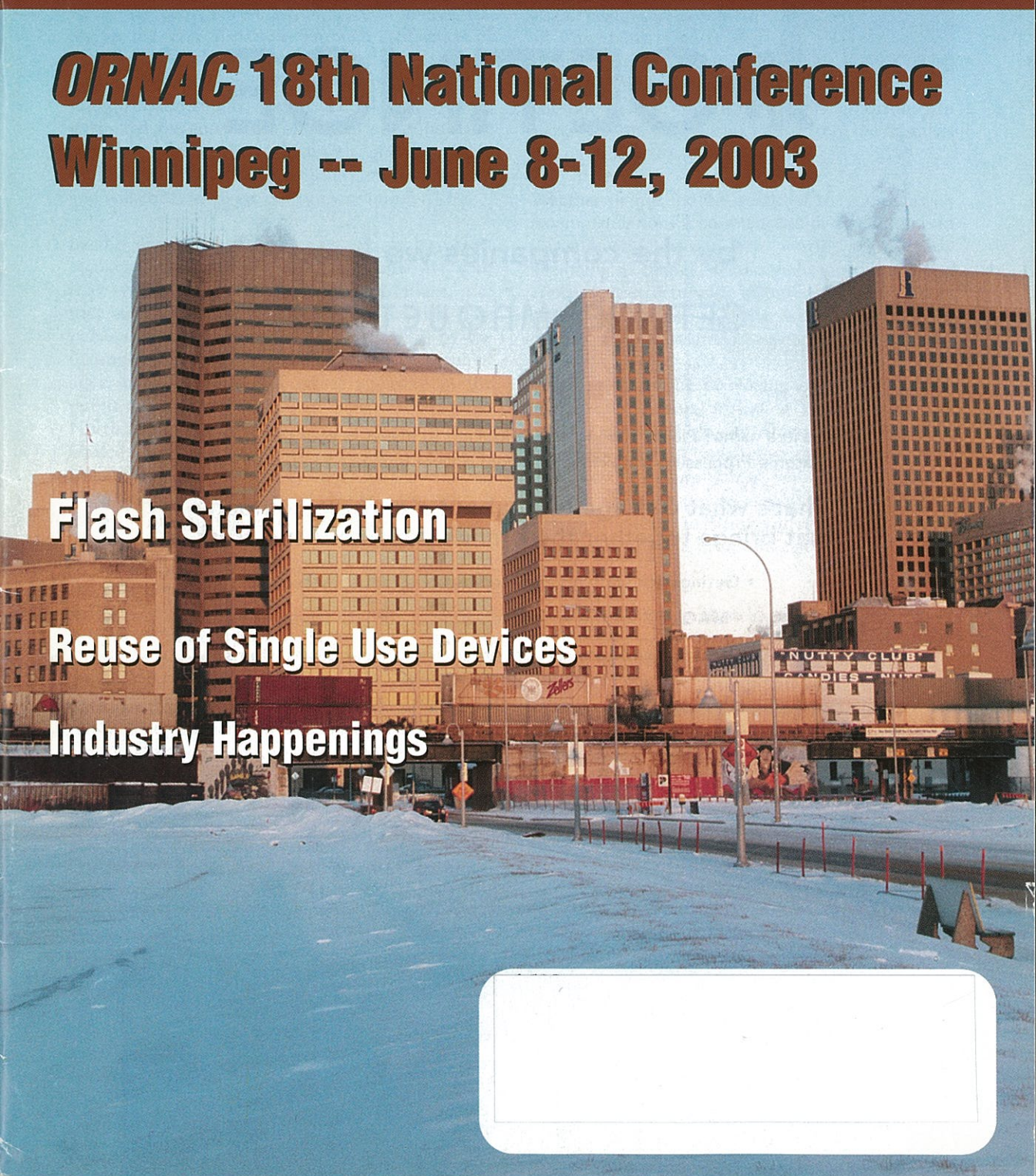
CANADIAN
March 2003

Operating Room Nursing Journal

ORNAC 18th National Conference Winnipeg -- June 8-12, 2003



Flash Sterilization

Reuse of Single Use Devices

Industry Happenings

President's Message

By Mary Knight, RN, BScN, MN, CPN(C)

The theme chosen for the 2002 Perioperative Nurses' Week "*Perioperative Registered Nurses: Ensuring Patient Safety*" was chosen because since the beginning of surgery as we know it, nursing activities within the perioperative setting have promoted safety for the surgical patient. Through verification of our patient's identity and surgical site, surgical asepsis, infection control practices, environmental safety, surgical counts, documentation, etc., we have integrated the core value of patient safety into our everyday practice in a high-tech and incredibly complex environment. Patient safety has always been, and will continue to be, our primary raison *d'_tré*.

In the broader healthcare context, it has been recognized that patient safety concerns are real; that systems are prone to error and failure, and that measures must be taken to reduce risk. The publication of "*To Err is Human*" (1999) by the Institute of Medicine in the U.S. placed the issue of adverse occurrences and errors squarely in the public domain, and created an impetus to action in North America. Reports in both Australia and the United Kingdom led to national efforts in both jurisdictions to promote systemic improve-ments in the safety and quality of health care, with a focus on minimizing adverse occurrences.

In Canada, the recent publication of the report of the National Steering Committee on Patient Safety: "*Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*" (September, 2002) is an attempt to advocate for a national approach to patient safety. Assumptions such as: safety is a fundamental aspect of quality health care; human error is inevitable; and, that underlying systematic factors contribute to most near misses, adverse occurrences and critical incidents underpin the recommendations of the Committee. Other assumptions include: collaboration across all sectors of the Canadian Health Care System must occur to ensure a coordinated and effective strategy for improving patient safety; the health care system must facilitate comprehensive identification of hazards; the health care system must develop an atmosphere of trust, in which openness and frankness in identifying and reporting problems is encouraged and rewarded (no "blame"); partnerships must be encouraged between all consumers and providers of health care; and, appropriate disclosure to all partners must be promoted.

Nineteen recommendations provide many interesting thoughts on how our patch-work quilt of provincial and territorial health systems could be connected to ensure a safer health care system for all Canadians. One of the greatest tragedies is not just that a critical incident occurs, but that we have not always had the opportunity to learn from our own mistakes, nor from the mistakes of our colleagues.

Whether or not the full scope of the Committee's recommendations is adopted, health care systems in Canada and around the world are already beginning to change. Traditional reporting systems are being re-structured to include reporting of "near misses" and steps are being taken to change the culture of blame related to reporting occurrences.

Recognition of the increasing complexity of the health care system, including its processes and rapidity of change has contributed to the emphasis on patient safety. It is also clear that our traditional processes to ensure safety are not sufficient to control adverse outcomes (2002). Patient safety, long the focus of the perioperative nurse, is moving to its rightful place front and center stage!

References:

Kohn, L.T. Corrigan, J.M. & Donaldson, M. (eds.) (1999). *To Error is Human: Building a Safer Health System. Washington: National Academy Press.*

National Steering Committee on Patient Safety (September 2002). *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care.*

***Mary Knight**, RN, BScN, MN, CPN(C), is President of the Operating Room Nurses' Association of Canada. She is the Director, Programs & Patient Services, Surgery & Women's Health Programs, at Victoria General Hospital in Winnipeg, MB.*

***Mary Knight**, infirmière enregistrée, BScN, MN, CSP (C), est présidente de l'Association des infirmières et infirmiers de salles d'opération du Canada. Elle est directrice des programmes et des services aux patients ainsi que des programmes de santé des femmes et de chirurgie, à l'Hôpital général Victoria à Winnipeg, au Manitoba.*

Message de la présidente

Mary Knight, inf, BScN, MN, CSP(c)

Le thème choisi pour la semaine de l'infirmière en soins périopératoires 2002, "Assurer la sécurité du patient", a été retenu parce que, comme nous le savons tous, les activités des soins infirmiers à l'intérieur du bloc opératoire sont axées sur la promotion de la sécurité du patient en chirurgie, et ce depuis le début de la chirurgie. A tous les niveaux, de la vérification de l'identité du patient et du site chirurgical, à l'asepsie du champ opératoire, aux pratiques de contrôle de l'infection, à la sécurité de l'environnement, aux décomptes chirurgicaux, à la documentation, etc., nous avons intégré la valeur de base qu'est la sécurité du patient dans notre pratique journalière, laquelle est dans un environnement incroyablement complexe et de haute technologie. La sécurité du patient a toujours été, et sera toujours, notre principale raison d'être.

Dans le contexte élargi des soins de santé, il a été reconnu que les préoccupations concernant la sécurité des patients sont bien réelles, que le système est sujet aux fautes et aux erreurs, et que des mesures doivent être prises pour réduire les risques. La publication de "L'erreur est humaine" (1999), par l'Institut américain de médecine, considérait équivalents les effets indésirables et les erreurs dans le domaine public, démontrant ainsi le besoin primordial de passer à l'action en Amérique du Nord. Des rapports de l'Australie et du Royaume-Uni ont entraîné la mise en commun d'efforts de la part des deux juridictions pour promouvoir des améliorations à apporter au système concernant la sécurité et la qualité des soins de santé, en mettant l'accent sur la diminution des effets indésirables.

Au Canada, la publication récente du rapport du Comité national de direction pour la sécurité des patients, "Bâtir un système plus sécuritaire : une stratégie nationale intégrée pour l'amélior-ation du système de santé canadien" (septembre 2002), est une tentative pour soutenir une approche nationale pour la sécurité des patients. Les hypothèses telles que la sécurité est un aspect fondamental de la qualité des soins de santé, l'erreur humaine est inévitable, et les facteurs systémiques sous-jacents contribuent de près à plusieurs manquements, effets indésirables et incidents critiques soutiennent les recommandations du comité. D'autres hypothèses sont également suggérées, soit la collaboration entre tous les secteurs du système de santé canadien doit se produire pour assurer une stratégie coordonnée et efficace pour l'amélioration de la sécurité des patients, le système de soins de santé doit faciliter une identification claire des risques, le système de soins de santé doit développer un climat de confiance dans lequel l'ouverture et la franchise dans l'identification et le rapport des problèmes sont encouragés et récompensés (aucun reproche), le partenariat entre tous les consommateurs et les fournisseurs de soins de santé, et la divulgation à tous les partenaires doit être encouragée.

Dix-neuf recommandations fournissent plusieurs réflexions intéressantes sur la manière dont notre modèle de travail dans les systèmes de santé provincial et territorial pourrait être organisé pour assurer un système de santé sécuritaire pour tous les Canadiens. L'une des plus grandes tragédies n'est pas seulement qu'un incident critique survienne, mais que nous n'ayons pas toujours pris l'occasion d'apprendre de nos propres erreurs, ni de celles de nos collègues.

Que toutes les recommandations du comité soient adoptées ou non, les systèmes des soins de santé du Canada et du monde entier sont déjà en train de changer. Les rapports traditionnels sont maintenant en restructuration pour inclure le rapport des erreurs évitées et les démarches entreprises pour changer la culture de blâme en relation avec le rapport d'incidents.

La reconnaissance de la grande complexité du système de soins de santé, incluant ses processus et sa rapidité des changements, a contribué à mettre l'accent sur la sécurité des patients. Il est aussi clair que notre méthode traditionnelle pour assurer la sécurité n'est pas suffisante pour contrôler les résultats indésirables (2002). La sécurité des patients, raison d'être de l'infirmière en soins périopératoires, est en voie de prendre la place qui lui est due, à l'avant-scène et au centre des préoccupations.

Références:

Kohn, L.T. Corrigan, J.M. & Donaldson, M. (eds.) (1999). *To Error is Human: Building a Safer Health System. Washington: National Academy Press.*

National Steering Committee on Patient Safety (September 2002). *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care.*

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Editorial Contents

Cover photo by Joan Porteous

Correction

In "Determining the Cost-Effectiveness of the Registered Nurse First Assistant: The Research Link" (Volume 20, Issue 4) reference is made to educated RNFAs as being "certified". This was incorrect. To qualify for certification (CRNFA), a RNFA must also complete 2000 hours of clinical work and obtain a passing grade on the RNFA exam.
We sincerely apologize for any confusion this error caused.

Author: *Karen Steindel, Co-Chair of the Conference Planning Committee*

18th National Conference

If you haven't done so already mark **June 8 to 12, 2003** on your calendar for the 18th National *ORNAC* Conference. The event will include 21 hours of educational sessions; the opportunity to see and discuss the latest products our medical industry exhibitors have to offer; great opportunities for networking with your peers from across the nation; excellent shopping possibilities and many fun filled social events. All of this will take place in Winnipeg, a city of nearly 700,000 people who pride themselves on their friendliness, generosity and creativity. Winnipeg is a city of diverse cultures and plays host to one of the world's largest multicultural festivals every summer. It is a city of parks, bicycle paths, an urban forest, and over 100 kms of navigable waterways.

Kate Woodhead, Keynote Speaker

Photo by J. Porteous

Winnipeg Convention Centre

PROGRAM

With over 21 hours of educational programming the conference offers many opportunities to fulfill accredited continuing education time requirements.

- **Keynote speaker** Kate Woodhead is joining us from England. Ms Woodhead is the President of the International Federation of Perioperative Nurses (*IFPN*) and her talk is titled *From Little Acorns, Great Oaks Grow* (*see page 33*).
- Other **international speakers** include *Cathy Fenwick* (*Keeping Spirit Alive at Work*) and *Dr. Marion Jones, RN, Ph.D.* (*Leadership Qualities that Enhance Perioperative Nursing*).
- 7 1/2 hours of sessions by CORL selected speakers are available for those delegates interested in **leadership issues.**
- There will also be lectures on **infection control** including *The Hot Zone: Canada's Level IV Virology Lab in Action and Prions are a Changing Practice. Dr. John Embil*, a local favourite and international speaker, will add humour to this subject with *The Bug Stops Here! Infection Prevention and Control.*
- Current **clinical topics** such as the implantable Venous Doppler and the Titan Project Implants for severe angina will also be presented.
- *Justice Colleen Suche*, now a judge, was once the lawyer representing the Winnipeg

Photo by J. Porteous

Inside the Convention Centre

Children's Hospital nurses in the Paediatric Cardiac Inquest in to 1994 cardiac deaths. She will speak on ***Systems Failures: When Things Go Wrong in the O.R.***. Legal issues such as documentation, as well as ethical issues such as confidentiality, will be discussed.

- Perioperative nurses from across Canada will **showcase their research projects** during 9 oral presentations. We have also put a **call out for poster presentations**. There will be an award for the best poster and an award for the best research project oral presentation.
- Time has been reserved for other hot topics to be determined at later dates.
- Our **closing speaker**, *Don Shapiro, Ph.D.*, the author of *Mom's Marijuana: Life, Love and Beating the Odds*, titles his remarks *A Funny Thing Happened on My Way to Surgery*.
- There will also be several corporate-sponsored breakfasts with speakers.

SOCIAL ACTIVITIES

Our social committee has planned a busy week of activities. Here are some of the highlights:

- Sunday night kicks off the conference with a wine and cheese "meet and greet"; Folklorama night on Monday features dinner with an international flavour followed by dancing; Tuesday night is our Tijuana Mexicana night at a local nightclub (snack is included, dinner is available for purchase); Wednesday evening delegates are free to explore the city's attractions;
- Plan to wrap up the 18th National *ORNAC* Conference with a Rock and Roll evening on Thursday June 12, 2003. Relax over dinner and then dance the evening away to rock n roll band Free Ride. There will be a fabulous door prize given out that evening but you must be present to win.
- To balance the mental stimulation with some physical fitness, Getinge-Castle will once again be sponsoring 6 sessions of aerobics. Weather permitting, we have some great scenic locations mapped out for these sessions.

ACCOMODATION

- The Delta Winnipeg will be the primary conference hotel. We also have rooms reserved at 3 other downtown hotels in a variety of price ranges.
- Hotel information and registration forms can be found in your registration/information package as well as at ***www.ornac.ca***. Please make your hotel reservations directly with the hotel. Deadline to guarantee conference rates is April 1st, 2003.

WINNIPEG

For information about Winnipeg visit ***www.tourism.winnipeg.mb.ca***.

REGISTRATION

- If you have not yet registered, registration forms are available at ***www.ornac.ca***. In addition, registration/ information packages were mailed out November 2002. Packages were also sent to the educators and managers at each site.
- The $425.00 registration fee (for *ORNAC* members) includes entry to all conference social events.
- This event's format will feature educational sessions on 4 full days.

PLANTING IDEAS • REAPING REWARDS

18th NATIONAL ORNAC CONFERENCE

WINNIPEG 2003

2003 NATIONAL CONFERENCE EXHIBITORS

Acart Equipment Ltd.

AMT Inc.

Ansell

Arizant Healthcare Inc

Bard Canada

Baxter Corporation

Cardinal Health/Allegiance Health Care

Carsen Group Inc.

DeRoyal Industries

Ecolab Professional Products/Huntington

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Health Point

Instrumed Surgical

Johnson & Johnson Medical Products

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Steris Canada Inc.

The Stevens Company Ltd.

Stryker Canada

Trudell Medical Marketing Ltd.

Ultramed

Watch Tower

As of February 15, 2003.

National Association of Theatre Nurses – 2002 Congress Report

By *Mary Knight, RN, MN, CPN(C)*

Last October 8-10th, I had the opportunity to attend the 38th Congress of the *National Association of Theatre Nurses*. The *NATN* Congress is held each year at the same time, and in the same location of Harrogate, Yorkshire, near the countryside of James Herriot fame. Nearly 3,000 delegates and a sold-out Exhibition of 240 companies made this the most successful Congress ever.

NATN Congress runs three full days, from Tuesday to Thursday, and offers a pre-Congress study day on Monday. This year's study day topics were "Back to Basics" and a Managers' Forum, "Healthcare records – will yours stand up to scrutiny?". The Congress theme was "Under the Spotlight", and the program most definitely examined many current issues in perioperative nursing and healthcare in general, including single use or reuse; moving forward with decontamination; increased National Health System use of the independent healthcare sector; managing change; challenging behaviours; and, risk management. The Chief Nursing Officers of Wales and Scotland discussed using your political voice, especially in the context of devolution, or decentralization of legislative authority that has occurred in those countries. There were many other sessions, covering clinical practice, support workers, research findings, and many other topics.

This year's Congress saw the institution of the Siobhan Rankin Lecture, delivered by Professor *Robert Pratt*, President of the U.K. Infection Control Nurses Association. The title was "*Preventing and managing bloodborne viral infections in perioperative care*". Another ongoing event is the prestigious Daisy Ayris Memorial Lecture, named after the founder of *NATN* . Being asked to deliver this lecture is a great honour, and a certificate and medal are presented at its conclusion. *Phyllis Davis*, Past President of the Australian College of Operating Room Nurses, delivered this year's lecture "The Essence of Perioperative Care". With engaging and irreverent Aussie wit, Phyllis explored the topic of essence, defined as "all that makes a thing what it is", and focused on the themes of quality and safety. Phyllis ended with a review of historical stereotypes of nurses, including analyzing the phenomenal knowledge and skills set of Cherry Ames, RN, nurse-extraordinaire!

NATN is a vibrant, proactive organization. It launched a new On-Line Education program, with members having access to interactive modules. Back to Basics, Health & Safety, and Research are the first three. A new publication was also launched, "Risk and Quality Management System", which provides quality assurance and risk assessment standards and guidelines. An audit tool is provided, and a CD ROM completes the package. Their website is ***www.natn.org.uk***

It is a most interesting experience to attend a perioperative nursing conference outside North America – things are definitely different. Many of the exhibits provide refreshments, and having cappuccino or ice cream served in the exhibits is not something we are used to!

A conference also has its social events, and our U.K. colleagues definitely know how to have a good time! Their hospitality was outstanding, and a special night is hosted specifically for all the international delegates. The Congress provides an opportunity for the International Federation of Perioperative Nurses to hold a meeting of its Council of National Representatives, as many perioperative organizations send their representatives to this Congress. This was my official reason to attend!

Photo by M. Knight

Closing Banquet- L to R: Kate Woodhead, Merja Fordell, Mary Knight, James Harrison, Marion Jones

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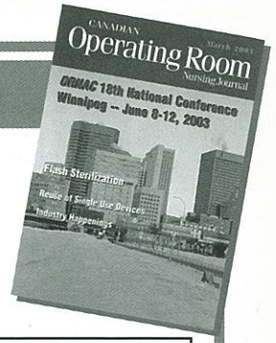


- ✔ Is your provincial organization planning an event?
- ✔ Are you involved with any interesting industry developments?
- ✔ Have you attended any local or international events?
- ✔ Do you know of someone who might make an interesting story?

If so, we'd love to hear about it!

Please contact us with your **story ideas** at **dmurphy@ClockworkCanada.com** or **902.497.1598**

OR

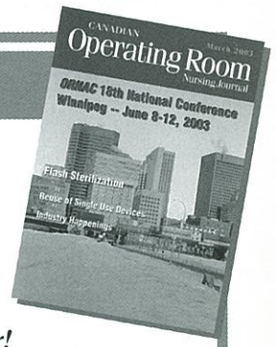
Send a **typed article** or **information about an upcoming event**, in electronic format (*Word or WordPerfect*) to: **dmurphy@ClockworkCanada.com**

Please be sure to provide us with an e-mail address and a daytime telephone number so that we can contact you to verify all details. Photographs should be submitted separately by mail (prints only, please). Please indicate with your article submission if photographs are available.

If you are a member of an *ORNAC* provincial association you could be eligible for the *ORNAC/Johnson & Johnson Drake-Thompson* Writing Award. Visit ***www.ORNAC.ca*** for details.

ORNAC and its representatives reserve the right to edit all articles for content and length. All efforts will be made to publish articles in the issue for which they were submitted but some articles will be published in later issues. We regret that original articles will not be returned to their author. Please provide contact information with all articles for the purpose of fact checking.

SOUMISSIONS D'ARTICLE



- ✔ Est-ce que votre organisation provinciale planifie une activité?
- ✔ Êtes-vous impliqués dans le développement d'un nouveau produit?
- ✔ Avez-vous participé à un évènement au niveau local ou international?
- ✔ Connaissez-vous quelqu'un qui aurait une histoire intéressante à raconter?

Si c'est le cas, nous aimerions beaucoup en entendre parler!

S'il vous plaît, faites-nous part de vos suggestions à : **dmurphy@ClockworkCanada.com** ou **902.497.1598**

ou

Faites-nous parvenir votre article dactylographié ou l'information concernant un événement à venir, en format électronique (*Word* ou *WordPerfect*) à : **dmurphy@ClockworkCanada.com**

Assurez-vous de nous fournir votre adresse électronique et un numéro de téléphone où il est possible de vous rejoindre le jour pour la vérification de tous les détails.

L'AIISOC et ses représentants se réservent le droit de modifier tous les articles en ce qui a trait au contenu et la longueur. Tous les efforts seront faits pour publier tous les articles dans la prochaine parution, mais certains devront être retenus pour une publication ultérieure. Nous regrettons que la copie originale ne puisse être retournée à leur auteur. S'il vous plaît, veuillez nous fournir vos coordonnées avec l'envoi de tout article pour nous permettre de vérifier avec vous certains faits.

Author: Muriel Shewchuk,
muriel.shewchuk@shaw.ca

Pearls of Wisdom

Meetings, Bloody Meetings – What are we Doing?

Meetings: An Addiction to Conquer!

It is time to take an inventory of meetings, do a personal assessment, and make some changes!

We have anonymous groups for all other addictions so lets build a *Meetings Anonymous Organization* (*MAO*). *MAO* is based on taking the daily, all consumptive need to "call a meeting" and change it to "lets go for a drink or a coffee". This approach is a whole lot more fun and we might get to know and understand our colleagues a little better. At any rate, the new health news is that we should have three drinks a day (especially red wine) for improved cardiovascular health so meetings could become a lot healthier.

Definition of Meetings: A collective discussion or assembly of more than one individual for a face to face encounter, frequently with a pre set agenda (that may have been generated from another meeting), often with a preset length of time that seems to usually be calculated in hours, or multiples thereof. This timeline seems to be based on tradition rather than the actual need for information to be shared or decisions to be made.

Why are meetings called, held, mandated, organized and ordered based on a routine that seems to be carved in stone?

Don't take offense- there are many vital, well run, productive, essential, mandatory meetings that are well organized and have effective outcomes that are in line with the time and cost involved. However, the many meetings can vary from this ideal. The reason for holding or attending meetings include, but are not limited to, the following:

- The terms of Reference state so; the by-laws state so; the CQI requires; a policy statement mandates it.
- The belief that multi stakeholders must have input into decisions because we live in a democracy
- The desire to attend every meeting in order to protect your turf. Some would say this is a way to avoid the real issues and the workplace environment
- Humans beings are social creatures; the debate, discussion, and challenges that are an integral part of meetings help fulfil the social need
- Meetings help us meet challenges, find support and form strategies
- By obtaining Input from expert members we help ensure likelihood of success
- Demands to remain current in specific areas such as policies and procedures require multidisciplinary input on an ongoing basis
- The belief that because the work is shared then the input must also be shared
- Many meetings are used as a controlled form of internal communication
- The fast paced changes in information and technology result in the need for frequent planning changes
- Fiscal and government agendas are the driving force behind many meetings

What do staff think about meetings? It's not pretty!

- Meetings take key people out of the "real work" environment so they are not visible and therefore do not really know what is going on
- "They" have meetings to decide our lives and we are not involved in the discussion or decision

Continued on Page 22

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Reuse of Single Use Medical Devices

During the ten years that I have worked at the Canadian Nurses Protective Society, we have had numerous calls from Operating Room nurses questioning the practice of re-using single use medical devices in their facilities and voicing their concerns about possible harm to patients, themselves and potential liability exposure. Interest in this topic has been rekindled by the recent Saskatchewan case involving the death of a patient from variant Creutzfeld-Jakob Disease (vCJD) and possible transmission of vCJD to 71 patients who may have been exposed to the same endoscope as the deceased while in hospital. In this article, I propose to address some of the concerns related to the reuse of single use medical devices by focusing on the prevalence of this practice, the legal risks involved, regulation of this practice, and risk management.

Author: *Ann Tapp, RN, B.A., LL.B, is a lawyer and registered nurse. She is currently a Professional Liability Officer at the Canadian Nurses Protective Society.*

PREVALENCE

Just how prevalent is this practice in Canada? In 2001, a study addressing reuse practices in Canada was conducted for the Advisory Committee on Health Services (ACHS). The findings from this study were released in May of 2001 and reveal that of the 802 Canadian hospitals surveyed 7% do not reuse and 40% of the hospitals indicated that they reused items from the list provided.

RISKS

Reuse is a concern because reuse of single use devices is not without risks. There are primarily three major risks related to this practice. First, there can be damage to the device's functional integrity because of the effects of resterilization on the physical and mechanical properties of the device, which could result in device failure or patient injury. Second, infection or transmission of disease may result from devices exposed to high levels of contamination during first use, build up of toxic residues and ineffective reprocessing. And, third, there may be health risks for health care personnel exposed to additional blood and body fluids, or reprocessing chemicals and gases.

LIABILITY ISSUES

Because of the risks, litigation may be initiated if a patient suffers injury as a result of the reuse of a single use item. And, if a number of patients suffer similar injuries a class action could be commenced. From a liability perspective, the two main areas of concern relate to the potential for actions in negligence against an institution for reuse of disposables and against health care providers for failure to obtain informed consent.

It is quite clear in the Canadian case law that in order to provide patients with reasonable and safe care a hospital owes its patients a duty to provide adequate and safe facilities and equipment. This legal duty incorporates the appropriate maintenance of equipment including the procedures for decontamination, resterilization and reuse of devices that have been designated by manufacturers as single use items. Consequently, if a patient suffers an injury or develops an infection or disease related to the reuse of a disposable, and the harm suffered can be attributed to the handling or reprocessing of the reused device, then the hospital may be found liable for its breach of the duty to provide patients with safe equipment.

As in all medical negligence cases involving hospitals, the court will hold the institution to a reasonable standard of care. In a reuse case, factors the court will look at include the practice in other comparable institutions, the foreseeable risk to a patient and the manufacturer's advice concerning reuse. In most cases, manufacturers of single use devices do not approve of the reuse of single use devices. This is the position taken by Medical Devices Canada (MEDEC), the main trade association for the medical device industry in Canada. MEDEC has stated that it "strongly disapproves of the reuse of single use devices. Organizations or individuals that choose to reuse single use products do so at their own risk and should be prepared to assume some liability. Institutions that reprocess and reuse single use devices contrary to labelled indications should be required to validate the procedure to the same standards as industry."

The second area of concern involves informed consent. The case law and provisions in consent to treatment legislation clearly state that health care providers have a legal obligation to obtain a patient's informed consent before providing medical treatment. In a case involving the reuse of disposables, the main issue will be whether the patient's informed consent is needed for the reuse of single use items. And if, yes, whether the duty to inform was met.

The seminal case in the informed consent area is Reibl v. Hughes. In that case, the Supreme Court of Canada stated that a patient must be informed of all the risks related to the procedure or course of treatment that would be material to the patient's decision to proceed or not proceed. When addressing the issue of materiality the court has indicated that factors that must be considered include the likelihood of the occurrence of a risk and the gravity of the potential consequences. Therefore, in a reuse case, in order to convince a judge that informed consent had not been given, the patient must establish that had he/she been informed of the risks related to the reuse of a single use medical device then he/she would not have agreed to proceed with the procedure or treatment.

If a hospital has reasonable protocols in place and research based evidence that there is no significant increase in risk from the use of the reprocessed item/device, compared to the single use of the same device/item, it is unlikely that a judge would find that reuse of a single use medical device is a material risk which must be disclosed to the patient for the purposes of obtaining an informed consent. Conversely, if the institution's research reveals that the reuse of the medical device poses a significant increase in risk to the patient, a judge would probably find that this information must be disclosed to the patient as part of the informed consent process.

REGULATION

Are there laws or guidelines relating to reuse? In the US, the Food and Drug Administration (FDA) regulations provide comprehensive requirements that must be complied with before single use items may be reused. These regulations place the responsibility for the safety of the reuse on the shoulders of the institution or individuals undertaking the reuse and require these parties (i.e. hospitals and third party processors) to comply with the same quality standards and all the regulatory requirements as the original device manufactures. The FDA regulations establish three device classes that are based on risk. Class I (least risk) devices are subject to general controls, Class II (moderate risk) are subject to special controls and Class III (greatest risk) must undergo pre-market approval.

In Canada, we do not have legislative requirements similar to the American FDA regulations. Health Canada has legal authority to regulate the sale of medical devices based on the provisions in the federal Food and Drugs Act. Because the Food and Drugs Act and its regulations set no requirements on the user of

Continued on Page 28

ORNAC/J&J Drake-Thompson Writing Award 2001-2002

CONGRATULATIONS to **Perri Brazill** *RN CPN(C) RNFA* on receiving the annual *ORNAC*/J&J Drake -Thompson Writing Award 2001-2002.

J&J Medical Products established a writing award to encourage Perioperative Nurses to publish articles that will assist in advancing Perioperative Nursing practice and assist in the education of Perioperative Nurses through informative, relevant articles.

This annual award was named **Drake-Thompson** in memory of *Mr. Chris Drake* and *Mr. Greg Thompson*, both former employees of *J&J Medical Products*, who died in a plane crash while on company business. All articles that have been published in the *Canadian Operating Room Nursing Journal*, and were written by *ORNAC* members, are reviewed and scored by the members of the *ORNAC* Awards committee.

Perri is the Patient Care Coordinator in the Cardiac Operating Room at the Health Sciences Site, St John's, NL. She has been an *RNFA* since 1997 and was instrumental in the development, implementation and promotion of the *RNFA* role. Her article, "*Infected Cardiac Myxoma: An Unusual Phenomena*" was published in October 2001.

Mr Charles LeBlanc was in St John's recently and made the presentation on behalf of *J&J*. ***Congratulations Perri!***

Submitted by: *Lynn Anderson, ORNAC Secretary*

L to R-Charles Le Blanc, Johnson & Johnson Medical Products; Perri Brazil, award winner; Lynn Anderson, ORNAC Secretary
Photo Courtesy: J & J Medical Products

- "They" are not here for me when I need them - "they" are in a meeting!
- Meetings take too much time and the real needs in the department are compromised as a result
- We don't get any post-meeting communication about what decisions were made and why they were made. (Note that even if minutes are made available staff are unlikely to read them or to assimilate the content)
- Meetings are a waste of time that are not necessarily based on a real need

The dynamics and profiling of meeting attendees – The Good, The Bad and the Ugly! Remember that most people are at a meeting because of their position not necessarily because of what they can contribute!

The "Good Dudes" – We want to keep them because they:

- Meet for the intended purpose or as mandated by constitution, standards, by-laws, or special needs
- Are always on time and always prepared
- Have read the minutes and look for substantive issues or errors, not trivial points, grammar, or spelling
- Take leadership roles in executive positions but don't hog them year after year
- Bring agendas, and provide information needed at the meeting in an organized fashion
- Are always cognizant of time and maintain a focused discussion
- Volunteer to do off-line work and circulate it in advance of the next meeting. Set an expectation that information distributed has been read
- Tolerance for excuses must only include being a patient in ICU or death certificate – accountability is critical.
- Are keen to stay on track, move forward efficiently and effectively to keep meeting length and frequency to a minimum
- Terminate Ad Hoc meetings that never seem to go away
- Attempt to get the "Bad Dudes" and The "Ugly Dudes" on track

The "Bad Dudes" – Need to get focused, get organized or get out! They:

- Go to meetings just because it's on the list of things to do or because of the position routines
- Are always a few minutes late and have an "other things are more important" attitude
- May believe that being late shows you are important or that others will be late so you should be late to save your own time
- Never read materials that were distributed. Their commitment to the process appears to be weak
- Arrive with no agenda or minutes, scrambling to borrow them, and causing a general disruption that results in a loss of 15 or 20 minutes while they get in sync with the meeting
- Are never prepared, make off the cuff irrelevant comments that destroy their credibility
- Tend to be disorganized, contribute nothing, and take nothing back to the staff
- Are probably oblivious to they impact they have on the group – it is unlikely their impact is intentional

The "Ugly Dudes"— They need to channel the negative energy into creative assistance! These individuals:

- Go to meetings because of their position or they have an axe to grind
- May or may not be on time; operate on a personal or hidden agenda with bullying tactics that are highly visible
- May or may not occupy key executive positions
- Argumentative, nitpicking, rude, hog the floor, loud, abrasive, pig-headed, disrespectful of other members' positions, responsibilities, and views
- Make meetings go off track, produce negative emotions and behaviour that derail the intended purpose of the meeting. All the while they are driving their own views or agenda
- Do not give credit to anyone. They are destructive to the purpose and the outcome of the meeting

The Ideal Meeting Profile – Time for Measuring Meeting Outputs!

- Establish a Motto and Operations Expectations that incorporate such aspects as member functions, responsibilities and accountability; a code of conduct; issue resolution processes; and effectiveness measures.
- Review the group's performance every 6 months or more and update the need for the meetings, goals for length of time, the desired results, and areas for improvement
- Select a Chair, a secretary, and a time monitor who are absolutely committed to efficient, focused, effective meetings and will help others stick to this goal
- Ensure agendas and minutes are received by attendees in adequate, agreed upon time; put in place consequences, with some humour, for those who are ill prepared have the group plan up front how they will deal with late comers.
- Develop and stick to a minute taking format that clearly identifies the topic, issue, the action to be taken, by whom and an expected date of completion (EDOC)
- Minimize the extraneous chatter, digression from meeting and DO NOT include in the minutes.
- Determine the expected date members can expect the minutes – hold the secretary to that – thereby eliminating excuses of insufficient lead time for work to be completed
- Do an audit of minutes and accomplishments quarterly and annually. Ask yourself are you value for dollars spent to your organizaiton. Be tough on ensuring outcomes, refocus or disband
- Start the meeting on the minute intended. As stragglers walk in late identify their time of arrival and record in the written minutes
- Get rid of the hourly concept and break it down into 15 minutes blocks. Plan like you were paying by the minute!
- At the end of each meeting ask – what did we accomplish? do the members feel good about the outcome? did we use our time wisely? if not, why not? This may need to be submitted by members in writing until they are comfortable about speaking out with no fear of retribution.
- End on time and leave the meeting and go back to productive work – do not hang around and waste time. Too many people seem to not know what to do if a meeting finishes early
- Instead of going to all meetings use teleconferencing for some – phone dealings are much more precise, focused and use less time; long rambling dissertations are not tolerated on phone calls.
- Calculate the dollar value of the attendance at these meetings and equate that to the actions and decisions made at each meeting. Would the meeting have been worth it if it had to show a profit?

We talk about balance in our work life and balance in our personal life. Now lets get some balance in ***meeting... bloody meetings***! Make every minute count and the hours will take care of themselves.

UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

British Columbia	Victoria	March 10-13, 2004
Alberta	Calgary	October 15-18, 2003
Saskatchewan	Humboldt	Fall 2003
Ontario	Toronto	June 20-23, 2004
Quebec	Quebec City	Fall 2004
New Brunswick	Saint John	April 25 - 26, 2003
Newfoundland	Burin	Fall 2003

ORNAC CONFERENCES

18 th National	Winnipeg, MB	June 8-12, 2003
19 th National	Montreal, PQ	May 2-6, 2005

INTERNATIONAL CONFERENCES

Nursing 2003 Symposium (www.nursingsymposium.com)	Lake Bueno Vista, FL	April 13-16, 2003
AORN (www.aorn.org)	San Diego, USA	March 21-25, 2003
NATN (www.natn.org)	Harrogate, UK	October, 2003
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Report From The Australian College of Operating Room Nurses (*ACORN*)

***Author**: Phyllis Davis, ACORN President 2000 to 2002*

The *ACORN* 10th National Conference was held in Melbourne May 22nd to 25th, 2002. The Conference theme *Evolution or Revolution* provided the speakers with the opportunity to address a range of topics that challenged us professionally, ethically, and personally.

Associate Professor Jane Gordon opened the conference with a thought provoking paper related to the 1995 study by Wilson et al entitled "*The Quality in Healthcare Survey*". The paper revealed that 16.6% of admitted patients experience an adverse event while in hospital that contributes to longer stays than originally expected. Jane explored the issues related to Clinical Governance and the occurrence of adverse events associated with hospital admission.

The delegates had a choice of four concurrent sessions each day and the introduction of "single stream sessions", where sessions all focus on the same theme (e.g. Infection Control) and take place in the same room.

The medical industry once again provided its generous support of *ACORN* with 101 stands available for the delegates to view.

The conference highlight was the inaugural ***Judith Cornell Oration***. The intention of this event is to provide a biennial opportunity to celebrate the achievements of Australian Perioperative Nurses and to introduce future visions.

Mrs Judith Cornell, AM, accepted the Board's invitation to present the inaugural oration. Judith was one of the two New South Wales Operating Theatre Association representatives to the inaugural planning meeting held in Melbourne in 1975 that lead to the 1977 Australasian Conference of Operating Room Nurses held in Canberra. Judith chaired this conference, at which it was decided to form the Australian Confederation of Operating Room Nurses (*ACORN*). Judith used her skills as an archivist and her interest in history to provide an overview of *ACORN* and its influences over the past twenty-five years.

Photo by P. Davis

L to R: Phyllis Davis, President; Judith Cornell, Orator

Also during the Conference *ACORN* members voted to accept overseas members and affiliate members. The inaugural overseas members are *Libby Campbell*, *Sharon Preddy*, *Janet Cohen*, *Kate Woodhead*, *Betty Shultz* and *Sheila Allen*.

The Conference was a great success and on behalf of the Board and Members of *ACORN* I invite you to join us in Adelaide, South Australia, April 28 to May 1st, 2004 for the 11th National Conference. For more information visit our web site at *www.acorn.org.au*.

medical devices, reuse of disposables is not a violation of the act or its regulations. Use is governed by provincial legislation. Health Canada is, however, in the process of examining their authority to regulate reuse and repro-cessors and is developing options for policies and/or regulatory action in this area.

At the provincial level, since February 24, 1999, Manitoba has placed a ban on the reusing of all "critical products" (one that penetrates skin or invades normally sterile parts of the body i.e. products with blood contact, or invasive into sterile body cavities). Quebec has also taken a position on this issue. In 1996, the Minister of Health for Quebec declared a moratorium on the reuse of single use cardiac catheters because of concerns that patients might be at risk of contracting CJD.. This position was modified in 1997 based on a report prepared for the Minister of Health by the Conseil D'Évaluation des Technologies de la Santé du Quebec (CÉTS). Based on the scientific evidence available at that time, CÉTS concluded that cardiac catheters should not be reused if they had come in contact with patients considered to pose a risk of being a vector for CJD. If the catheter was used on patients not within that category, CÉTS concluded that "given the current state of knowledge, the reuse of single use angioplasty and angiography catheters does not pose any unacceptable risks as regards the possible transmission of Creutzfeldt-Jakob disease."

Although there is no current Canadian federal or provincial/territorial legislation governing reuse of single use devices, there are comprehensive guidelines on reuse published by the Canadian Health Care Association. These documents set out factors that should be considered before establishing a reuse program. They provide a framework that can help an organization make an informed decision about the risks and benefits of setting up this type of program. The guidelines also contain a comprehensive review of the literature and suggested parameters for the development of a reuse program. A classification system, similar to the system set out in the American FDA regulations, and guidelines for resterilization are also included.

RISK MANAGEMENT

How can an organization limit the risks related to reuse of single use medical devices? The best method of limiting risk is to **not** reuse. Many hospitals have decided to take this position. If a decision is made to reuse, or to continue to reuse, the CHA guidelines suggest that the first step is to set up an interdisciplinary reuse committee. This committee would be responsible for setting up the framework for the reuse program and overseeing its implementation and ongoing evaluation.

An effective program should include: a cost analysis at the outset to demonstrate the cost effectiveness of reusing; a formal written reuse policy which is endorsed by management; written protocols emulating industry standards by setting up step-by-step reprocessing procedures which produce outcomes that are quantifiable, documented and supported by test data; consistent application of these protocols to each disposable item that is to be reused; and a quality assurance component which ensures that the reused product can be safely used for patient care and does not expose health care workers to increased risks. The program should also include staff education and incorporate audits to ensure that the protocols are being applied consistently and appropriately.

If your hospital is reusing single use medical devices, or, is considering whether to do so, it is important to remember that reuse should **not** be done on an ad hoc basis. Your reuse program should demonstrate that single use devices that are reprocessed are as safe as reusable medical devices that have been appropriately reprocessed.

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FLASH STERILIZATION (STEAM)

Author: *Barbara Bolding RN, BSN, MBA. Barbara Bolding is a Sterile Processing educator and consultant based in British Columbia. She currently works as a clinical educator for Johnson & Johnson Medical Products.*

Flash sterilization is an integral part of every OR nurses job and like everything else in health care, the processes and recommended practices regarding it are constantly evolving. A number of years ago flash sterilization used to be defined as "steam sterilization using the unwrapped method" (AAMI Recommended Practice 1986). The more current definitions describe it as steam sterilization of items for immediate use or emergency sterilization. You may also hear it referred to as "just in time" sterilization. However it is described, the underlying premise of flash sterilization is that the goods have not been pre-packaged and conventionally sterilized (AAMI ST37-1992). The absence of packaging creates good news and bad news. The good news is that items can be sterilized more quickly than those in conventional packages. The bad news is that items must be used immediately because they cannot be stored.

In order to ensure "flashed" products are safe for patients, there are a number of things that you should know about the process. *ORNAC*, The Canadian Standards Association (CSA), AORN, and the Association for the Advancement of Medical Instrumentation (AAMI) all have recommended standards of practice related to flash sterilization. They are in general agreement regarding the conditions under which flash sterilization may be undertaken. These are:

- There is an urgent need for the item;
- Work practices ensure proper preparation (cleaning, inspecting and arrangement) of the items prior to sterilization;
- The physical layout of the area ensures direct and aseptic delivery of the freshly sterilized item to the sterile field; and
- Implants should not be flashed.

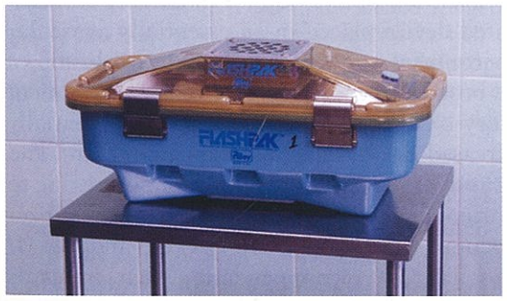

Photo by J. Porteous

Riley flashpak container

Flash Sterilization Exposure Times

Most flash sterilizers operate at a temperature of 132° C (270° F). At that temperature, the standard exposure times for flashed items will depend on two things:

- the contents of the load i.e. hard goods or porous (soft) goods; and
- whether air removal in your sterilizer is vacuum assisted or operates via gravity displacement (Check your operator's manual).

At 132° C- GRAVITY	
Hard Goods*	Porous/Soft Goods**
3 min.	10 min.
At 132° C- VACUUM	
Hard Goods*	Porous/Soft Goods**
3 min.	4 min.
At 132° C- FLASH CONTAINER IN GRAVITY *(as per manufacturer's instructions for use)*	
Hard Goods*	Porous/Soft Goods**
5 min.	10 min.

* Hard goods are non-porous items. They are solid metal instruments that require outer surface sterilization only.

** Soft goods are any items that could absorb or trap air, such as towels, plastic items, or items with lumens such as needles or fine suction tips.

The Importance of Proper Preparation

No item will be sterile if it has not first been properly cleaned. Protein soil cannot be sterilized and any soil left on an instrument will prevent complete sterilization from occurring. Items for steam sterilization must be completely opened and/or disassembled because steam is a surface sterilant and any instrument surface not fully exposed will not be completely sterilized.

Improper preparation of instruments is one of the main reasons for flash sterilization failure. There is little enough time available between cases for even the most routine tasks. When

FLASH STERILIZATION (*cont.*)

trying to fit thorough cleaning and preparation of instruments into the limited time of change-over and trying to clean and prepare instruments in an OR area that often does not have adequate cleaning space and equipment there are numerous opportunities for error.

Aseptic Transfer

Because aseptic delivery from sterilizer to the sterile field is a problem for most ORs, many centres are using some type of closed container to protect the sterility of items during transfer. One commonly used flash container is a plastic instrument tray with an inner mesh basket and a lid that snaps in place. Properly prepared instruments are put into the container along with a sterility integrator, the lid is secured and the entire container is placed in the flash sterilizer chamber for the appropriate time. Upon cycle completion, the entire container is transferred to the theatre where the circulating nurse removes the lid allowing the scrub nurse access to the instruments.

In order to use a flash container, there are a number of checks that should be performed daily. These will be detailed and illustrated in the "Instructions for Use" that accompany each container. One particular type of container requires the user to:

- Ensure the container is clean;
- Vent the valves in the lid and in the tray. This should be done at the beginning of the day when they are cold;
- Verify that both valves are correctly seated; and
- Remove residual water between uses.

Some flash sterilizers have a setting that will allow the item(s) to be lightly wrapped for flash sterilization, The item must still be used immediately, but the wrapper protects the items during transport between the sterilizer and the sterile field. The use of a flash container, a specially designed sterilizing cycle, or a similar system addresses the problem of aseptic transport between the sterilizer and the sterile field. It greatly reduces the chance of post-sterilization contamination and thus improves the safety of flash sterilization. However, it alone does not ensure effective sterilization.

Monitoring

Even with proper preparation and aseptic transfer between the sterilizer and the sterile field, sterilization is still not guaranteed. Flash sterilizers must be kept in good working order. Their monitoring and maintenance standards should be no different from the sterilizers in the Sterile Processing Department. The monitoring standards include the following :

- The parameters (time at temperature) of each cycle should be recorded. For Q.A. purposes the record should be verified and initialled by the person removing the item(s) from the sterilizer. The record should include information to connect the instrument(s) and cycle to the patient on whom the flashed items were used
- A chemical process indicator or integrator should be placed in each container or basket prior to sterilization, and the correct change to the indicator should be verified on completion of the cycle. If the sterilizer is a vacuum type, an air removal test (Bowie Dick) should be performed daily and results recorded; and
- A biological test of the sterilizer should be performed daily in each machine and on each type of cycle that will be used.

There are two types of biological indicators (B.I.) on the market today –standard and enzyme fluorescence. It takes up to 48 hours to obtain final results from a standard B.I. The enzyme type test is much quicker and can provide a flash sterilization results in one hour. The advantage of a quick result is obvious. In some instances B.I. results can be available before an item is used, and often results can be known before a patient leaves the OR. This is especially important when implants are involved.

Implants

As the 1997 *AORN* Recommended Practice: Sterilization, points out, "a minimally contaminated device placed in an essentially avascular environment and left there at the conclusion of the procedure could increase the risk of patient injury or infection". Because of the potentially increased risk of infection from an implant, and because of the risk of sterilization failure due to shortcomings in work practices and/or sterilizer function, *ORNAC*, *AORN*, *CSA*, and *AAMI* all make the recommendation that implants should not be flashed. Most ORs follow this recommendation to the best of their ability.

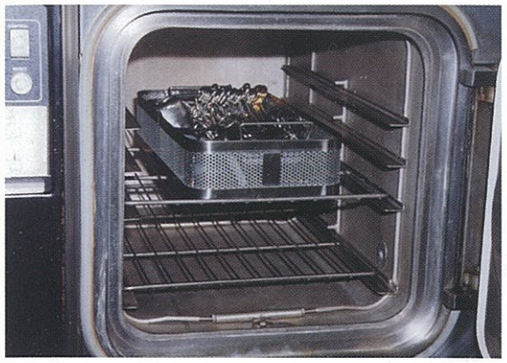

Photo by J. Porteous

Gravity displacement sterilizer with pan of instruments inside

Although manufacturers now supply many implants in a sterile state, not all are pre-packaged and sterilized. Large, small, and mini fragment sets with their numerous plates and screws are obvious examples to the contrary. If these sets have to be flash sterilized, a fast B.I. result provides an additional measure of assurance that the product is safe to use.

Conclusion

The message to take away from this brief review of flash sterilization is that there are many factors that contribute to the safety of the process. Failure of any of the steps can lead to sterilization failure and subsequent harm to patients. Cleaning and preparation of instru-ments, loading and unloading of the sterilizer, selection of sterilization time and temperature, and sterilizer function must all be correct in order to achieve sterilization and to protect patients.

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Perioperative Nursing: From Little Acorns, Great Oaks Grow

Kate Woodhead is an internationally recognized expert in perioperative nursing. Currently President of the International Federation of Perioperative Nurses (*IFPN*), Kate is Past Chairman of the National Association of Theatre Nurses (*NATN*) in the United Kingdom. Kate is a frequent presenter throughout the UK, and won the Best Lecture Award at the 2nd European Operating Room Nurses Association Conference in 2000. **This year she will present the key-note address at the *ORNAC* National Conference.**

Kate is an experienced theatre manager, whose main practice is project and consultant contracts. She has recently been involved in several quality and risk management projects, including the modernization of sterilisation and decontamination, skill mix review and audits. Kate also has extensive experience with the variant Creutzfeldt-Jakob Disease outbreak in the UK.

Kate has been making her own personal contribution to the dissemination of perioperative knowledge in less privileged parts of the world. Along with a colleague, she has provided programs on perioperative nursing to colleagues in two African countries, where our colleagues face unbelievable challenges every day to provide the absolute basics of care to their patients – with no electricity or only intermittent supply, no run-ning water, theatres that had no roof, few drug supplies, and so on. In one country, no perioperative education had been given in 36 years!

Kate's insightful and thoughtful presentation will expand your perioperative nursing horizons far past the shores of Canada and North America – a wonderful way to kick start our Conference!

20th *ORNAA* Conference Celebrates 25 years

October 16 – 19, 2002 Edmonton, Alberta

Submitted by: *Nadine Englehart*

• 234 delegates registered • 52 exhibit booths

ANNUAL GENERAL MEETING

This year's *ORNAA* Snips and Snaps Writing Award was presented to *Kendall O'Brien* from Calgary for her article on Limb Perfusion. *ORNAA* executive recognized all past presidents of *ORNAA*, with 11 of 13 present at the conference. A nice surprise was a visit from past *President Jane McLain* all the way from Norway. *ORNAC* was also well represented at the Edmonton Conference. *Mary Knight*, *Marg Farley*, and *Alicia Mattheis* were all able to spend some time getting to know the *ORNAA* delegates and executive. A commemorative 25-year booklet and a silver *ORNAA* pin were presented to all delegates. Thanks to *Muriel Shewchuk* for her continued support of *ORNAA* and her determination to have Perioperative Nurses maintain their skill levels and keep them current!! Muriel funded 59 OR nurses from Calgary!

K-BRO BREAKFAST AND TOUR

- A great tour and scrumptious breakfast was sponsored
- 20 scrub bears were given away as well as a $500.00 and a $1,000.00 gift certificate to IKEA

DINNER IN DENIM, SPONSORED BY ALBERTA EXHIBITOR'S ADVISORY COMMITTEE

Delegate and exhibitor dining etiquette were tested throughout the night, but one wonders if the judges were following the protocol of "*Miss Manners*" or Martha Stewart?

Photo by M. Ensninger

L to R: Back – Heather Allen, Heather Perl, Michele Romanyshyn, Terri Zukiwski, Gwen Baldwin. Front – Diane Johnson, Kim McLennan-Robbins, Andrew Stephen, Peggy Ziegler

Photo by M. Ensninger

Calgary group in medieval attire

Rosy Roppo, Marketing Manager, The Bay, West Edmonton Mall orchestrated a fashion show after dinner.

A round of applause goes to the delegates and exhibitors who strutted their stuff down the runway from "*Safari Jim*" to "*Hot Pants Sheila*" to "*Sophisticated Marjorie*." Not often has Gord Steinki from Edmonton's Global News been at a loss for words.

MEDIEVAL BANQUET

Delegates were bused en mass to the hall where we were greeted by Queen Gwendolyn, King James, and their fine prince. All in true medieval style, sans cutlery, we enjoyed a great dinner and the 'wenches' met all our needs. The castle staff and the young Irish dancers entertained us royally, and the participation of the audience made it most enjoyable. King James knighted Sir Deb and Lady Denise who will forever look at gold coins with a new meaning.

AEAC also sponsored a draw with the proceeds going to Breast Cancer Research. Three lucky winners are now sporting either a diamond tennis bracelet, a diamond necklace or diamond earrings.

While it may seem we only had fun, the educational component of the conference rode high. From sterile packs to change in technology; from hypothermia to "Zap" facts; from ARO and CJD to herbal remedies; from hazards to patients, devices and healthcare professionals to computerization and the future of nursing; we had it all including plenty of humour and laughs.

Congratulations to Kim McLennan-Robbins and her terrific Planning Committee. What a great job! We look forward to keeping the support for ORNAA going and to seeing everyone next year in Calgary!

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