

# Canadian Operating Room Nursing Journal

Published Quarterly. Vol. 15, No. 2, June, 1997

- Anne Hughes wins the Isabelle Adams Award
- Joan Donald - First OR nurse to achieve doctorate
- Latex Allergy in the nursing population
- Canada wide status of RN first assistant programs



# Canadian Operating Room Nursing Journal

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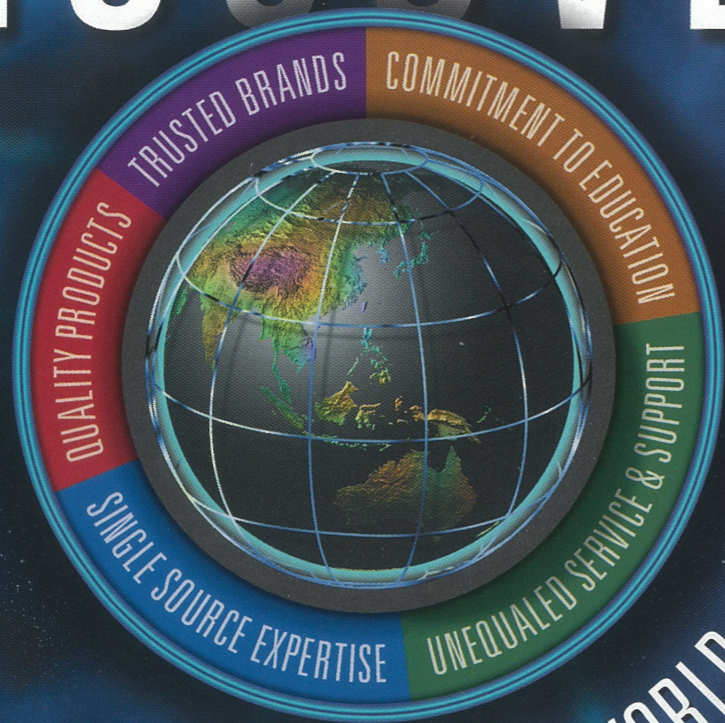


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## ORNAC Board of Directors - 1997 - 1999

**Front row** seated (l to r) Corina Balcom (NB), Secretary; Jackie Waisman (AB) retiring from Board as Past President; Vija Hay, (ON) Immediate Past President; Donna Farid, (NS) President, Marlene Hill (PEI), President Elect. **Middle row** (l to r) Kendall O'Brien (AB), Paula Dryer (PEI), Jean-Yves Latreille (PQ), Monique Perazzelli (PQ), Marla Ewen (SK), Sandra Poirier (NB), Mary Knight Kubasiewicz (MB), Rosemarie Atwill (ON), Sandra Grimwood (BC). **Back row** (l to r) Gloria Nemecek (AB), Sharon Ball (ON), Marg Farley (SK), Carolyn Hughes (PEI), Nora Slater (NB), Shelly Zareski (NS), Lyn Thorne (NS), Sheila Billiard (NF), Lillian Budden (NF), Faye Meuser, (BC). Not Shown: Shirley Thorn (MB).

## ORNAC's 15th National Conference Ottawa, 1997

**Photo Right:** Johnson&Johnson Medical Products paid their traditional tribute to ORNAC and the National Conference delegates with the presentation of an original watercolor by an Ottawa artist. Paul Montador, President of J&J MP presents Vija Hay, Conference Chairperson and ORNAC Past President with the original. Prints were presented to each of the 500 conference delegates.



The colorful opening ceremonies in the Ottawa Convention Centre featured the ceremonial flags, the pipes and drums, folk dancers and the Royal Grenadiere Guards.



# Reality, Respect, and Responsibility

By Donna Farid, RN, PGOR, CPN(C)

As I reflect on becoming President of ORNAC, my prevailing thoughts have to do with three R's: **Reality, Respect, and Responsibility**. Although each of these words represents an independent focus, they are also interdependent. The **Reality** of being President is here and now. In my role as President-Elect, although I actively participated on the Executive of ORNAC, my main function was one of observation, gathering information, meeting stakeholders, and learning. Vija Hay's guidance during this time was invaluable, and I will certainly continue to seek her input and feedback over the next two years. Thank you, Vija, for all that you shared with me. I am most appreciative.

I have a deep and abiding **Respect** for all that ORNAC stands for and all of those it represents. Out of this respect comes a strong sense of **Responsibility** to work together with the Board and Executive to maintain ORNAC's well established reputation and high regard among many professional associations, health care and educational institutions, the surgical supply industry, and the membership. This reputation is a result of a tremendous amount of work by dedicated Perioperative Nursing leaders from every province, who volunteer their knowledge, time and effort to represent Perioperative Registered Nurses nationally. We will endeavor to continue to address current and future health care issues that affect all of us.

When I received the Chain of Office on May 2nd in Ottawa, I informed the audience that I was the first staff nurse to become President of ORNAC. I believe this gives me a special insight into the concerns, needs, and issues of the majority of the membership, the direct patient care providers. My mandate over the next two years is to speak out on behalf of Perioperative Registered Nurses at every opportunity. But I must emphasize that it is no longer sufficient to sit back and expect others to secure your future for

you. It is imperative for all nurses to become involved in proudly promoting their professional commitment to the best patient care in Canada.

Look at the incredible response in the certification process. In just three years, over 1,000 nurses have successfully written a National Certification exam the largest specialty nursing group to seed certification in the country. This speaks volumes about the commitment of Perioperative nurses to their professional competence!

Dr. Judith Shamian, speaker at the closing of the 15th National ORNAC Conference in Ottawa, said:

•“Registered Nurses must take stock of the issues, as women, and as professionals.”

•“We must make alliances internally and especially externally to halt the chipping away at our professional roles and the giving away of the body parts of our patients, and instead, promote recognition of the holistic care we want to give.”

•“The professional nurse is one who applies knowledge, science and art to patient care, and is continuously reprioritizing the nursing process and tailoring it to patients and their families.”

•“This professional high level care is worth supporting.”

Join me in this campaign to inform and educate the public to increase their awareness of the expert care they deserve to receive during their surgical experience.

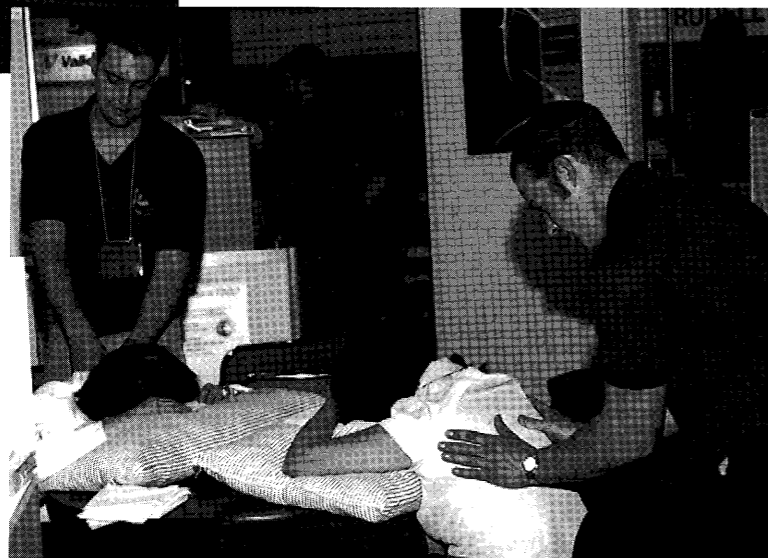
Donna Farid, RN, CPN(C), is the 1997-1999 President of the Operating Room Nurses Association of Canada. She is a Staff RN in Cardiovascular Surgery at the Queen Elizabeth II Health Science Centre, Halifax, Nova Scotia.

Audrey Macdonald wins the 1997 Johnson&Johnson Medical Products Drake-Thompson Writing Award of \$3000 for her article “Measuring Quality: Evaluating Personal Competencies” published in the March/April, 1996 issue of this Journal. Making the presentation at the National is Paul Montador of J&J.

Below: J&J took a new approach in their National Conference exhibit. Instead of focusing on product they highlighted a current need of the OR nurse - stress management by hiring a dozen message therapists to work out delegate stress. In a stress profile test conducted at the exhibit 66% of the nurses indicated stress levels of “fair to poor”, however 67% showed they were coping with their stress in a good manner- probably because 69% reported having strong social support. Medium to high signs of anger was present in 56% of those surveyed.



Dr. Joan Donald stands to take the applause and the expression of pride from her friends and the delegates at the National Conference. She is Canada's first OR nurse to achieve the doctoral level. Joan is a past president of ORNAC and former winner of both the ORNAC writing award and the prestigious Isabelle Adams Award for Excellence in Perioperative nursing.



ORNAC National Conference

Anne Hughes Presented the Isabelle Adams Award



Maxxim Medical Canada sponsored a fantastic Rock 'n Roll/Las Vegas Night with gambling, dancing and draws for three trips to Las Vegas. Winners were Pauline Lynch, Saint John, NB; Connie Newcombe, Saint John, NB and Marie Josee Parent, Montreal. Winners of Maxxim's \$500 shopping spree in the Rideau Centre, Ottawa were: (Shown in the photo with the Maxxim staff are (centre row l to r) Val Tilley, St. John's, Nfld.; Jane Pearson, Halifax and Helen Friend of St. Catherine's.



Anne Hughes (centre) was presented with the 1997 Isabelle Adams Award for Excellence in Perioperative Nursing. (See cover & opposite page). Shown with Anne are two former winners of the award - Muriel Shewchuk (left) Administrative Director, Surgical Services, Surgical Suites and Outpatients, Calgary Regional Health Authority, and Dr. Joan Donald (right) Mount Sinai Hospital, Toronto.

Anne Hughes was presented the 1997 Isabelle Adams Award For Excellence in Perioperative Nursing at the 1997 ORNAC Conference in Ottawa.

The Isabelle Adams Excellence in Perioperative Nursing Award was established on the initiative of the Operating Room Nurses of Québec in 1987 to recognize the special commitment and contribution of a perioperative nurse. The first award was presented in Vancouver in 1988 and has been presented every second year at the ORNAC National Conference.

Telemedicine session. She has been chairperson of various OR Provincial Committees, was a member of the Planning Committees and has moderated sessions at Provincial, National, and World OR Conferences. She co-authored an article, *Rumor and Gossip in the Operating Room*, in 1996. She is an item writer for the Perioperative Nursing Certification Exam and is a committee member for the Perioperative Post Basic Program being offered through the Centre of Continuing Nursing Studies, St. John's NF. She is always ready to assist and is an active participant in the current review of the ORNAC Standards.

Commitment to excellence in perioperative nursing has been continuous for Anne Hughes. During the period that she taught the Operating Room Post Basic Course she demanded the very best from her students. While she was Head Nurse in Orthopaedics she set very high standards for herself and others to follow. As Nurse Manager she preached ORNAC Standards; she followed them and explained to others how they worked and what they meant to perioperative practice. She has always insisted that her nurses be the Patient's Advocate during the intraoperative phase. Patient confidentiality, safety, quiet environment and well being were always a prime concern. She was instrumental in the implementation of a computerized booking schedule in her workplace. She has always been generous in sharing her knowledge with her staff, peers and the various medical supply companies who invited her to participate in their panel discussions as a resource person.

Anne Hughes has actively pursued a variety of educational interests since becoming a Registered Nurse in 1967. She completed Part One of a Midwifery Diploma, 1967-68, a Post Basic Course in Operating Room Technique and Management, 1973-74, the CHA Departmental Management Course, 1985-86, and from 1978 to present she has been a Bsc Biology candidate. She obtained her Certification in Perioperative Nursing at the first writing in 1995.

Anne's perioperative career spans a period of thirty years. During the first ten years she gained a wide variety of experience as a staff nurse in London, England, Montreal, PQ, St Anthony, NF, Edmonton, AB, and Lunenburg, NS. During the next ten years she used this knowledge and experience in her role as Instructor of Staff Development. She then spent two years as Head Nurse in an Orthopaedic OR and for the final eight years she was Nurse Manager of the Operating Room and Recovery Room of the General Hospital, St. John's NF.

Today she finds time for outside activities and has recently joined Teachers on Wheels.

Anne Hughes is a very worthy recipient of the 1997 Isabelle Adams Award For Excellence in Perioperative Nursing.

Her commitment to perioperative nursing does not end in the workplace. She was President of N&LORNA from December, 1986 to June, 1989, an ORNAC Board Member from 1986 to 1990, and Secretary of ORNAC from 1990 to June, 1993. She has presented at various Provincial Conferences, the 1996 Atlantic OR Conference and has done a



Aerobics conducted by fitness expert Lyn Walters of Vancouver Hospital has grown in popularity over the years at the ORNAC Conferences. Only 10 percent of the delegates participated in Aerobics at the 1981 National in Banff. This year 50 percent of the delegates did the 40-minute morning or early evening work-outs daily through the conference week. Congratulations to the Aerobics sponsor

Getinge (Castle) and the company's staff. Shown in the photo above - one of the afternoon work-outs. (Inset Photo to the Left) front row, centre) Bob Bothwell, Vice President of Getinge (Castle) Canadian Operations. (Centre row, left to right) Lyn Walters, Susan Kerr, St. Paul's Hospital, Vancouver) and Shannon Murphy, also of Vancouver.



# ORNAC in a Nutshell

By Corina Balcom, Secretary ORNAC.

The Board and Executive of the Operating Room Nurses Association of Canada met in Ottawa, April 26 & 27, 1997. The meeting was attended by five Executive and twenty Board members. Following are highlights of the meeting:

1. Plans were finalized to conduct a Forum during the National Conference. The purpose of the forum is to determine the major issues of concern of OR nurses across Canada and in so doing give ORNAC board members more direction.

2. The Executive conducted a self evaluation of ORNAC using a document "Standards for Associations" from the Canadian Council on Health Services Accreditation. ORNAC has a process in place that meets the Standards, but needs to look at outcomes.

3. There is a need for a study guide for the CNA certification exam. The Standards/Education Committee will review study guides presently used by several provinces and endorse a final document as a guide rather than pursuing the development of one from the CNA.

4. A National Membership ad-hoc committee has been formed to investigate ORNAC membership cards and numbering system.

5. The Awards Committee announced ORNAC - Johnson & Johnson Bursary recipients for 1997:

Brenda Kingdon,	Manitoba	\$500.
Karen Parsons,	Nova Scotia	\$250.
Barbara Benoit,	B.C.	\$100.

6. The Bylaws Committee continues to update, revise and develop new policies for the Rules and Regulations Manual to guide Board members.

7. A draft of the 1998 Standards has been circulated to the Executive and Board for review. Plans are for French and English versions of the new document to be available, January 1998.

8. The Telemedicine schedule for the Fall 1997 session has been prepared and will be published in the Journal.

9. A Position Statement has been prepared on the Environment and will be in the new Standards document. This committee has changed to an ad-hoc status.

10. The French Translation committee is making plans to prepare the ORNAC video "Behind the mask" in French.

11. Public Awareness will be investigating the

costs of a WEB page for ORNAC. The Committee will also prepare a statement on the RN in the OR which can be used as a framework for release to media, the government and other agencies. A pamphlet will be developed for the public to promote perioperative nurses.

12. The Advanced Nursing Practice committee has been working closely with the Canadian Anesthetic Society (CAS) and Canadian Society of Respiratory Therapists (CSRT) in preparing a proposal for "Funding for a National Analysis and Competency Profile for Anaesthetic Assistants". Approval for funding is being sought through Human Resources Development Canada.

ORNAC has observer status at NAFTA meetings on the Nurse Anaesthesia Educational requirements and mobility between NAFTA countries Project, in order to ensure it is understood there is no role for nurse anaesthetists in Canada.

13. Plans for the World Conference in Toronto, September 8-12, 1997, are in the final stages. Canadian attire for Friendship night will be available at the World Conference. Several Canadian speakers have been chosen including Muriel Schewchuck as keynote speaker and Dr. Joan Donald as the closing speaker. Others include Marion Morrissey, Marla Ewen, Jean Reeder and Audrey MacDonald.

International Planning committee members are seeking an expanded role for the member countries and have initiated discussion and a proposal for the formation of an International Perioperative Nursing Organization. This may include:

- (a) being a stand alone organization,
- (b) being affiliated with ICN, or
- (c) expanding their current role with AORN.

14. Future National Conferences are being planned for Halifax, June 13-18, 1999, Banff in 2001 and Manitoba in 2003.

15. The meeting concluded with elections. The ORNAC Executive for 1997-1999:

President:	Donna Farid
Past-President	Vija Hay
President -Elect	Marlene Hill
Treasurer	Shelly Zareski
Secretary	Corina Balcom

(Adapted from the minutes of April 26 & 27, 1997.)

# Past President's Message

By Vija Hay, RN, CPN(C)

As my term as President draws to a close, I wish to thank the Executive and board Directors who have served ORNAC in the past two years. I value their support, dedication and commitment to this Association. We have shared the same vision and worked by consensus. Through their efforts the Association continues to progress.

I particularly thank Jackie Waisman, Past President, who leaves the Board. Her commitment to ORNAC spans many years of service as a Board of Directors member, Executive, Committee member and Chair, as well as Chair of a National Conference.

I also thank the Provincial Associations for work well done, and the continued strong motivation to maintain their Associations viability.

We proudly congratulate Joan Donald in recently attaining her Ph.D., and Anne Hughes on being the recipient of the Isabelle Adams Excellence in Perioperative Nursing Award.

During the past two years we have seen unending transition and have been challenged in our careers. ORNAC is well aware of the impact of changing economy and technology on our profession and patient care. It is encouraging to note that ORNAC has remained strong and the membership numbers remain stable. In alignment with our Mission Statement of promotion and advancement of excellence in perioperative patient care, and professional and personal enhancement of OR Registered Nurses, the Executive and Board have worked to advance perioperative nursing practice, participated in and promoted perioperative certification, reviewed and revised ORNAC Recommended Standards of Practice. Striving for accountability and quality, the Executive carried out a self-evaluation of the Association, and held an open Forum at the National Conference. We are compiling a report from this Forum for the next issue of the Journal.

As President of ORNAC, my focus has been on promoting excellence in perioperative nursing practice, promoting professional responsibility and accountability through dialogue with our membership.

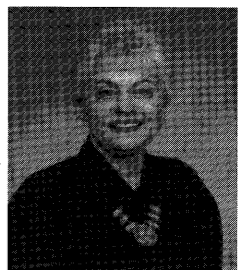
As we move into the future, we in ORNAC and as individual nurses need to challenge the old ways of doing things and look for opportunities to move out of old patterns. But let us not lose sight of our past and our core values, so as to stay true to our profession and our patients. Recognize professional and personal achievements and celebrate successes.

I look forward to assuming the new responsibilities of Past President, and will continue to work in promoting excellence and advanced perioperative practice, to foster partnerships, and to assist in creating direction of ORNAC that serves its members.

In closing, I urge you to embrace the future, explore new opportunities, and be current and aware of key issues. I call on you to become partners with ORNAC in dealing with new issues and new directions in shaping our professional future.

It has been an honor and privilege to be President of ORNAC. Thank you and best wishes for your personal and professional success in the future.

Vija Hay, RN, CPN(C), is a Consultant, Surgical Services, Ottawa. She is the immediate Past President of the Operating Room Nurses Association of Canada.



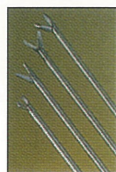
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# RN First Assisting - 1997 Canadian Update

By Grace A. Groetzsch, RN, BScN, MEd, CPN(C)

Unlike the United States, Canada appears to have little formal history of nurses functioning in a RN first assistant (RNFA) role. On examination, however, perioperative nurses are first assisting in Canada daily, and more recently formally as RNFAs. Other than in the province of Quebec, the term RN first assistant appears to not be formally utilized in Canada. The Operating Room Nurses Association of Canada (ORNAC) has coined the term Perioperative Nurse - Surgery (PNS). This avoids the use of the word "assistant" with its various connotations. Interestingly though, all hospitals who formally utilize perioperative nurses in this role utilize a title that encompasses the word "assistant".

The first Canadian province to formally recognize the RN first assistant role was Quebec in September 1994. Informal lobbying began in 1980 (Perazzelli, 1997), with the first proposal brought forward in 1991 at the Annual Meeting of the Ordre des infirmieres et infirmiers du Quebec [OLLQ]. OLLQ (1995) developed and published a position paper entitled *Perioperative Nursing Care: The Role of the Nurse First Assistant*, and concludes "that the role of nurse

first assistant has a place in the evolving context of professional practice. It answers the community's health-care needs and meets the demands of the health and social services system in the province of Quebec (p. 15)." Original prerequisites for consideration in the program included a minimum five years of perioperative experience, experience in the appropriate surgical service as a scrub nurse, and certification in perioperative nursing from the Canadian Nurses' Association. As of September 1997, three years of perioperative experience will be adequate for entrance into an RNFA program. With a Bachelor's degree (complete or in process) two years of perioperative experience will suffice.

Although Quebec had now endorsed the RN first assistant role, no training programs existed. To bridge the gap until a formalized program could be established in an educational institution, two nurses were trained by a cardiac surgeon at the Heart Institute of Montreal starting in early 1996.

Curriculum from the Heart Institute of Montreal (1995) is divided into three modules. The didactic portion of the course (186 hours) is heavily weighted towards the technical aspects of the intraoperative role. Preoperative and postoperative functions appear to be minimal. Participation in 30 operative procedures with evaluation by mentor surgeons results in successful completion of the third module. Nurses

### Abstract

Canada appears to have little formal history of nurses functioning in a RN first assistant (RNFA) role. On recent examination, however, perioperative nurses are first assisting in Canada daily, and several provinces have started programs. The following articles provides an overview of RNFA activities as of April 1997.

### Author

Grace A. Groetzsch, RN, BScN, MEd, CPN(C), is currently an RNFA student of Delaware County Community College, PA. She is a staff nurse in the operating room of the Orthopaedic and Arthritic Hospital, Toronto, teaches in the perioperative nursing programs at Humber College and is a perioperative/educational consultant for health care industry.

may assume the role of first assistant during single cardiac revascularizations and single valvular replacement procedures only. During complex procedures, the Professional Corporation of Physicians of Quebec stipulates that a medical assistant be in attendance (Daigle, 1996).

The outcomes of the one year pilot project at the Montreal Heart Institute are currently being evaluated. Outcomes to be measured include a comparison of procedural time when a resident, general practitioner, or RNFA assists, case distribution between the three categories of assistant, explanations of these distributions, and morbidity analysis such as rate of deep surgical site infection (First Hand, 1996). All indications (Perazelli, 1997) indicate that the project is a success, although a formal written report is not yet available in English. The program at present continues and is advertised in the *Canadian Operating Room Nursing Journal* (1997) as an "Expanded Role" - In House Program (p. 10).

In September 1996 a plastic program was started at Ste. Justine, Montreal with two nurses enrolled. One nurse, however, left the program for family reasons. The plastic program has 186 structured classroom and study hours, followed by 390 clinical hours, with a stipulated minimum number of specific plastic surgical cases.

The programs at the Heart Institute of Montreal and Ste. Justine are to be replaced by a RNFA program at the University of Trois-Rivieres which accepted its first 42 applicants in the fall of 1996 (Perazelli, 1997). At present, 24 perioperative nurses are registered for the second intake of the program in September 1997. Graduates of the university program will be able to work in all hospitals, unlike those from the hospital based programs. Remuneration for the nurses practising in the role is currently comparable to that of any registered nurse in Quebec.

1996 saw Newfoundland gain recognition for a RN first assistant program. The Newfoundland & Labrador Operating Room Nurses Association (N&LORNA) began lobbying the Association of Registered Nurses of Newfoundland (ARNN) in 1992. In 1995 a document was published which addressed the issue of advanced nursing practice and the need for nurses to take on expanded roles. No position was maintained on the RN first assistant role by the ARNN until November 1996 at which time it positively endorsed the concept of registered nurses functioning as first assistants. Several requests were received from various hospitals and in December, 1996 the Medical Board of Newfoundland & Labrador approved the role for one institute only, the Health

Science Centre, St. John's. The Newfoundland & Labrador Medical Association, the physician's union, has vetoed the position currently for all other hospitals within the province.

At present the Newfoundland program is in the development phase. It is hoped that four nurses will participate in a self-directed learning module, followed by clinical experience within the cardiovascular specialty. The steering committee (Walsh, 1997) has examined the content of the Montreal program and ORNAC's blueprint for curricula development. They are currently creating a job description and determining the role title, along with drafting the prerequisites for acceptance into the program, curriculum details and evaluation methods. It is hoped that the program will be university affiliated and will accept the first four successful applicants some time in 1997.

**“ Graduates of the [Trois-Rivieres] University program will be able to work in all hospitals, unlike those from the hospital based programs ”**

In Ontario, the College of Nurses of Ontario (CON) has been lobbied by members of the Operating Room Nurses Association of Ontario (ORNAO) since 1993. In a letter to Tyndall (1995) the CON acknowledges that the expectations within the preoperative and postoperative components of the Perioperative Nurse - Surgery role are within the scope of practice of nursing. Concern was expressed relating "to the overall accountability the nurse assumes when she/he formally functions in the "first assistant" role, than to the performance of specific procedures, such as cautery, suturing etc. (p.2)." Resolution of the above concern has to date not occurred. CON (March, 1997) published a document entitled "Determining the Appropriate Category of Care Provider" in which it utilizes the question "Can a RN act as a first assistant in surgical procedures?" The conclusion reached states that the first assistant role is beyond the limits of RNs. The rationale for this conclusion states "The role requires a medium level of autonomy and may involve independent surgical responsibilities in unexpected situations. For example, the surgeon may require more extensive surgical assistance or become unable to continue to intervene for personal or health reasons (p. 14)."

The situation in Ontario is unique in that the legislative and professional branches of nursing are two separate bodies, i.e. the College of Nurses of Ontario, and the Registered Nurses Association of Ontario (RNAO). Every practising nurse must belong to the College of Nurses, however, membership to RNAO is voluntary, with only fourteen percent belonging to the association. Whereas the CON's mandate is public protection, RNAO (1997) is actively seeking to carve out new roles for registered nurses within a reformed health care system. The bottom line, however, remains with the College of Nurses. RN first assisting, however, has occurred in Ontario for decades.

Collins (1997) relates that the Orthopaedic & Arthritic Hospital, Toronto was founded in 1955 by two orthopaedic surgeons, Drs. Bateman and Wright. All operating room nurses were certified by Miss O'Connor, the Chief Nursing Officer, to first assistant at surgery. Operating room nurses routinely sutured, retracted and cauterized vessels until affiliation of the Department of Orthopaedic Surgery with the University of Toronto in 1981. With the introduction of additional orthopaedic surgeons, orthopaedic fellows, and the retirement of Dr. Bateman in 1983, nurses no longer were able to first assist.

**“...Nursing practice boundaries have historically expanded and contracted based on the supply and demand situation in other disciplines, particularly medicine ”**

The Toronto Western Hospital (Dale, 1996) introduced the concept of a registered nurse surgical assistant for cardiovascular surgery in 1981 receiving approval for the position, from nursing administration, for a "physician assistant" in 1983, just as the Orthopaedic & Arthritic Hospital was phasing out the use of nurses as assistants. This nicely exemplifies the Canadian Nurses Association (1993) statement that nursing practice "boundaries have historically expanded and contracted based on the supply and demand situation in other disciplines, particularly medicine." A reduction in the number of surgical residency positions, an expansion of the cardiac program and the requirement for consistency in patient care was the impetus for the founding of this nursing position, physician assistant. The physician assistant role at Toronto Hospital, Western Division encompasses the preoperative, intraoperative and postoperative phases of a client's

surgical experience, plus research activities.

Preparation for the role has primarily been based on the apprentice model, with no formal educational preparation. The position is remunerated from the cardiac budget, salaried at the current union nurses's rate of pay. In 1994 a second registered nurse was recruited as a physician assistant. The role underwent a title change to "surgical assistant" in 1995 to avoid confusion with a nurse clinician role on the cardiac unit. The untimely death of the second surgical assistant in 1996, coupled with budgetary restraints means that only one surgical assistant currently remains in the position.

The Advanced Practice Committee of the Ontario Operating Room Nurses Association (ORNAO) has been dialoguing with educational institutions since 1995 to develop a university based program for the PNS/PNA roles. Initial efforts with McMaster University in Hamilton were abandoned in 1996 when it became apparent that McMaster University was inflexible in offering the program at anything other than a Master's level of preparation. At present, Ryerson Institute, a degree granting university in Toronto and the Mitchener Institute (formerly the Toronto Institute of Medical Technology) are interested in facilitating the development of a RNFA program. Discussions continue.

The author, however, believes herself to be the first registered nurse in Ontario to be undergoing formalized education offered through a recognized U.S. educational institute to become a RN first assistant, planning to undertake the internship component in Ontario. One perioperative nurse in Niagara Falls has recently completed a RNFA course, however, obtained her internship hours in the U.S. and remains unemployed as a RNFA in Canada. The first registered nurse in Canada to remain in Canada and have the designate RNFA, appears to be Lisa Blaskovits from Alberta.

Blaskovits (1996) outlines her experience in a recent article entitled "The Rocky Road to RN First Assistant". Although the Alberta Association of Registered Nurses is very supportive of the RN first assistant role, the hospital's insurer:

"formally limited my ability to act as a surgical assistant. I would, in future, be able to utilize instrumentation, provide exposure manually or by use of instruments or retractors, provide hemostasis through use of cautery, suction, or clamping and tie appropriate surgical knots. I would not be allowed to suture".

Blaskovits is currently working in another hospital as a Nurse Clinician outside the operating room. As

this is a rural hospital, she is frequently asked to assist with surgery, due to the unavailability of residents and general practitioners, and thus functions as an unpaid RN first assistant on a limited basis. Gawryletz(1997) is a nurse working in Calgary, Alberta who has completed the didactic segment of the same RNFA course as the author. However, she remains stalled in obtaining an internship position.

Although first assisting in the Calgary region has not yet come to fruition, in January 1997, a RN Surgical Assistant program was implemented in nearby Edmonton. Application to the program is currently restricted to registered nurses employed in the operating room suite of the University of Alberta Hospital (1997). The program is limited in its didactic and clinical components to the intraoperative phase of surgery. Nurses apply to learn first assisting for one specific surgical specialty (cardiovascular or neurosurgery or plastic surgery) and are then limited to practising as a surgical assistant in that specialty only. Surgical assistants are reimbursed at the same level as registered nurses with currently no extra money paid for overtime. The impetus for the program is surgeon driven as the number of surgical residency positions declines. At present, four nurses are in the cardiovascular program, four in the neurosurgery program and eight nurses started the plastic surgery program in April 1997.

Simon (1997) states that the Registered Nurses Association of British Columbia (RNABC) recognizes the RNFA role as being within the scope of nursing practice. The British Columbia Operating Room Nurses Group (BCORNG) began lobbying RNABC in 1991, and have been supportive of the concept since its inception. BCORNG and the British Columbia Institute of Technology (BCIT) are actively pursuing recognition of the position in British Columbia (BC) with the Health Administrators Association of BC and provincial government. A PNS program planning team is in place with membership from BCORNG and BCIT. A business plan is being developed, and once approval for the RNFA role is received from the government, BCIT will offer a program. BCORNG and BCIT will contribute funds for curriculum development.

In 1996, the Saskatchewan Union of Nurses approached the Saskatchewan Registered Nurses Association (SRNA) regarding the RNFA role. SRNA is described by Farley (1997) as being silent, but supportive. RNFA practice would be covered under the current scope of nursing practice, but would require a legislative change to the Public Hospital Act. Cur-

rently, the act specifies that only a physician can assist during surgery for reimbursement. Several surgeons are interested in the RNFA concept, and meetings have taken place with the Saskatchewan Operating Room Nurses Group (SORNG). SORNG has monies set aside for a pilot project.

**“...No one curriculum is followed and it appears that it is “each man for himself”, with no coordination of activities throughout a province, much less the country” .**

Provincial operating room nursing associations continue to lobby their respective nursing association on behalf of the PNS (RNFA) role. The Nurses Association of New Brunswick has passed a resolution ratifying the PNS role. At present, however, no programs exist, nor are there any nurses being trained by individual hospitals.

Nowhere is Rothrock's statement (1993) “the window of opportunity for RN First Assistants is wide open in the 1990's” more applicable than in Canada. Unfortunately, this author's research has identified that no one curriculum is followed and it appears that it is “each man for himself”, with no coordination of activities throughout a province, much less the country. ORNAC needs to continue to not only promote the role, but also influence the manner in which the role is being implemented. With continued acceptance of the role, hopefully this issue will resolve over time, and Canada's RNFA programs will stand as a united front.

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# Where Is The "Nursing" In The RNFA/PNS Role ?

By Grace A. Groetzsch, RN, BScN, MEd, CPN(C)

Many individuals who are not perioperative nurses struggle with the notion that the Registered Nurse First Assistant (RNFA) or Perioperative Nurse - Surgery (PNS) role is "nursing." The Canadian Nurses Association (1993) aptly states that an expert nurse's advanced practice may look very much like some of the activities of physicians, but that does not mean it is not nursing practice (p.20).

A review of RNFA and PNS literature makes it understandable why some cannot "see" the nursing. Much is made of the five unique intraoperative nursing behaviours of a RNFA:

- **Handling tissue;**
- **Providing exposure;**
- **Using instruments;**
- **Suturing; and,**
- **Providing haemostasis.**

Often little is articulated about the pre, post and other intra-operative nursing behaviours. The following definition and scope of practice was compiled for the College of Nurses of Ontario. Other individuals may find the following definition, role description and role responsibilities helpful. By articulating clearly what the RNFA role truly encompasses, only then can we move forward to have the role recognized and compensated across Canada.

## Definition

The RNFA/PNS is an experienced perioperative nurse functioning at an advanced level of perioperative nursing practice.

## Role Description

The RNFA/PNS provides continuity of care to clients requiring a surgical or diagnostic intervention.

The provision of this nursing care incorporates the promotion of health through pre and post-operative teaching, and the provision of care throughout the perioperative experience for the treatment of health conditions through supportive, therapeutic and palliative means in order to attain or maintain the client's optimal function.

The RNFA/PNS utilizes the nursing process to assess, plan, implement and evaluate the client's care throughout the perioperative experience.

The RNFA/PNS collaborates with the surgeon in performing a safe operation with optimal outcomes for the patient. The RNFA/PNS practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience.

The RNFA/PNS utilizes knowledge gained through an intensive formal education program and a clinical internship to make autonomous and interdependent decisions regarding patient care in the performance of the role. In this role, the RNFA/PNS provides leadership through the integration of clinical practice, research and education.

## Role Responsibilities

*Preoperative nursing behaviours that can be performed by an RNFA/PNS include:*

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- Providing preadmission management and planning.
- Obtaining the client's history and performing a health/physical assessment.
- Client/family/community teaching.
- Striving to assure that the client demonstrates knowledge of the physiologic and psychological responses to the operative or other invasive procedure.
- Providing client/family emotional support.
- Initiating the perioperative nursing plan of care in collaboration with the client and family.
- Initiating the discharge planning process.
- Assuring that the client's value system, lifestyle, ethnicity, religion, and culture are considered, respected, and incorporated as appropriate in the perioperative plan of care, which reflects the client's level of function and ability during the perioperative period.
- Communicating the plan of care to the operating room staff, including any special needs of the client.

## Intraoperative nursing behaviours that can be performed by an RNFA/PNS include:

- Application of the principles of asepsis, universal precautions and infection control..
- Coordination and provision of care to prevent the following negative client outcomes:
  - injury related to positioning;
  - injury due to extraneous objects;
  - injury related to transfer/transport;
  - injury related to physical/chemical/electrical/laser/radiation means; and,
  - infection.
- Anticipation of normal and abnormal human physiological responses to the surgical and anaesthetic intervention.
- Applying anatomy, physiology, disease pathology and operative technique relative to operative procedure.
- Performing client positioning, prepping and draping.
- Assisting in maintaining the client hemostasis status as directed by the surgeon (e.g. clamping blood vessels, coagulating bleeding points, ligating vessels).
- Providing exposure of the surgical site through the appropriate use of instruments, retractors, suctioning and sponging techniques as directed by the surgeon.
- Handling tissue as directed by the surgeon.
- Performing wound closure as directed by the surgeon (peritoneum, fascia, subcutaneous tissue and skin).

- Participating in, and working effectively as a multi-disciplinary team member.
- Evaluating the effectiveness of care provided on an ongoing basis.

## Postoperative nursing behaviours that can be performed by an RNFA/PNS include:

- Performing post-operative assessments, including analysis of progression of wellness and any symptoms of complications.
- Providing postoperative teaching to the client/family, including discharge instructions.
- Coordinating postoperative client management and discharge planning.
- Assessing management of client's pain.
- Changing dressings and removing sutures, drains, catheters, or IVs as well as other behaviours delegated by the surgeon.
- Providing wound management.
- Providing collaboration and consultation on client care for optimal health maintenance.
- Identifying perioperative transition issues for the client.
- Sharing of knowledge, best practices, and research findings.
- Performing physician office visits that include any of the above behaviours, or follow-up care and procedures.
- Determining potential for making follow-up visits/communication to provide post-operative care or assessment.
- Assessing potential for follow-up for evaluation, quality assurance, and research purposes. ■

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# The Role of the Operating Room Nurses in the Treatment of Necrotizing Fasciitis

By Amoy Lowe, RN, CPN(C)

The Canadian public heard about necrotising fasciitis - the "Flesh Eating Disease" the week before Christmas, 1994. The media headlines were filled with news of this disease which the premier of Quebec had contracted. Like many professionals in the health care sector we speculated what was happening between each of the news bulletins updating his health. One of the experts frequently quoted by the media was Dr. Donald Low, Microbiologist at Mount Sinai Hospital. The Premier survived his bout with this disease, but had his leg amputated to prevent the spread of the infection.

I had worked in the Operating Room at Mount Sinai for more than 15 years and had never seen a case of necrotizing fasciitis. Little did I know that I would soon have the opportunity to see necrotizing fasciitis in one of the patients I cared for in the Operating Room.

Necrotizing fasciitis is a soft tissue infection with the inflammatory process spreading rapidly through fat and muscle fascia. In some cases, it even spreads through the epidermis (Low, 1995). It is the emergence of a severe virulent group A Streptococcal infection which causes the sometimes fatal disease. The clinical spectrum includes shock, bacteremia, respiratory distress syndrome, and in 30% of patients, death (Stevens, 1994). One of the presenting features of this disease is the disproportionately intense pain which presents with little evidence of severe infection on initial presentation (Low, 1995). A history of trauma, however insignificant, is usually present. The disease spreads rapidly over two to four hours from the original site of injury to the surrounding tissue.

The current protocol of treatment of necrotizing fasciitis was developed by the Departments of Microbiology and Orthopaedics at Mount Sinai Hospital in

Toronto. The patient is admitted immediately to hospital. The protocol consists of antibiotic therapy of Penicillin and Clindamycin and surgical intervention. Debridement and irrigation is performed to assess the degree of destruction to the tissue.

In the Emergency Department (ER) or upon transfer to the Intensive Care Unit (ICU), the patient has multiple lines inserted for hemodynamic monitoring. Patients with necrotizing fasciitis may present with peripheral vascular dilation and decreased systemic vascular resistance. A Swan Ganz is inserted to monitor cardiac status. Patients may exhibit signs of tachycardia and decreased cardiac output due to weakened cardiac muscle. A Central line is inserted to monitor hypovolemia and resulting hypotension. An arterial line is inserted so that blood pressure can be continuously monitored and arterial blood samples can be obtained as necessary. Many patients exhibit signs of increased arterial CO<sub>2</sub>. A Foley catheter is inserted to measure hourly urinary output. A decrease in intra vascular volume will result in the kidneys retaining fluid and toxins due to poor filtration. Renal hypertension may occur which can result in renal failure. This invasive monitoring allows complete hemodynamic assessment preoperatively, intra and post operatively.

The patient is then transferred to the Operating Room (OR) for assessment of tissue damage.

The Operating Room must be prepared to receive a patient who is in shock. The anaesthetist may require the additional help of a respiratory therapist

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and nurse. Management of a patient in shock will require intensive intervention in response to hemodynamic monitoring. A circulator will be required for the scrub nurse and an additional circulator for the anesthesiologist.

The patient is anaesthetized and positioned allowing exposure of the infected area. Free draping may be appropriate as the extent of the tissue damage may not be visible prior to incision. A pre-scrub of the infected area with Providine-Iodine is completed before prepping and draping. A longitudinal incision is made. Multiple cultures (anaerobic and aerobic) of the fluid and tissues are taken. A Microbiologist will be standing by for immediate examination of the cultures. The necrotic tissue is debrided and the wound is irrigated with copious amounts of Normal Saline (NaCl) 0.9% with 50000 units of Bacitracin. The optimum application of irrigation should occur under pressure with a pulse lavage system. It is essential that all staff within the sterile field wear protective eye and face shield because of the extensive irrigation.

The wound is left open, packed with Bacitracin soaked gauze and held in place with retention suture. The protocol requires that the patient return to the Operating Room on alternate days for subsequent irrigation and debridement under emergency conditions if the patient's condition should not respond to initial therapy. Final closure of the wound will be dependent upon the patient's recovery.

The patient will be continued on a therapy of Penicillin 4 Million Units every six hours and Clindamycin 600 mg every eight hours (Green, McGeer & Low, 1996).

## Case History

A twenty year old engineering student of Chinese descent was seen at Kitchener-Waterloo Hospital. The patient had been well until the evening of February 26, when during a basket ball game, he fell on his left knee and opened a cut on the anterior aspect. The cut was rinsed, the knee wrapped with a cloth and he continued to play. He presented himself to the Kitchener-Waterloo Hospital Emergency Department at approximately midnight. He required seven sutures to close the knee wound. It was noted that the wound appeared clean, with no evidence of swelling, erythema or pus. The patient had minimal discomfort and was able to walk home. The next morning the sutures appeared clean, however the patient noted increased swelling and erythema proximal to the wound. The student walked to school and performed

his activities of daily living. At 1530 he noted increased pain in his left knee and had difficulty in walking. It was so pronounced that he purchased a set of crutches. He felt feverish and lethargic and returned home at 1800 and went straight to bed. He awakened throughout the night with chills and fever. The next morning he noted an area of larger erythema along the anterior and posterior aspects of his left leg. The leg was warm to touch and tender. At 1300 he returned to the Emergency Department. The sutures were removed and necrotic tissue was debrided. An incision and drainage was performed along the anterior aspect of the initial abrasion and pus was aspirated. The pus was sent for culture and sensitivity. The patient was admitted to hospital. An intravenous of Ancef 2Gms q6h was started. His temperature was 37.4. Laboratory analysis revealed a white blood cell count of 18.6 with 94% neutrophils and 20% bands and a creatine kinase of 163. At 2200 on February 28 it was noted that the area of erythema on his left leg had increased. Only one gram of Ancef had been administered. On March 1, it was noted that the erythema appeared to have progressed distally toward the ankle and proximately to the groin. The patient was experiencing increasing pain and neuropathic discomfort in the form of pins and needles in the involved area. An area of streaking erythema was noted along the anterior aspect of the thigh. Examination revealed an increase in temperature to 38.7 BP 130/80 and a pulse of 92 and regular. An x-ray of the leg was normal.

A culture of the area from initial pus aspirate was positive for group A streptococcus. A dose of Clindamycin 600mg was given intravenously. After consultation with physicians at Mount Sinai Hospital the patient was transferred for further assessment and treatment.

Upon arrival at Mount Sinai Hospital the patient was prepared for surgery. A Swan Ganz and central line were inserted along with two large bore IV's. A Foley catheter was inserted to monitor hourly output.

## The Operation

The Operating Room was prepared for a soft tissue dissection of the leg area. The patient was anaesthetized and an endotracheal intubation performed. The Anesthesiologist was supported by a Respiratory Technologist and Registered Nurse. A second Registered Nurse circulated for the surgical team. The left thigh and hip were prescrubbed and prepped with Betadine solution. The sterile field was estab-

lished with free drapes. A longitudinal incision was made following the lateral aspect of the left thigh and extending distally to the knee. The incision was taken down through to the subcutaneous tissue. Necrotizing fasciitis was noted, as characterized by necrosis, oedema and odour of the tissues. Multiple biopsies and cultures were obtained of both fascia and underlying muscle tissue. Debridement of infected tissues was carried out. The muscle tissue was noted to be pink and healthy after irrigation of superficial fascia using nine litres of NaCl with 50,000 units of bacitracin per litre. This solution was applied using a pulse lavage system. The sub fascial layer was not involved in the infection. The wound was left open, packed with Saline and Bacitracin soaked dressing. The patient tolerated the procedure well with no intra operative complications. Estimated blood loss was approximately 100 mls. The patient was transferred post operatively to the ICU.

Laboratory analysis confirmed the diagnosis of group A Streptococcal Fasciitis. The patient subsequently returned to the Operating Room for debridement and irrigation with packing change. The wound was left open and secondary wound closure followed. The patient continued with intravenous and oral antibiotics. Physiotherapy visited him and provided him with isometric exercises for strengthening of his left quadriceps muscle. The patient was allowed to weight bear as tolerated with crutches. The patient was discharged from hospital on March 10 with an appointment to follow up with the Microbiologist and Orthopaedic surgeon at Mount Sinai Hospital, Toronto.

#### Four Cases Treated

Mount Sinai Hospital has treated four such cases since without loss of limb using our established combined protocol of hemodynamic patient monitoring, intravenous antibiotics, and surgery involving debridement and irrigation.

"Minor trauma can precipitate a severe soft tissue infection. Pain can be the earliest and only finding. Prompt recognition of the process, antibiotic therapy and most importantly, early surgical debridement are the cornerstones of therapy," (Defers & Low, 1991).

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# Latex Allergy in the Nursing Population

By B. Cowperthwaite, K. LaPlante, B. Mahon & T. Markowski

Latex allergies have received more attention in medical texts over the last ten years. On reviewing the literature, there is documentation surrounding the effects of latex gloves with respect to allergies. There is less about specific information related to nursing and the health of nurses with respect to allergies. Yet, Pisarcik Lenehan (1997) states "An estimated 2,200,000 nurses (or one in 10 of all nurses) . . . have a latex allergy." More recently, reactions such as "airway compromise and anaphylaxis" (Pisarcik Lenehan, 1997) have been increasing. With these reactions noted, a latex allergy can be career-ending for a nurse practicing in an acute care facility. For that reason, we have chosen to analyze major health issues related to latex allergy in the nursing population. The Neuman model will provide the framework for devel-

oping effective strategies to deal with this issue.

Latex is present in patient related equipment such as intravenous tubing, adhesive tape, ambu bags, band-aids, tourniquets, endotracheal tubes, enema tubing as well as countless others. It is evident that, in providing only the basics of patient care, nurses are constantly exposed to latex products. This exposure puts nurses at risk for developing latex sensitization and/or latex allergies. Direct contact of the latex protein by wearing gloves and inhalation of latex particles aerosolized from powdered latex gloves cause the most exposure. Turjanmaa reported in 1987 that 5.6% of the nurses in surgical units were allergic to latex, compared to 2.9% in the general health care population. (Steiner & Schwager, 1995). Charpin reported a 10.6% latex allergy in operating room nurses and Iacobelli in 1992 reports a 14.4% latex allergy in operating room personnel (Steiner & Schwager, 1995). Although allergic reactions to latex were documented more than 50 years ago, it is only recently that emphasis was placed on this increasing health care problem.

Many reports of latex allergy concern atopic individuals; that is, individuals with a clinical hypersensitivity state that is subject to hereditary influences. There is a positive association between atopic status

#### Abstract

This paper analyzes the major health issue "latex allergy," and risk reduction for nurses (aggregate). First, the historical significance of latex in the environment is discussed along with our rationale for choosing latex allergy as a major health issue. Identification, description and justification of the use of Neuman's systems model are evident throughout the paper. In this model, assessment is incorporated into the nursing diagnosis of the nursing process. The second category of the nursing process, planning of actual goals, is negotiated with the client/client system. Intervention strategies are implemented in the last stage of the nursing process, nursing outcomes. The last two categories are formulated into a chart for better clarification of the goals with rationale. Lastly, an evaluation of the goals is discussed.

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and the risk of a latex allergy. Among the group of OR nurses studied in Marseille, those with a history of allergic rhinitis and/or asthma had a 4.4-fold higher risk of being allergic to latex. (Levy, Charpin, Pecquet, Leynadier, & Vervloet, 1992). Health care workers with atopic allergies have been reported to have a 24% prevalence of positive results of skin-prick-testing and 50% of this group were clinically asymptomatic (Sussman & Beezhold, 1995).

Steiner and Schwager (1995) note that:

Since 1987, when the Center for Disease Control and Prevention issued recommendations that all hospitals adopt "universal precautions" to prevent the spread of the human immunodeficiency virus (HIV) to health care workers, including the use of gloves for care of all patients when blood or body fluid contact might occur, . . . the problems of latex allergy have increased dramatically.

Not only did the use of latex gloves increase from 800 million to 10 billion within a two year period (Kellett, 1997), but the process to make the gloves changed to keep pace with demand. Kellett also states:

The result was a huge influx of cheap, poorly produced . . . latex gloves. When the amount of protein and latex allergens are extracted from latex glove material and measured, the results are startling. The allergenic effect can vary up to 3000-fold between the best and worst latex gloves. (p. 28)

Rubber gloves were first implicated as a cause of contact dermatitis in 1933 (Steiner & Schwager, 1995). The first immediate hypersensitivity reaction to latex was described by Nutter in 1979. The prevalence of latex allergies in the general population is approximately 1% (Sussman & Beezhold, 1995). Almost 50% of the reported cases have occurred in health care workers and in patients undergoing surgical procedures or internal examinations (Levy et al., 1992). While gloves have latex content, they also contain a secondary concerning problem. Most gloves have powder inserted to allow easier donning. Kellett (1997) states:

The corn starch powder, used as a lubricant and donning aid, is a major contributor to the problem of latex allergy. The latex protein allergens on the glove absorb onto the powder granules, thus concentrating the allergen. This makes it easier for the allergens to enter the skin or mucous membranes. When gloves are put on and removed, this powder-antigen complex is released into the atmosphere,

entering lungs and open wounds.

Another explanation for the increased prevalence of latex allergies is the likelihood that physicians are better able to identify and diagnose the allergy. Recognition has probably lead to higher reported cases.

In order to understand latex allergy, the nature of the manufacturing of latex needs to be understood. Natural latex rubber is a processed plant product from the latex or the milky cytosol of the rubber tree *Hevea Brasiliensis*. Latex is composed of various lipids, phospholipids and proteins. The proteins are responsible for allergic sensitization predisposing to IgE mediated reactions. Chemical additives are added to the product to preserve, to cure, and to give latex its desirable properties of flexibility and protection. Although the chemical additives are not the cause of the immediate generalized allergic reaction, they contribute to some of the local skin reactions. Latex allergy prevalence rates of 10% have been reported among heavy glove users such as surgeons and operating room nurses (McCormack, Camerson, & Biel, 1995).

The first of four types of reaction associated with latex, is Contact Dermatitis. It "is the most common clinical reaction associated with latex" (Sussman & Gold, 1996). The client may present with dryness, cracking, scaling, erythema and vesicle formation on their hands.

Irritant Contact Dermatitis, the second type of reaction, "is a non-allergic skin rash . . . due to mechanical irritation from sweating or rubbing of the hands under the glove and from residual soaps . . . in prolonged contact with the gloved cutaneous surface" (Sussman & Gold, 1996).

Allergic Contact Dermatitis (ACD), also referred to as chemical sensitivity dermatitis, is often characterized by eczematous skin on the top of the hands to the wrist where the glove ends. In ACD, the etiologic agents involved are chemical additives such as accelerators or antioxidants, which are used in the production of latex rather than latex proteins (Sussman & Gold, 1996).

Sussman & Gold confirm that contact dermatitis, irritant or allergic contact reactions may increase the risk of latex sensitization due to a skin barrier breakdown. This may precede the onset of an IgE mediated hypersensitivity reaction.

The final reaction caused by latex is the Immediate Allergic Reaction. Sussman & Gold state:

"An immediate allergic reaction (or IgE mediated hypersensitivity reaction) is caused by latex proteins which directly sensitize the patient and subsequently cause allergic symptoms."



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The Immediate Allergic Reaction may be localized or systemic. Reactions are triggered by direct contact or inhalation of the protein on the skin, mucosal or serosal surfaces. The reactions vary in severity from mild to life threatening. Between 1988 and 1992 the Food and Drug Administration in the US received reports of more than 1000 systemic allergic reactions to latex, 15 of which were fatal. Severity cannot be predicted; people who have had mild reactions may react severely at next exposure (Sussman & Beezhold, 1995). At this point, the disease process needs incorporation into the Nursing framework.

### Neuman's Systems Model

In Neuman's framework, "The central core is a basic structure of survival factors common to the species, such as variables contained within it, innate or genetic factors, and strength and weakness of the system parts" (Fawcett, 1995). The outermost ring, the flexible line of defence, forms a protective buffer for the client's stable state. This accordion-like mechanism provides greater protection against a latex invasion when it is expanded away from the normal line of defence and less protection when it contracts closer to the normal line of defence. This second protective mechanism, normal line of defence, represents the adjustment of the client system to environmental stressors (latex). Like the flexible line, the normal line of defence expands or contracts, but more slowly. The normal line of defence is penetrated by the latex stressor when the flexible line of defence cannot withstand the impact. Now, an illness in the form of a latex reaction occurs as a result of the normal line of defence being rendered ineffective against the invasion of the stressor. The third protective layer, the lines of resistance, is involuntarily activated when latex invades the normal line of defence. These lines attempt to stabilize the client system by using internal factors that support the basic structure, i.e., activation of the immune system and mobilization of white blood cells. If the lines of resistance are ineffective against the invasion of latex allergens, energy depletion occurs and death may ensue. The system can reconstitute if the lines of resistance are effective (Fawcett, 1995).

The two major components in Neuman's model are stress and the reaction to stress. When we look at latex allergies, the stress will differ depending upon what caused the allergy. Was it due to the latex proteins, irritation of the gloves, chemicals in the

gloves, amount of time latex gloves were worn, or did sensitivity occur due to a breakdown in skin barriers? (Fawcett, 1995)

Neuman refers to the environment and how both the client and the environment may be affected either positively or negatively by each other. The environment plays a major role in the development of a latex allergy. Some individuals may have a genetic predisposition to develop an allergy due to risk factors such as atopic conditions or persisting food allergies (Fawcett, 1995).

The idea of maintaining optimal system stability fits well with the stated goals to prevent latex allergies. This is done by primary prevention to reduce exposure. If a nurse has already been sensitized, our goal is to prevent further reactions. This is done by reducing exposure to the latex protein through prevention. Throughout our interventions the nurse attempts to reduce or eliminate the stressor causing the reactions. By doing this we are attempting to achieve optimal system stability (Fawcett, 1995).

Neuman's nursing process format consists of three categories: nursing diagnosis, nursing goals, and nursing outcomes. Nursing diagnosis encompasses data collection about the dynamic interactions among the physiological, psychological, sociocultural, developmental, and spiritual variables which make up the client system. These five variables are part of the basic structure, the flexible line of defence, the normal line of defence, and the lines of resistance. Neuman incorporates assessment into the nursing diagnosis of the nursing process. She believes that proper assessment requires taking into account both the client's/client system's perception and the caregiver's perceptions of the five variables (Fawcett, 1995). According to Kellett (1997), a complete medical history is essential to diagnosis of a latex allergy. It is essential to determine if the client/client system is in a high risk group. This group consists of health care workers, latex industry workers and clients who have had multiple procedures.

First, a data base will be established incorporating the dynamic interactions of the five variables, and how they are affected by the three types of stressors (intrapersonal, interpersonal, extrapersonal). Intrapersonal risk factors are concerned with the internal environment, and consists of all the interactive influences within the boundaries of the defined client/client system (Fawcett, 1995).

## Intrapersonal Risk Factors

### Physiological Risk Factors

These risk factors include the client's/client system's auto-immune response to stressors. Some individuals have specific antibodies called IgE antibodies, which make them hypersensitive to the proteins found in natural rubber latex. This IgE mediated reaction to latex proteins is responsible for most of the severe allergic reactions (Sussman & Gold, 1995).

Diagnostic testing, to validate this excessive immune response include patch testing, skin-prick testing, intradermal testing, basophil histamine release testing (BHRT), lymphocyte proliferation treating (LPT), radioallergosorbent testing (RAST), enzyme-linked immunosorbent assay (ELIZA), latex allergosorbent testing (LAST), and inhalation challenge testing (Sussman & Beezhold, 1995).

The patch test is a method for allergen identification in allergic contact dermatitis. The immunogenic rubber additive chemicals of appropriate concentration are taped on a client's back for 48-96 hours, and the skin is observed for a reaction (Sussman & Beezhold, 1995).

In the skin-prick test, an antigen in solution is dropped onto the skin, and the skin is pricked gently with a needle through the solution. Skin-prick tests are almost 100% sensitive and specific, and are therefore very reliable. The incidence of untoward reaction is small (Holtzman, 1993).

Intradermal testing is also 100% sensitive because the diluted antigen solution is injected intradermally. The reaction is graded from 1+ to 4+. This type of testing carries a greater risk of systemic reaction because the antigen cannot be wiped from the skin (Holtzman, 1993).

According to Holtzman only 93% of clients with latex contact urticaria were reactive in the basophil histamine release test, and only 20% in the lymphocyte proliferation test. Also, radioallergosorbent concordance with the skin-prick test varies from 59% to 93% depending on the allergy. Steiner and Schwager (1995), believe the radioallergosorbent test to be highly specific with a 50-60% sensitivity. Also, the enzyme-linked immunosorbent assay has a 66% specificity with an 87% sensitivity. Holtzman (1993) found that the latex allergosorbent test correlates with an "r" value of .92 to the latex radioallergosorbent test. A negative latex-specific IgE test does not rule out a latex allergy.

Inhalation challenge tests, or bronchial provocation tests can assess the response of a client to the aerosolized latex allergen. Anaphylactic-type reactions have been noted using this method. The goal of bronchial challenge testing is to detect and quantify airway hypersensitivity (Steiner & Schwager, 1995).

Clients are in a high risk group if they have had symptoms such as hives, swelling, eye/nasal itching, sneezing, coughing, wheezing which is an IgE mediated hypersensitivity reaction. The body produces these IgE antibodies as a part of its defence mechanism against the invasion of the latex stressor (antigen). This reaction causes the release of mast cells and basophils, which release histamine leukotrienes, prostaglandins and kinins (Kellett, 1997).

Allergic contact dermatitis is a specific immune-response of sensitized lymphocytes to chemical additives contained in latex products. This delayed hypersensitive response usually occurs 48-96 hours after exposure. Skin becomes dry, crusted, and thickened with hard bumps and sores (Sussman & Gold, 1996).

According to Neuman (1995) this latex stressor disrupts the forces which operate within or on the system. Latex causes a disequilibrium in the system as a result of the invasion of this tension producing stimuli (Fawcett, 1995).

Sussman & Beezhold (1995) state "Other risk factors are female sex." Grzybowski, et al. (1996) further state "Biologic mechanisms responsible for association between latex allergy and possible risk factors require further investigation. The different proportions of detectable anti-latex IgE between sexes may be due to hormonal influences . . .".

Nutritional assessment is very important in latex allergy. Sussman & Gold (1995) believe that people with certain food allergies, including banana, avocado, chestnut, apricot, kiwi, papaya, passion fruit, pineapple, peach, nectarine, plum, cherry, melon, fig, grape, potato, tomato, and celery may have a coexisting latex allergy. Other food and food products include, apple, pear, carrot, hazelnut, wheat, rye, mugwort, profilin, potatin, plant stress proteins, and ficus. The observed cross-reactivity of latex with avocado, kiwi and chestnut probably occurs because latex proteins are structural homologous with other plant proteins (Sussman & Beezhold, 1995). It is interesting to note that individuals with food allergies may be at risk for developing latex allergies. In a study done by Pecquet, 50% of the patients seen had an allergic reaction to a fruit. The most frequently mentioned being banana, avocado, and kiwi. Less frequently noted were apricot, chestnut, grape, passion fruit and pineapple (Levy et al., 1992). Not all clients with these food allergies will be allergic to latex, and not all clients with a latex allergy will react to these foods (Sussman & Beezhold, 1995).

### Sociocultural

The risk factors within the sociocultural variable include conditioned responses. Nurses are known to overuse latex gloves to protect themselves from viruses, (Zaza, Reeder, Charles & Jarvis, 1994).

Other variables include any attitudes, values, or norms of clients, that put them at risk for latex allergy. Our cultural environment determines what we believe in, and shapes our lives. Nurses' beliefs of folk diseases and medicines may also put them at risk (Neuman, 1995).

#### Psychological

Examples of psychological risk factors include: lack of motivation for wellness, lack of sense of self, lack of well-being, lack of belonging, depression, emotional pain, isolation, fear of reactions to latex, powerlessness, and relocation trauma. Also, nurses are at risk if they lack awareness and understanding of latex allergies, the related interventions and treatment (Neuman, 1995).

#### Developmental

Risk factors under the developmental variable include age, level of education, and any change from the normal developmental pattern that puts clients at risk (Neuman, 1995).

#### Spiritual

Spiritual distress occurs when nurses have a lack of belief in hope and the pursuit of optimal wellness. This occurs when nurses feel they have no control over latex exposure and subsequently allergens control their life. Nurses in spiritual distress have lost hope for a positive outcome. The spiritual variable controls the mind and the mind controls the body. It includes a sense of power, creative energy, hope or hopelessness or despair, love, caring, etc. Lack of spirituality leads to spiritual distress, loneliness, powerlessness, anxiety, fear, guilt, anger, depression, hopelessness, and a low self-esteem (Neuman, 1995).

### Interpersonal Risk Factors

The external environment consists of all the interaction of influences existing outside the client/client system and is interpersonal and extrapersonal in nature. First the interpersonal risk factors will be assessed. These stressors occur at the boundary between the system and the proximal external environment (Neuman, 1995).

#### Physiological Risk Factors

These physiological variables, include any latex products found in the home, i.e., toys, latex paint,

carpet etc. Risk factors also include any latex products found in the hospital and/or in close proximity to the workplace.

If risk factors are present, support people are required to respond to an emergency situation. If no support people are readily available, the degree of risk is increased.

#### Sociocultural

Detrimental family environment produces stress. Children in the home need to conform to their peer group behaviours. If they are restricted from having normal clothing or popular toys, they are not accepted as readily into a peer circle of play. Conversely, by having the in-fashion articles, they may put themselves or others at risk. Support of people's values and attitudes may also put the client at risk. In the work environment, a latex allergy is often not taken seriously. Health care workers will mimic media shows where gloves are peeled off with no concern for aerosolized particles. The economic realities in the hospital often hamper the effort to reduce latex products. Role conflict and expectations at work may also put the individual at risk.

#### Psychological

In poor family relationships their lack of support, communication, awareness, and understanding of latex allergy puts individuals at risk. Poor co-worker relationships and their unwillingness to decrease latex in the workplace increase the risk for all employees. Ineffective crisis response from family, friends, and health care professionals further increases the risk.

#### Developmental

The developmental risk factors for latex allergy include support people's lack of maturity, lack of knowledge and poor communication.

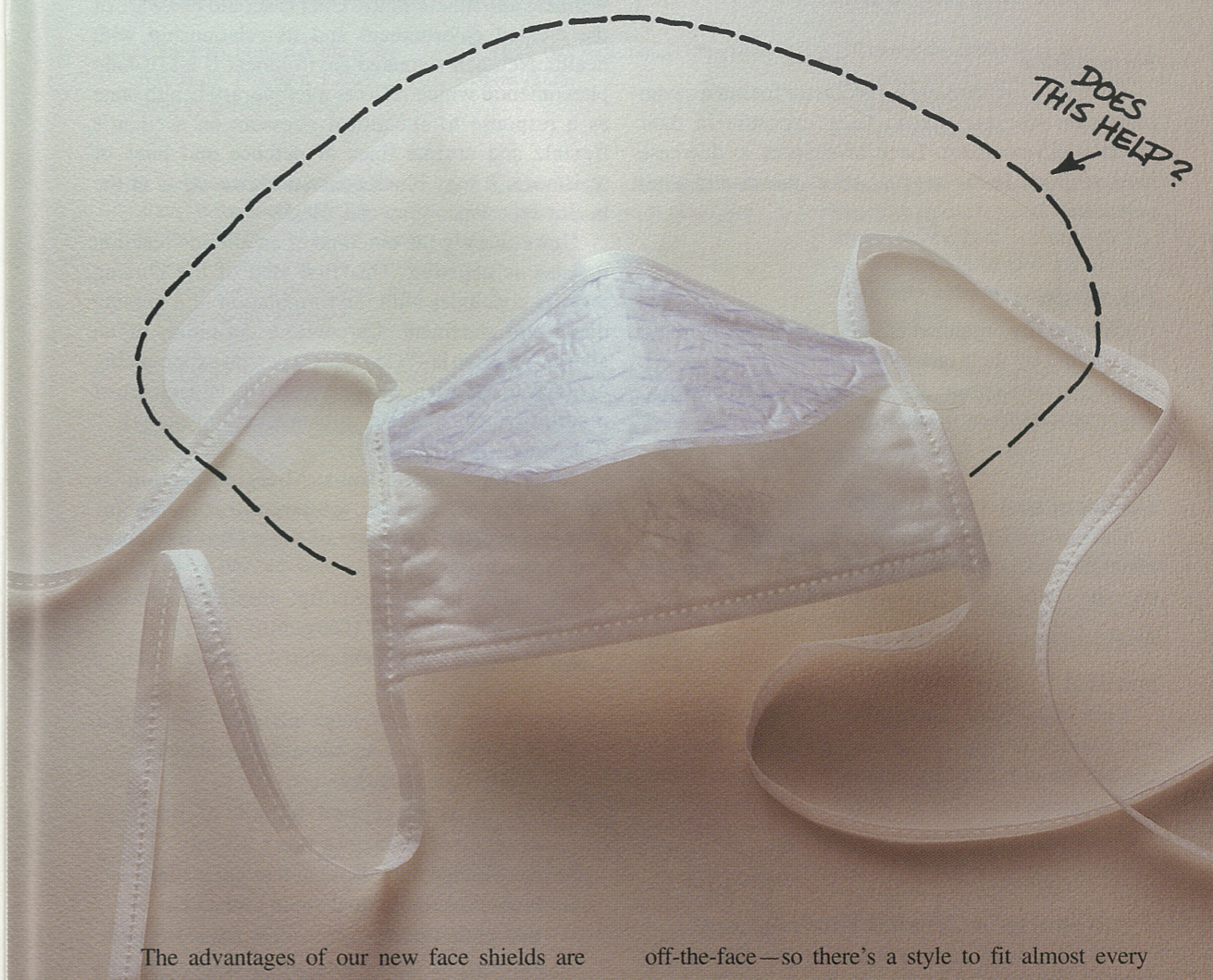
#### Spiritual

The spiritual risk factors include support people's lack of belief in hope and their pursuit of optimal wellness for themselves and the client.

### Extrapersonal Risk Factors

Extrapersonal stressors are also in the external environment. They occur at the boundary of the client/client system and the distal external environment (Neuman, 1995).

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### Physiological Risk Factors

The physiological variable includes latex as an environmental hazard both inside and outside the workplace. Lack of a support system is exemplified by the substandard, or inappropriate product labelling by manufacturers, and the failure to decrease the protein and chemical content of latex products. Also, hospitals have been slow to develop policies in response to the increasing hazards of latex.

### Sociocultural

Financial concerns are a risk factor for nurses who must stop working due to latex exposure in their external environment. Lack of support to decrease latex products in the hospital affect nurses and other personnel.

### Psychological

Community organizations and businesses increase risk factors by their continued use of latex products. Prolonged workplace latex exposure can increase sensitization of health care providers.

### Developmental

Lack of available educational programs, marketing strategies, social policies and government programs puts the client at risk for sensitization to latex.

### Spiritual

Lack of spiritual support from religious affiliation and control of life circumstances, i.e., a locus of control [external versus internal] influences client's available choices.

### Neuman's Created Environment

It is very important to discover the client/client system's created environment. "It is dynamic and represents the client's unconscious mobilization of all system variables (including the basic structure energy factors) toward systems integration, stability and integrity." (Fawcett, 1995). It offers a protective coping shield for system function as the client is usually not aware of the host of existing psychosocial and physiological influences. The created environment's insulation effect changes the possible response of the client to environmental stressors - for example, the

denial of latex allergy. The client's perception is directly related to coping. The created environment is intra, inter and extrapersonal in nature. It is based on unconscious knowledge, self-esteem, belief, energy exchanges, system variables and predisposition. This is apparent when fearful nurses continue to expose themselves to latex in order to maintain their job.

All causal factors must be evaluated as to innate internal or external factors affecting the client in wellness and illness states. Clients should be aware of the created environment and its relationship with health. Neuman's created environment is a self-help phenomenon which reflects a temporary health state as a response to situational stressors on a client's flexible and normal lines of defence and lines of resistance. It may block conscious awareness of the health experience (Fawcett, 1995).

Unfortunately the outcome of an allergic reaction to latex is negative. This first step of the nursing process concludes with the formulation of a nursing diagnostic statement. Carpenito's definition of an allergic reaction is - "Describes a person experiencing or at risk to experience hypersensitivity and release of mediators to specific substances (antigens)." (Carpenito, 1995, p. 1020)

"Potential complications: Allergic Reaction" is one of the 52 specific collaborative problems grouped together because of their high incidence and morbidity.

The following are potential nursing diagnoses related to latex allergy: (Carpenito, 1995)

1. Impaired adjustment related to nonacceptance of latex allergy.
2. Anxiety related to latex allergy.
3. Fear related to an identifiable dangerous source (latex allergy).
4. Hopelessness related to lack of personal choice secondary to latex allergy.
5. Knowledge deficits related to latex allergy.
6. Ineffective individual coping related to depression in response to identifiable stressors.
7. Relocation stress related to relocation of a work site.
8. Risks for altered respiratory function related to an environmental allergen.
9. Spiritual distress related to conflict between religious and spiritual beliefs and prescribed health regimens.
10. Impaired skin integrity related to disruptions of epidermal and dermal tissue secondary to an allergic reaction.

## Summary of Nursing Goals with Rationale

### Primary Prevention Immediate Goals:

1. Strengthen flexible line of defence to decrease risk of developing sensitization to latex.
2. Identify high-risk client by screening - using a Latex Allergy Questionnaire.
3. High-risk client referred to allergist for allergy testing, including latex. *\*High risk clients: -use gloves regularly, -have existing allergies, particularly to food, -have hand dermatitis or eczema.*
4. Educate the client about signs & symptoms of a possible latex allergic; encourage to report them.
5. Facilities wide review of glove usage to determine appropriateness of use to prevent the unnecessary use of latex gloves.

**Rationale:** \*Maintain client optimal level of wellness. \*Reduce encounter or risk of an encounter with a destructive stressor -, i.e., natural rubber latex \*Strengthen flexible line of defence by preventing stress and reducing risk factors to develop sensitization to latex. \*Prevent stressor invasion. \*Motivate toward wellness.(Fawcett, 1995).

### Secondary Prevention Immediate Goals:

1. Provide latex safe working environment, i.e., latex reduced or latex restricted.
2. High-risk individuals identified to co-workers.
3. Latex-allergic clients use only non-latex gloves and other non-latex products.
4. Other persons in same work environment change to low protein, low powder or powder free latex gloves.
5. Develop a database of all hospital latex products.
6. Environmental and duct cleaning to eliminate accumulated latex particles from air handling systems.
7. Clients with contact dermatitis requiring frequent glove usage should:  
*i. wear white cotton gloves under non-latex gloves to prevent heating and sweating of hands. ii. avoid using oil-based hand lubricants following surgical scrub and before donning latex gloves. iii. use unscented soaps free of colour, chemicals, antiseptics, and deodorants.*

**Rationale:** \*Strengthen the internal lines of resistance through early case finding and treatment of symptoms. \*Protect basic structure. \*Maximize and optimize internal/external resources to obtain stability and energy conservation. \*Motivate, educate and involve client/client system in health care goals. \*Facilitate appropriate treatment and intervention measures. \*Support positive factors toward wellness. (Fawcett, 1995).

### Tertiary Prevention Immediate Goals:

1. Provide latex safe environment, i.e., use only non-latex gloves and avoid all latex containing products.
2. Clients should have proper identification (eg. medic-alert) and always carry an epinephrine auto-injector device.
3. Awareness of non-employment exposure to latex, eg. undergoing dental and medical examinations, wearing household cleaning gloves, using latex condoms, blowing-up balloons etc.
4. Counsel latex-allergic client with positive history and skin tests on the risk of continued work in environments with high latex use.
5. Client referral to an allergist to increase understanding of latex allergy and prevent further sequelae.
6. Support client/client system toward appropriate goals; educate, reeducate, orient as needed.

**Rationale:** \*Attain and maintain wellness and protect the client's reconstitution to return to wellness following treatment (Fawcett, 1995).

### Primary Prevention

#### Intermediate Goals:

1. The client will acquire information regarding risk behaviours and prevention strategies.
2. Promote awareness/education re latex allergy with other health care providers.
3. Education on potential health risks related to latex sensitivity in areas of high glove usage.
4. Encourage hand-washing after glove removal to remove residual powder. Avoid touching eyes, noses and mouths while wearing gloves.
5. Mask when handling products containing latex to protect from airway exposure to airborne particles.
6. Clients with allergic contact dermatitis should have allergens identified by patch testing. Patch testing can detect delayed hypersensitivity responses to contact dermatitis.
7. Multidisciplinary latex allergy task force to develop policies and procedures for detection, care and education of all health care providers.

**Rationale:** \*Awareness as intervention for prevention. \*Reduce or change client reaction to stressors, and to prevent further penetration by stressor (Fawcett, 1995).

#### Future Goals:

1. Latex free hospital environment.
2. Mandatory labelling of latex rubber in medical devices.
3. Appropriate package labelling re: latex protein content of consumer goods.
4. Ongoing research for sensitive and specific serologic method for diagnosing latex sensitivity as skin-prick testing can cause anaphylactic reaction.
5. Epidemiologic surveillance funded to help identify *i.* the incidence and prevalence of latex allergy *ii.* the evolution of contact of systemic reactions *iii.* allergies to food that crossreact with latex

**Rationale:** \*Decrease/eliminate environmental hazards. \*Facilitate reconstitution of the lines of defence and rehabilitation of the functioning client system to prevent irreversible complications or degeneration (Fawcett, 1995).

### Secondary Prevention

#### Intermediate Goals:

1. All suspected latex reactions reported immediately and evaluated.
2. Consultation service available for evaluation of latex allergic client.
3. Maintain a journal of exposures and responses to occupational exposure.
4. Do not rely on hypoallergenic claims of glove manufacturers.
5. Encourage the hospital to consider purchasing only CGSB certified gloves. [Canada has a voluntary medical glove certification program run by a standards testing agency called the Canadian General Standards Board-CGSB. The program reviews the aspects of glove quality].

**Rationale:** \*Support positive factors toward wellness. \*Provide advocacy by coordination and integration (Fawcett, 1995).

#### Future Goals:

1. Provide structure to maintain and enhance immediate and intermediate goals, i.e., establish continuous improvement/quality assurance programs to monitor ongoing goals.
2. Incorporate new research based interventions as they are developed.
3. Quality assurance programs to follow clients who develop latex allergy.
4. Track research and incorporate findings into primary prevention.

**Rationale:** \*Support positive factors toward wellness. \*Provide advocacy by coordination and integration (Fawcett, 1995).

### Tertiary Prevention

#### Intermediate Goals:

1. Policies developed and reviewed regularly regarding occupational latex allergies.
2. Measures to be taken for latex-related illness.
3. Modified and alternate work sites identified when reallocating the allergic employee is required.
4. Encourage membership in Canadian Latex Allergy Association.

**Rationale:** \*Support client/client system toward goals. \*Coordinate and integrate health service resources (Fawcett, 1995).

#### Future Goals:

1. Provide structure to maintain and enhance immediate and intermediate goals, i.e., establish continuous improvement/quality assurance programs to monitor ongoing goals.

**Rationale:** \*Support client/client system toward goals. \*Coordinate and integrate health service resources (Fawcett, 1995).

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## Nursing Goals and Nursing Outcomes Related to Latex Allergy

It is possible to determine the type of intervention required as well as the rationale to support the goals by utilizing the Neuman system and relating all the latex allergy factors affecting the nursing population. According to Neuman, the desired outcome goals to correct the variances from wellness must be negotiated with the client (Neuman, 1995). For example, a nurse who has not developed a sensitization to an allergen, but works in a high-risk area such as the operating room or labour and delivery, intervention should begin at the primary prevention-as-intervention level. The goal here would be to expand the flexible line of defence to offer greater protection against a stressor invasion. If the nurse presents with a contact dermatitis with or without a food allergy, intervention should begin at the secondary prevention level. Intervention at this level will minimize the allergic individual's subsequent exposure to the allergen. Once the cause of symptoms is established, it is possible to take appropriate actions to minimize them. If the individual has overt symptoms of sensitization and has completed latex allergy testing, with a positive diagnosis of latex allergy, intervention should begin at the tertiary level.

## Evaluation

"The final step of the nursing process concludes when the results of intervention, termed outcome goals, are evaluated to confirm their attainment." (Fawcett, 1995).

Evaluation is an ongoing process and can serve as a systematic risk management approach to latex sensitivity with each phase categorized and evaluated as implemented. Risk management steps include risk identification, risk assessment, and risk control. Steps taken at each phase can be monitored for effectiveness of the risk management approach by eliciting the client's perspective in order to establish the success or failure of intervention (Neuman, 1995).

Interventions for evaluation in the latex sensitive client focus on primary prevention in order to sustain the basic structure and retain system stability. Neuman (1995) states that "nursing outcomes are evaluated continuously to determine if the plan of care needs to be changed." For example, new employees can be screened on induction of employment to determine individuals who fall into the "high risk" category of developing a latex sensitization/allergy. Long term

employees should not be overlooked and latex screening should be included in routine Occupational Health screening programs. (*A sample of a Latex-Allergy Screening Questionnaire, including 24 questions and a list of potentially allergy causing foods, is available in Sussman & Gold, 1996.*) The evaluation processes would be completed as a combined effort by the Occupational Health and Safety Department and the Latex Allergy Task Force. Statistics would include the percentage of nurses attending latex education sessions, reporting of signs and symptoms of latex sensitization, requests for information regarding latex allergy and the number of Latex Allergy Questionnaires completed and returned.

Other areas to evaluate include information gathered through the distribution and return of a Letter to Manufacturers. The letter would seek information regarding product latex content, and the increase/substitution of non-latex products versus latex products in the stores department. The Letter/Questionnaire to Manufacturers could state:

"As a result of documented incidents of anaphylactic reactions by patients and staff from exposure to natural rubber latex products, the Administration of (hospital/health care agency) has directed Materials Management to determine the natural rubber latex content of all items in the hospital inventory. We currently stock the following product, purchased from your company, as a hospital inventory item". (*See References for: Gegring, 1996, Letter to Manufacturers.*)

Nursing practice policies would be monitored and updated annually to reflect changes in practice. A concurrent total workplace environmental audit, including air sampling and product usage can be conducted in areas where a latex sensitive nurse has been identified.

It should be noted that evaluation could be complicated by nurses' unwillingness to report symptoms of latex exposure due to fear of losing their job.

Evaluation continues after confirmation of our outcome goals, and reformulation of goals may be necessary. For example, re-education through continuous inservicing programs may be required to meet our goals. These programs would constantly encourage nurses' participation in workplace latex-related issues. "Consequently, the client outcome acts as feedback for additional system input" (Fawcett, 1995.)

## Summary

The documentation in this paper has proven that latex allergy is a major health issue for nurses. Many goals have been formulated to help nurses reduce the exposure of latex in their environment. Our goal should be to provide a latex safe working environment and efforts should focus on reducing latex exposure in the nursing population.

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# Conference Calendar

## September 8 - 12, 1997

X World Conference of Operating Room Nurses, Toronto Convention Centre, Toronto, Ontario, sponsored by the American Operating Room Nurses Association.

## October 18, 1997

Operating Room Nurses Association of Hamilton & District - **One Day Seminar**, 8:30 - 3:30 at the White Oaks Inn, Niagara on the Lake. Contact: Susan Barrett (905) 878-2383 ext. (2310).

## October 18, 1997

Operating Room Nurses of Alberta Association Annual General Meeting and Workshop - Calgary, Alberta. (Please refer to Provincial newsletter for exact location when announced.).

## April 23 - 25, 1998

16th Biennial Conference - B.C. Operating Room Nurses Group. Harrison Hot Springs, Harrison, B.C. Theme: "Towards 2000"

## October 22 - 24, 1998

Operating Room Nurses of Alberta Association - 18th Provincial Conference - Red Deer, Alberta. Theme - "Speaking Out."

## Canadian Nurses Association Perioperative Nursing Certification

Next Exam Date: **April 4, 1998.**

Deadline for application: **November 21, 1997.** To obtain candidate information for the next exam date Phone 1-800-450-5206

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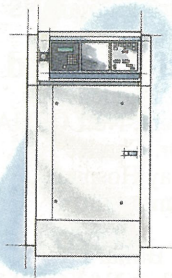
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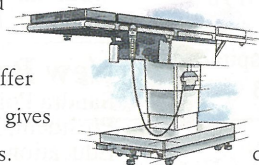
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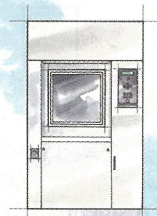
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