Canadian Operating Room Nursing Journal

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Overdraping Costs $$$

Event Related Outdating

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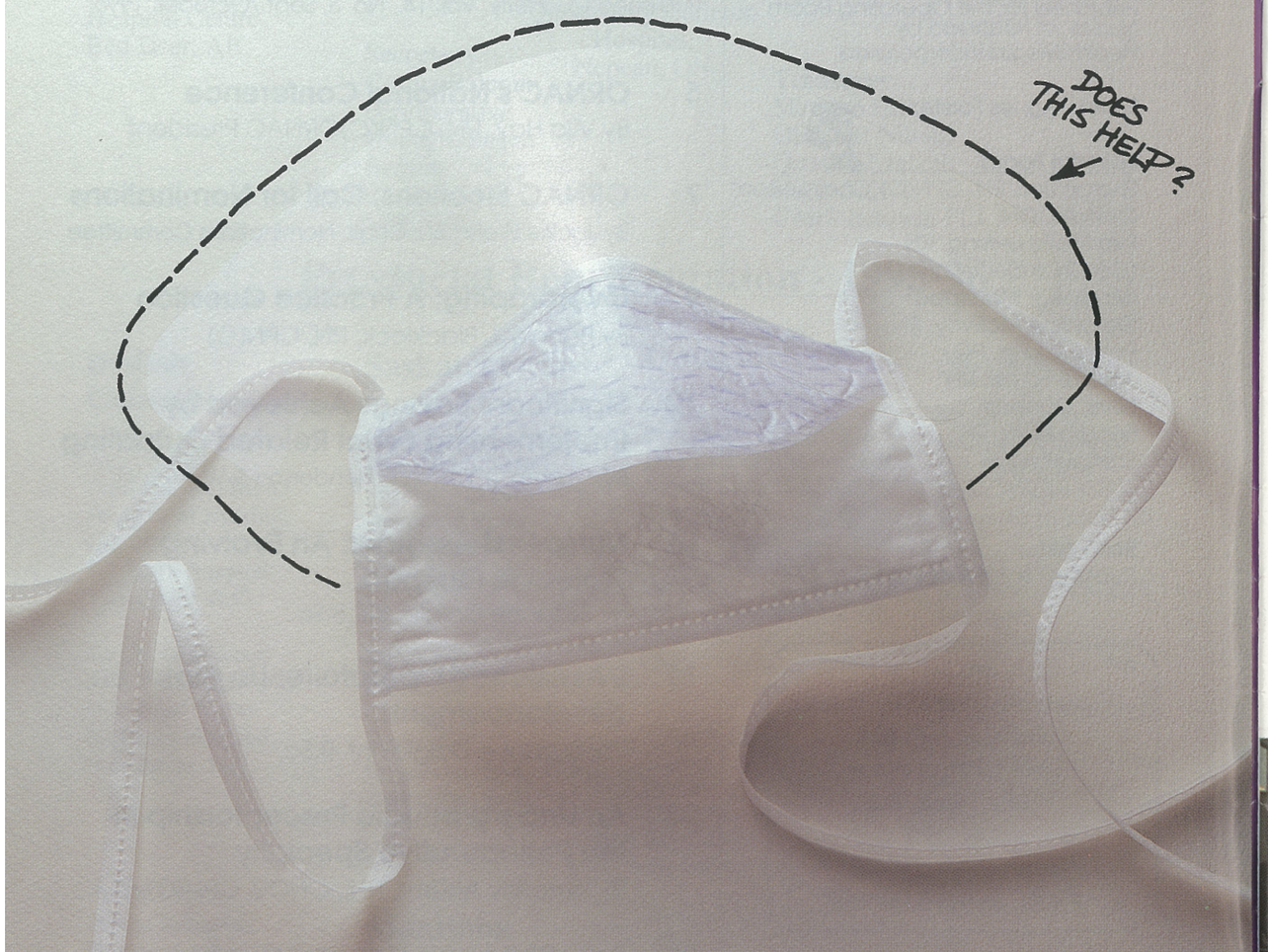

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ORNAC's National Conference

By Vija Hay, RN, CPN (C)

1997 seems to be a favored year for major conferences in Canada. Next year will provide many educational opportunities for nurses, but it will also present a dilemma as to how many conferences and which conferences to attend.

The conferences of interest to perioperative nurses are: ORNAC's National Conference in Ottawa in April; ICN's Conference in Vancouver in June; and the World Conference of OR Nurses in Toronto in September. *(Continued page 6)*

ORNAC Executive (*Photo above - Front row, l to r*) Donna Farid (Pres-Elect), Vija Hay (President), Marlene Hill (Treasurer). (*Back Row l to r*) Corina Balcom (Secretary), Jackie Waisman (Past-President)•

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President's Message - *continued from page 5*

Each conference has individual features and benefits for delegates, each is unique in itself. Obviously the ORNAC Conference is the main event for our Association and Canadian perioperative nurses, and has an impact on the continued operation of ORNAC. The success of the conference depends on many factors, but largely on delegate and exhibitor support.

Let me provide you with some information as to the process of bringing a conference to you. The ORNAC Conference is held every two years. Provinces wishing to host a National Conference apply to ORNAC Board as many as 10 years in advance. Booking of convention facilities is done as soon as a host city is determined. Contracts with facilities and companies are signed several years in advance. This involves financial commitment at various stages. The conference planning committee begins work at least two years in advance. Planning a conference of this magnitude is a major commitment for ORNAC and the volunteer group of perioperative nurses who donate a tremendous amount of time and energy to bring this event about.

One of ORNAC's objectives is to promote educational programs. The conference certainly fills that mandate. Not only does it give the unique opportunity to keep up to date with professional and clinical developments in the OR, but it also provides a forum to share concerns, issues and visions for the future of our specialty practice. As well, there is opportunity to dialogue with Board and Executive of ORNAC.

In this climate of rapid change in the health care system, as well as technology, it is crucial to participate, learn, dialogue and network.

Donna Farid and I attended CNA's Biennial Convention in June. It was evident that nurses recognize the importance of today's issues and future directions. Over 1000 nurses from across Canada attended the conference, the largest number since 1982.

I hope it is possible for you to attend all these conferences in 1997, to participate and network on a national as well as a global basis. Foremost I encourage you to join us at **ORNAC's National Conference in Ottawa, April 28 - May 2nd, 1997.**

Vija Hay, R.N., C.P.N. (C), is the President of the Operating Room Nurses Association of Canada. She was most recently Director of Nursing Services, Queensway Carleton Hospital, Nepean, Ontario.

ORNAC Elections - April, 1997

As the dates of the next ORNAC National Conference quickly approach us, it is once again time to prepare for the elections of the ORNAC Executive.

Following past practice, the election will take place during the ORNAC Spring Board meeting on April 27, 1997. The Nomination Committee is anticipating a number of nominees this election year and therefore encourage each of you to be in touch with your Provincial ORNAC Board Members or ORNAC Executive Members (they are listed in this journal - see page 2) to review the eligibility criteria and those eligible to be nominated for an ORNAC Executive position.

Your current ORNAC Executive and Board members have the nomination form required to be completed in the election process.

As you make nomination choices, please consider the many Operating Room Registered Nurses across Canada who will be represented by those elected to the ORNAC Executive. We need someone who is committed to those nurses and the objectives of ORNAC. We need someone who has the time for many volunteer hours that are required to make this organization thrive. Those being nominated need to know that OR Nurses across Canada will support them as they meet the many challenges of health care today and tomorrow! They need to know this is about being a team and reaching out for each other every day!

The election in April, 1997 will fill the positions of President-Elect, Secretary and Treasurer. As most of you are aware the current President-Elect assumes the position of President and the current President assumes the responsibilities of the Past President.

Dates to Remember:

September, 1996
ORNAC Executive and Board members have an eligibility list and nomination forms available.

November 30, 1996
Nomination form must be received by the Chair of the Nomination Committee.

December 30, 1996
Nominee acceptance deadline.

March, 1997
Nominee portfolios to be published in the *Canadian Operating Room Nursing Journal.*

April 27, 1997
Election of ORNAC Executive at the National Conference in Ottawa.

June, 1997
Election results published in the *Canadian Operating Room Nursing Journal.*

Should you have any questions regarding the election and/or process please contact your Provincial ORNAC Board Member, ORNAC Executive Member or myself. I can be reached at:
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Over-Draping: A Practice Question

By Bonnie J. Blacklock RN, CPN(C)

Increasing dialogue on over-draping can be heard between operating room practitioners and disposable drape suppliers. Examination of the issues related to over-draping is multifactorial with the provision of optimum outcomes for surgical patients being the most significant factor. Other factors to consider include draping standards and literature, the features of reusable drapes versus disposables, actual drape utilization, and the ever present fiscal bottom line. When draping practices are questioned and potential over-draping identified, practitioners must be assured that using fewer drapes will not adversely affect their patients.

With the introduction of disposable drapes, surgical supply companies duplicated reusable drape configurations as closely as possible. This was partly in response to consumer demand specifications and partly a marketing strategy to assure consideration of the disposable products over their reusable counterparts. Cost containment initiatives of the 90's have spearheaded the examination and the attempted elimination of "sacred cows" (Patterson, 1990; Shewchuk, 1996). In other words, close scrutiny is being given to some operating room practices which seem based more on tradition than on reason or fact. One such "sacred cow" related to over-draping is the squaring-off of the boundaries of the prepped surgical site with drape towels prior to application of the disposable drape(s) and/or adhesive plastic incise drape.

Abstract:

Traditional OR practices are under scrutiny today and perioperative pracitioners are being asked to examine practices which do not affect the quality of patient care but potentially impact the cost of delivery. This article focuses on overdraping related to disposable products and proposes improved liaisons between supply and demand.

"...Some OR's even use cloth huck towels with disposable drapes, discarding the ones provided".

The original rationale for using drape towels stemmed from the use of cloth drapes and was two-fold. First, cloth HUCK towels provided absorbency away from the surgical field, helping to prevent strike-through and contamination. Second, these side towels, afforded a layered aseptic boundary in the event that the fenestration needed to be smaller or the actual

Author

Bonnie J. Blacklock RN, CPN(C), (formerly Bonnie Ebbers) is OR Nurse Consultant on a per diem basis for Baxter Canada - Surgical Division, Area Manager (part-time) of the Okanagan Region of B.C. for McQuaid Consulting Group Inc., specializing in organizational knowledge management, and a Casual Staff Nurse in the Operating Room of the Kelowna General Hospital, Kelowna, B.C.

drape was to shift during the operation. With the inception of disposable drapes, little consideration was given to the superior adhesion and fit to the operative field and the moisture resistant qualities they provided. Conversion to disposable products found both practitioners and suppliers continuing to use and supply drapes consistent with the previous reusables.

A recent investigation of the use of drape towels in a variety of facilities in Canada and the United States, demonstrates that the practice of using drape towels with disposable drapes persists but is certainly not consistent. Some OR's even use cloth huck towels with disposable drapes, discarding the ones provided. The use of disposable drape towels by surgeons and operating room personnel would seem to have more to do with habit and deeply held values (Patterson, 1990) rather than a need to decrease the size of the drape fenestration. This is understandable given that many practitioners began their operating room experience using layers of cloth drapes. Certainly, advancements in the features of disposable drapes since their introduction is also a factor. Reinforced, absorbent, impervious, and elastic fenestrations coupled with the adhesive boundaries now found in disposables raises questions about the need for drape towels at all. A single disposable drape provides the equivalent thread count required by layered reusables (ORNAC Standard 1.5.19, 1993) in addition to possessing superior moisture resistance. Strike-through contamination and the shifting of the drapes during surgical procedures are both minimized when disposable drapes are used.

"...Many managers are now faced with the issue of regional standardization of products...".

Practice standards published by the Operating Room Nurses Association of Canada (ORNAC) and the Association of Operating Room Nurses (AORN) provide no clear directives on the use of drape towels. Their standards provide practitioners with guidelines only on draping fabric requirements, procedures, selection, aseptic application, and removal of drapes (AORN, 1995/96; ORNAC, 1993). The only reference to the layers required applies to the utilization of cloth drapes and states "...there shall be a minimum of two layers" (ORNAC Standard 5.3.3, 1993). Strike-through is addressed by ORNAC in Standard 5.3.11 (1993): "To complete the draping procedure, a barrier drape should be placed around the operative site whenever strike-through is likely to occur."

"...Skin towels are unnecessary when a plastic incise drape is utilized...".

Very little has been published in OR texts and journals with regards to over-draping. Both operating room texts reviewed suggested that towels "may" be used (Meeker & Rothrock, 1995; Atkinson & Kohn, 1986). *Alexander's Care of the Patient in Surgery* (Meeker & Rothrock, 1995) goes on to state that skin towels are unnecessary when a plastic incise drape is utilized. OR journals offer few articles on over-draping and none specifically addressing the use of drape towels. In its first examination of "sacred cows", *OR Manager* published two articles on overdraping and on how much draping is really necessary (Patterson, 1990). Patterson is quick to observe that though draping has been an operating room ritual for more than a century, most draping practices have not been formally studied. Of the studies referred to, most have to do with the testing of drape fabrics for moisture permeability which is seen to be the most important issue. Results show that disposable drapes performed well and better than reusables in the long term.

Site Visits

Site visits, over the last four years, to six western Canadian hospital operating rooms using disposable drapes revealed continuing use of drape towels by most practitioners prior to the application of the drape sheet. These towels are placed around the boundary of the prepared surgical area and infrequently used to decrease the size of the drape fenestration. The decision not to use towels is generally based on surgeon preference. Operating room nurses remain very much involved in directing and applying the drapes for most surgical procedures. Perioperative nurses have raised questions during disposable drape implementations about the need for drape towels but continue to use them. A growing trend towards managed care is replacing surgeon's preferences with clinical acceptability (Patterson, 1996) and will help to bring suppliers and user groups together. It is essential that surgeons participate in any decisions related to overdraping (OR Manager, 1995).

Telephone Survey

A telephone survey of operating room nurse managers and clinicians in eight major facilities conducted in August, 1996, indicated continuing queries related to the need for and use of disposable drape towels. Their comments referred to the actual practice utilization similarities of reusable and disposable products and the features afforded by disposables which have not been assimilated into practice. All agree that the practice of using drape towels with disposable drapes is based more on tradition rather than logical rationale and is questionable unless a smaller fenestration is required. Some managers observe that often drape towels get used simply because they are supplied and they are uncertain on how to delete them from the contents of predetermined disposable packs. In addition, many managers are now faced with the issue of regional standardization of products and are being directed to obtain consensus within user groups on the acceptability of drape products (*OR Manager*, 1995). This is seen as an opportune time to tackle overdraping issues like the use and supply of disposable drape towels.

Of utmost importance to all involved in this debate is patient safety. We are reluctant to change practices for fear of compromising the outcome for our surgical patients. The old adage, "if it isn't broken, don't fix it, applies to the persistent use of disposable drape towels. On the other hand, fiscal responsibility to our medical system warrants consideration. Is it not time to review, evaluate, and work to change those operating room practices which do not adversely affect quality patient care but do impact on the cost of the overall system? The use of drape towels to square-off the surgical site prior to disposable drape application is only one of these practices. Patient focused interdisciplinary teams and drape manufacturers need to work together to provide superior surgical experiences for patients while eliminating unnecessary and potentially costly practices. ■

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Attention all Perioperative Nurses

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Significant Savings Achieved By Implementing

Event Related Outdating

By J. Lamb, S. Foster, E. Henderson, & W. Krulicki

Abstract

The event related outdating(ER0) theory is based on the assumption that items that are properly cleaned, wrapped, sterilized, stored and handled will remain sterile indefinitely unless the integrity of the package becomes compromised. The authors describe how one Surgical Suite (performing approximately 600 cases/month) implemented an ER0 program with estimated annual savings of almost $10,000/year.

Introduction

The event related outdating (ERO) theory is based on the assumption that items that have been properly cleaned, wrapped, sterilized, stored and handled will remain sterile indefinitely unless the integrity of the package becomes compromised. Hospitals have traditionally outdated or reprocessed re-usable sterile products (RSP) based on unscientific dates that were established years ago. These predetermined expiration dates vary among institutions. An ERO policy does not jeopardize patient care or increase interoperative risks. Although not widely practiced in Canadian hospitals, ERO is supported by research and practice standards.

Literature Search

As long ago as 1984, Mayworm suggested that the practice of outdating sterile goods was archaic. Instead, he postulated that properly packaged material would remain sterile indefinitely. A literature search revealed there have been several studies supporting this theory. A study by Klapes et al in 1987 showed that storage periods of up to fifty weeks did not increase the probability of contamination, regardless of the wrapping material. More recently, Donovan, Turner and Smith (1991) presented two case studies where hospitals converted their central sterile storage policy and procedure from "time related" to "event related". This eliminated the need of expiration dates on their in-house sterilized products. Chadwick (1994) describes successfully implementing an ERO system

Authors

The authors are employees of the Calgary Regional Health Authority, Bow Valley Site. At the time this project was undertaken, Jeanne Lamb, RN, BN, was Assistant Nursing Unit Manager of the Surgical Suite. Sheila Foster is the working leader, Surgical Reprocessing. Dr. E. Henderson, Ph.D., Epidemiology, Associate Professor, University of Calgary, is an Epidemiologist, Infection Control. Wally Krulicki is a research technologist, Infection Control.

Table1

Monthly Testing of Randomly Selected Items

Method of Sterilization	Items Tested N (%)	Types of Packaging N (%)	Items Tested N (%)
Steam	122 (66.7)	PeelPack	79 (64.8)
		Clothwrap	24 (19.7)
		Other	19 (15.5)
ETO	61 (33.3)	Peel/Stripack	48 (78.7)
		Other	13 (21.3)

at the York Central Hospital. Current standards and recommended practices of the Association for the Advancement of Medical Instrumentation (AAMI), the Association of Operating Room Nurses (AORN), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Center for Disease Control (CDC) support ERO (*AORN*, 1994, Schroeder, 1994) . The Canadian Standards Association states that "shelf life is event related" (Canadian Standards Association, 1991). In addition, the Operating Room Nurses Association of Canada (ORNAC) *Recommended Standards of Professional & Clinical Practice* state that "Shelf life is event related rather than time related. Dates shall be utilized as a method to rotate materials and reduce the time packages and items are exposed to factors that may result in contamination" (ORNAC, 1993).

Table2

Estimated Cost Savings

	Weekly Savings ($)	Annual Savings ($)
Materials *	35	1820
Sterilization	157	8164
Total**	**192**	**9984**

*Wrappers, filters, tape, cart covers, etc.
**Staff were assigned other duties

Implementation

Following the literature review, it was determined by OR management and Infection Control that there was enough evidence to support ERO. In January 1995 a search of the OR produced twelve items with expiry dates from January 1991 to November 1994. Most of these reusable items were articles that did not require sterility to be maintained (e.g., oral suction). Eleven of these items were in peel packs, and one was in a cloth wrapper. Mean time from expiry date was 809 (+/-155 days). The range was 81 - 1496 days. These items had originally been either steam or ethylene oxide sterilized (ETO). The items were aseptically cultured in a HEPA-filtered hood. All surfaces were sampled using two swabs. One swab was placed on a SABOURAUD AGAR plate (for fungi) and the other in Mueller-Hinton broth (for bacteria). Cultures were incubated at 37degrees C and checked daily. No growth was detected after seven days observation. A draft policy and procedure was developed and presented for approval to the Infection Control Committee. This policy included:

(1) discontinuation of expiration dates;
(2) labeling of each RSP with sterilization date and sterilization load indicator for recall purposes;
(3) inspection of all packaging prior to use for external or internal indications of damage;and
(4) emphasis on the importance of proper storage and rotation of inventory.

Results

The policy and procedure was implemented in February of 1995. A continuous quality monitoring process, whereby ten items per month were randomly selected for culturing was also implemented at this time. (Table 1). After eight months of quality assurance monitoring, there was no growth on the sterile items. It was decided at that time to reduce the quality monitoring to ten items every six months.

Our OR does approximately 600 general surgery, major orthopedic, neurosurgery, plastic, urological and peripheral cardiovascular procedures per month. The estimated savings for materials and sterilization costs is $9984 annually (Table 2). The time saved by the staff in gathering, re-wrapping, reprocessing and reshelving the items was not included in the estimates. The ERO policy has been implemented in Labour and Delivery as well as another Surgical Suite in the city. Hospital-wide implementation throughout the Calgary Regional Health Authority is recommended. Use of this policy can achieve significant savings .

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Nurse First Assistant: An Evolving Project in Québec

By Suzanne Daigle, Inf. B. Sc.

Striving for the highest levels of professionalism, a changing work environment in the operating room, scientific and technological advances in surgery, requirements expressed by surgeons in 1992 and 1993, and the setting of quotas for resident physicians have all contributed to the urgency of reexamining the role of nurses vis-a-vis patients.

In reality, nurses have often been placed in situations where they have had to play both the role of scrub nurse and of first assistant.

The purpose of this project is to establish the role of nurses within the medico-surgical team in order to optimize the quality of care.

Given the needs identified and the keen interest expressed by all those involved, the Montreal Heart Institute, following a request made by its surgeons, presented a project to the Ordre des infirmières et infirmiers du Quebec (OIIQ) and the Professional Corporation of Physicians of Quebec (PCPQ) for their approval.

Indeed, in September 1994, the OIIQ moved in favour of recognizing the function of nurse first assistant for perioperative nursing care.

For its part, the PCPQ gave its support to the pilot project by allowing the Montreal Heart Institute to have nurses take on the role of first assistant. The nurses recruited for this first official experiment in Quebec will be able to assist surgeons once they have received adequate training.

A Definition of Nurse First Assistant

The role of nurse first assistant can be defined as follows:

The nurses first assistant assumes responsibilities that are different from those of the scrub nurse. She provides immediate and ongoing support to the surgeon at the operating site by performing a variety of tasks inherent to the surgical procedure in order to optimize results for the patients. She constantly interacts with the surgeon and is under his direct supervision.

The function of nurse first assistant as described by the OIIQ document entitled (Position paper: Perioperative Nursing Care) is distinct from operating assistance as defined by the PCPQ since the latter is a medical responsibility which consists of actively participating in the surgical procedure, making judgement calls, and making decisions requiring knowledge of medical science. (Bulletin, vol.15, no 3, July 1975).

Nature of the Function

Essentially, the nurse first assistant must ensure the patient's safety and provide technical and clinical assistance to the surgeon.

The specialized activities performed by the nurse first assistant are:

- Positioning the patient.
- Preparing the skin (daubing).
- Performing haemostasis using mechanical and thermal methods. Clamping, cauterizing and ligating vessels.
- Ensuring organs and tissues are exposed.
- Suctioning, sponging and holding the retractors.

Suzanne Daigle, Inf. B. Sc., is Operating Room and Sterilization Coordinator, Montreal Heart Institute.

This article describes the current status of the Nurse First Assistant Project launched at the Montreal Heart Institute in 1995.

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ant (surgeon, resident physician or general practitioner), as defined by the C.P.P.Q., must be ensured during the main portion of the surgical procedure.

surgeon:

- Anticipating the various steps of the surgical procedure.
- Performing effectively when complications do occur.

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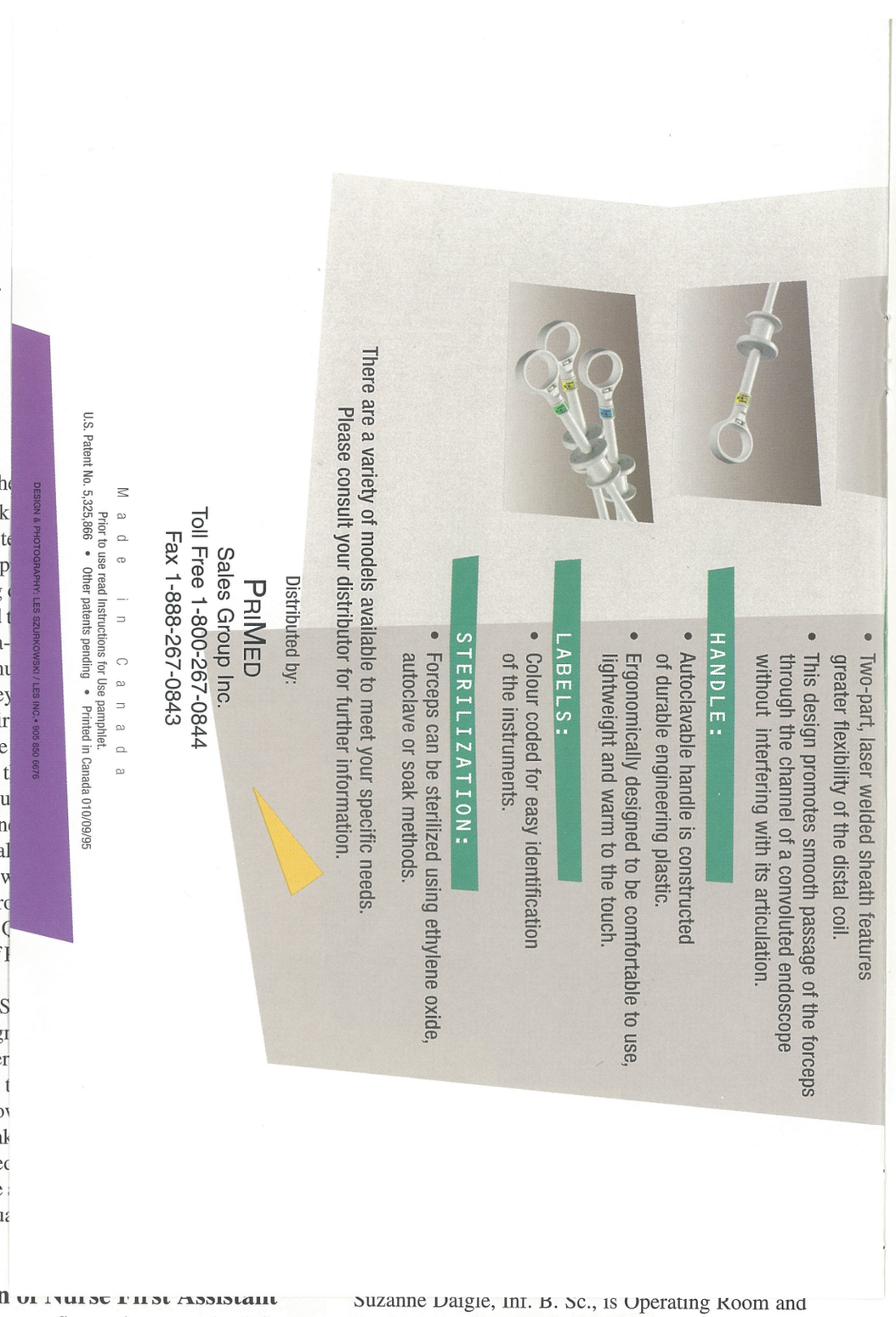

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Suturing fascia, subcutaneous tissues, and skin, making knots.

Using any instrument, at the request of the surgeon.

Policies and Rules for the Implementation of the Nurse First Assistant Function

In order to monitor the implementation, development and evaluation of this project, mechanisms were put in place by those concerned and approved by the appropriate authorities.

Rules Concerning Nursing Care

• A nurse acting as first assistant should not at any time also act as scrub nurse.

• A nurse always has the right to refuse to perform a task if in her opinion, she has neither the knowledge nor the required skills to perform such a task.

• A nurse acting as first assistant must always be under the direct supervision of a surgeon.

Administrative Policies

• A pilot project involving a nurse first assistant must receive the approval of the Board of Physicians, Dentists and Pharmacists as well as the Board of Directors of the Montreal Heart Institute.

• The head nurse establishes and implements an evaluation process for the nurse first assistant as well as the quality of the tasks performed.

• The nurse first assistant may take on the role of scrub nurse or circulating nurse at the request of her immediate supervisor.

• Budgetary envelops required. To assign a nurse first assistant funds must be budgeted so as not to adversely affect existing nursing care.

• This is a pilot project. The possibility of making it a permanent function will be evaluated in one year.

Rules Pertaining to Medical Care

• The presence of a surgeon is required at all times during the surgical procedure.

• When required, the presence of a medical assistant (surgeon, resident physician or general practitioner), as defined by the C.P.P.Q., must be ensured during the main portion of the surgical procedure.

• Nurses will assume the role of first assistant during single cardiac revascularization and single valvular replacement procedure~. During complex procedures such as reinterventions, multiple valvular replacements or complex surgical procedures, the presence of a medical assistant is required.

Training Program

In order for the function of nurse first assistant to be recognized, specialized knowledge and skills must be acquired. To meet this need, a 186 hour training program was developed.

The purpose of the Training Program is to allow nurses to acquire and develop the specialized skills required to provide clinical and technical support a surgeon needs to safely perform a surgical procedure.

Program Prerequisites include:

- Basic Cardiac Life Support (CPR).
- Knowledge of asepsis principles, sterility control, infection prevention, medical waste and principles of patient positioning.
- Specific knowledge of cardio-vascular nursing care:

Cardio 1: Cardio-vascular physiology and basic rythmology (28 hours).

Cardio 2: Ischaemic diseases of the heart: angina and infarction (14 hours).

Cardio 3: Evolutionary process of heart failure: From heart deficiency to cardiogenic shock (14 hours).

Program Content

The 186 hour program, including the 56 hour prerequisite program, is divided into three distinct modules:

The **first** deals with maintaining a secure environment for the patient:

• A description of the nursing care functions.

• A description of preventive measures to avoid biological risks.

• Applying preventive measures to avoid physical risks: burns, pressure points.

• Understanding our own stress and how to make it work to our advantage.

The **second** deals with clinical assistance to the surgeon:

• Anticipating the various steps of the surgical procedure.

• Performing effectively when complications do occur.

The **third** deals with technical assistance:

- Proper use of equipment during the procedure.
- Manipulating tissues (using haemostasia techniques).
- Anticipating use of thread and needles.
- Suturing tissues and fascia.
- Anticipating and facilitating surgical procedures.

During the third module, the nurse undergoes OTJ training. Two tutors (surgeons) supervise the training. The nurse takes part in 30 operations: 20 myocardiac revascularization procedures and 10 valvular replacement procedures.

She must master the following techniques:

- Taking and preparing the saphena.
- Closing the leg wound.
- Assisting in the arterial, venous and cardioplegic cannulation.
- Providing technical assistance during coronary and aortic anastomosis.
- Assisting during cannula exeresis.
- Assisting during aortic and mitral valve replacements.
- Assisting in closing the sternal bone.
- Closing the sternal wall (subcutaneous and cutaneous).

A progress report is prepared after every procedure. Each nurse must undergo an evaluation at the end of the training period in order to ascertain that she has met all of the objectives. The evaluation is made by the two teaching surgeons.

Maintaining Proficiency

The nurse first assistant is responsible for maintaining her proficiency. To this end, she establishes and maintains a record of proficiency in which she writes down her ongoing training activities. She makes selected readings. She establishes and meets her personal development goals and objectives.

Implementation

Two nurses have already been selected for this project.

During the selection process, we took into account:

- Basic training: University Degree in Nursing Sciences (in hand or soon to be completed).
- Curriculum Vitae: five (5) years experience in an operating room, including two (2) in the specialty.

Selection Interview Questions

- Vision of the role: functions, responsibilities, cooperation.
- Conceptual abilities: knowledge, technical aspects, cognitive strategies.
- Judgement: Case studies, analysis, problem solving.

The two nurses have completed their training. Their integration into the role of nurse first assistant is ongoing. Evaluation of this pilot project will be done in February, 1997.

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Montreal Heart Institute: *Surgical Assistant Nurses. a Pilot Project on Operating Assistance,* September, 1995.

Ordre des infirmières et infirmiers du Québec: *The Function of Nurse First Assistant. Position Paper,* September, 1994.

Professional Corporation of Physicians of Quebéc: *Assisting the Surgeon in the Operating Room (Operating Assistant)*, Bulletin, vol.XV, no. 3, July, 1975.

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Summary

Changes in the work environment, quotas imposed on the number of resident physicians, scientific and technological advances, and nurses having to play two roles, that of scrub nurse and of nurse first assistant, have all contributed to the development of a new role, that of nurse first assistant.

For the purpose of providing optimal quality care to patients and at the request of its surgeons, the Montreal Heart Institute has presented a project to the Ordre des infirmières et infirmiers du Québec and the Professional Corporation of Physicians of Québec.

The project was accepted by both bodies. The OIIQ moved in favour of recognizing the function of nurse first assistant in September, 1994, and the PCPQ gave its approval for the project on March 30, 1995.

A 186 hour training program was developed. The two selected nurses have been trained and have been integrated into a medico-surgical team since February, 1996.

The Nurse First Assistant pilot project will be evaluated in February, 1997.

L'Assistance Opératoire: Un projet en développement

Par Suzanne Daigle, Inf. B. Sc.

La recherche de l'atteinte des plus hauts niveaux de professionnalisme, le changement de contexte du travail en salle d'opération, l'évolution scientifique et technologique dans le domaine chirurgical, les demandes formulées par les chirurgiens en 1992 et en 1993, et le contingentement des médecins résidents provoquent la nécessité et l'urgence de revoir les interventions faites par les infirmières auprès des usagers.

Dans la pratique, les infirmières étaient souvent placées dans des situations où elles devaient assumer simultanément le rôle d'infirmière en service interne et celui de première assistante chirurgicale.

Ce projet de développement vise à établir le rôle des infirmières et leur assistance à l'intérieur de l'équipe médico-chirurgicale afin d'optimiser la qualité de soins.

Compte tenu des besoins du milieu doublés d'un vif intérêt des intervenants, l'Institut de cardiologie de Montréal, à la demande des chirurgiens, a présenté un projet à l'Ordre des infirmières et infirmiers du Québec ainsi qu'à la Corporation professionnelle des médecins du Québec, pour approbation.

Dans ce contexte, l'Ordre des infirmières et infirmiers du Québec s'est prononcé, en septembre 1994, en faveur de la reconnaissance de la fonction d'infirmière première assistante pour les soins infirmiers périopératoires.

De son côté, le Collège des médecins du Québec a donné son appui au projet-pilote autorisant l'Institut de cardiologie de Montréal à confier aux infirmières le rôle de premières assistantes. Les infirmières recrutées pour cette première expérience officielle au Québec pourront seconder les chirurgiens après avoir reçu une formation adéquate.

Description du projet

La fonction de l'infirmière première assistante se définit comme suit:

- L'infirmière première assistante assume des responsabilités différentes de celles de l'infirmière en service interne. Elle apporte une collaboration immédiate et continue, au chirurgien, au niveau du site opératoire en procédant à l'exécution de diverses manoeuvres inhérentes au déroulement de l'intervention chirurgicale afin d'atteindre les résultats optimaux pour les usagers. Elle agit en interaction constante avec le chirurgien et sous sa supervision directe.

La fonction de l'infirmière première assistante, telle que définie par le document de l'OIIQ (Prise de position: Soins infirmiers périopératoires) est distinguée de l'assistance opératoire telle que définie par la Corporation professionnelle des médecins du Québec, cette dernière étant une responsabilité médicale qui consiste à prendre part activement à l'intervention chirurgicale, à poser des jugements et à prendre des décisions nécessitant obligatoirement des connaissances médicales (Bulletin, vol. 15, no 3, juillet 75).

Nature de la fonction

Essentiellement, l'infirmière première assistante doit contribuer à assurer la sécurité de l'usager et à apporter une aide technique et clinique au chirurgien.

Daigle, Suzanne, Inf. B. Sc, Coordonnatrice du bloc opératoire et de la stérilisation, Institut de cardiologie de Montréal, Québec, Canada.

Cet article présente le projet de développement de l'infirmière première assistante instauré à l'Institut de cardiologie de Montréal en 1995.

Les activités spécialisées accomplies par l'infirmière première assistante sont:

- Positionner l'usager.
- Préparer la peau (badigeon).
- Faire l'hémostase à l'aide de moyens mécaniques et thermiques. Clamper, cautériser et ligaturer les vaisseaux.
- Assurer l'exposition des organes et des tissus.
- Succionner, éponger, tenir les écarteurs.
- Suturer les fascias, les tissus sous-cutanés et la peau, faire des noeuds.
- Utiliser tout instrument à la demande du chirurgien.

Politiques et règles adoptées pour la mise en application de la fonction d'infirmière première assistante

Afin d'encadrer la mise en place, le développement et l'évaluation de ce projet, des mécanismes ont été déterminés par les intervenants du millieu et approuvés par les directions concernées.

Règle des soins infirmiers

- L'infirmière qui agit comme première assistante ne devrait, en aucun temps, agir simultanément comme infirmière en service interne.
- L'infirmière a toujours le droit de refuser de poser un geste lorsqu'elle juge qu'elle n'a pas les connaissances ou habiletés nécessaires pour le faire.
- L'infirmière qui agit comme première assistante chirurgicale doit toujours être sous la supervision directe du chirurgien.

Politiques administratives

- Le projet-pilote de l'assistance opératoire par une infirmière doit être adopté par le Conseil des médecins, dentistes et pharmaciens de l'Institut de cardiologie de Montréal et son Conseil d'administration.
- L'infirmière-chef détermine et applique un mécanisme d'évaluation de l'infirmière première assistante chirurgicale, ainsi que de la qualité de ses activités.
- L'infirmière première assistante peut assumer les fonctions de service interne ou de service externe à la demande de son supérieur immédiat.
- Les enveloppes budgétaires reliées à l'assignation d'une infirmière première assistante chirurgicale doivent être prévues de façon à ne pas affecter les soins infirmiers existants.
- Il s'agit d'un projet-pilote dont la pertinence de le rendre permanent sera réévaluée dans un an.

Règles de soins médicaux

- La présence du chirurgien en tout temps durant l'intervention chirurgicale est requise.
- Présence d'un assistant médical (chirurgien, résident ou omnipraticien), telle que définie par la Corporation professionnelle des médecins du Québec, pour le temps principal de l'intervention chirurgicale, lorsque requise.
- Les infirmières assumeront le rôle de premières assistantes chirurgicales dans les cas de revasculation cardiaque simple et de remplacement valvulaire simple. Dans les cas compliqués tels que les réinterventions, les remplacements valvulaires multiples ou les chirurgies complexes, la présence d'un assistant médical est requise.

Formation

La reconnaissance de la fonction d'infirmière première assistante nécessiste l'acquisition de connaissances et d'habiletés spécialisées. Pour combler ce besoin, un programme de formation d'une durée de 186 heures a été élaboré.

But du programme de formation

Permettre aux infirmières d'acquérir et de développer des habiletés spécifiques afin de pouvoir apporter l'aide clinique et technique dont le chirurgien a besoin pour procéder de façon sécuritaire à l'intervention chirurgicale.

Pré-requis au programme

- Basic cardiac life support (RCR).
- Connaissances concernant les principes d'asepsie, le contrôle de stérilité, la prévention des infections, les déchets biomédicaux et les principes de positionnement de l'usager.
- Connaissances spécifiques en soins infirmiers cardio-vasculaires:

Cardio 1: Physiologie cardio-vasculaire et rythmologie de base (28 heures).

Cardio 2: Maladies ischémiques du coeur: Angine et infarctus (14 heures).

Cardio 3: Processus évolutif de la défaillance cardiaque: De l'insuffisance cardiaque au choc cardiogénique (14 heures).

Encadrement pédagogique

Le programme d'une durée de 186 heures incluant les pré-requis au programme (56 heures) est subdivisé en 3 modules distincts:

Le **premier** concerne le maintien d'un environnement sécuritaire pour l'usager:

- Décrire le cadre de la pratique infirmière.
- Décrire les mesures préventives des risques biologiques.
- Appliquer les mesures préventives des risques physiques: brûlures, points de pression.
- Comprendre son stress et connaître les moyens pour le rendre bénéfique.

Le **second** concerne l'apport de l'aide clinique au chirurgien:

- Prévoir le déroulement de l'intervention chirurgicale.
- Agir efficacement lors de complications.

Le **troisième** concerne l'apport de l'aide technique:

- Utiliser le matériel adéquatement lors de l'intervention.
- Manipuler les tissus (Appliquer les techniques d'hémostase).
- Prévoir l'utilisation des fils et des aiguilles.
- Suturer les tissus et les fascias.
- Anticiper et faciliter la technique chirurgicale.

Au cours du troisième module, l'infirmière fait son stage de formation pratique. Deux tuteurs cliniques (chirurgiens) supervisent son stage. L'infirmière doit participer à 30 opérations, soit: 20 interventions de revascularisation myocardique et 10 de remplacements valvulaires.

Elle doit maîtriser les techniques suivantes:

- Prélèvement de la veine saphène, préparation de la veine.
- Fermeture de la plaie de la jambe.
- Assistance à la canulation artérielle, veineuse et cardioplégique.
- Assistance technique lors des anastomoses coronariennes et aortiques.
- Assistance lors de l'exérèse des canules.
- Assistance particulière lors des remplacements de valves aortiques et mitrales.
- Assistance à la fermeture de l'os sternal.
- Fermeture de la paroi sternale (tissu sous-cutané et cutané).

Une fiche de progression est complétée après chaque intervention. Chaque infirmière est soumise à une évaluation de fin de stage afin de certifier qu'elle a répondu à tous les objectifs. Cette évaluation est complétée par les deux chirurgiens enseignants.

Maintien de la compétence

L'infirmière première assistante est responsable de voir au maintien de sa compétence. L'infirmière première assistante maintient à jour un dossier de compétence. Elle fait le registre des activités de formation continue. Elle effectue des lectures dirigées. Elle élabore et réalise ses objectifs personnels de développement.

Mise en oeuvre

Nous avons procédé à la sélection des deux infirmières impliquées dans ce projet de développement.

Lors du processus de sélection, nous avons tenu compte:

- Formation de base: Baccalauréat en Sciences infirmières ou en voie d'obtention.
- Curriculum vitae: 5 années d'expérience en salle d'opération dont 2 ans dans la spécialité.

Entrevue de sélection: Questions concernant

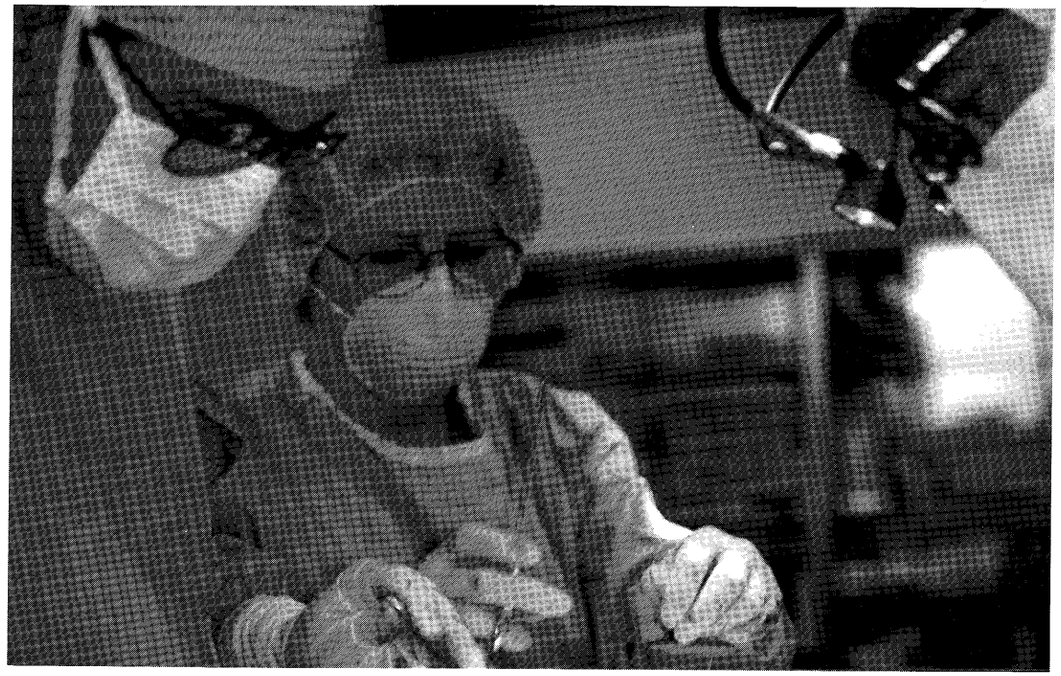
- Vision du rôle: Fonctions, responsabilités, collaboration.
- Habiletés conceptuelles: Connaissances, aspects techniques, stratégies cognitives.
- Jugement: Mise en situation, pensée, réflexion, résolution de problèmes.

La formation des deux infirmières est terminée. L'intégration des deux infirmières dans le rôle d'infirmière première assistante est en cours.

L'évaluation de ce projet-pilote se fera en Février 1997.

Références:

Institut de cardiologie de Montréal: *Infirmières assistantes chirurgicales dans le cadre d'un projet-pilote en assistance opératoire*, septembre 1995.



Colette Pelletier (centre) performing as First Assistant with cardiac surgeons at the Montreal Heart Institute.

Photo Left - Christiane Godin, RN, Montreal Heart Institute. *Photo Right* - Colette Pelletier, R.N., Montreal Institute. Both are training as First Assistants.

Ordre des infirmières et infirmiers du Québec: *La fonction d'infirmière première assistante, Prise de position,* septembre 1994.

Collège des médecins du Québec: *Assistance du chirurgien en salle d'opération (Assistance opératoire),* Bulletin, vol. XV, no 3, juillet 1975.

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Abrégé

Les changements du contexte de travail, le contingentement des médecins résidents, l'évolution scientifique et technologique, le cumul des deux fonctions pour les infirmières soit: infirmière en service interne et infirmière première assistante, ont amené le développement d'un nouveau rôle, celui d'infirmière première assistante.

Dans un souci de donner des soins d'une qualité optimale à l'usager, à la demande des chirurgiens, l'Institut de cardiologie de Montréal a présenté un projet à l'Ordre des infirmières et infirmiers du Québec et au Collège des médecins du Québec.

Le projet a été bien reçu des deux instances. L'Ordre des infirmières et infirmiers du Québec s'est prononcé en faveur de la reconnaissance de l'infirmière première assistante en Septembre 1994 et le Collège des médecins a donné son accord au projet en date du 30 mars 1995.

Un programme de formation d'une durée de 186 heures a été élaboré. Les deux infirmières sélectionnées ont reçu leur formation. Leur intégration à travers l'équipe médico-chirurgicale est en place depuis Février 1996.

Une évaluation de ce projet-pilote se fera en Février 1997.

An Undergraduate Preceptorship in the Perioperative Specialty

By Kimberly Andrus, RN, CNOR, CPN(C)

At Mount Sinai Hospital the clinical nurses are experienced with instructing post-graduate students enrolled in the perioperative certificate programs offered by various community colleges. However, this summer I had the unusual experience and pleasure of teaching an undergraduate nursing student from the University of Toronto. In the past a clinical rotation in the operating room was a compulsory component of the basic nursing program. Over the years the presence of basic students in the operating room has decreased as the curriculum in nursing schools changed and the development of sub-specialties evolved. As a clinical preceptor, I decided that before the undergraduate student arrived I had to adjust my methods of teaching and my clinical expectations of this particular student.

This article will discuss the issues around teaching the undergraduate nurse in a specialty area such as the operating room, my methods of integrating the student into this specialized environment, and the outcome of this unique experience.

Undergraduate Students in the Perioperative Specialty

The most obvious issue regarding a student's clinical rotation in the operating room was the student's clinical experience and objectives. In this situation the student had no experience within the hospital setting and the purpose of the rotation was to assist the student with gaining clinical confidence before entering into her final year where she will be expected to function more autonomously. Although the student outlined her objectives specifically to the area she was assigned, my objectives in teaching had a broader scope than simply teaching technical skills.

Another issue regarding an undergraduate student in this setting was integrating her into the environment with respect to other professional disciplines. Continuous communication with the nursing, respiratory therapy, surgical and anaesthesia staff was necessary to avoid any unfair assumptions regarding the student's role. Mount Sinai Hospital is a large teaching hospital for the local universities and colleges and the number of students working in this environment is very high. This issue was not a problem for the student because she was very confident with her knowledge and aware of her limitations.

Finally, the issue of ongoing evaluation between the preceptor and student was an important part of this experience. I encouraged the student to guide her own experience and provide me with feedback regarding all clinical situations. This open relationship allowed us to establish a rapport that was non threatening and condusive to learning. Giving a student the opportunity to take responsibility for her own learning experiences under my guidance enabled her to feel that she was functioning as part of the surgical team.

Author

Kimberly Andrus, RN, CNOR, CPN(C) is a Clinical Perioperative Nurse and Preceptor at Mount Sinai Hospital, Toronto. She is a member of the Faculty of Nursing at the University of Toronto, and is currently working towards her baccalaureate degree in nursing at Ryerson Polytechnic University.

Teaching Methods

When the student arrived in the operating room a brief tour of the department was provided and for the first week she was given the opportunity to observe surgery. This was done to allow the student to familiarize herself with the environment and introduce her to the staff. As an introduction to the perioperative nursing specialty, I gave her some short handbooks on the following topics: scrubbing, gowning and gloving, the fundamentals of aseptic technique, and sponge, needle and instrument counts. Although she was not expected to master these skills and no formal teaching was provided, the student took the initiative to learn them and familiarize herself with our routines.

Basic technical skills were taught on the job regarding sterilization, aseptic technique, catheterization skills and airway management skills. My approach with the student was to act as a resource for the technical skills and I provided her with various learning resources such as video tapes, textbooks, and lecture and demonstration with the opportunity to practice under my supervision. The resources used were intended to supplement my teaching and promote the student's autonomy with respect to her own learning experience in the environment.

Although the student was assigned to work within the perioperative environment, I did not focus my teaching solely on the technical skills. My main focus was to facilitate the student's clinical confidence by guiding her to use the theoretical knowledge she has acquired at university.

This was accomplished by guiding the student to problem solve in all situations. When discussing a situation, I had the student explain the rationale behind her behaviours and actions, questioned her regarding alternative nursing behaviours, and assisted her with understanding the medical management of the perioperative patients.

Many clinical situations involving patient teaching, technical skills, and legal issues were visited during this clinical rotation. These experiences were expanded and nursing theory was incorporated by guiding the student to imagine the same situations on the unit, in the community, and in a third world environment. Given these different clinical environments, the student was encouraged to describe the possible variations in her nursing care and explain the rationales for the variations. This technique encouraged the student to problem solve and allowed her to broaden her critical thinking patterns outside the perioperative specialty area.

In conclusion, the student was given an introduction to the perioperative nursing specialty which will enable her to make decisions regarding what specialty she prefers. When teaching, however, making the patient and his/her needs the focal point of the student's nursing care rather than the specialized skills involved in perioperative nursing gave the student a consolidation with her theoretical knowledge.

Outcome

The student was given a final evaluation regarding her critical thinking skills, ability to work with other professionals, technical skills, and work attitude. She was also provided with an evaluation form to enable us to assess our preceptorship program in the operating room.

The outcome of both evaluations was very positive and the clinical rotation was productive. The most important point of evaluation I used when describing this experience as productive was that there was a noticeable difference in the student's clinical confidence and independence when she finished her rotation. ■

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BC Children's Hospital Nurses Swim 300 Strokes

By Genelle Leifso RN, CPN(C) and Lynda Magnuson RN, CPN(C)

At the BCORNG 15th Biennial Conference held in Victoria, BC in March 1996, those attending the opening ceremonies heard Bob Lord speak about the value of completing small achievable goals and the role these individual achievements play in pursuing and attaining greater objectives.

Nine nurses from the BC Children's Hospital Operating Room registered for the March, 1996 Canadian Nurses Association (CNA) Certification Exam in Perioperative Nursing. This was done with some trepidation since few of these nurses had written credit examinations recently and some had minimal experience with multiple choice exams. In addition to the obvious exam-related stress there was also tension associated with placing one's practice of many years under scrutiny. After all, the mean nursing practice of our group was around 25 years.

Having determined that we would accept the challenge of the exam, a study group was organized in January, three months prior to the exam. Each member received a study package prepared by the Education Committee of the BCORNG. This contained articles and study questions related to perioperative nursing. One participant made arrangements for a weekly meeting time and place, then circulated the information. Another went to the hospital library and arranged to borrow all of the reference books listed in the CNA Examination Resource booklet. As we all became library cardholders we were able to request these resources in sequence. Another group member researched recent AORN journals for self study articles, questionnaires and other topics which seemed relevant. We also had access to study information from recent BCIT and St. Paul's Hospital OR Post Graduate

Congratulations to BC Children's Hospital OR Nurses. *(Front row l to r)* Barb Carmichael, Patsy Ferrar, Lynda Magnuson. *(Back row l to r)* Genelle Leifso, Helen Calveley, Mary Jane Kay, Muriel Edwards, Gladys Jarvic. *(Missing)* Barb McKnight.

The Discontent of the Nineties - One Nurse's Perspective

The nineties ! Will any of us survive this decade ? Will operating room nurses be able to cope with the ever changing kaleidoscope of the health care system? I wonder what Florence Nightingale and all those brave pioneers of our profession would say about all that is happening. The word "patient" is no longer acceptable. Instead we speak of the "client" or "consumer". The nurse is no longer a nurse, but a business manager because health care is now measured in big dollars and only those institutions that can illustrate the economics of big business seem able to survive. I see these ever changing patterns and I cannot help but fear the outcome because some of these changes are happening so fast. For example, the entire restructuring of services, the unprecedented loss of jobs, and the emotional consequences. Most of all I wonder about the ability of the "client" to survive all of these changes.

The "client" must now become an independent being. His illness should not be prolonged; family participation and education around illness should be encouraged. These are all positive changes. But it seems these changes are being implemented too rapidly. There is also the feeling less time is devoted to bedside care at a time when it is most needed. Could our high-tech approaches prevent us from engaging in satisfying human relationships that come from moments of intimacy between nurse and patient ?

The human element of nursing that we knew and loved is no longer present and a deep sense of loss is felt by many of us. One thing about change is that one can never go back to what was. We move on and it is not always for the better. Somehow the emptiness that has resulted has to be addressed.

Throughout my long career I have worked and become good friends with many men and women who have brought their caring presence to this healing profession. In recent years I have noticed a growing discontent and disillusionment, and this saddens me. I believe that in order to survive the onslaught of technological changes, some serious thought must be given to the nursing profession as a human service. Nurses must not feel dispensable or disposable. After all, we are a *caring profession*, committed to alleviate suffering. We must always put people first.

Amoy Lowe, RN, Operating Room Nurse, Mount Sinai Hospital, Toronto.

Certification - continued from page 25

Nursing Programs. Each member took various articles and books home weekly and when finished passed these on to other members.

While no formal teaching sessions were held, our group seemed to thrive on discussion. We shared our knowledge and asked questions which had been stimulated by our research. The ORNAC Standards were reviewed in depth. This experience had immediate impact on our own standards of practice.

Finally exam day arrived. The exam, written at St. Paul's Hospital in Vancouver, was in two sessions with a break in between, time enough for lunch and a short walk around the hospital site. The booklet for each session contained approximately 100 multiple choice questions. The exam tested our knowledge and skills in competencies unique to OR nursing. Practice in answering multiple choice questions, samples of which were provided in the BCORNG study package, proved to be most beneficial.

After many weeks of waiting our results arrived. We all had earned the professional designation of Certified in Perioperative Nursing (C)anada, CPN(C).

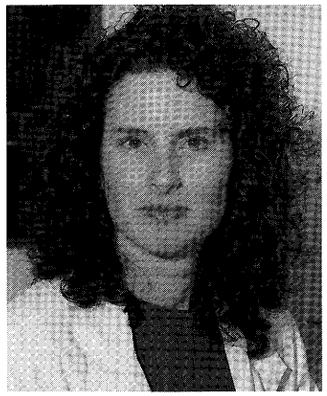
Our group would like to thank the members and Executive of BCORNG for the financial and educational support given to us in our endeavours to reach our goal. Lifelong learning is an idea currently being promoted in our society. It can be a daunting objective. We have completed our first 300 strokes. Our next 300 will be to accumulate our continuing education hours to maintain our status as certified perioperative nurses. This achievement has given us courage in our pursuit of lifelong learning.

Go for The Goal. Start Swimming!

Authors

Genelle Leifso RN, CPN(C), Lynda Magnuson RN, CPN(C), Treasurer, BCORNG, and staff nurses at BC Children's Hospital, Vancouver.

Obituary



Laura Ruth Dale, RN, BScN, died suddenly at her home in Toronto, June 9th, 1996. Laura was a Surgical Assistant, Cardiovascular Division, Toronto Hospital - General Division. She co-authored the article *"The Registered Nurse - Surgical Assistant"* published in the May/June, 1996 issue of this Journal. She also appeared on the cover in June with her colleague and co-author Joanne Bos, as Canada's First Surgical Assistant

Study links laughter with ability to fight infection

A professor of psychoneural immunology at the State University of New York has discovered a link between laughter and the levels in the body of immunoglobin A, an antibody in the mucous that lines the nasal cavity.

Dr. Arthur Stone, asked 72 men to fill in forms for 12 weeks, describing how their day had gone and to preserve a daily mucous sample inside the fridge.

Later analysis of the samples showed that "on days when they had laughed a lot and had good things happen, there was more antibody (immunoglobin A) found, and on bad days there was much less.

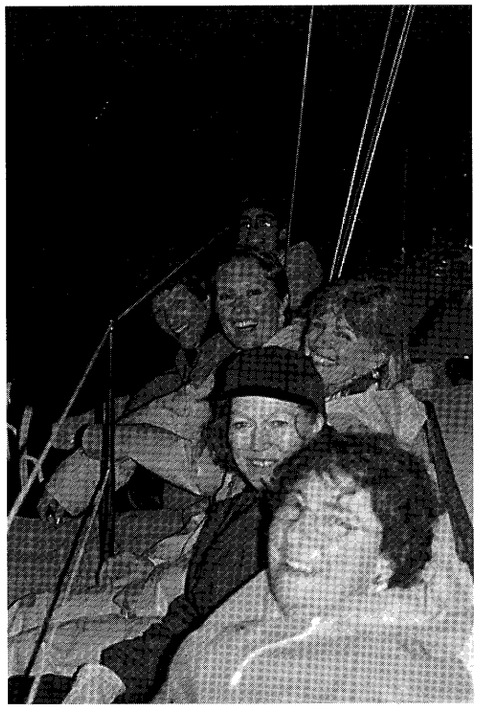
Immunoglobin A, which helps the body fight illness by marking out invading bacteria and viruses for destruction, is just one of the substances whose levels are increased by laughter.

In an account of the benefits of laughter in the 60's, Norman Cousins, former editor of the publication, *Saturday Review*, believed that laughter triggers pain-killing substances in the brain.

Cousins, who was was diagnosed with ankylosing spondylitis, eschewed the analgesic and anti-inflammatory drug treatments that were prescribed for the inflammation and pain involved. Instead he opted for massive intravenous doses of ascorbic acid (aspirin), and high levels of humour induced through various means: movies, books, tapes, videos. He wished to stimulate the production of naturally occurring analgesics, i.e., endorphins and encephalins.

His experiences and road to recovery were recorded in his book *"Anatomy of an Illness."*

Both Arthur Stone and Norman Cousins, among others, have demonstrated that depression impairs the function of the immune system, and that there is a correlation between stress, depression and cancer, among other disorders. It follows that those who recognize and appreciate the importance of emotions (laughter) have an advantage over those who do not.



They finished last in the annual H.O.R.N.I. Sailing Race, but they had a great time. *(Photo top to bottom:)* Judy Little, Helen Kjemperud, Michelle Hyrcha, Charlene Tomlinson, Sheena Warebridjt and Judy Platzer, all from the Burrard Street Surgery in Vancouver. The O.R. nurses of Royal Columbian Hospital, New Westminister, B.C. were the winners.

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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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.

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Conference Calendar

November 22, 23, 24, 1996
Saskatchewan Operatign Room Nurses Group presents
"OR Nursing In The Line Of Fire"
Keynote Speaker - **Estlle Davison-Crews** on Women Working with Women. Location: Saskatoon Inn, 2002 Airport Drive, Saskatoon, Sask. For Inquiries Contact: Marla Ewen, Operating Room, Royal University Hospital, Saskatoon, PH: (306) 655-2127. FAX: (306) 655-1044

ORNAC '97 - April, 1997
15th National ORNAC Conference
Ottawa, Ontario.
Sponsored by the Canadian Operating Room Nurses Association. For contacts and details see page 15.

September, 1997
World Conference of Operating Room Nurses, Toronto Convention Centre, Toronto, Ontario, sponsored by the American Operating Room Nurses Association.

Telemedicine Canada

November 6, 1996 (W11018)
A Cost-Effective Sterile Repack Program: A Collaborative Effort. **Presenters:** John Sealy, London Hospital Linen Service Inc. and Pat Procok, Team Leader/Manager, St. Joseph's Hospital, London, Ontario. Moderator: Gloria Nemecek, Lethbridge, AB, President-Elect ORNAA.

November 27, 1996 (W11093)
Don't Knock It 'Til You Block It: Trials and Tribulations of a Regional Anesthesia Block Room. **Presente**r: Christine Chandler, Nurse Educator, POD Coordinator, St. Joseph's Hospital. Moderator: Carolyn Hughes, Charlottetown, PEI, President-Elect ORNPEI.

January 15, 1997 (W01013)
Too Hot To Handle: An Update on Malignant Hyperthermia. **Presenter**: Edie Shackleton, Nurse Clinician, Peter Lougheed Centre, Calgary. Moderator: Lyn Thorne, Halifax, NS, President-Elect ORNANS

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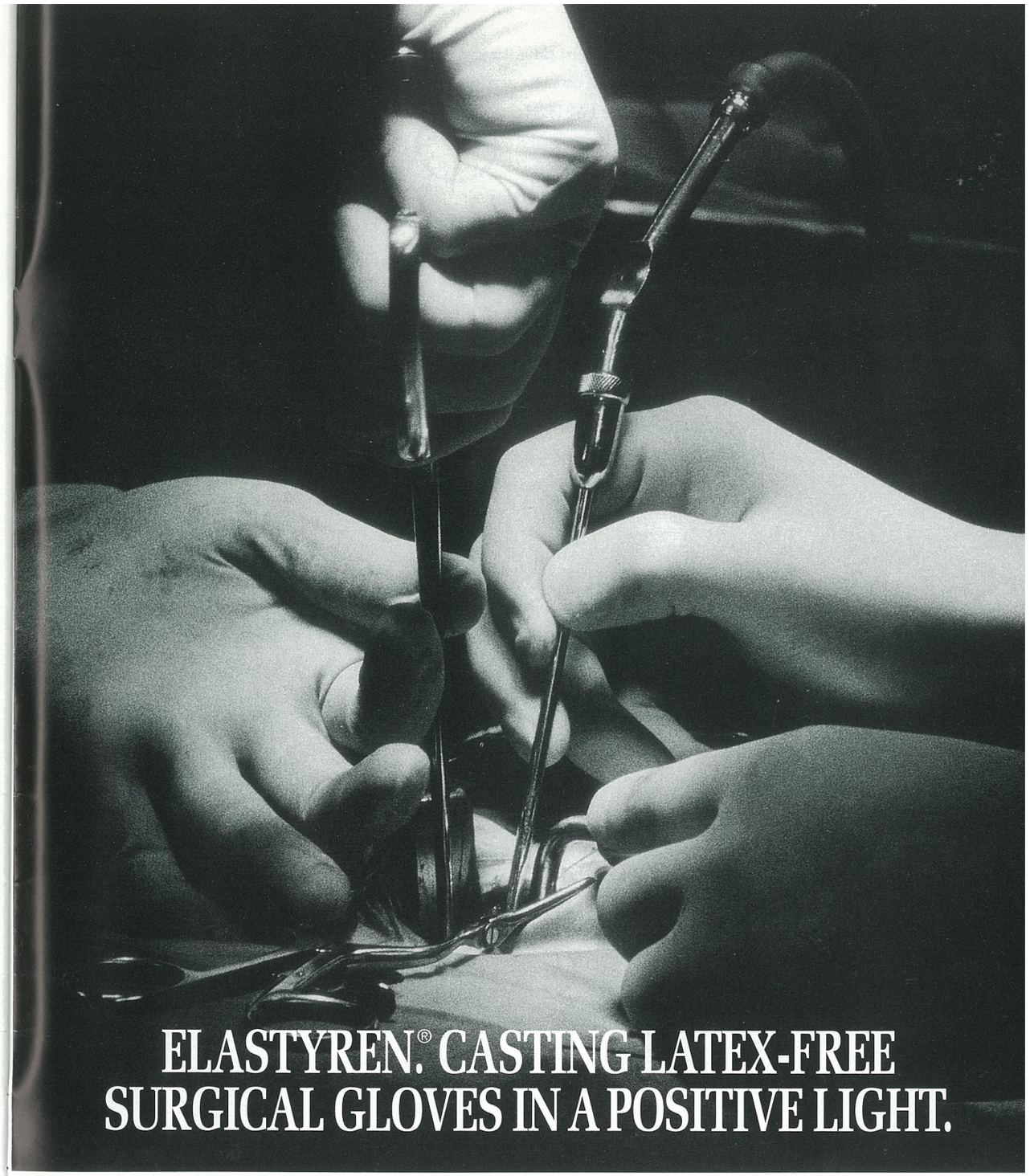

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