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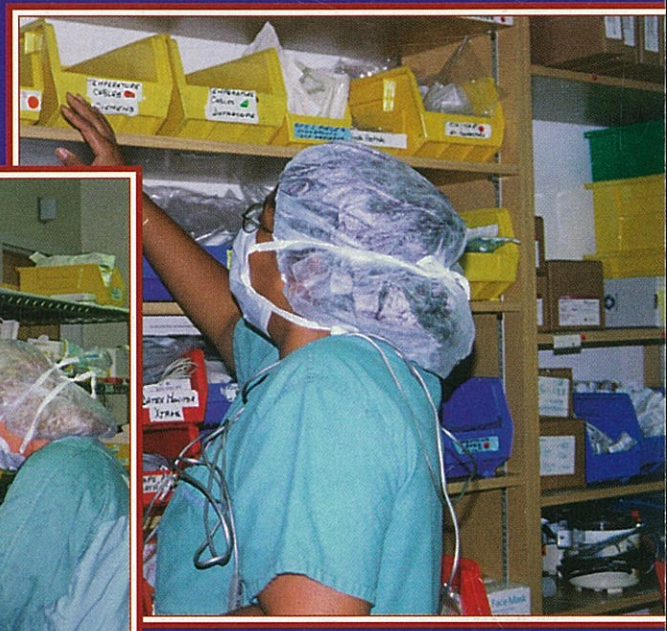

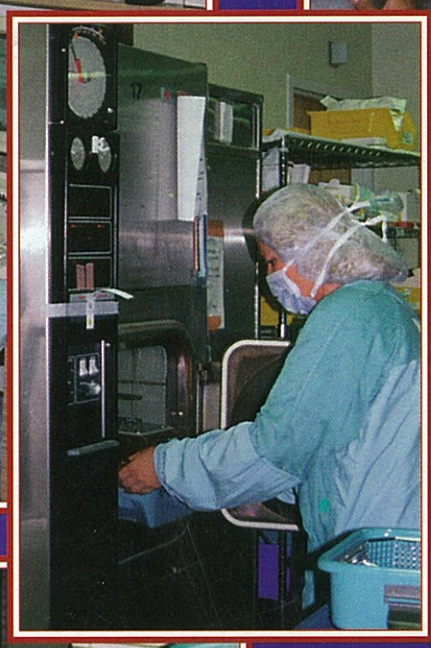

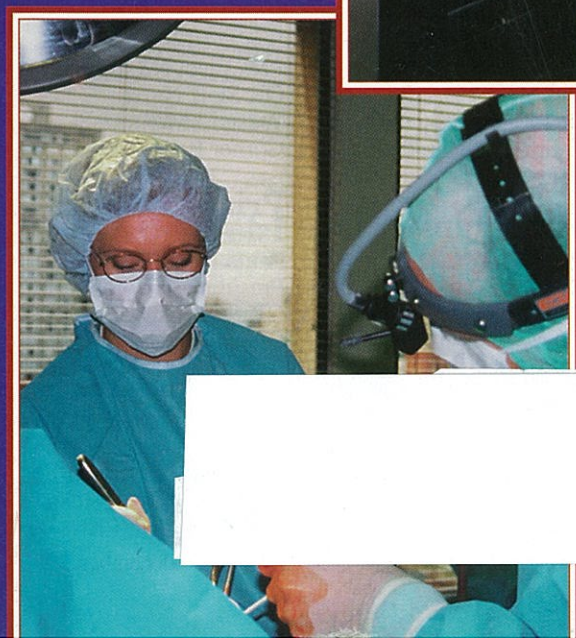

Blueprint for PNA & PNS

n urement

Canadian Operating Room Nurses Association of Canada

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Dialogue With ORNAC

By Vija Hay, RN, CPN (C)

In my previous President's Message I wrote about the National Conference in 1997, and the opportunity for delegates to dialogue with ORNAC Board of Directors. I want to elaborate on this topic.

At the September, 1996 Board meeting I addressed the future direction of ORNAC, and the need for assessment of ORNAC. To be an effective organization, it is essential that we as the Executive and Board know what operating room nurses regard as the issues in their professional lives, and recognize how well ORNAC serves the membership.

To begin the process we will initiate a self evaluation of ORNAC, and will hold a Forum at the '97 Conference to identify and discuss key issues for nurses in perioperative nursing. We need to know the real world of our members and the real needs, not just what we as an Association perceive them to be.

I have been fortunate this past year to be invited to attend Provincial Conferences across the country. My message to provincial delegates has been to encourage dialogue with ORNAC. Being at these conferences gave me the opportunity to talk to many O.R. nurses and discuss the concerns they have about perioperative nursing. It also gave me encouragement and pride to see how well the conferences were organized, large and small, the excellent choice of topics and presenters, and as well, the local support from exhibitors.

For me it is important to know the pulse of the membership, so that I am able to make recommendations and statements about perioperative nursing to other national and international organizations. I regularly report on key and emerging issues in perioperative nursing to CNA.

I look forward to our dialogue in April in Ottawa. Prepare for the ORNAC Forum: identify your three major key and emerging issues. Bring these to the Forum, or mail them to me or your Board member for discussion and recommendation. The main issues will be identified, collated, followed up, and distributed or published. Recommendations for action can then be incorporated in ORNAC's future directions.

Prepare, participate and prosper through progress.

Vija Hay, Consultant, Surgical Services, Ottawa, is President of the Operating Room Nurses Association of Canada.

'97 National Conference Planning Committee

Photo: Front row (l to r:) Judi Tyndall, Protocol/Publicity, Rosemarie Atwill, Co-Chair Hospitality Convenor, Vija Hay,Chair, Araina Clark,Hostess/Convenor, Diane Aboud, Exhibitor Convenor. Back row (l to r:) Wilma MacDonald, Registration Convenor, Janet MacCullouch, Protocol/Publicity Convenor, Alaine Young, Exhibitors, Sharon Ball, Program, Heather Macdonald, Secretary/Treasurer. Absent: Mindy Shinoff, Program.

ORNAC '97

April 28 - May 2, 1997

15th National Conference

Ottawa Congress Centre Ottawa, Ontario

Program Preview

Welcome to Ottawa !

The Conference Planning Committee is working diligently to bring you an exciting conference in Ottawa April 28 - May 2, 1997. The program looks really interesting - something for one and all.

Ottawa is a beautiful city. We hope you will stay a few extra days to visit the Capital Region. So much to see, so much to do! It may be still a little cool, so bring a coat.

The hotels are all within walking' distance of the Ottawa Congress Centre. The Westin is designated as the Headquarters Hotel and is adjacent to the Congress Centre - no need to go outside.

We request your support in booking accommodation in the designated hotels by specifying you are an ORNAC Conference delegate. Rooms have been blocked at these hotels at special rates. Non registration at these hotels will negatively impact contractual arrangements with the hotels, with subsequent loss of revenue for ORNAC.

We look forward to seeing you.

Vija Hay, Chair, '97 National Conference.

Speakers & Conference Topics

Pat Heim - "Gender Audit"
Bev Malone - "Shared Visions & Hallucinations - Acquiring a taste for chaos.
Estelle Davis Crews - "How to work with poops and still keep your shoes white"
Angela Jackson - Motivational Speaker
Dr. D.H. Johnson - "Arthroscopy Update 1997"
Karen Martz and Anne MacDonald - "Reuse of Single Use Items"
Jean Reeder, Past President AORN- Keynote Speaker
Lois Bruning- "Facing up to change"
Dr. B. Benoit - "Surgery in the Cerebello-Pontine Angle"
Dr. H. Stern - Colorectal Topic
Nurallah Rahim - "Pediatric Cranial Vault Reshaping"
Toni Labricciosa - Case Study - "Transient Osteoporosis During Pregnancy: The Perioperative Nurses Roles"
Judy Chadwick and Karen Waite - "Implementing a case cost system in O.R."
Keith Lowe- "Nursing in a multicultural community"
Cindy McLellan - "A new approach to accreditation
Susan Burnell-Jones - "The MORE Program Meets the O.R. Staff" Experience"
Vivian Quirling- "Hey, what about me?"
Doris Grinspun - RNAO.
Marg Duchano - "Taking care of yourself
Denise Mazzarella - "RN First Assistant".

Special Events

Welcoming Reception - Sunday PM, April 27.
Workshops/Focus Groups - SundayAM, April 27.
Johnson & Johnson Night - Tuesday, April 29.
Embassy Night Dinner - Wednesday, April 30.

Rates & Registraiton

5-day Package	RN Member	RN Non-Member
	$385	$500

5-day Package includes Embassy Night Dinner. Photocopy of Regional/provincial membership must be included with registration form which will be sent to hospitals in January, 1997. For registration information contact: Wilma MacDonald #57 - 280 McCellan Road, Nepean, Ontario. K2H 8P8. PH **(613) 829 - 4339.**

Plan now ! to attend the 15th National Conference

ORNAC '97 •
April 28 - May 2, 1997
15th National Conference
Ottawa Congress Centre
Ottawa, Ontario

Sponsor: Operating Room Nurses Association of Canada

Theme: "Changing The Guard" "Relève de la Garde"

Contacts:

Registration
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#57-280 McCellan Road
Nepean, Ontario.
K2H8P8
(613) 829-4339

Exhibitors

Diane Aboud
657 Ingram Cres.
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K1J7A7

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Responses of Perioperative Nurses to Organ Procurement Surgery

By Soledad Page, RN, MSN

Introduction

Perioperative nurses play a vital role in the process of organ donation. Although these nurses are not involved in the care and maintenance of the organ donor, their participation in the procurement surgery invites a mixture of emotions that need to be acknowledged. It is perioperative nurses who witness the removal of vital organs, the termination of life support, and the final end of life for the organ donor. Frequently, these nurses are left alone to provide post mortem care to the donor body. These experiences of the perioperative nurses are potentially emotionally charged. The purpose of this paper is to gain an understanding of the perioperative nurses' experience through a descriptive analysis of the responses of perioperative nurses to procurement surgery.

Abstract

For many hospitals, organ retrieval surgery has become a reality. Organ retrieval surgery is an emotive procedure, fraught with ethical and moral dilemmas (Barzizza, 1990; Kawamoto, 1992). Perioperative nurses who participate in the procurement phase of organ donation are subject to emotions that could be potentially difficult. There is a need for greater understanding of perioperative nurses and their responses to procurement surgery.

Increased knowledge of the procedure of organ procurement surgery, in addition to greater emotional support and follow-up can only serve to improve perioperative nurses' belief in themselves as an important link in the process of organ donation, procurement and transplantation.

Literature Review

There is a paucity of studies that investigate the experiences of perioperative nurses related to organ donation. In the studies reviewed, perioperative nurses were investigated as a subgroup of the target population of nurses. Findings in the studies suggested that the majority of the perceptions of perioperative nurses in relation to organ donation were influenced by the procurement surgery (Kiberd & Kiberd, (1992); Wolf, 1994; 1991). Further, Kiberd and Kiberd (1992) found that nurses perceived support from physicians and from management was inadequate. In addition, the nurses felt that educational opportunities related to organ donation were significantly lacking.

Lived Experience

To augment the literature, five perioperative nurses who have participated in organ procurement surgery were interviewed. All of the participants were experienced female perioperative nurses with clinical operating room (OR) experience ranging from

Author

Soledad Page, RN, MSN, is a Clinical Instructor (OR, PAR, DS) at the Prince George Regional Hospital, Prince George, BC. This article is an edited version of the major essay submitted as a requirement for the degree of Masters of Science in Nursing. Mrs. Page obtained her master's degree in May, 1996.

ten to twenty years.

The topic and purpose of the interview, together with a request for volunteers were presented to the perioperative staff at an acute care regional hospital (bed capacity of 219 Acute care beds and 72 long term care beds). Six originally volunteered from a group of 15 nurses. One nurse failed to keep the interview appointment and was therefore, dropped from the project. Each interview was tape recorded and lasted approximately 30 to 45 minutes.

The following questions were used to frame the interview.

1. When you find out an organ procurement is to be done during your shift and your participation is required, what is your response ? What influences how you respond ?

2. In an organ procurement surgery, do you prefer to be a scrub nurse or a circulating nurse? Why?

3. What was it like to participate in an organ procurement surgery ?

4. Do you believe organ procurement is a worthwhile procedure? Why or why not?

5. What factors about the organ donor affect how you feel about participating in organ procurement ? Give your reasons.

6. Are there things that could make participation a more worthwhile experience?

Findings

Attitude towards organ donations

All five nurses expressed support for organ donation. Their support was evident in their signed donor cards. These nurses pointed to the recipient-related benefits as the primary reasons for their support, however, their knowledge of long term transplantation results was significantly lacking.

Responses to participating in organ procurement

In general, the responses of the nurses to participation in organ procurement surgery were inherently influenced by professional responsibility. Although one nurse responded to participation with "dread", the other nurses used terms such as "challenged", "feel good about it", and "feel honored to be a part" to describe their responses. No one expressed undue discomfort at being asked to participate.

The response of "dread" was due to the multiple activities in preparation for and during the surgery. Multiple organ retrieval surgery is a multifaceted, fast-paced and coordinated effort where everyone involved has designated tasks to carry out. Once the surgery starts, many activities occur simultaneously. The visiting procurement team members may ask for different things at the same time, an event which can cause increased anxiety for the perioperative nurse.

Beliefs regarding the value of organ procurement

The nurses believed the long term benefits of a successful organ transplantation far exceeds the financial expense incurred in procuring and transplanting the organs. To these nurses, a person with corneal disease who gains eyesight after a corneal transplant is priceless.

Attitude towards the actual end of life

The nurses reported that they admitted the donor to the OR as a "patient", however, they recognized that a heart-beating cadaver donor was brain dead prior to organ procurement. Two nurses alluded to confusion between brain death and cardiac death:

"...is still a patient, not just a receptacle for organs...", and

"...always little questions are on your mind...is he really done?"

Emotional experience of participation

Several factors were identified by the nurses that made their experience in procurement surgery difficult.

1. Age of the donor

The nurses surmised that being parents themselves, they would unintentionally form some kind of parental affinity to a young organ donor. Their grief over the loss of a young life might be more profound, and that they may feel angry that a young organ donor would have been denied a chance to experience a full life.

"...child death is so much harder to deal with ...because they haven't begun to live their life".

2. Termination of life support

Once the ventilator was turned off, some of the nurses felt is was "gruesome" to take viable organs from a dead human body.

3. Religion, and beliefs and values

One nurse found removal of the eyes particularly disturbing. She was perplexed by how a donor without eyes would see in the afterlife. Another nurse reported experiencing a sense that the donor's spirit was hovering above, watching how the body was treated.

"...how else is he going to se in heaven...he's got no eyes!?"

"...I often feel that they're looking down at me and how I treat them".

4. Giving post mortem care

Once the designated organs and tissues are procured, the retrieval team departs. The noise, the sense of urgency pervading the OR at the beginning and during the surgery are gone, replaced with a sense of stillness. Although they were feeling lonely and abandoned, they provide post mortem care to the donor body, a task they claimed was unpleasant.

"When everyone is gone, I do have an abandoned feeling. There's the two of you....but it's just like they've grabbed the organs and ran...he's done his thing and he's gone...".

"You're left with the clean up...with the dirty part".

5. Attitude of the procurement team

The nurses claimed that the behavior of the procurement team impacts the perioperative nurses and their experience in retrieval surgery. They claimed that they prefer everyone involved in the surgery behave professionally and with dignity.

Other Findings

The nurses reported utilizing coping strategies unconsciously during surgery to lessen their discomfort. Some effective coping mechanisms they reported were: keeping in mind the recipient related benefits, and focusing their energy and attention to the task at hand and that of assisting the procurement team.

The nurses further reported that they seldom discuss their experiences with their colleagues and/or their significant other. In addition, although a debriefing program may be in place, perioperative nurses were not always aware of its availability, and/or how to access the program.

Conclusion

Organ procurement is a sad event, ending with the biological death of the organ donor in the OR. Although it is well known that death occurs rarely in the OR (Jeffries, 1993), organ procurement surgery is altering this view. Increasingly, perioperative nurses provide post mortem care to donor bodies in the OR.

The literature review and the interviews with the perioperative nurses indicate that support for perioperative nurses is needed. Patient care managers can offer support with flexible staff assignments, and by acknowledging the challenging nature of the surgery. Education sessions on the individual hospital's stance on organ donation may be offered to caregivers. Sessions may be coordinated with organ procurement agencies and offered on site during the year. In addition, although critical incident debriefing sessions are available, all caregivers concerned should be offered, perhaps through scheduling, the opportunity to participate.

Perioperative nurses should be encouraged to recognize that, although they view organ procurement as a part of the perioperative role, they have the freedom to express their thoughts and feelings about their participation, and to seek help when the need is identified. They could foster support for each other by exploring each other's responses to the surgery, and listening to each other's expression of emotions.

This is not to say all perioperative nurses are emotionally affected by the surgery. Although many studies have been conducted about organ donation, the procurement aspect is still largely unexplored. This may be due to the physical isolation of perioperative nurses in surgical suites combined with the intense and subjective nature of the topic. ■

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The Rocky Road to RN First Assistant

By Lisa Blaskovits, RN, (CNOR)

Sometimes ignorance is a blessing. Had I known three years ago what I know today, I may have decided to become an interior decorator instead of a R.N. Surgical Assistant. However, in hind sight, I have to say it has been the most challenging, exciting, and satisfying work I have ever done in my nursing career.

This is not to say the work is finished. Becoming a certified R.N. First Assistant appears to have been the easy part. Developing infrastructure, from a national, all the way to an institutional perspective, has become the time consuming task. We have, as a group, made great strides and we are well on our way to having the R.N. Surgical Assistant accepted as a standard in urban institutions. My story is just a small cog in the big wheel, but many have found it interesting, informative, and even inspirational. So I relate it here.

ORNAC's 1993 Conference Introduced the R.N.F.A. to Canadian OR Nurses

I had first heard of the concept of the R.N. Surgical Assistant in May, 1993 when one of my nursing colleagues attended a lecture by Dr. Jane Rothrock in Quebec City during the National Conference of the Operating Room Nurses Association of Canada. We discussed it upon her return, and decided it wasn't an unreasonable concept. We were, at the time, both members of the Open Heart Team at the Holy Cross Hospital in Calgary. During the initial phase of bypass surgery, when the second surgeon was harvesting the great saphenous vein, the scrub nurse assisted the first surgeon to open the chest, harvest the Internal Mammary Artery and go on Cardiopulmonary Bypass. Throughout the surgery, the scrub nurse was expected to maintain hemostasis in the leg wound until the wound was closed at the end of surgery.

And so, in our estimation, we were already Surgical Assistants performing many of the necessary tasks. It was just a matter of becoming certified and recognized.

To become certified, I would have to attend a course in the United States, as a Canadian course had not yet been developed. To do this, I had prerequisites to meet. I required a U.S. nursing license, CNOR certification (equivalent to CNA - perioperative nursing certification) and ACLS certification.

I chose to write the U.S. nursing (NCLEX) exams in California as that state has reciprocity across the U.S. After six weeks of daily study sessions I found myself at the Los Angeles County Fairgrounds in Pomona, California with 10,000 other hopefuls. This was an experience burned into my memory.

Back home in Canada, I threw myself into an ACLS course offered by a local college, and later that year, travelled to Helena, Montana to sit for the

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Author

Lisa Blaskovits, RN, (CNOR), is a U.S. certified RNFA, and is presently employed as a Nurse Clinician, Mineral Springs Hospital, Banff, Alberta.

"I spent close to $10,000 on books, tuition, airfare, and accommodations, to mention just the major expenses. I wasn't able to find funding for a role not as yet recognized in Canada."

CNOR exams. All this behind me, I could concentrate on the Registered Nurse First Assistant course itself. After surveying several colleges in Sacramento, Phoenix, Arizona, and Media, PA, I decided on Linfield College in Portland, Oregon. It was closer to Calgary and this would save on travel and communication expenses. The course and its co-ordinator were also very flexible in meeting my particular needs and restrictions as a foreign student in their institution.

I drew up a proposal outlining the course, and my wish to intern at the Holy Cross Hospital and distributed the proposal to the Department of Cardiovascular/Thoracic Surgery and the Administrative offices.

Surprisingly enough, the surgeons were incredibly receptive, encouraging and supportive, and all five agreed to precept my internship. Nursing Administration was somewhat more skeptical. Regardless, I had paid my tuition and was determined to go as far as I could with this. I flew to Portland for the two weeks of didactic and lab training and returned to Calgary to commence my internship.

160 Hours of Surgical Time Required

I was required to log 160 hours of straight surgical time to complete my RNFA internship. I was also required to show competency in all areas specific to surgical assisting: exposure and visualization, tissue handling, hemostasis and suturing.

Because of my unique situation and being able to claim only 30 minutes to one hour of surgical assisting time for three to five- hours of scrub, I was allowed to collect intern hours retroactively for two years. This allowed me to meet all requirements for the surgical assistant internship within the allotted six week time period.

As the Chief of Cardiovascular/Thoracic Surgery, Dr. V. Aldrete acted as my main preceptor and provided evaluations of my performance as required by Linfield College. He also spent countless hours with me outside the theatre, practicing knot tying, suturing, and discussing surgical cases. His enthusiasm was a great encouragement for me.

Quality Assurance Limited My Ability

Unfortunately, after months of meetings, letters, and conference calls with various professional organizations, including ORNAA, AARN, and CNPS, the hospital's Nursing Administration (specifically Quality Assurance) 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.

Lisa Blaskovits, RN, (CNOR), RNFA

Insurance Restrictions

The reason for this decision was based on the hospital's insurer at the time. The Alberta Hospital Association based their insurance on community standards. Since no other O.R. nurse employed in an urban hospital in our center (Calgary) was allowed to function in this capacity, I also would not be allowed to practice as an Surgical Assistant.

The politics of it was enough to make me pull my hair out! I was allowed to tie knots on vessels close to the heart and on vessels used to bypass onto the heart. Imagine the consequences two hours post-operatively of an improperly tied knot. I was allowed to push an awl through the sternum and to pull a wire back through. Imagine, through carelessness, the results of an awl puncturing the left ventricle or aorta. I was allowed to retract scarred pericardium and even the heart itself. Yet, I was not allowed to suture subcutaneous and skin tissue which has, in comparison, very minimal risk associated with it.

I fully understood the hospital's reluctance to allow me to practice at an advanced level. .After all, who wants to be legally responsible for the first R.N.F.A.? And, I had time on my side. So I decided to wait until the year 2000 before giving up on the RNFA role in Canada.

In the end, I left the open heart team to pursue a Nurse Clinician position in a rural hospital. I am presently out of the Operating Room more than I would like, but also find that I'm frequently being asked to assist because general practitioners and residents are sometimes difficult to find for surgery.

In the two years that it took me to become a R.N.F.A., I estimate I spent close to $10,000 on books, tuition, airfare, and accommodations, to mention just the major expenses. I wasn't able to find funding for a role not as yet recognized in Canada. I was left to my own resources.

Would I do it again? . . . In a minute! As I stated in the beginning, it's been a wonderful adventure.

Over the past three years, I have given several lectures on my experiences as RNFA and I always like to close with a quote from Florence Nightingale's *"Notes on Nursing":*

> "No system can endure that does not march. Are we walking to the future or to the past? Are we progressing or are we stereotyping? We remember that we have scarcely crossed the threshold of uncivilized civilization in nursing; there is still so much to do. Don't let us stereotype mediocrity, we are still on the threshold of nursing." ■

Perioperative Nurses receive CNF Certification Awards

The Canadian Nurses Foundation (CNF) announced several names as recipients of the 1996 Perioperative Certification Awards through the Canadian Nurses Association Certification Program. Winners were **Lilia Faustino**, Ontario; **Linda Allen**, Nova Scotia; and, **Joyce Mauro,** Ontario, who were recently Certified in their Perioperative Specialty.

CNF is the only national foundation committed solely to promoting the health of Canadians by helping nurses pursue their educational and research goals. The funding that makes these awards possible is acquired from nurses, corporate donors/sponsors, bequests and gifts from individuals and organizations who support the goals of the Foundation.

CNF offers Research Grants from $5000 to $15,000, Leadership Awards of $1,000 and several smaller Certification awards.

For further information contact:

The Executive Director,
Canadian Nurses Foundation
50 The Driveway, Ottawa, ON K2P 1E2
PH: (613) 237-2133 FAX: (613) 237-3520

Attention all Perioperative Nurses

The Isabelle Adams Excellence in Perioperative Nursing Award

To be Awarded at the 1997 National Conference in Ottawa

Do you know of an outstanding ORNAC member, who through her dedication and commitment has made a difference in the field of perioperative nursing and deserves to be recognized for her contribution ?

The Isabelle Adams Excellence in Perioperative Nursing Award was established for this purpose on the initiative of the Operating Room Nurses of Québec in 1987. The first award was presented in Vancouver in 1988 and is presented on the year of the National Conference.

Nomination papers can be obtained through your Provincial President or by contacting:

Shelly Zareski
Chair, Awards Committee
5572 Northridge Road A 1206
Halifax NS B3K 5K2
(902) 454-0463 FAX (902) 428-3214

Modular Post-Basic Grads - Paula Mullin, Donna Wheaton, Shirley Gallant and Carol Ann Howe of Hotel Dieu Facility. From the of the Miramichi Facility - Aletha Connell, Jane Houck and Corina Balcom

Modular Post-Basic Perioperative Nursing Program grads

The self-directed learning Modular Post Basic Perioperative Nursing Program developed by Sandra Piorier , Education Coordinator - The Moncton Hospital Operating Room recently graduated its second class. This group is the first outside of The Moncton Hospital to complete the program. . Education liaison for the program was Margaret Cassidy (Regional 7 Hospital Corporation).

Congratulations to all the new graduates - Paula Mullin, Donna Wheaton, Shirley Gallant and Carol Ann Howe (of the Hotel Dieu Facility) and Corina Balcom, Aletha Connell and Jane Houck (of the Miramichi Facility). Nineteen hundred and fifty (1,950) hours of self-directed study is dedication plus. Congratulations all !

By **Kenda J. Lynn**, Secretary, NBORN

N.B.O.R. Nurses' Institute attracts 88 of its members

The New Brunswick Operating Room Nurses held its 22nd annual Spring Institute in Bathurst, NB, April 19th and 20th,1996. The Institute was hosted by Region 2 of the NBORN. The education day, social evening and a short business meeting was attended by 88 members and 27 exhibitors. The conference theme "Thriving Not Just Surviving as an OR Nurse" was enjoyed by all.

Alice Hébert-Breau spoke on "How to be a Winner Today in Our Profession". "Burnout among Professional" was presented by Pierette Matte-Lavinge. An interesting session on Computers in the OR was also presented.

The Conference concluded with the election of officers for the 1996 - 1998 term: President - Sandra Poirier (Moncton); President Elect - Nora Slater (Bathurst); Vice President - Tina Kennah (Fredericton); Treasurer - Hèlen LeBlanc (returning); and Secretary - Kenda Lynn (Moncton).

The 1997 conference will be hosted by Region 5 - NBORN in Woodstock, NB, May 9th and 10th. The theme will be: "Taking Care of Me".

Blueprint for:

Curricula Development For the Role of Perioperative Nurse Anesthesia (PNA) and Surgery (PNS)

The increasing complexity of role of the perioperative nurse has led to the development of perioperative nurse anesthesia (PNA) and perioperative nurse surgery (PNS). The PNA/PNS will possess advanced knowledge, judgement, and skill required to provide quality, individualized, cost effective client care in a rapidly changing technological, economical and social environment.

The Operating Room Nurses Association of Canada (ORNAC) has developed a document to be used as a 'blueprint' to provide direction for educational institutions developing curricula to prepare experienced perioperative nurses for practice within the PNA/PNS role in diverse perioperative environments.The following is an excerpt from the 'blueprint' document.

Goals

The goal of PNS/PNA curricula is the preparation of a practitioner who bases practice on advanced knowledge of nursing art and science, and on the content relevant to specialized health care from other disciplines.

Graduates will be reflective critical thinkers, self-directed lifelong learners and collaborative practitioners who function independently and interdependently within an interdisciplinary team.

They are responsible and accountable for their own practice.

Philosophy

The following statements reflect ORNAC's beliefs about the individual, environment, health, perioperative nursing, learning and research.

Individual

Society is composed of individuals who are unique beings with dignity and work. Perioperative nurses value clients as biopsychosocial beings who possess needs basic to their existence. Clients have a right to achieve and/or maintain an optimal level of health congruent with their own beliefs and values.

Environment

Individuals live, learn and work in an environment affected by social, economic, ecological, physical and political factors. The environment influences the way individuals perceive their health and learning and may be modified or changed to promote health and growth.

Health

Health is the individual's perception of the degree to which homeostasis is achieved and/or maintained. Provision of perioperative nursing care is a dynamic process aimed at promoting health, independence, preventing injury and disease, or ensuring a peaceful and dignified death for clients undergoing surgical intervention.

Perioperative Nursing (PNA/PNS Practice)

Perioperative nursing is complex and diverse and is focused towards providing a continuity of individualized care to surgical patients and their families. Caring, advocacy, continuity and consistency of coordinated patient care and adaptability in a constantly changing, technological environment are the characteristics of the PNA/PNS nurse. These nurses are reflective critical thinkers who base their practice on an expanded body of knowledge of perioperative nursing and knowledge from other health sciences. They work interdependently and dependently within interdisciplinary teams and collaborate with other health care providers to facilitate the achievement of optimal health for their perioperative clients. Perioperative nursing is affected by specific technological changes, and economic and cultural forces. The PNA/PNS has specialized skills and knowledge related to their expanded scope of perioperative practice.

Life-long Learning

The PNA/PNS is responsible and accountable to maintain competence and currency through continuous lifelong learning.

Nursing Research

Perioperative nursing(anesthesia and surgery) practice is supported by theory and research.

Definitions

Perioperative Nurse Anesthesia (PNA)

The registered nurse with advanced perioperative nursing education and skills functions collaboratively with the anesthetist to provide care for the patient undergoing anesthesia during the preoperative, intraoperative an postoperative phases. The increasing complexity of the role of the PNA compels a higher level of expertise than was previously required of the circulating nurse. PNA practice may vary depending on patient populations, practice environments, services provided, accessibility of human and social resources, institutional policy and provincial regulations of nursing practice.

Perioperative Nurse Surgery (PNS)

The registered nurse with advanced perioperative nursing education and skills provides assistance during the surgical intervention under the direction of the surgeon. This role has separate responsibilities to that of the scrub role. The PNS collaborates with the surgical team to coordinate the care of the client throughout the perioperative period. This new perioperative role requires a different body of knowledge and skills than was previously required of the scrub nurse. PNS practice may vary depending on patient populations, practice environments, services provided, accessibility of human and fiscal resources, institutional policy and provincial regulations of nursing practice.

Scope of Practice

Perioperative Nurse Anesthesia

Unique in the role of collaboratively providing anaesthesia assistance, nursing activities may include but are not limited to:

- preoperative assessment and collaborative planning of anesthesia delivery.
- participating in pre and post operative client teaching and discharge planning with surgical patients and their families.
- preparing, establishing, and maintaining devices to monitor homoeostasis.
- participating in air~vay management.
- preparing, establishing, maintaining and monitoring regional anaesthesia
- responding to and recognizing anesthetic or surgical life-threatening emergencies.
- assessing and collaboratively planning the post anesthetic recovery care of the client.

Perioperative Nurse Surgery

Unique in the role of providing surgical assistance, nursing activities may include but are not limited to:

- Assessing clients preoperatively and collaboratively planning for the surgical intervention
- Participating in pre and post operative client teaching and discharge planning with surgical patients and their families.
- Providing surgical assistance under supervision of the surgeon by: the careful handling of tissue, deliberate selection and proper utilization of retractors, providing Hemostasis intraoperatively and prior to wound closure, and closure of surgical wounds.
- Applying knowledge/skills from nursing, microbiology and pharmacology to prevent and/or minimize the risk of surgical infections and promote wound healing.
- Consulting or participating in short and long term planning of the postoperative care of the surgical patient.

Glossary

1. Perioperative nursing (scope of practice):

- The scope of perioperative nursing practice is a continuum ranging from basic to advanced professional and clinical nursing activities. The perioperative nurse focuses on identifying and meeting the individual needs of the surgical patient
- The registered nurse working in the perioperative environments draws from a unique body of basic and advanced knowledge of anatomy, physiology, psychosocial concepts and pharmacology related to the surgical patient (adult, child and neonate).
- Working in collaboration with the health care team the perioperative nurse performs skills based on

a continuum from basic to advanced, supported by perioperative nursing education and research within the boundaries of agency policies and practice.

2. Perioperative phases: (preoperative, intraoperative, postoperative) ORNAC (1995) has defined these phases as:

Preoperative - the period of time (approximately 30 - 90) minutes prior to and including patient transport to the procedure/operating theater, (it is envisioned that this time will be expanded to allow for preoperative assessment, teaching, and planning for surgery/anesthesia and discharge as required within the scope of practice of the PNA/PNS roles).

Intraoperative - the period of time of entry of the patient into the operating theater to the completion of the surgical/diagnostic procedure.

Postoperative - the period of time following completion of the surgical procedure, to transport and transfer of care to appropriate post-operative care nurses, (it is envisioned that this time will be expanded to allow for PNA/PNS postoperative consultation with a variety of patient care givers and for the evaluation of patient outcomes).

3. Advanced perioperative nursing knowledge: knowledge related to perioperative nursing that is beyond the requirements for an entry level of perioperative practice and basic nursing knowledge.

4. Circulating nurse: the perioperative nursing role with prime responsibility for the coordination of safe, supportive, individualized care of the surgical patient throughout the perioperative period. The nurse works collaboratively with the surgical team to prepare, monitor and maintain a safe environment and facilitate the efficient, safe and effective sequencing of surgical events. Working in collaboration with anesthesia she/he facilitates induction, maintenance and emergence from anesthesia by providing nursing care to ensure patient safety and comfort. The primary focus of this role is patient advocacy.

5. Scrub nurse: the perioperative nursing role with prime responsibility for preparation and maintenance of a safe sterile environment. The nurse facilitates surgery through the organized and dextrous nursing skills that facilitate the surgical intervention. She/he works collaboratively and primarily with the sterile surgical team. Patient advocacy pertaining to safety within the surgical field is the focus of this role.

6. Perioperative Nurse Anesthesia (PNA): the nurse with advanced perioperative nursing education and skills functions collaboratively with the anesthetist to provide care for the patient undergoing anesthesia during the preoperative, intraoperative an postoperative phases. The increasing complexity of anesthesia compels a higher level of expertise than was previously required of the circulating nurse. PNA practice may vary depending on patient populations, practice environments, services provided, accessibility of human and fiscal resources, institutional policy and provincial regulations of nursing practice.

7. Perioperative Nurse Surgery (PNS): the nurse with advanced perioperative nursing education and skills provides assistance during the surgical intervention under the direction of the surgeon. This role has separate responsibilities to that of the scrub role. The PNS collaborates with the surgical team to coordinate the care of the client throughout the perioperative period. This new perioperative role requires a different body of knowledge and skills than was previously required of the scrub nurse. PNS practice may vary depending on patient populations, practice environments, services provided, accessibility of human and

fiscal resources, institutional policy and provincial regulations of nursing practice.

Outcomes

The graduates of this program will:

1. use reflective critical thinking to make sound clinical judgements

2. function as a professional as defined by the CNA Standards of Practice and the ORNAC Recommended Standards for Professional and Clinical Perioperative Practice

3. base practice on theory and research

4. practice in collaborative partnerships with clients and their families and as members of multidisciplinary health care teams

5. practice independently and interdependently within the scope of practice of the PNA/PNS roles

6. effectively manage resources (human and fiscal)

7. communicate in a clear and confident manner in order to establish shared meaning, and

8. maintain competence through lifelong learning.

Criteria for Admission

1. Baccalaureate in nursing (5 year period for this to be mandatory)

2. graduate of recognized perioperative nursing program

3. CNA certification in perioperative nursing

4. minimum of five years of current perioperative nursing experience in both roles and in a broad range of surgical specialties.

**Nurses who do not meet criteria 2 or 3 may be evaluated for competency through:*

- *self evaluation*
- *peer evaluation*
- *prior learning assessment, theory/clinical testing*

Curriculum Threads

It is recommended that all curricula include the following curriculum threads:

Hoizontal Threads

reflective critical thinking
professionalism
systematic inquiry
independent/interdependent practice
communication
collaboration
leadership/management
lifelong-learning

Vertical Threads

individual
health
advanced perioperative practice

Core Content (PNA/PNS)

The following is a suggested list of content areas that are deemed to be core content for both PNA and PNS programs.

- comprehensive assessment
- basic anatomy and physiology*
- basic pharmacology*
- communication/interviewing
- teaching and learning and planning for discharge
- research utilization
- professional aspects related to PNA/PNS roles
- current health care issues/trends

**A&P and pharmacology at the level required for introductory perioperative practice should be ascertained through review courses or a challenge examination procedure*

Suggested Course Content

Perioperative Nurse - Surgery

advanced anatomy & physiology - all systems
pathophysiology related to surgery
surgical techniques
  planning for the surgical procedure related to:
    diagnosis
    pathophysiology
    anatomical landmarks
providing assistance for surgery
    positioning
    preoperative skin preparation
    draping
    incision
    exposure
    tissue protection
    haemostasis
    suturing
    wound closure
    wound dressing/drainage
advanced principles of infection control
    asepsis
    microbiology
    pharmacology
    wound management
patient assessment and preparation for surgery

management of surgical instrumentation and equipment
management of surgical complications
management of surgical crisis
hemodynamic complications
metabolic complications
cardiac complications
patient safety
post operative considerations
immediate postop care related to surgery
discharge planning
medication and wound regimes
evaluation of outcomes

Perioperative Nurse - Anesthesia

advanced anatomy & physiology systems:
respiratory
cardiovascular
hematological
nervous system
endocrine
renal
pathophysiology related to anesthesia
pharmacology related to anesthesia
assessment and preparation for anesthesia
planning for anesthesia (including risk assessment)
anesthetic techniques, principles and administration (induction, maintenance, and reversal)
techniques:
general
obstetrical
pediatrics/neonatal
pain management
managing anesthetic technology
supplies and equipment
monitoring devices
anesthetic machine
anesthetic monitoring techniques
invasive
non-invasive
post anesthetic patient care management
assessment
management of respiratory function
pain management
homeostasis management
evaluation of outcomes
providing assistance during anesthesia
role
skills
patient care/nursing strategies
management of anesthetic crisis
respiratory
metabolic
cardiovascular
hematological
management of anesthetic complications
patient safety.

The ORNAC document (March, 1995) Perioperative Nurse Anesthesia (PNA) and Perioperative Nurse Surgery (PNS) provides a more detailed list of suggested content for inclusion in curricula for the PNA/PNS roles.

Bibliography

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Operating Room Nurses Association of Canada (1993) *Recommended Standards for Nursing Professional and Clinical Practice.* ORNAC

Telemedicine Canada - 1997

February 26, 1997	**Tourniquet Safety: Hazards and Guidelines for Use**	**Dr. James McEwen**, Biomedical Engineer and Director, Medical Devices Development Centre, Vancouver Hospital and Health Science Centre. Moderator: **Sandra McManus,** Computer Applications Analyst, Nursing, Surgical Suites, St. Joseph's Health Centre, London.
April 2, 1997	**The New Bugs: Dealing with Antibiotic Resistant Micro-organisms**	**Sheila MacDonald**, Manager/Infection Control, Queen Elizabeth Health Centre, Victoria General Hospital Site, Halifax. Moderator: **Glenda Tapp**, Education Coordinator, OR/PARR, St. Clare's Mercy Hospital, St. John's, NF.
April 23, 1997	**Glutaraldehyde: Risks and Benefits of a Cold Sterilant**	**Lynne Trott**, Clinical Education Consultant, Advanced Sterilization Products, Johnson & Johnson Medical Products, Toronto. Moderator: **Rob Richardson**, Nurse, Operating Room, Trail Regional Hospital, Trail, BC.
May 14, 1997	**Quality Management in Perioperative Nursing**	**Mary Knight Kubasiewicz**, Manager, Operating Room, The Salvation Army Grace Hospital, Winnipeg. Moderator: **Kim Benedict**, Nurse, Orthopaedics OR, Queen Elizabeth Health Science Centre, Victoria General, Halifax.
June 4, 1997	**Perioperative Care RN: First Assistant, Canada's 1st Program in Place**	**Monique Perazzelli**, President,Corporation of Operating Room Nurses of Quebec, Head Nurse, OR, Ste. Justine Hospital, Montreal. Moderator: **Charlene Robinson**, Surgical Services Manager, Cape Breton Regional Hospital Site, Sydney, NS.
June 25, 1997	**Preventing Burnout: Dealing with Stress in the New Work Environment**	**Dr. Lucille Peszat**, Director, Canadian Centre for Stress and Well-Being, Toronto. Moderator: **Corina Balcom**, Nurse Manager, Perioperative Services, Region 7 Hospital Corp. Miramichi Facility, Newcastle, NB.

Telemedicine Canada - Under the Joint auspices of the Faculty of Medicine, University of Toronto and the Toronto Hospital. Contact: Natalie Riegler, Nursing Education Coord. Tel: (416) 599-1234 FAX (416) 598-1848

So You Want To Be an RN - First Assistant !

Susan Renee Guerra, RN, MN, CNAA, CNOR, is Course Coordinator for the RN First Assistant Program at the University of California in Los Angeles. She outlined the California program to a packed conference room during the recent ORNAA annual conference in Edmonton. In addition to her teaching role, Ms Renee Guerra is a Surgical Services Consultant, Baxter Corporation.

Definition of an RNFA

Advanced practice implies functioning outside normal practice, for example as a Nurse Anesthetist or Nurse Midwife. Ms Renee Guerra defined the role in the following statement: "A perioperative nurse functions in an expanded role in the five unique behaviors as an RN First Assistant. They are:

1. **Handling Tissue**
2. **Providing Exposure**
3. **Using Instruments**
4. **Suturing, and**
5. **Providing Hemostasis**

Other proactive steps she recommended to become an RNFA would be to:

• Examine the Provincial Nurse Practice Act and Petition the Provincial College of Nurses to include provisions for the Expanded Role, such as the Quebec College of Nurses have done in that province.

•Examine your hospital policies, procedures and bylaws and petition hospital administration to include RN's as providers of first assisting functions.

• Examine your Provincial Laws for Hospitals (e.g. Hospital Act), and begin lobbying for change, if necessary.

• Obtain Practice Privileges through the Interdisciplinary Practice Committee.

• Develop Support for the Advanced Role through discussions with Management, Physicians and Colleagues. (This is regarded as the most important step. Seek out the surgeons who need the RN First Assistant to support your plans and seek the support of all your nurse managers.

Ms Renee Guerra suggested OR Nurses seek first the support of your Provincial Professional Associations, then a reputable program which would offer 40 to 56 hours of didactic studies; include 100 to 120 hours of preceptorship; offer University/College Credits; and a Suture and Knot tying practicum.

Prerequisites

Most programs stipulate a prerequisites of 2 to 3 years minimum operating room practice, OR Certification, and the most controversial prerequisite in Canada - that of a future Masters of Science in Nursing. This she felt was not a practical prerequisite and a point which would have to be resolved in the near future.

Reimbursement

The question of who pays what will also have to be resolved. Will Government pay for the RNFA, the Physicians, the Hospital or some other fund. These questions she felt needed to be explored, along with the many questions of the legal implications. The "Scope of Practice" would have to be established and Malpractice Insurance provided.

The RNFA program at UCLA, according to Ms Renee Guerra started with 27 OR nurses and is now offered twice a year to accommodate all the qualified applicants. It costs $1200 U.S. dollars to take the California program, and some schools charge as much a $1400 U.S. The RNFA in California can earn $5 per hour more than other R.N.s and some make far more than that.

She told the Alberta OR nurses it would take "...education, perseverance, professionalism and a trail blazing spirit to become an RNFA." ■

How to Submit Your Article to the OR Journal

The Canadian Operating Room Nursing Journal is intended to serve the information needs of perioperative nurses in hospitals and clinics throughout Canada. Readers include staff nurses, head nurses, nursing supervisors, coordinators, clinical instructors, directors of nursing and many other speciality nurses. The journal is peer-reviewed and published quarterly by Health Media Inc. under the aegis of the Operating Room Nurses Association of Canada (ORNAC).

Manuscripts are reviewed by the editorial review board members appointed by ORNAC, and when necessary by outside experts. Submissions are invited on new surgical techniques, descriptions of new technologies or new programs and educational material. Selection is based chiefly on the following criteria: originality, timeliness and relevance to the needs of the journal's readers.

Preferred length is approximately six to ten typed, double-spaced pages, numbered consecutively throughout(including tables, figures,references,which should be on separate pages). Authors should submit **three copies** (one should be the original or an excellent photocopy) of the manuscript and include:

1. An abstract summarizing the article.

2. An autobiographical statement that includes the author's full name, current title and academic qualifications. e.g. Jane M. Smith, RN, MNSc, is head nurse, Thorasic Surgery Unit, General Hospital, Perth, ON.

All illustrations, graphs, tables, etc. should be clearly labelled and, if necessary, reference should be made as to where they are to be inserted in the text. The author should submit the original manuscript and two(2) copies for reviewers. A copy of the edited text will be sent to the author for final approval.

References are arranged in alphabetical order by author surname. References are cited in the text by author-date method of citation, e.g. (Smith, 1987). Follow the APA Manual for style when typing the list of References, e.g.:

Smith, M. & Curtis, J. (1987). Ethics in Nursing (2nd ed). New York: Oxford University Press.

Benjamin,G. (1987).Opportunities for nurse entrepreneurs. *Nursing Outlook* 35(4),182-184.

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Authors will receive a letter from the publisher announcing reciept of the article. Later a letter of acceptance and possibly some revisions may be suggested by the editorial review board.

Manuscripts submitted to the Journal **should not** be submitted to another publication or newsletter while under review or awaiting publication.

Award for Authors valued at $3000

In 1983 with the launching of the "Canadian Operating Room Nursing Journal", Johnson & Johnson Medical Products committed an annual $3,000 award to be presented to the author of the best article of the year published in Journal.

The award recognizes Canadian nurses who contribute to the advancement of perioperative nursing knowledge and education of their colleagues through the medium of the Journal.

The Editorial Awards Committee was established in 1983. The first award was presented at the National Conference in Jasper in 1984, and is presented annually at the National ORNAC Conference or at a Provincial Meeting. The recipient receives a plaque as well as the cash award which is administered by ORNAC. This year's Awards Committee Chairperson is Shelly Zareski of Halifax, Nova Scotia.

Conference Calendar

ORNAC '97 - April, 1997
15th National ORNAC Conference
Ottawa, Ontario.

Sponsored by the Canadian Operating Room Nurses Association. For registration contacts and program details please turn to page 6 of this issue.

International History of Nursing Conference
June l2-15, 1997
St. Paul's Hospital - Vancouver, B.C.

Planning for the conference, to be held in connection with the 'International Conference on Nursing' (ICN) in Vancouver, June 15-20, is moving on several fronts. The ICN is being held in Canada for the first time, so this is a special event for Canadian Nurses. The International History of Nursing Conference preliminary program and registration form has been mailed out and registrations are coming in. Sixty (60) papers and 11 posters have been accepted by the international review panel. Two plenary panels are planned to present international nursing history perspectives.

The Thursday evening public session will begin with a salute to Canadian history. Nursing and the Royal Canadian Mounted Police will spotlight their shared history in Canada's north, followed by Monique Begin's keynote address on Canada's Health Care System.

Planning for social activities has been helped by corporate donations for specific events. There is good response to our call for national costumes and exhibits. Special historical publications are being planned and will be available at the conference. Downtown hotels are at a premium. Conference participants are encouraged to seek accommodations early. This is shaping up to be an exciting international history event with 15 countries participating to date.

Come and join us. More information through Sheila Rankin Zerr, 5333 Upland Drive, Delta, B.C. V4M2G3.
Tel: (604) 943-3012.

June 26 - 28, 1997

National Neuroscience Conference in Saskatoon, Sask. For more information contact Lori Stricker at (306) 766-6407 or (306) 924-2447.

September 8 - 12, 1997

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

Alberta Conference examines the "challenges of change"

Edmonton: Vija Hay, President of the Operating Room Nurses Association of Canada, brought greeting to the Operating Room Nurses Association of Alberta's 17th Provincial Conference, October 16th to 19th, 1996.

"I commend the Planning Committee on organizing an excellent program. Your theme "The Challenge of Change - Transition from Mystery to Reality" can be debated and discussed at length, and will be addressed in sessions throughout the conference. What better place than Alberta to talk about change and reality: it has stared you in the face, you have lived with and through it, and are probably experts at it.

But now we are all on the merry-go-round of change and reality that seems to spin at an accelerated pace and won't let us off. Obviously these health care changes and realities have affected us personally and professionally, have affected our families, our colleagues and friends and our patients, as well as Registered Nurses across North America and other parts of the world. It also affects ORNAC as a National Association.

Like many of you, I am concerned about the future of Operating Room Nurses and perioperative practice. To reflect on my comments in Vancouver as I became President: "As we move into an uncertain future, we will individually and as an organization face the most challenging tasks and times of our careers". We now need to manage this change and realize that change creates new dimensions of performance. We now need to have a clear plan and strategy for focusing on those things that will gain the greatest results.

As OR nurses we have always had a clear view of reality. But traditionally the public and other health care workers saw the OR as a mystery. Mystery is synonymous with "anything that baffles". We know the reality of our practice, and we have often been baffled to explain it clearly to others. Now, the doors of mystery are open for transition into reality.

The founders of ORNAC had a commitment to make a national Association a reality, and gave us the opportunity to exist to enhance and advance our specialty practice. As an Association we continue on a passage of reality to facilitate change and influence the future for the profession and our patients."

President Hay said Provincial Associations were the supporting structures of ORNAC and Alberta had been part of the change and transition by providing active participation and leadership in ORNAC.

ORNAC has accomplished a great deal, she said and enumerated its milestones:

- ORNAC Recommended Standards of Practice (currently under review),
- Certification in Perioperative Nursing (a great success),
- Work on Advanced Practice 1st Assist Anaesthesia and Surgery (the first course a reality in Quebec), see "ORNAC Blueprint on page 16.
- Liaisons with Jurisdictional Associations and CNA, and other national and international organizations.

"To be effective as a National Association", she said, "it is important for ORNAC to assess and evaluate our Association, and to know about our members' real world and what the members need and want. For this we need the involvement of all OR nurses. Canada's OR nurses must tell us what they need and we need to listen to those needs. To bring this to reality, we plan to have an Open Forum at the National Conference for dialogue on key issues and needs of members. I truly look forward to this exchange."

She left the Conference with this thought: "Challenge produces action and the bigger the challenge the more the action. The more action , the greater the opportunity for advancing and promoting perioperative practice. Face the future with confidence in yourself and your expertise. Take pride in your accomplishments."

Alberta to host ORNAC Conference in 2001

Gloria Nemecek, OR Staff Nurse at the Lethbridge Regional Hospital, Lethbridge, Alberta was elected President ORNAA at the 17th Provincial Conference. In addition to her duties as President of ORNAA she will Chair the 17th National Conference in Alberta in the year 2001.

Kendall O'Brien, Staff Nurse - Operating Room, the Peter Lougheed Centre, Calgary, was named ORNAA President-Elect.

ORNAA's 1996 Conference Planning Committee. Back row (l to r) Gwen Baldwin or Melody Davies , Peggy Ziegler, Jan Wydareny, Marilyn Starling, Heather Johnson & Marge Wade. **Front Row** (l to r) Kim Robbins, Marjorie Phillips, Sandy Makaryshyn, Clair DeBruijn, Heather Perl & ReginaLeonard.
On the floor - The Phantom!

Closing speaker for the ORNAA Annual Conference **Jim Beaubien** and moderator Peggy Ziegler. Jim lectured on the challenges of the time and offered a package of coping methods for striving and surviving in the new economy.

Alberta **Exhibitor's** Association Committee (L to R) Andrew Stephens of 3M Canada; Sheila Tomlinson of Immuno; Bill Wilkins of Smith& Nephew-Richards; Shane Gormley, Valleylab Canada ; and Clair DeBruijn, Ingram & Bell .

The Phantom Nuns of St. Michael's Hospital, Lethbridge, Alberta dressed in fashion black for the Halloween Party.

The 1996 ORNAA Executive and Board

Front row (l to r) President Elect Kendall O'Brien, President Gloria Nemecek, and Past President Dahlia Robinson. **Middle row:** Shannon Tsui, and Alice Kitt. **Back row** (l to r) Dearla Liivam, Sue Love, Trudi Dangerfield, Marilyn Starling, Kim Robbins (Secretary), and Rosemary Strand (Treasurer).

Photo below: Gloria Nemecek (right) presents **Betty Barrett**, Unit Manager, Surgical Suite, Lethbridge Regional Hospital the ORNAC/Johnson & Johnson Medical Products Bursary Award for 1996 of $500.

Marilyn Starling (ORNAA Education Director) presents **Marjorie Phillips**, University Hospital, with the Snips and Snaps Writing Award during the ORNAA 17th Provincial Conference.

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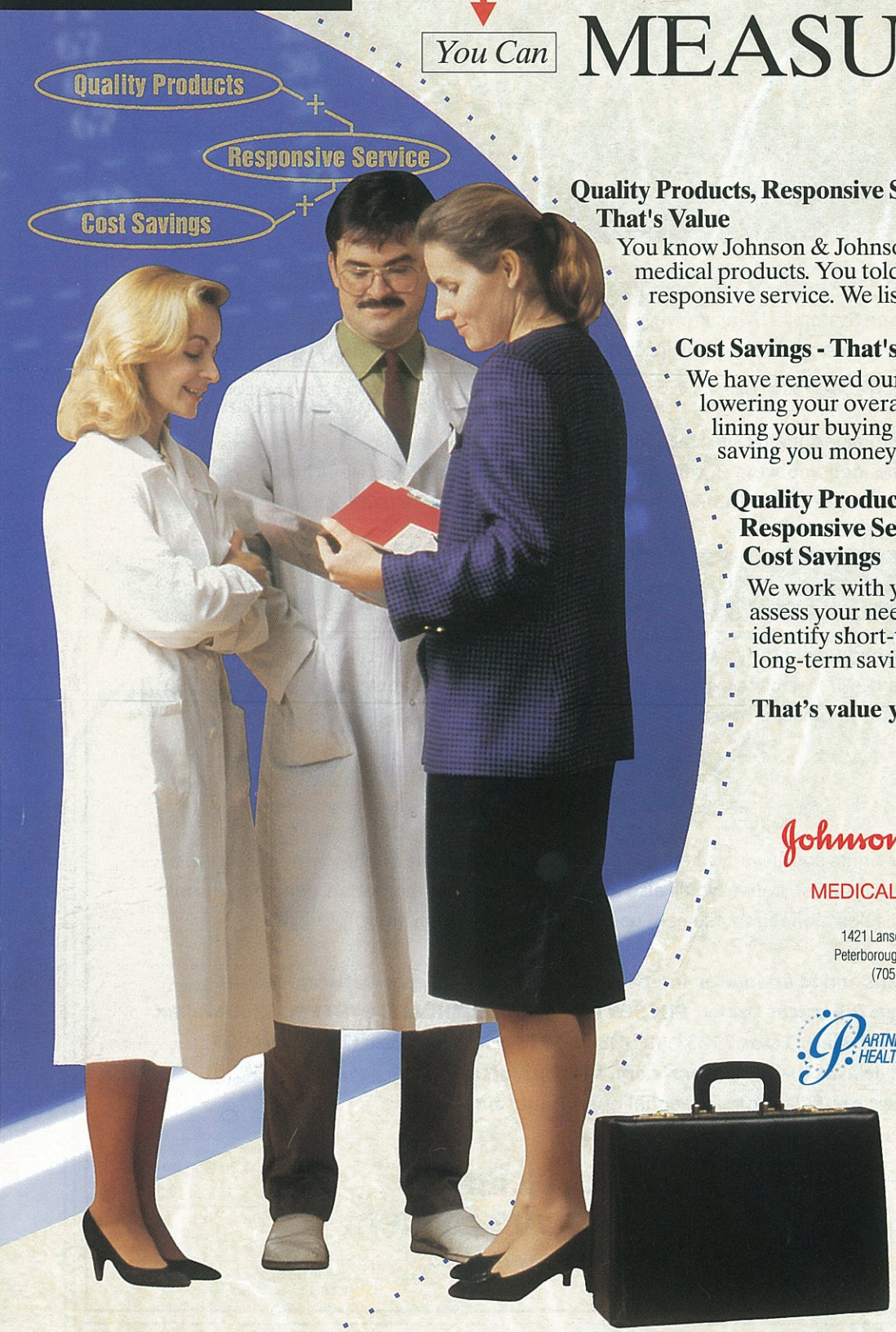

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