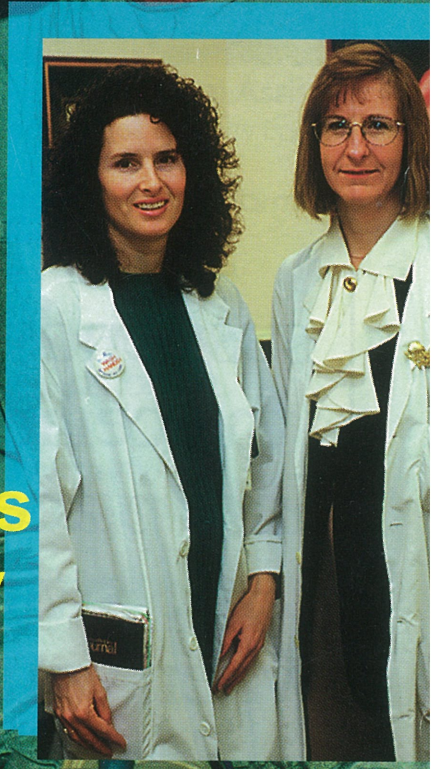
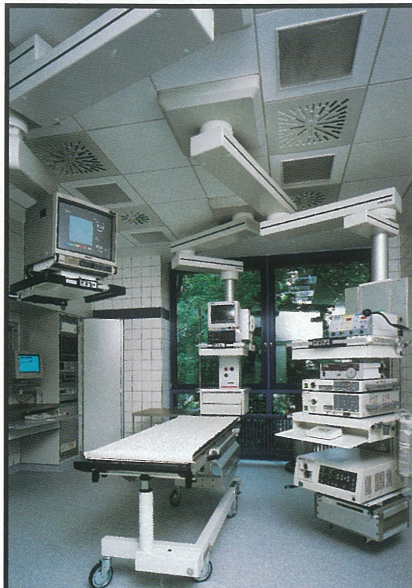


Canadian **Operating Room** Nursing Journal

Published Quarterly. Vol.14, No. 2, June, 1996



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Canadian Operating Room Nursing Journal

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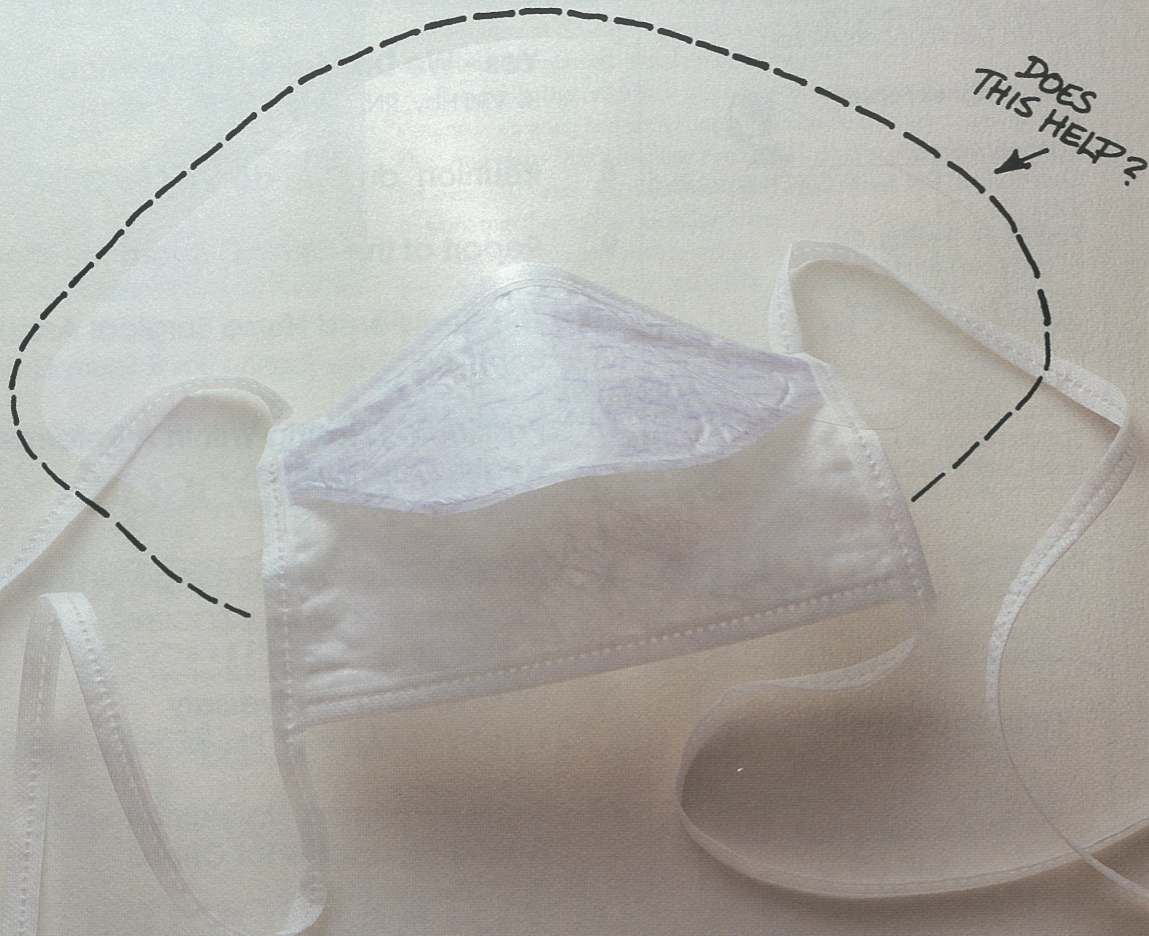
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Cover: Surgical Assistants **Laura R. Dale** (left) and **Joanne Bos** (right) both photos. **See page 10.**
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Yes - We Do Make A Difference

By Vija Hay, RN, CPN (C)

The question, "Are Registered Nurses making a Difference" is not new, but it is being asked more frequently and louder. The Canadian Nurses Association Biennial Convention in June is titled "Nurses Make the Difference - Ask a Nurse". At the recent Operating Room Nurses Association of Ontario Provincial Conference in Toronto a large focus group analysed the question of why do we need a Registered Nurse in the Operating Room.

On May 9th, over a hundred nurses marched on Parliament Hill in Ottawa to voice their concern regarding the direction of health care and the diminished role of the Registered Nurse. These nurses handed out pamphlets entitled "Registered Nurses Make the Difference" and "We are the Solution".

What can we as Registered Nurses, as Perioperative Nurses do to make a difference? My answer is: become involved, speak out for nursing, be an active member of Regional, Provincial and National Operating Room Nurses Associations. Participate on committees, attend local meetings. As well, be an active member of Provincial Professional Organizations. Take part in hospital committees, become politically active, be positioned and ready to speak on behalf of nursing and influence change.

Take every opportunity to speak out in the community and consider writing articles or letters to the editors in your local newspapers.

ORNAC's Executive and Board of Directors and members continue to make a difference through certification, lobbying for advanced practice, devel-

oping standards, reviewing and revising standards, conducting research projects, and through individual achievements.

At the April, 1996 ORNAC Board meeting, Karen Steindel, representing Manitoba, and Judi Tyndall, Ontario, completed their term on the board. I thank them for their contribution - they made a difference. I congratulate Shelly Zareski on receiving the Award of Excellence in Nursing, given by the Registered Nurses Association of Nova Scotia. My congratulations also to Lynda Wilson from Ontario on receiving the ORNAC - Johnson & Johnson Medical Products Drake Thompson Writing Award for her article on Continuous Quality Improvement published in the March/April, 1995 issue of this Journal.

We often take ourselves and our associations for granted. Only when we reflect on the past, do we realize our accomplishments and the impact we have made in our professional lives. The work to date, and the work we will contribute in the future will make a lasting difference to Perioperative Nursing.

Participate and make a difference to your patients and to your profession. ■

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.



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1996 Bursary Award Winners

Recipients of the ORNAC/Johnson & Johnson
Medical Products Bursary for 1996 are:

Judi Tyndall, OR Clinician, Hamilton Civic
Hospitals, Henderson Division, Hamilton ON.
Award - \$2,000.

Shirley Thorn, Unit Coordinator OR/NFA/
Endoscopy Units, Concordia Hospital, Winni-
peg MB.
Award - \$2,000.

Betty Barrett, Unit Manager Surgical Suite,
Lethbridge Regional Hospital, Lethbridge AB.
Award - \$500.

Sharon Gabriel, Clinical Educator, Mt. Sinai
Hospital, Toronto ON.
Award - \$500.

The four winners are each currently enrolled as
part time student in the Bachelor of Science in
Nursing or Masters programs.



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 differ-
ence in the field of perioperative nursing and deserves to be
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The Isabelle Adams Excellence in Perioperative Nursing
Award was established for this purpose on the initiative of
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Nomination papers can be obtained through your Provin-
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Why Do We Need an RN in the Operating Room ?

Toronto. At the May '96 Conference of the Operating
Room Nurses Association of Ontario, 268 nurses
packed a meeting room in a Focus Group to discuss
why the Operating Room needs an RN. Within 30
minutes, 13 group leaders reported back with a multi-
tude of valid and various reasons. The most frequently
given reason was the RN's patient assessment skills.

Registered Nurses have a broader base of knowl-
edge, (e.g. anatomy, pharmacology, aseptic technique)
and are educated in critical decision making and
nursing assessment skills. Their research based educa-
tion prepares them to question patient care programs
and offer a holistic approach to total patient care.

The practice standards and high technical skills
required by the RN in today's operating room are
reviewed through a Perioperative Certification Pro-
gram and measured against nationally recognized
professional and clinical standards - the ORNAC
Standards. The competencies of Operating Room
Registered Nurses are set by a national body.

The most comprehensive reason given was this:
**"Registered Nurses are the most 'multi - skilled',
cross trained, flexible and adaptable for the job!"**
Such skills are especially necessary in smaller centers.

Registered Nurses are trained in crisis intervention
and management, and in anticipating the needs of the
surgeon, anesthetist and patient. The RN is trained in
Nursing Process - to plan, assess, implement and
evaluate. RNs can relieve each other - scrub and
circulate - reducing downtime. The RN is educated to
administer narcotics and monitor outcomes. Another
important reason among the hundreds listed by the
Focus Group was that research has shown lower
mortality and morbidity rates with an all RN staff.

Finally, the public expects a highly trained regis-
tered nurse in charge of their care - especially in the
operating room. Unfortunately, the public is not aware
that governments are considering the use of fewer RNs
in the OR - where the RN is the patient's advocate.

Nearly half of the 1,045 members of ORNAO
registered for the 4th Provincial Conference. It was an
excellent conference - educationally and socially. See
the Conference address of Dr. Beverly Malone and
Kathleen MacMillan in this issue, along with photo
spreads of the conference on pages 20 and 21.

Agnes Forster, Editor.

Réunion du C.A. de L'A.I.I.S.O.C.

Les 13 et 14 avril 1996, le C.A. et l'exécutif de l'Association des infirmières et infirmiers de salles d'opération du Canada se réunissaient à Ottawa. Cinq membres de l'exécutif et vingt membres du conseil y ont participé. En voici les faits saillants.

1. Les communications entre l'A.I.I.C. et l'A.I.I.S.O.C. se poursuivent. L'A.I.I.S.O.C. a demandé à l'A.I.I.C. de l'appuyer dans sa promotion du rôle de l'infirmière en salle d'opération. L'A.I.I.C. estime qu'il s'agit là d'un dossier de juridiction provinciale. De plus, chaque de l'infirmière et chaque groupe de l'infirmières doivent faire leur propre promotion.

2. L'A.I.I.S.O.C. continue de se pencher sur le guide d'étude pour l'examen de certification. Le deuxième examen à l'intention des infirmières en soins périopératoires a eu lieu en mars et 400 infirmières y ont participé. L'A.I.I.C. remettra une épinglette à chaque candidat heureux.

3. Le Comité de la traduction poursuit ses travaux de traduction des documents et autres dépliants de l'A.I.I.S.O.C. Les traducteurs et imprimeurs travaillent ensemble afin que les versions française et anglaise des normes de l'A.I.I.S.O.C. puisse être diffusée en même temps.

Nous étudions la possibilité de faire traduire certains manuels de salle d'opération puisque la France et la Belgique ont manifesté de l'intérêt.

4. Lors de la réunion, on a remis le prix Drake Thompson de Johnson & Johnson pour 1996. Lynda Wilson de St. Catharines en Ontario s'est mérité le prix pour son article intitulé 'Continuous Quality Improvement - A Staff Nurse's Perspective' paru dans l'édition de mars 1995 du Journal de l'Association. Nos félicitations.

5. Les gagnantes des bourses J & J de l'A.I.I.S.O.C. pour 1996 sont: Judi Tyndall, Ontario, Shirley Thorn, Manitoba, Betty Barratt, Alberta and Sharon Gabriel, Ontario

6. Le Comité des mises en candidature est à préparer la prochaine liste de candidats aux postes de l'exécutif de l'A.I.I.S.O.C. Les élections auront lieu avant la prochaine conférence nationale en avril 1997.

7. Le Comité de recherche a fait ses commentaires sur le document intitulé 'Skin Preps, Cover Gowns and Surgical Masks'. Ceux et celles qui ont répondu au questionnaire sur les 'Vaches sacrées' dans les salles d'opération ont indiqué que plus d'information était nécessaire.

8. Le Comité des normes et de l'enseignement est à revoir le manuel des normes en vue de sa prochaine parution en 1998. Le processus permet à toutes les provinces d'y participer.

9. Le Comité d'appui à la rédaction examine la possibilité

d'inclure l'abonnement au Journal dans les tarifs de l'A.I.I.S.O.C. Le groupe travaille également avec le Comité de la traduction afin qu'un article paraisse en français dans chaque numéro du Journal.

10. Le Comité du milieu de travail est à préparer un énoncé de position de l'A.I.I.S.O.C. sur la gestion des déchets, document qui sera inclus dans le manuel des normes.

11. Le Comité des relations publiques travaille sur un vidéo faisant la promotion des soins périopératoires et de l'A.I.I.S.O.C. Le projet est financé par l'A.I.I.S.O.C. et Johnson & Johnson.

12. Lorne Flower était l'un des membres fondateurs du Comité national des exposants et un grand défenseur de l'A.I.I.S.O.C. Un fonds à sa mémoire a été créé pour l'Association.

13. Lors de la conférence bi-annuelle de l'A.I.I.C. en juin à Halifax, Vija Hay et Donna Farid représenteront l'A.I.I.S.O.C. L'Association commémorera un conférencier lors de la conférence ICN à Vancouver en 1997. Le montant sera représentatif du nombre d'infirmières certifiées en soins périopératoires au Canada.

14. Le Comité de planification internationale poursuit ses travaux en marge de la conférence mondiale de l'A.O.R.N. qui aura lieu à Toronto en septembre 1997. Le thème de la conférence sera: La globalisation des partenariats en soins périopératoires. Les propositions concernant des conférenciers doivent être soumises au Comité au plus tard le 1er juillet 1997.

15. Le Comité sur la pratique spécialisée en soins infirmiers a présenté une ébauche d'un plan de cours pour les infirmières en soins périopératoires, chirurgie et anesthésie. J. Tyndall continuera d'agir comme observatrice pour l'Association aux réunions de l'ALENA.

16. S. Grimwood a fait rapport sur la Conférence nationale 1995 de Vancouver, conférence qui a connu un vif succès. La préparation de la prochaine conférence nationale à Ottawa en 1997 se poursuit sous le thème: 'La relève'.

17. Faits saillants provinciaux:

D'un bout à l'autre du pays, on est préoccupé par les coupures, les fusions et les fermetures d'institutions, la composition du personnel, les changements apportés aux descriptions de tâches des RNA et LPN et leur impact sur les fonctions des infirmières diplômées.

L'Association provinciale des infirmières de la Nouvelle-Écosse décernera un prix d'excellence à Shelly Zareski. Nos félicitations.

Tiré du procès-verbal de la réunion des 13 et 14 avril 1996 par Corina Balcom Secrétaire de l'A.I.I.S.O.C.

Highlights of the ORNAC Board Meeting

By Corina Balcom, Secretary ORNAC.

The Board and Executive of the Operating Room Nurses Association of Canada met in Ottawa, on the 13 & 14 of April 1996. The meeting was attended by five executive and twenty board members. Following are highlights of the meeting.

1. Communications between CNA and ORNAC are ongoing. ORNAC has requested CNA support advocating the RN's role in OR. CNA believes this is a provincial responsibility as well as nurses in groups, and individually must promote themselves.

2. ORNAC continues to research the need of a study guide for the Certification Exam. The second writing of the Certification for Perioperative Nurses was held in March with over 400 OR nurses taking part. A Certification pin will be awarded to all successful candidates by CNA.

3. The French Translation Committee continues to work on translation of ORNAC documents and pamphlets. Plans are underway with translators and printers so that the French ORNAC Standards will be ready for distribution at the same time as the English Standards. Investigation into translation of some OR textbooks is on going with interest shown internationally from Belgium and France.

4. The Johnson & Johnson Drake Thompson Writing Award winner for 1996 was announced at the board meeting. The winner is Linda Wilson of St. Catharines, Ontario for her article "Continuous Quality Improvement- A Staff Nurse's Perspective", published in the *Canadian Operating Room Nursing Journal*, Vol. 13, No. 1, March/April, 1995. Congratulations to Linda!

5. The ORNAC J&J Bursary- Award winners for 1996 were announced:

Judi Tyndall, Ontario Shirley Thorn, Manitoba
Betty Barratt, Alberta Sharon Gabriel, Ontario

6. The nominations committee is preparing the next slate of officers for ORNAC executive. Elections will be held at the Board meeting prior to the National Conference in April 1997.

7. The Research Committee presented a literature review on "Skin Preps, Cover Gowns, and Surgical Masks". Respondents to the previous Questionnaire on "Sacred Cows in the Operating Room" indicated that more information was required.

8. The Standards/Education Committee is in the process of reviewing and revising the Standards document in preparation for the next issue in 1998. Structure of the review is allowing all provinces to be part of the process.

TELEMEDICINE session for Operating Room Nurses continue to be scheduled.

9. The Editorial Advisory Committee is investigating the feasibility of having subscription rates included in the ORNAC fee schedule. The group is also working with the translation committee in an attempt to have a French article in each issue of the CORNJ.

10. The Environmental Committee is preparing an ORNAC position Statement on the Environment. Revision on Waste Management in the Standards document will be from this group.

11. The Public Awareness Committee is concentrating on the making of a Video to promote Perioperative Nursing and ORNAC. Financing is a joint effort of ORNAC and Johnson & Johnson Medical Products.

12. A memorial fund has been established for ORNAC in memory of Lorne Flower. He was a founding member of NEAC and a strong supporter of ORNAC.

13. ORNAC will be represented at the Biennial CNA conference in Halifax in June by Vija Hay and Donna Farid. ORNAC will be helping in sponsoring a speaker for the ICN conference in Vancouver in 1997 with a donation of money, to correspond with the number of Certified Perioperative Nurses in Canada.

14. The International Planning Committee continues to make plans for the AORN World Conference to be held in Toronto in Sept. 1997. Theme for the conference will be "Celebrating Global Partnerships - Perioperative Nursing". Speaker proposals must be submitted to ORNAC's IPC member by July 1, 1996.

15. The Advanced Nursing Practice Committee presented a "Blueprint" for Curricula Planning for PNS, LPNA Roles. Judi Tyndall will continue to represent ORNAC at the NAFTA meetings as an observer.

16. Sandra Grimwood presented a report on the successful 1995 National Conference held in Vancouver. Planning for the 1997 National Conference in Ottawa is on going with the theme to be "Changing the Guard".

17. Provincial Highlights: - concerns across the country are similar with downsizing, facility mergers, hospital closures, staff mixes and changes in RNA and LPN job descriptions reflecting RN duties.

Shelly Zareski will receive an Award of Excellence from the Nova Scotia Provincial Nurses Association.

Congratulations Shelly!

Adapted from the Minutes of April 13 & 14, 1996

The Registered Nurse Surgical Assistant

By Laura R. Dale, Joanne Bos and Sherry Espin

Introduction

In 1981, The Toronto Western Hospital introduced the first Surgical Assistant position. This position evolved as a result of the reduced numbers of surgical residents, the need for consistency in patient care and the expansion of the cardiac program. The purpose of this article is to provide an overview of the Surgical Assistant position at The Toronto Hospital.

This position requires commitment, the need to be conscientious and organized as every day can bring new challenges, both expected and unexpected. The rewards come from patients through their expression of appreciation and their recovery.

How The Position Evolved at the Toronto Hospital

At our institution the first Registered Nurse Surgical Assistant began her career on a Surgical Unit in 1977, where she worked for one year. She then transferred to the Cardiology/Cardiovascular Unit and worked there for two years. From there she participated in an eighteen month operating room practicum.

In 1981, during a cardiac rotation she was approached by a cardiac surgeon as to her interest in becoming a Surgical Assistant, then titled a Physician Assistant. The surgeon explained that her job would involve harvesting the great saphenous vein and assisting during heart operations. She felt honored and excited to have the opportunity to embark upon this new expanded role. However, it was not until 1983 that Nursing Administration approved the position.

As a Physician Assistant she would start her day with cardiac team rounds. The cardiac team would see all postoperative patients to assess for: cardiac function (including auscultation of heart and chest, examination of legs for edema and reviewing cardiac ECG rhythms), indications for infection, incision healing, coping with recovery and ambulation. The opportunity for teaching was provided as patient concerns were addressed. She participated in patient discharge planning and assisted in the writing of discharge letters. The Physician Assistant would then go to the operating room where she worked with the two cardiac surgeons, harvesting the great saphenous vein, closing the wound in the leg and then second assisting at the chest.

Authors

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Learning how to harvest the great saphenous vein was through demonstration and gradual practical application. Training began with assisting the resident or staff surgeon with harvesting the vein. She began to suture the patient's leg wound and progressed to complete closure. She then started to take the great saphenous vein with assistance. With experience her ability to assess and apply the knowledge and skills learned eventually allowed her to independently perform the saphenectomy.

Research Involvement

The Physician Assistant was also taught how to enter patient information into a data base computer program for quality assurance and research purposes. This data was analysed and presented monthly at Morbidity and Mortality rounds. In July of 1990 the Cardiovascular Division merged and relocated. This involved an increase from two to five cardiac operating rooms. The move did not come without its difficulties for all of those involved. The Physician Assistant was confronted with uncertainty of a new environment and staff. In performing the job with care, and demonstrating her abilities as an expert gained her acceptance and respect.

In 1984, the Physician Assistant began participating in research with a cardiac surgeon. In the research laboratory she organized the equipment and supplies (instruments, drapes, video equipment, echocardiography, etc.) and assisted as the scrub nurse. An experimental heart valve was examined, perfected and trialed successfully in an animal model for six months. In 1991, this heart valve developed in the research laboratory was granted Investigational Device Exemption (IDE) for a five year clinical trial. The Physician Assistant became the Patient Coordinator of this study. In 1996 this heart valve was approved for use in Canada.

In 1994, the Division of Cardiovascular Surgery recruited a second Registered Nurse to be trained as a Physician Assistant. Not realizing that such an opportunity was even a career possibility, she accepted the job with excitement. Following the first Physician Assistant, her mentor, brought much variety and possibilities for learning. In the operating room she was taught by the first Physician Assistant how to harvest the great saphenous vein (g.s.v.). In the research laboratory she learned to organize and assist in a research study. Additionally, research related tasks were taught both by her mentor and the cardiac surgeons.

Duties and Responsibilities

In 1995, the title Surgical Assistant was established. This title was changed to differentiate the roles of the assistants within the operating room and the cardiac units (a position held by Nurse Clinicians).

A typical day as a Surgical Assistant is often not so typical. Starting at seven in the morning the day begins with postoperative patient rounds conducted by the physicians and clinical assistants and/or the day begins with reviewing charts for patients involved in research studies. Once a week teaching rounds occur to discuss patients and to have presentations from a guest speaker. At eight o'clock, with coffee in hand, the past and the present day's events are reviewed by the Surgical Assistants. Then to the operating room where the first procedure begins (see Table 1).

Tasks required during the operation depend on the scheduled procedure. As one of two assistants for the surgeon, the Surgical Assistant helps to make the operation progress smoothly by organizing the field, suctioning, retracting and cauterizing. For an aortocoronary bypass the great saphenous vein is harvested.

Harvesting the great saphenous vein begins with landmarking its most common occurring site. The vein is usually harvested from the left leg because of positioning of the surgical team.

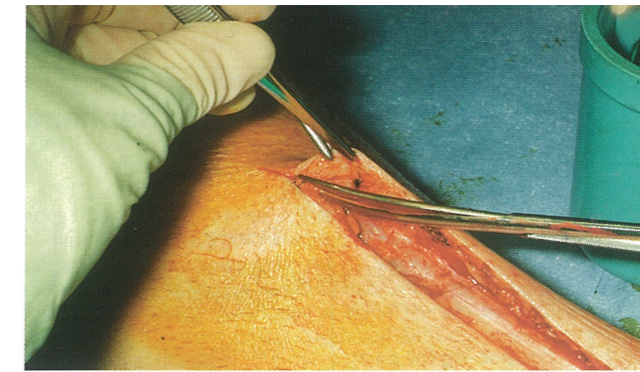
Before harvesting begins the surgeon indicates the length of conduit required for the coronary artery bypass graft (CABG). The epidermis, dermis, fat and fascia anterior to the vein is cut. As the incision is made the bleeding sites are cauterized to allow for optimal vision and to decrease blood loss. Once the required length of vein is visualized then the saphenectomy begins. Harvesting the vein involves: dissecting the tissue surrounding it, ligating of the venous branches using a 3-0 silk tie on the proximal end and a 5 millimetre titanium steel clip on the distal end and cutting in between. This procedure is continued along the entire length of the vein. Once the length of the great saphenous vein is released from the tissue it is ligated with a 0-0 silk or 2-0 dexton tie and cut at the proximal and distal ends. The vein is marked for identification and then it is removed. The vein is then dilated with a Ringer's lactate solution. Dilating the vein assists in assessing the vein's quality and to see any additional branches that may need to be tied. The vein is kept moist until it is utilized in a Ringer's lactate solution on the scrub nurses table. The leg is then sutured closed. The Surgical Assistant (S.A.), also assists with retraction of the heart while the distal

**Table 1
OPERATING ROOM
Preparing Patient for Operation**

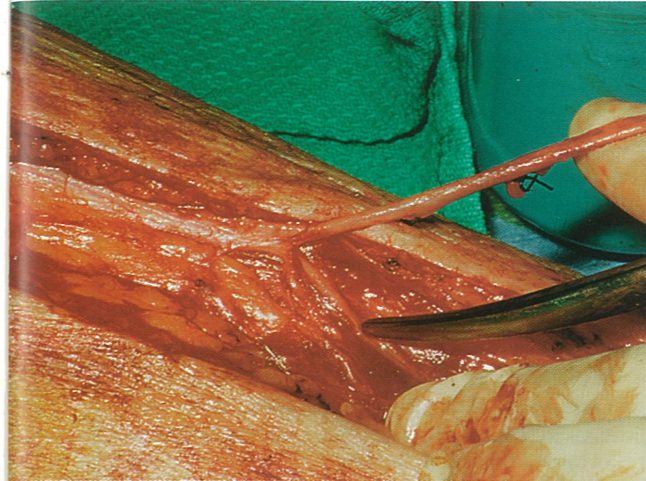
Procedure	Purpose	Description
View angiogram	To familiarize self with condition of patients (pt.) vessels and heart preoperatively, and potential length of vein to be harvested	With frequent viewing of angiogram the Surgical Assistant becomes more familiar with the irregularities and differences in patients vessels
Retrieve pt. x-rays Display x-rays on viewer	For surgeon to review	Surgeon can see the location of irregularities of the heart (size, position, aneurysms, etc.) pertinent to the procedure
Review patient chart	Familiarize self with pt. history and potential complications	Areas that may be of concern, eg. previous "vein stripping", vascular problems, prostate problems, redo surgery, diabetes
Insert urethral foley catheter	To empty bladder and to calculate output To assess kidney functioning intraoperatively	Sterile insertion of foley. Use of a urojet (freezing) with difficult catheterization and contact doctor or urology if need for dilators - which are retrieved and set up for the doctor
Position patient on operating room table	Pt. is positioned as close as possible to the surgeon Position may vary with operation	Having the patient close to the surgeon decreases back straining Patient supine, arms secured at patient's sides, legs in stirrups for prepping
Prep. patient	To decrease the microbial count of the skin	Betadine scrub from - chin to ankles, bedside to bedside then dried with sterile towels. Repeat above with betadine solution
Draping	To create a sterile field	Assist with draping; feet wrapped, legs set on top of drapes, leg not used for saphenectomy covered with a sterile towel



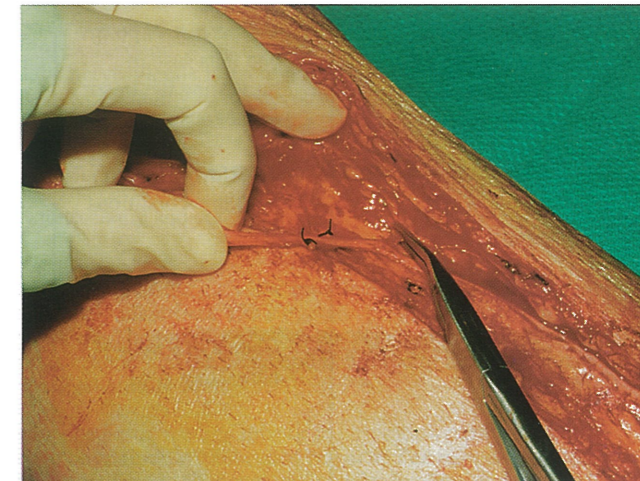
▲ Prepping the patient



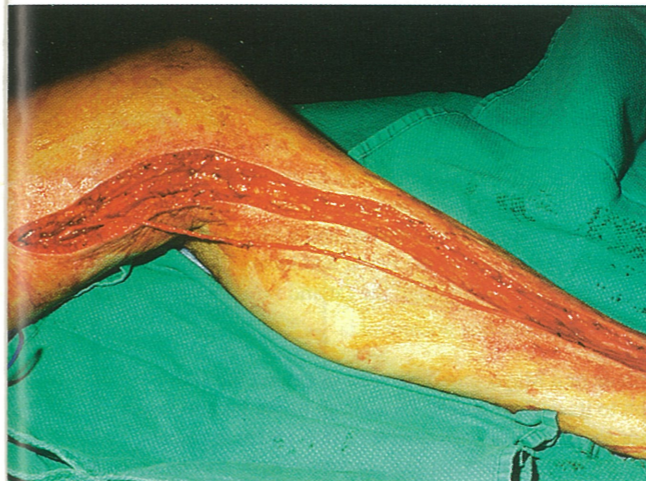
▲ Cutting Tissue Superior to Vein



▲ Tips of scissors identify saphenous nerve.

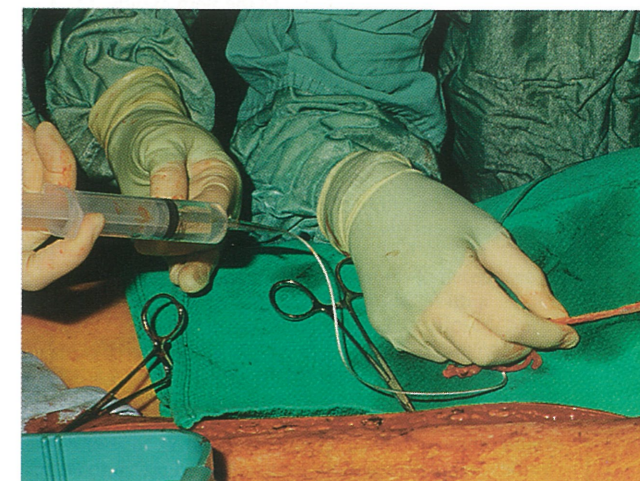


▲ Clipping a branch. Black silk ties indicate tied branches.

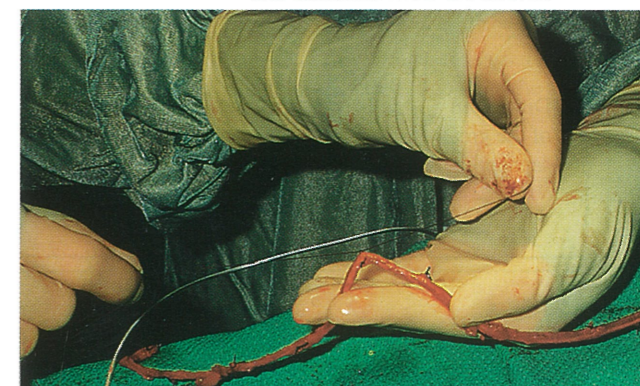
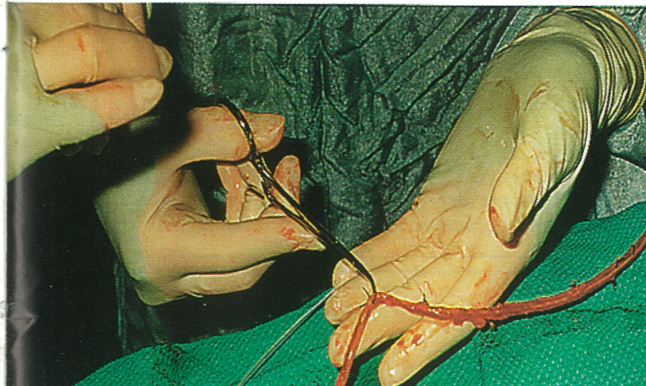


▲ Dissected the g.s.v. before removal.

▼ Clamping a branch of the g.s.v. for tying



▲ Dilation of vein. ▼ While setting first knot, clamp is removed and additional knots are thrown.



Saphenectomy - Table 2

Procedure	Purpose	Description
Choice of leg via visual exam, history and physical	Determining which leg to use for saphenectomy	Determining factors may include previous injury, poor circulation or ulcers. In addition, if the vein has varicosities, has been stripped or used for a previous bypass operation
Position leg for g.s.v. harvesting	Facilitate harvesting of the g.s.v.	Bend leg at the knee and externally rotate at the hip
Position leg for lesser saphenous vein harvesting (when required)	To increase exposure and thus ease in harvesting the lesser saphenous vein	Bend both knees together and rotate the hip of the operative leg internally. (The lesser saphenous vein is utilized when the g.s.v. is not present or is not appropriate)
Position of the surgical team	To allow for optimal working conditions	The scrub nurse stands diagonally from the surgeon Left leg - Most commonly used leg because of the teams positioning and ease in harvesting Right leg - The Surgical Assistant stands on the left side of the OR table until the vein is harvested, then moves to the right side
Incision location	Choice of g.v.s. harvesting site	Harvesting the g.s.v. from the thigh, ankle or both is dependent on: the diameters of the coronary arteries to be grafted, the visual assessment of the quality of the g.s.v., the potential complications in tissue healing and the surgeon's choice
Landmark vein	Landmarking superior to the vein avoids unnecessary trauma to the tissue and allows for optimal vision of the g.s.v.	Thigh - The g.s.v. branches from the femoral vein and lies on the internal aspect of the thigh. It sits medially to the vastus medialis muscle, posterior to the fascia, within the adductor canal. Ankle - The g.s.v. lies anterior to the tibial malleolus and continues up the medial side of the leg in relation to the saphenous nerve
Initial incision	To expose the vein	With a 22 blade a 5-10 cm incision along the direction of the vein is made perpendicular to the skin. If the vein deviates from its anatomical position a forcep and a Metzenbaum scissor are used to separate the tissue and locate the g.s.v. Dissection is continued through the fat and fascia where the g.s.v. is exposed
Exposure of the great saphenous vein	To remain superior to the g.s.v.	A 22 blade or a Mayo scissor is used to extend the skin incision to its desired length. Dissecting of the fat and fascia superior to the vein is continued for 10 to 15 cm segments following the veins path until the desired length is obtained. Often it is necessary to use the self retaining retractor to assist in retracting excess tissue. Following the g.s.v. in this organized manner allows the Surgical Assistant to see the path that the vein is taking. This process avoids unnecessary tissue flaps and it maximizes exposure of the vein
Dissection of the great saphenous vein	To remove the vein required for the bypass surgery	The tissue surrounding the g.s.v. is retracted with a forcep and is cut using a Metzenbaum scissor. Once the vein is exposed for a 1-2 cm circumferential area gentle digital retraction of the vein is begun. The S.A. avoids cutting too close to the vein to prevent damaging the adventitia layer and cutting unvisualized venous branches

Ligation of vessels	Increase exposure, decrease blood loss and to prevent postoperative haematoma	As the g.s.v. is dissected small vessels are encountered. Some are small enough to be cauterized. Larger vessels are clipped
To release the g.s.v. from the leg	To obtain a conduit for bypass grafting	Venous branches are clipped at least 5mm distal from the g.s.v. with a medium, 5mm, titanium hemoclip. The venous branch is tied at a distance from the g.s.v. as to prevent a stricture or bulge in the g.s.v. This establishes a symmetrical conduit and decreases turbulence of flow. The branch is then cut medially. This procedure is continued until the required length of vein is obtained
Preserving the saphenous nerve	To decrease postoperative leg paresthesia and pain	Below the knee the saphenous nerve lies anteriorly and superiorly to the g.s.v. Cutting the tissue surrounding the vein can be challenging, as there is little tissue between the vein and the nerve. Gentle retraction is used to avoid trauma to the nerve. Occasionally the saphenous nerve is sacrificed in order to preserve the g.s.v.
Ligation of the g.s.v.	To remove the g.s.v. for the CABG	The proximal end of the g.s.v. is clamped with a right angle clamp and cut. The distal end of the g.s.v. is clamped with a mosquito clamp and cut
Marking the end of the g.s.v.	To identify the proximal and distal ends of the g.s.v.	Upon removal of the g.s.v. the proximal and distal ends are immediately identified. The surgeons' preference determines the method. The proximal end of the vein is sutured to the coronary artery and the distal end is sutured to the aorta, thus creating an arterial conduit
Dilation of the g.s.v.	To assess the quality of the conduit, to release spasm, to flush and to identify any branches that are not tied or that need to be retied	Using a pediatric feeding tube or the irrigation cannula and a 10cc syringe filled with lactated ringer's. The vein is set onto a dry sterile towel - thus making it easier to identify any leaks in the vein. The Surgical Assistant inserts 5 cm of the feeding tube into the distal end of the g.s.v. and dilates the vein while occluding the flow in 10cm segments
Ligating the proximal & distal ends of the g.s.v. in the patient	To prevent bleeding	The ends are tied with a heavy silk or a 2-0 absorbable synthetic suture This occludes the blood flow and thus the Surgical Assistant can remove the Right angle and Mosquito clamps that were applied before removing the g.s.v.
Cauterizing	Preparing for leg closure To accomplish haemostatis	Any bleeding vessels are cauterized or clipped with a medium hemoclip to avoid haematoma formation in the leg wound
Leg closure - Subcutaneous	To approximate wound to allow for healing, to decrease skin tension and infection	The leg is assessed for the incision's depth, to determine the number of subcutaneous layers to be closed. With a 2-0 absorbable synthetic suture the layers are closed. Special attention is given to closing the dead space to prevent haematoma formation and approximating the same subcutaneous layers on both sides of the incision
Leg closure - Skin	To approximate wound thus allowing for wound healing	Four methods of skin closure can be used dependent on the patient's condition or the surgeon's choice: Staples - a fast method, but the skin edges must be precisely approximated to prevent dehiscence. A 3-0 cutting absorbable synthetic suture into the subcutaneous layer. Steri-strips - when the skin edges are completely approximated. A running mattress suture technique using a nonabsorbable monofilament suture on a straight needle. This technique is used in situations when the leg wound needs more support or the skin is friable
Dressing	To decrease the risks of infection and to absorb any discharge from the incision	A sterile dressing is applied to the leg wound prior to removing the drapes

anastomosis is performed (see Table 2). After the leg is closed the Surgical Assistant changes her gloves and assists the surgeon at the chest.

Research Responsibilities

As Patient Coordinator the Surgical Assistant preoperatively obtains an informed consent for the patient to participate in a clinical trial, orders bloodwork and an echocardiogram. The patient is seen by the Surgical Assistant at three months and on the anniversary date of their surgery for a five year period. Follow-up visits involve, assessing the patient for complications and addressing the problems by notifying appropriate medical staff, answering any questions and reinforce patient teaching as required, taking a venous sample and having an echocardiogram. Research forms are completed at each patient visit to inform the sponsoring company of the patient's progress, and to monitor cardiac and non cardiac related complications.

As an assistant to research, patient charts are reviewed and telephone follow ups are made. Patients are assessed as to their condition (i.e. quality of life, pain, reoccurrence of disease, need for medication and complications). Based on the collaboration of data an assessment is made and if necessary a plan is established with the patient as to an appropriate intervention.

Realities

As a Surgical Assistant each week comes with variety. A typical week consists of spending three or four days in the operating room assisting the cardiac surgeon. The other days are spent in the office working on research related activities: this involves seeing and/or telephoning patients, collecting patient data, updating computer entries and contacting research sponsors. This time is also spent reviewing the patients' chart for the following week to complete an initial assessment of the patients' history and cardiac function.

The need to be flexible and adaptable is important, for example one can start a day expecting to scrub in on a case but then discover that research data needs to be collected or refined. Alternatively, one may arrive at work to find that the planned day in the office is changed because of operating room requirements. A procedure may take longer than expected, thus one needs to adapt quickly. During lunch hours and/or at the end of the day, telephone messages are answered, in hospital patients are seen and/or their charts are reviewed.

Flexibility is essential as needs of the day vary. Self motivation and commitment are vital. Some days can be long and stressful, and work that one wants to accomplish accumulates requiring overtime hours to catch up. Alternatively, some days can be less demanding allowing one flexibility of working hours.

The rewards of the job are obtained through a feeling of fulfilment that one was apart of the team that assisted in the patient's treatment and hence the improvement in their quality of life. Patients often express gratitude for 'the opportunity to live a new life'. Rewards are also received through the expression and demonstration of appreciation from the surgical team.

As part of the institution's commitment to research and teaching the Surgical Assistant is encouraged to attend in-house seminars and local meetings/conferences. The Cardiovascular Division sponsors the Surgical Assistant to attend an annual conference, and courses in epidemiology, statistics and computer use.

Future Direction

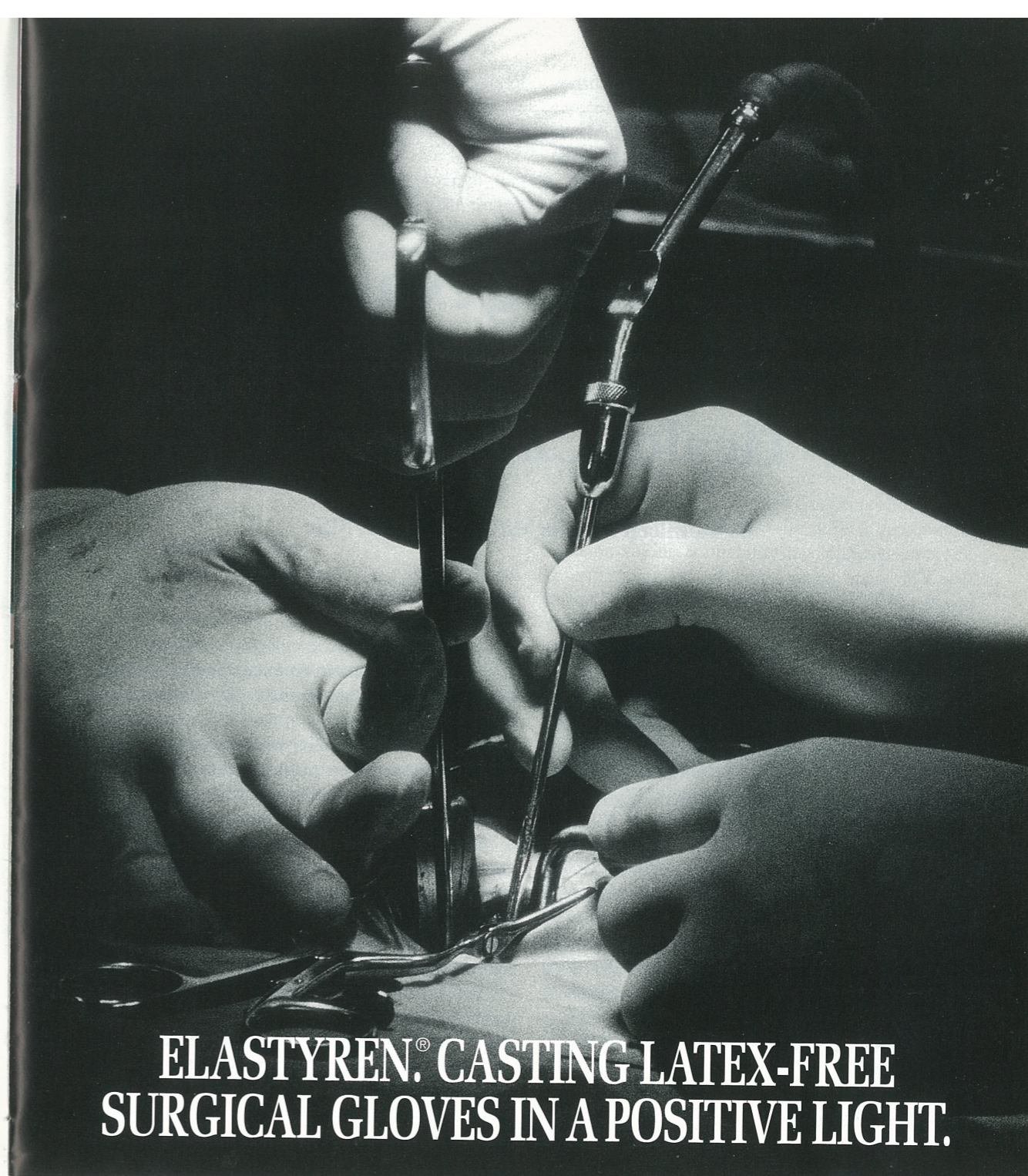
As the healthcare system becomes more efficient, expectations on health care workers increase. Academic government funding has limited the number of medical resident positions within The Toronto Hospital and thus the numbers of assistants within the operating rooms has decreased. These positions need to be filled by qualified staff.

The role of Surgical Assistant in the United States has been in existence for many years. Training programs are approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and students are certified through an examination. In 1981 as an education organization, the Association of Physician Assistants in Cardiovascular Surgery (APACVS) was begun.

At The Toronto Hospital this expanded role is possible because of the support and encouragement received from all members of the health care team. To fulfil the need for the Surgical Assistant and other Advance Practice roles, nurses' knowledge and abilities are being recognized and utilized to their maximum benefit.

Acknowledgements

The authors wish to acknowledge Dr. T. David, Head, Division of Cardiovascular Surgery, Dr. L. Mickleborough, Cardiac Surgeon, Dr. R.J. Cusimano, Cardiac Surgeon, The Clinical Assistants and the O.R. Nurses at the Toronto Hospital, Toronto, Ontario. ■



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Positioning Nursing Within a Reformed Health Care System

By Kathleen M. MacMillan, RN, MA, MSc

This article will discuss the many changes in the Ontario health care system and the role that nurses can play in making the change effective, in ensuring that stated goals are met and that the health of the citizens of Ontario is improved and not compromised during the change process.

In his address to the Canadian Club in February, 1996, Ontario's Health Minister Jim Wilson outlined his vision for the future. Let me precis it for you. Consider his key messages and their relevance for nursing.

Firstly, Mr. Wilson summarized how our health care system has evolved to date: largely haphazardly, with a focus on construction of hospitals and on the care of the ill. Open ended payment systems encouraged and rewarded spending without accountability for outcomes.

Patient programs are still largely uncoordinated with expensive duplication and overlap among hospitals. This means that tax dollars are going to support large bureaucracies that could be spent on actual patient care and health promotion and illness prevention activities.

In Ontario, in the last five years, 6,700 hospital beds have been removed from the system without the closure of a single building - even though this number of beds is equivalent to 33 mid-sized hospitals.

(The former Ontario premier Bob Rae has been heard to comment that we have an "edifice" complex.)

We have been unwilling to go that extra step and so hospitals have been unable to realize the savings that we should have in administration and overhead costs. This is stealing funds from direct patient care.

Mr. Wilson says the only way to fix the health care system is to totally restructure it. The government is prepared to listen to health care providers on the front lines - to give them the tools to restructure the system so that we can provide more effective and appropriate health care.

The health care vision outlined consists of two main pillars: 1) patient focus, and 2) accountability. The former is the goal and the latter is how we reach that goal. The government is committed to maintaining funding at the same level (the existing 17.4 billion dollar health care budget), while focusing on patient

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This article was originally the Keynote Address to the 4th Provincial Operating Room Nurses Association of Ontario Conference, May 6, 1996.

needs and increasing accountability for the delivery of services designed to meet those needs.

Optimal care is described by Mr. Wilson as resting on three key principles:

1) Match the dollars to the patients - programs that deliver services directly to the patient in the setting that best serves their needs.

2) When you save dollars, you reinvest them in the patient, and

3) Unfettered access to the health care system - meaning primary care reform.

In his address, Mr. Wilson states that the barometer of success should not be if all health interests are satisfied but if the outcomes are improved, through a more accountable health care system.

We need to link funding with accountability and emphasize improved patient outcomes.

Government's vision

Now, what does this mean for nurses? As described, it is a vision which is congruent with the nursing vision. How do we make this vision a reality?

Our health care system doesn't need more money. Nurses have been saying this for years. Existing monies need to be reallocated. The recent Ontario Nurses Association membership survey data supports this. Ninety-four respondents said that the system needs to be reformed - so nurses support restructuring in principle.

For OR nurses, like other nurses, change is familiar. Over the past two decades, we have seen surgical techniques evolve so that trauma and blood loss are minimized. This has led to shorter hospital stays, simpler wound care and reduced complications, partially why we need fewer hospitals.

A lot of the better outcomes are related to the presence of registered nurses who are extremely knowledgeable about perioperative care. Nurses who prepare patients so that their anxiety is alleviated, nurses who observe the patient and assist during induction of anesthesia, during surgery and in the immediate post-operative period. Skilled Registered Nurses who engage in assessment, treatment, discharge planning, rehabilitation and planning for long term care needs. Registered nurses who are vital ingredients of quality assurance and accountability.

Nurses could play an even larger role in the health care system, one that could contribute to cost-effectiveness as well as quality.

Most of these contributions are invisible to the

consumer. The average surgical patient has no concept of the important role of registered nurses in providing safe perioperative care and improving patient outcomes.

I will talk about some suggested nursing activities to improve this state of affairs in four categories:

Achieving a high quality nurse provider. Ensuring that appropriate nursing interventions are used, Ensuring that nurses practice to the extent of their scope of practice, and social activism and advocacy.

1. Achieving a high quality "provider"

Firstly, we need a better quality of provider and a different kind of nurse. For years, we have been producing nurses to staff hospitals, based on concepts of hospital care in the 1960s and 70s. We have been producing nurses who worked on clients and not with them. Now we need nurses with skills in autonomous decision making, community development, advocacy, case management and crisis management. We need nurses for whom the client is the patient, the family and the community; nurses for whom the client is the decision maker and the nurse aids and supports the process.

"...OR Nurses have a reputation for being insular and for caring only about what happens inside the OR. This must change ..."

Why should OR nurses care about what happens in the community? Well, for example, if your community does not have adequate resources for home care following discharge, hospital stays will be longer, or there will be re-admissions, and this will reduce OR bookings.

OR Nurses have a reputation for being insular and for caring only about what happens inside the OR suite. This must change if you are to play a role in a different health care system.

Achieving a different kind of nurse involves three things: education (both basic and continuing), leadership, and what I will term "fertilizing and weeding the garden".

Education for registered nurses is on the brink of major change world wide. In Canada, five provinces are now committed to Baccalaureate education for preparation of Registered Nurses. Others are examining the issue carefully. *(continued on page 22)...*



Shown at the English Pub Night: L to R: Sharon Wilson, Port Perry Community Hosp., Pat Drysdale, Bowmanville Hosp., Joanne Drury, Oshawa General, Fran Fawcett, Whitby General, Peri Sturgeon, Whitby General Hosp. and Maggie Skaliks, DON, Surgery/CSR, Cobourg District Hosp.



ORNAO 1996 Conference Planning Committee

Front row L to R: (standing), Helen Friend. Seated - Lynda Wilson, Secretary Treasurer, Sharon Ball, President, and Judi Tyndall, Immediate Past President and Conference Chairperson. **Back Row:** (L to R) Alaine Young, Janet MacCullough, Wanda Collins, Janice O'Neill, Mindy Shinoff, Janet Rinaldi, Beth Stone, Audrey Macdonald and Susan Smith.



Photo left: ORNAC President Vija Hay shown at the Past President's cabaret table with Martin Rosenbaum, (right) of the newly formed Sherwood-Davis&Geck, and an unidentified gentleman (left) behind the streamers.

▼ Cheers to the ORNAO entertainment committee on English Pub Night/Comedy Cabaret-Top Drawer! Great Dinner as well! Party goes included **(Photo below)** L to R: Brian Bonnell of MDT Canada (Chairman of the ORNAO Exhibitors Advisory Committee), Janet Young-Laurin and Kathy Marshall, both of Royal Victoria Hospital, Barrie, Ont.

ORNAO Celebrate 15th Anniversary

Five ORNAO Past Presidents returned to celebrate the 15th Anniversary, May 5 to 8, 1996 in Toronto during 4th Provincial Conference of the organization.

Photo Right, (L to R) Carole Starr, Peterborough, Hilda Gatchell, Oshawa, Ann Hayes, Hamilton, Vija Hay, Ottawa and Carol McDougall, South Carolina. ORNAO Past Presidents and terms of office were:

- 1st President - Ann Hayes (1982-84)
- 2nd President - Val Sherriff (1984-86)
- 3rd President - Carole Starr (1986-88)
- 4th President - Carol McDougall (1988-90)
- 5th President - Hilda Gatchell (1990-92)
- 6th President - Vija Hay (1992-94)
- 7th President - Judi Tyndall (1994-96)

At the head table a red rose (as always) marked a place for the late Val Sherriff, who served as ORNAO president as well as president at the national level.



Photo below: Lynda Wilson, (left) is the '96 winner of the \$3000 Johnson&Johnson Drake Thompson Writing Award. (See # 4, page 9). Presenting is Dave Patterson of J&J, who recently transferred to California. **Sharon Ball,** new ORNAO president, also chairs ORNAC Awards Committee. See more Awards information on page 7.



▼ **Photo Below:** The Andrew Sisters sing and dance for ORNAO delegates. John Flower, an exhibitor with Southmedic Inc. (right) is also a member of the Kingston-based "Music Hall" Comedy Cabaret group.



ORNAO '96 Keynote Address

(continued from page 19).

In Ontario, a new health care system will require a different kind of nurse to the one which we have been preparing. Future nurses will require different knowledge and skills to play a role in a community-based health care system. This has implications both for basic education and for continuing education. The College of Nurses of Ontario's Quality Assurance Program, mandated by the *Regulated Health Professions Act*, will also increase demand for continuing education. The nature and quality of that education can be influenced by nurses.

I would suggest that nurses want different courses than those which have been offered to date. They want courses that are academically and clinically sound and which build on prior knowledge. They want education which supports career progression and is broadly recognized. Diploma prepared nurses want courses that articulate with degree studies.

Educational facilities respond to pressure from consumers. Nurses must be prepared to state what they want and to refuse to take those courses that do not meet current needs. I do not believe that courses which focus on technical skills alone are going to meet your needs in the future. Nursing practice cannot remain a-contextual and a-political if it wants to survive and thrive.

Leadership in nursing is essential to positioning nursing for a reformed health care system. We no longer need managers for professional nurses. We need transformational leadership to foster professional practice through the development of professional practice environments. This means flattening hierarchies and treating clinical nurses as true colleagues, (after all, we are a practise discipline, so we must value practice). Functioning within relationships which are mentoring and supportive and abandoning the patriarchal models most of us currently practise within is a vital component.

When I speak of alternate organizational structures, I am not endorsing any particular models. Many have only served to retrench traditional hierarchies and have not delivered on the promised emancipation for nurses. Organizational structural change alone,

"... Those nurses who require supervision are practising below the standard. This is simply not acceptable...."

without an underlying philosophical change, will not achieve professional equality.

Some will say that there are nurses who require supervision and so this would not work. I say, if you want to bring about change, you do not focus on the lowest common denominator. Your leadership strategies should be targeted to elevate the mean level of practice. For too long, we have developed agency policies for the lowest common denominator. It is time to stop. Those nurses who require supervision are practising below the standard. This is simply not acceptable.

"...Some of us have been working for twenty years - but we have had one year of experience twenty times..."

Now for fertilizing and weeding. I strongly believe that the level of practice of many nurses has been stunted by the environment in which they practice, and that much can be done to improve practice with different management techniques and organizational structures. It is time, however, that we made up our minds whether we are a profession (with accountability to the public) or a support group (with accountability to ourselves). We have a small number of colleagues among us who do not meet the current standards of practice and are unlikely to meet the new demands that our system will impose on us. Some of us have been working for twenty years - but we have had one year of experience twenty times. At the same time, we have exceptional nurses who are either unemployed or underemployed. Part of nursing leadership is to create an environment that puts pressure on those nurses who are holding us back and rewards those who are prepared to push the envelope. We cannot afford to continue to support nurses who will not, or cannot, grow and change and worse, to restrict those nurses who want a more professional practise by maintaining structures designed to meet the needs of lower functioning nurses. Continuing to do so hurts our profession and denies our clients the benefit of excellent nursing care.

Jean Gunn, a noted nurse leader of the 1930's once said that every patient deserves the best possible nurse, and not just some cheap substitute. If we are willing to tolerate substandard nurses, it is hard to argue against the use of unregulated workers. The actual difference in the quality of care provided by a

registered nurse and that provided by a cheap substitute ought to be crystal clear.

We have good data on the cost-effectiveness of care provided by registered nurses in acute care. If you want access to this information, contact the Registered Nurses Association of Ontario (RNAO) for their reference list and annotated bibliography on unregulated workers. Every nurse should be familiar with this literature - it is your best defence against substitution.

The information is based on agency-wide outcomes. Those hospitals in the US which have at least 85% registered nurses, and those with the best educated nurses, have the lowest mortality rates, the lowest morbidity rates, the shortest lengths of stay and the lowest rates of readmission. This is cost-effectiveness with a capital "C".

2. Ensuring that appropriate nursing interventions are used

Next, appropriate interventions can only be provided with utilization of research and empowerment of nurses to use research findings. Access to research findings is critical for nurses. The government's emphasis on outcomes and accountability are going to make this essential for nursing. We can no longer provide care based on habit, routine, or outdated agency policies which restrict nursing autonomy. This indicates that all nurses must have some exposure to critical review of research literature. This is a current standard of practice in Ontario and most nurses cannot meet it.

How many OR nurses work in agencies that continue to prepare operative sites by shaving the skin? Often the evening prior to surgery? Research findings that indicate that this is a dangerous practice dates from the 1930s and particularly compelling research designed to confirm this was conducted in the 1970s, yet practice has remained unchanged in many institutions. What has prevented these research findings from being implemented more broadly?

The Province Wide Nursing Project, a one million dollar nursing project funded by the Ministry of Health and now commencing in the province of Ontario, is designed to facilitate access to research information for practising nurses. It is also designed to aid nurses in breaking down some of the traditional barriers to professional practice and to integrating services across the agency-community spectrum. There are three collaborating centres which are consortia of acute care, long term care and community agencies. The centres are located in the Ottawa, Cornwall and London areas.

Hopefully, in the near future, primary nurses in acute care facilities will talk directly with primary nurses in the community and there will be more congruence between methods and supplies used to provide care across the system. Accountability for nursing outcomes will be achieved by using the latest research information and evaluating the impact on patients, the system and other care providers.

3. Ensuring that nurses practice to the extent of their scope of practice

My remarks related to scope of practice are in reference to the recent passage of the Controlled Acts for Nursing, which were published recently. These were originally tied to the Controlled Acts for Nurse Practitioners, and this legislation was held up with the change of government. I am pleased to report, that after a two year plus wait, registered nurses will now be able to initiate their controlled acts.

Our next steps must be to ensure that all nurses are given the tools and the support to practice to their full extent.

Nurses now must consider how this legislation can work for them and for the people which they serve.

The province wide Nursing Project will also examine the scopes of practice of both RNs and RPNs to ensure that we are making use of the knowledge and skills of both types of nurses.

Once again, this will require leadership on the part of nurse managers and educators. I strongly suggest that we begin to move away from models that cause nursing practice to vary considerably from one employer to the next and that we look at a more global approach. This is enabling legislation and the possibilities for increasing nursing autonomy and decision making are considerable. For example, marrying the controlled acts for nursing with medical protocols can create situations in which nurses can make decisions within certain parameters - making *decision making* at the nurse-patient interface more appropriate and timely.

This applies, for example to oxygen administration, to advanced cardiac life support in emergencies, to wound care, and to the role of registered nurses as first assistants in the OR.

The possibilities only expand if we place nurse practitioners in the picture. The Health Professions Regulatory Advisory Council report on the Nurse Practitioner has been received by the Ontario Ministry of Health and is currently being reviewed. It should be released shortly.

(ORNAO '96 Keynote Address Continued on page 26).

BCORNG honor Founding Members

The 15th Biennial BCORNG Conference, March 14-16, '96 in Victoria, B.C. under the chairmanship of Ann Mazuruk, was a very special event as participants celebrated thirty years of continuous service. BCORNG President Faye Meuser extended invitations to all the Past Executive and Founding Members, and the majority attended. Six members of the founding group were among the honored at the opening ceremony with the presentation of special pins in appreciation of their commitment over the years.

Greetings were extended by various people including ORNAC President, Vija Hay from Ottawa.

BCORNG History - 1966 - 1996

In May, 1966, 75 nurses attended a meeting chaired by Ethel (Blenkinsopp) Robertson who suggested forming an OR Interest Group. The nurses immediately agreed. The first executive was: Joan Flower, President; Ellen Schrodtt, Vice President; Anita Williams, Secretary; Corrine McGibbon, Treasurer.

The purpose of the new organization would be to: "further education of OR nurses in keeping step with new technology and procedures, and stimulate interest in the OR clinical field".

The first executive was directed to send an announcement of the group's beginnings to all OR nurses in all BC hospitals, and \$39.20 was collected to help start the organization.

680 Members

The Province was divided into regions with their own Executive consisting of Regional Presiding Officer (RPO), Secretary, Treasurer, plus a Program Committee. There are presently seven regions plus approximately 44 corresponding members making a membership of 680 operating room nurses.

The RPOs meet for a full day twice a year with the Provincial Executive, this method remains today. The original fee for membership was \$1.00. Today the fee is \$40.00 for a two year membership. Each region is responsible for maintaining a Hospital Representative in every hospital within the region. This position is

vital to the preservation and longevity of BCORNG for communicating and exchanging ideas to the membership.

During its first two years the Executive and founding members formed the regions, developed the Constitution and Bylaws and presented the first conference in 1968, at St. Paul's Hospital Auditorium with over 400 delegated and 26 exhibitors.

The majority of the biennial conferences were held at the Hotel Vancouver. By 1976 BCORNG hosted the first Western National. Since then there have been Nationals hosted in '88 and '95 at the Vancouver Trade and Convention Centre. The World OR Nurses Conference was hosted here in 1991. The first Biennial Conference hosted outside Vancouver was successfully conducted by the Kamloops - Okanagan Region in Vernon in 1994, followed by Victoria in 1996. Fraser Valley Regional will host the conference at Harrison in 1998.

Bursaries for educational purposes are available through the Finance Committee, a program which has been in existence since the early 1970s.

BCORNG's communication link with its members is a newsletter, *News & Views*.

In 1973 a "Resource and Information Committee" was formed to answer all the requests for information. The '82-84 executive incorporated this membership service into the Education Committee.

What a long way BCORNG has come from the meagre beginnings of 75 members and a treasury of \$39.20 in 1966.

With these past performances as an indication of the members collective ability to succeed, who would question that BCORNG will not take up new and broader challenges as we enter the 21st century.

Report submitted by Gloria Stephens

BCORNG Executive - 1996-98

President - Faye Meuser.
 President-Elect - Sandra Grimwood.
 Recording Secretary - Rob Richardson.
 Corresponding Secretary - Ann Mazuruk.
 Treasurer - Lynn Magnuson.



BCORNG Past Executives & Founding Members celebrate 30th anniversary in Victoria, March 14 - 16, 1996. Front Row: L to R: Joan Flower, Faye Meuser Catherine Jensen, Gloria Stephens, Ellen Schrodtt, Margaret Bisal, Barbara Kubik, Joan Burnett, Kay Raisbeck, Jean Kerr, Mamie Simon, Shirley Hemerling, Sharon Dawe, Laura Foster and Margaret Mellan. **Back Row:** L to R: Rob Richardson, Joanne McMurdo, Loma Murphy, Lynda Magnuson, Gladys Jarvie, Sandy Stewart, Sandra Grimwood, Karin Henderson, Candace Franke

Photo Right:
 Mrs. R. Robertson (Miss Blenkinsopp).....



BCORNG Celebrates 30th Anniversary

BCORNG Past Presidents and Founding Members: (L to R) Gloria Stephens (70-72), Laura Foster (76-78), Jean Kerr (74-76), Joan Burnett (68-70), Marg Mellan (82-84), and Ellen Schrodtt - 1st Vice President (66-68) and (72-74).

Below L: Joan Flower - BCORNG's **First President** - 1966 to 1968.
First Vice President - Ellen Schrodtt (R).



ORNAO '96 Keynote Address by Kathleen M. MacMillan

(continued from page 23).

Now some nurses say to me, "Do you think that nurses want that kind of responsibility?" and I say yes, if they are real nurses. Nurses have always been responsible and accountable. For those who do not want to be responsible for a broader, more autonomous practice, there is always the solution of weeding.

4. Social activism and advocacy.

Finally, we need to consider advocacy and social activism as a legitimate role for nurses. Clearly, the code of ethics of the CNA and the CNO standards of practice tell us that, if the system is not fostering professional practice and quality patient outcomes, we must act to change it.

This is a nursing responsibility, if we are to have a health care system that is responsive to the needs of the people which we serve. Unfortunately, nurses have been socialized to believe that professionalism is not compatible with social activism. This is patently untrue and has done a disservice to the profession and to our clients.

Who is the primary nursing customer? It is the client - not the employer, not the health care system and not the physician, although we must work collaboratively and productively within those frameworks.

If we truly believe in the determinants of health, we know that factors such as housing, nutrition, education, social support, freedom from violence and socioeconomic status contribute as much, and possibly more, to health than just the health care system. This is where nurses could play a significant role in promoting a parallel vision. Nothing is more powerful than a client and a nurse working together to achieve change.

We need to form partnerships with people so that they know what nurses actually do, so that our health care system is restructured in a manner that is most likely to deliver the quality, and cost-effectiveness, that we are all in search of. We must be accountable for this as much as for our clinical practice and we can make politicians accountable for delivering on their vision of the future.

All of the right messages are there. Restructuring of the health care system is long overdue. The messages are congruent with what nurses have been saying for some time. The ability to make the stated messages

reality rests at least partially with nurses.

Reforming the health care system is not just a matter of closing hospitals or of recreating community services. These are important but not sufficient changes.

We need a paradigm shift and that includes a shift in how we think about nursing practice and how we function within that system.

Truly professional nursing practice needs a paradigm shift in management, in education, in a focus on outcomes as well as on process, and a new sense of accountability and responsibility that is based on a clear duty to clients. We can only demand a high quality health care system if we are prepared to provide high quality nursing.

If we remember what we are here for, and if we make the provision of quality health care a priority, we will be preparing ourselves for the future and we will be providing the right advice to policy makers. After all, the presence of this much chaos and uncertainty must provide unique opportunities where traditional approaches have led to stagnation. Nursing must not let these opportunities pass them by. ■



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Shared Visions & Hallucinations Acquiring a Taste for Chaos

By Beverly Malone, RN, BSc, MSc, PhD

Why would anyone speak about shared visions, or more interestingly, about hallucinations. These are not things that we usually announce to the public. There is some retribution that can occur if you actually announce, "I am presently hallucinating". I am a Psychiatric Nurse, and I know where they take you when you make those kinds of announcements.

Today we are seeing a lot of need for vision. We know that changes are happening. We know that the next century is coming up, not just the next century, it is the next millennium. This is a major change, a major shift in health care, and not just in Canada and the U.S., health care is shifting globally. In nursing, we should not be overly amazed and overly confused in terms of the fact that change is occurring.

In my nursing history, I don't remember a time when change was not occurring. There has always been something phenomenally fast going on about the changes within health care, and especially within nursing, and we have not necessarily been in charge of the changes. When you are not in charge, when you are not shaping changes, you are frequently just caught up in them. One of the things nursing has developed is a great ability to deliver quality care in the middle of chaos. There is not a nurse I know who cannot manage that, and do that extremely well. We need to start thinking about acquiring a taste for the chaos. We really need to understand that we have been bending in the wind for a long time, we have seen those folks who refuse to bend and we have seen them break. We know that our task, as advocates for quality patient care, is to shape a system that is frequently disorganized, that is frequently led by troubled people, that is frequently just an interesting crazy place to be and that out of that we pull good care for our patients. I know that it is not just a matter of the care being easily pulled out, it takes some wit. It takes some ability. It takes some power to pull good care out

of a system that was not designed with patients in mind. In fact, a system that was not necessarily designed with nurses in mind.

Hospitals and health care systems just didn't care much about us. It takes power to shape it, massage it and get the best care out of it for your patients. I know you have been doing that, and I know that I have been doing that over the years. And so, I see this move to understand that we can really start managing change. We must get our sea legs and centre our balance so that we can make sure that we can manage the changes that are coming and the changes that are already here.

We can acquire a taste for something that is unusual. We can change. Acquiring a taste for chaos is acquiring a taste for change, and I want to encourage you to do just that.

One of the things that happens when we come to a magnificent conference like this, is that we have a mountain-top experience. We are with people who are energized, who have ideas, who are saying - "Look, there are things that can be managed in this profession, 'care' is one of them, and nurses do it better than anybody else. It is time that we started to stand and take control of those things we can take control of." You can get a real high on that - you're on the mountain top.

We all know that at the closing of a conference, the

Author

Dr. Beverly Malone is Dean of the School of Nursing at North Carolina Agriculture and Technical State University in Greensboro, North Carolina. Currently she is running for President of the American Nurses Association. This article is an abridged version of her Closing Address to the 4th Provincial Conference of the Operating Room Nurses Association of Ontario, May, 1996.

truth is you have to go back down into the valley to do the work. The question is, what shall you take with you from the mountain top. I don't suggest that you take everything that you heard and that you learned here, because it is a heavy load. The people down there may not be very welcoming, saying "Oh, we are so glad that you went to the mountain top, and that you brought down the message".

Instead, usually it is - "Where have you been. Do you realize what went on while you were gone"? We don't want to hear about your good time. You need to be here, let me tell you what happened, because you were not here". And that is just your family members, that is not even work!

Hallucinations

You probably have a vision about what could happen back in your hospital if only you could implement A,B,C, and D. If you could make that happen, things would be at least more manageable.

That is what I call an hallucination. Whatever your vision is, the truth of the matter is, if you cannot share it with others, it is nothing short of an hallucination. A vision that is not shareable is an hallucination. There are some nurses walking around, and who every now and then call themselves leaders, who are steadily hallucinating. They've got a vision, but they can't share it with anybody. They don't want to share it with anybody. They want it to be their vision. Sometimes in nursing we get very possessive about an idea, or about an image that we have in our minds, and yet, the beautiful thing about a vision is that it grows into reality only by sharing. You actually have to let your vision go and share it with others in order for it to be implemented.

How are you going to present your changes in your hospital? Are you just going to walk into your area of work and say, "Guess what guys, I've got this great idea", in the middle of everything? I don't think so. I think you might want to think, now how am I going to package this idea, this change that I have in mind - and who am I going to share it with first?

Get Support for Change

What kind of support do you have for your ideas? Could you get some support before you shared it with everybody? When I say support, I am talking about the three types of support that we always need. There is support from the bottom, that is the folks who work

with us and for us, and there is support from the top, that is usually administrative support. There is also support on our sides. You need at least two out of three of those types of support at all times, otherwise you drown.

Get two out of three forms of support at all times. If your group has been short staffed because you have not been there, you may not want to immediately present your vision of change. It may not be the time. If there has been a major crisis while you have been away, which tends to happen, you may not want to immediately bring in the idea of a change. You might want to look at where you present it. I have seen people present major ideas, major changes, in the middle of hallways.

Nurses do a lot of work in the middle of hallways and I have never understood how we thought we could actually get something done in the middle of a hallway. There are usually quite a few folks coming by, there is usually a lot of activity, and so folks can't really concentrate. We have enough trouble concentrating in a conference room, and a hallway seems to be quite a bit much to ask folks to actually focus on what you are talking about.

Why would you want to introduce change anyway? Be clear about why you want change. There should be a real concrete reason why you want change to occur, and who will be affected by the change is also a major issue. How? When? Why? Where? and Who?

In Nursing, we have a long history of others making decisions and never consulting us. Have you ever had a building erected, only to find out that whoever designed the nursing stations obviously was not a nurse. The people who are most affected, the people who use the change, should be included in the planning or the discussions.

You don't need to get everybody on board before the idea is opened to discussion. What you really need to be after is a critical mass. You want maybe a core of 5, 6, 7, whatever critical mass feels OK to you.

It takes power to make change. It takes power to deliver good nursing care. If you don't have any power, you are a detriment to your patients.

We need nurses who have power, and nurses have a lot of power, but we just don't acknowledge it. We don't admit it. It's as if we had it and we left it somewhere. We dropped it and we forgot where it was. Or, we think that the physicians are going to figure out that we need it and they are going to just walk up and say, "I know you have been wanting my power base for a long time, I came to just drop

it off for you".

That really is hallucinating, colleagues, if you think a doctor is going to walk up to you and offer you some power. We have got to make sure that there are other ways of getting power in order to manage change.

Five Types of Power - (1) Informational

The only reason you would want power to make changes, I believe, is that all roads lead to quality care. In the middle of all the chaos, our obligation is to make sure that our patients get good care and to do that, we have got to make sure that power is available, that we know how to use it, and that we use it with elegance.

There are five types of power and the first is called informational power. We have more information about patients than anybody else. We act as if we don't have any informational power and I have been wondering about this for a long time - why nurses don't share information with other nurses. Frequently, we take our information and we stuff it in our pockets and we take it home. I have been in nursing more than 20 years now, and I am pretty clear about what we do and how we do it. Not always why we do it, but I am pretty clear about what we do, and we don't share information with other nurses, even if it is about improving the quality of care. Let me give you some examples.

When I was an undergraduate student one of my sweet elderly patients said to me: "Honey, you are the best nurse I have ever had". I said, "Yes, ma'am". And she said, "when you leave, my care falls apart", and I said "Yes ma'am". Doesn't it make sense, that when Beverly Malone walks out of the institution, the care drops significantly. Now you say, but Bev, didn't you know better, didn't you know that the real proof of the pudding of good care is that it remains high whether you're there, or whether you're not.

I know 40 year old nurses who today feel the same way. "Girl, I am afraid to take a day off, the place falls apart when I am not there. You could walk by the institution, it is lower in the ground when I am not there". I would ask you to consider that as nurses, if we think like that, why would we share information with somebody like that? If I am doing such a great job why would I take that information and share it with other nurse, when I don't believe they are going to use it anyway.

Not sharing information is eating away at our informational power base. It keeps us from implementing changes. Nurses don't share information. We come up with great ideas, but we don't necessarily share them.

I used to be a Clinical Nurse Specialist, I was like a troubleshooter for the entire University Hospital. They thought I was brilliant. Whichever shift called me, I could go to another shift and find the answer. Somebody on another shift had already figured out a solution for the problem. They just hadn't shared it with anybody. So, I would just go to that other shift, ask "what do you think about this"? And they would give me the solution, and I would just take that information back to whoever had the problem and they would say, "wow, you are so brilliant"! I would say, yes of course - just take the credit. I would also add that one of the things you might want to do is start calling on the other shifts and talking to them about some of the problems they had worked on and solved.

So, that is informational power, I just want to bring it to your attention. I believe that there may be some informational misuse of power back home somewhere, and that if you are going to bring a change back down from the mountain, why not take an informational change back. Why not encourage some folks to speak to each other in relatively humane ways, you know, some bottom line basic ways of dealing with each other. Those are the kind of changes that we could initiate.

(2) Legitimate Power

The second type of power is called legitimate power. Legitimate power indicates that you didn't steal it from anybody, you didn't borrow it, nobody had to give it to you, you earned the power. Now we take our national boards to be licensed as registered nurses. In the States when I did mine, I took mine in a barn. It was the State Fair Grounds, and we knew the animals had been in there just the day before. It had that antiseptic smell to it, but we knew the cows and the pigs had just recently vacated the place. I remember, they kind of lined us up (we are very regimented in nursing) so it was like a sort of concentration camp at the time, and our monitors were like the Gestapo.

I remember that my colleagues who took the exam with me handled it in very different ways. One of my friends cried the entire time. They just put down boxes of Kleenex after boxes of Kleenex. She passed just fine. So if any of you have a tendency to cry, don't worry about it, you can get through anything, just get yourself lots of Kleenex. It shouldn't stop you from accomplishing anything.

Another of my friends said. "it's coming up, it's coming up"! And it did. It was on the floor. After that

she felt much better. She took the exam and passed.

Another of my friends did the southern thing, when in doubt, pass out. Can't you just imagine getting in a very stressful situation and just passing out. I think I am going to save that for a big one, maybe with my adolescents over something, they will not know what to do. When in doubt, pass out. That is what she did, and when they revived her, she took the exam and did just fine. So, whatever you had to do to get through it, when you were finished, you were empowered to provide care to patients. That is power!

Now, there are other types of legitimate power. Some of you are nurse managers and nursing administrators and there is power that comes with being in a position.

(3) Charismatic Power

The third type of power is called charisma. Doesn't that sound exciting? Charisma. It has a very romantic quality to it and many nurses think that you are either born with it or born without it, but that is not necessarily true. It is a learned behaviour. In the U.S. we package politicians all the time, we make them look as if they are awake and oriented. If we can do that with politicians, I know we can do it with nurses. I know we can have charisma, but we are not packaging each other well. We tend to exhibit and demonstrate the pain in nursing. I think nurses luxuriate in pain. We have a special relationship with it. We value it, instead of just looking for some of the joy. Showing the joy in what you do is really the best definition of charisma.

We sit down and process and organize and we plan everything. Rarely do we take into account the quality of the work life, the environment that we bring ourselves into every day. We need to do some problem solving about what kind of atmosphere, work atmosphere, we have. We can bring about these kinds of changes ourselves.

(4) The Power of Coercion

The fourth type of power is coercion. It has a Mafia sound to it, doesn't it? Well, let me tell you, I have four adolescents. I have tried informational power with my children. I have read to them from books about how they should treat their mother. It has no effect. None. I have tried legitimate power with them. I have reminded them, I was there when you came out, and they say, "well mom, you should feel real special to have been at such a blessed event". I have tried

charisma with my children, "I'm Bev, I'm your mom, let's rap", they said "mom, you're awful old to be acting like that". Coercion. Two alternatives, one being more attractive than the other. I have told my young people - "You know, those people out there, those folks out there, they are your friends. They will be old and grey by the time you see them again unless you do your homework". I get movement. Not great movement, but movement.

I bring to you coercion as something that works with adolescents. I think that it could be a recommendation that applies to any problem that you have in the world. Coercion, two alternatives, one being more attractive than the other. So, colleagues, I bring to you coercion as a type of power, to make changes happen. I hope you give it some consideration.

(5) Extended or Referential Power

The fifth and final type of power is called Extended power, or Referential power. It is the kind of networking workshops we have been going to. It is about the fact that in the United States, there are 2.2 million nurses, and we act as if there are three of us, and we can't decide on anything together. It is the fact that if we would understand the power of one another, we would understand that together we can make a lot of things happen. That is extended power in nursing. So I bring those five types for your awareness and for your use.

Now, I want to give you my own personal definition of power, and to do that, I have got to come down off this platform.

This is a demonstration, colleagues. This is my own personal definition of power. The definitions that I gave you about the five types, they are in the literature. You can find them anywhere. This definition, though, is a unique one, it is Bev Malone's definition of power. So you have to watch.

This is a chair, for those of you who cannot identify it. Power is moving an object from point A to point B. It is not abstract, it is not theoretical mishmash that we can't understand, it is simply moving a chair from point A to point B. There are days when the most powerful thing we can do is move our body from the bed to work.

Let me move it to another level. Moving someone's mind from point A to point B is called education. We know that is powerful. Moving our own minds from point A to point B is a miracle, because we have to be convinced that our minds need to be changed.

That is power, moving an object from point A to point B. Simple.

There is a second level of power that I want to bring up right now. Could I have a volunteer from the audience please. This is Betty Gaudet, colleagues, and she has offered her assistance to me, and I appreciate it. Thank you very much Betty. Would you move that chair from point B back to point A for me? Would you give Betty a round of applause?. Did you notice how hard I worked? Did the chair get moved? So a power transaction occurred.

Does nursing have a problem with that kind of power? Oh yes. There are some nurses who believe, if they don't put their hands on the chair, the chair has not been moved. That is what wears us out in this profession. Too many times we have to do it ourselves, it has to be done just the right way. Did you hear what Betty said? She said, "I hope I do this right". There are so many times that we get caught up in doing it the right way, because in nursing, the right way, is - guess what - my way. The perfect way is my way in nursing because that is what we do. We hold other colleagues of ours accountable for doing it our way.

Now, I have to admit that there were some things I had to do to get Betty to help me. Did anybody notice that? What did I have to do? Ask. Does nursing have a problem with that? Oh you better believe it. Nurses say, I shouldn't have to ask you to help me, you should look at me and know that I need some assistance. If you have any kind of assessment skills at all, you should be able to just look at me, and Betty, you should have just got up and come up here and moved that chair. I shouldn't have to open my mouth to ask for assistance.

Do you realize how pathologically frightening that is? That is called paranoid schizophrenic behaviour. We expect our colleagues to look at us and know what we need.

Now colleagues. Let's be realistic here. We talked about hallucinating earlier - we are still hallucinating. We need to start to learn, in this profession, how to ask other people for what we need. We need to open our mouths and say, "This is what I need from you, I need some assistance". I recommend that highly. If there is a change you want to take from the mountain top back home - take that one. It is a wonderful way to make some changes.

Now the other thing that I had to do with Betty, and you helped me, was give her some applause. Also, I actually had to step back, and Betty stepped forward. In Nursing, we have some problems with that. Once

we step forward in nursing, we have no idea how to step back. If we want others to work with us, to assist us, colleagues, we are going to have to learn how to step back and allow others to step forward and to get the applause. Did Betty move the chair exactly from point A to B? No, she was off the mark. Yeah. Betty you were off the mark. If I were in my true nursing mode Betty, I would tell you, don't you ever move another chair for me in your life. When Bev Malone moved that chair, I heard music, there was rhythm to the way Bev moved that chair. You had no rhythm, Betty, none at all!

That is what we do with people. When they help us and they assist us and they don't do it exactly our way, we tell them, don't ever do it again. And then we forget we told them and wonder why no one ever gives us any assistance. Well, you told them, and they remembered.

You have to let go of that kind of thinking colleagues. It will wipe us out. It will power us out. That is why many of us think we can't miss a day at work, we have to be there with our hands on the chair.

Asking for Assistance

We have got to let go. We have got to get into the second level of power and allow others to assist us. We have to open our mouths and ask for the assistance. We need the assistance and we need the help in this Nursing Profession.

I know that this Conference Planning Committee was not able to do it alone in a solitary fashion, they had to get assistance, one from the other, and guess what, they had to ask each other. Anything we do, colleagues, we are going to have to learn how to work together in a different way. So much of nursing education is built on solo, independent behaviour. It creates a false illusion for the student. They think that nursing is about me and my patients.

It has never been about me and my patients. There has always been a bigger system out there. There has always been a system that had to be negotiated and other players that had to be brought in. We have got to start looking at our basic nursing education and start teaching nurses how to value working with other people, allowing others to assist them, not always having to do it themselves.

Nursing has an interesting way of doing work. There is a natural rhythm to working and resting. Work and Rest. Work and Rest. And Work and Rest. Holistic, you can hear the balance in there. Nursing is

work and work and work. Exhaustion. Work and work and work. Exhaustion. Work and work, pneumonia. Now, we can stay home. Unless it is walking pneumonia, and then of course, we have to keep going.

We have got to understand that we have to take better care of this unique person called a nurse. There are ways in which we can do it. Allowing others to help us move the chair is a powerful way to provide room and space for yourself to breathe.

The first level of power is for you to move the chair yourself. No doubt about it, that is one way to get things done, and you have done it before. The second level of power, actually asking for some assistance, and getting another person to move the chair, is a higher level of power. The third level - there is a third level. Betty, if I can convince you to move the chair from A to B on a 24 hour basis, I can get on a plane and fly home, and I can run any institution in the country. Because, that is what we do in institutions. In health care institutions especially, we move patients from point A to point B on a 24 hour basis.

Many of you have spent a lot of time doing that. But we have got to get others to assist us, and we have to learn how to walk away from it and it will continue at a higher level of care, whether we are there, or whether we are not.

So that is my definition of power. Thank you Betty. Could we have another round of applause for Betty.

So, those are the five types of power. I gave them to you, and then I gave you my own personal definition of power. Another part of it has to do with what keeps us from using the power bases that we have, in terms of working with our clients, and with other nurses.

Managing Stressors

The thing that tends to stop us from using our power bases to manage change, to initiate change, I believe has to do with stress. S-T-R-E-S-S. We have no idea of how to exactly manage our stress. I gave you a hint when I gave you the example of work and rest and I have to say to you personally, that at one period of my life, where I was a Nursing Administrator, I had walking pneumonia three years in a row, so I speak from where I live. I know that we wipe ourselves out at times. I am suggesting to you, that if you are on that road, one of the changes you could take back down from the mountain, is how to manage yourself in a more effective way. That would have a lot to do with managing the chaos that sometimes you feel. I believe a lot of it is self-induced, that we are already messed

up and confused and disorganized because of our own stress, because of our own inability to manage ourselves. Then, whatever external stresses come, it just creates even more confusion.

If we could start taking better care of ourselves, I believe we would have a better shot at managing chaos and perhaps even acquiring a taste for it.

Inevitable Stress

Let me give you some of the stressors. There are three types I want to bring to your attention. The first type is called inevitable stress. Anybody got any ideas about inevitable stresses? Cutback are an example of inevitable stresses. There are choices we can make about allowing that to stress us. There are stresses that we really don't have a lot of choices about - Death, Aging and Sickness.

If you live long enough, you will get sick. If you never had a sick day in your life, you died first. If you live long enough, you will get sick. We have problems with that as healers. We are all healers in nursing. So we try to keep death and illness away from us to a strong degree, but I suggest to you that those are issues that we struggle with in nursing, as human beings, we struggle with it. Aging - anybody notice that one as a stressor? Oh yes, the cosmetic companies have noticed it as a stressor too, and they have turned it into an opportunity. They make quite a bit of money on all of us in terms of aging. Those are inevitable stresses. If you stay young, then you died early.

Imposed Stress

The second type of stress is called imposed. That means someone had the audacity to give it to you. People actually give you stress... and you accept it. They cannot give it to you unless you accept it. So there are those of us who have our hands extended, waiting for our shipload of stress. Some of you don't even realize it, but in your marriage vows, oh yeah, "and you will accept all the stress that I bring into this relationship" and you said, "I do". You didn't even notice this, that those who love you can give you stress the best. Have you noticed the correlation? Those who are closest to you have the best access to impose their stress on you.

There are ways to not accept it. Let me give you an example. When you get a shipload of stress and you look at it and you say, "but it doesn't even look like mine", "it doesn't smell like mine either", just rewrap

it, put it in a nice box, and ship it back - it was shipped to the wrong address. Return to sender.

I had a friend who said, "when they send stress my way, Bev, I keep my hands to my sides, to make sure I am not in a position to accept it, and I just move over to the side, and it moves right by me. I just let it drop wherever it falls. I don't accept it".

Those are nice, clear, behavioural strategies - to give back the stress to those who impose it on you.

One of the profile characteristics of a nurse is, we love to be liked. Oh we are pleasers from way back. But we shouldn't get it mixed up by allowing people to dump on us.

Chosen Stress

There is a third type of stressor. This one is very interesting, it is called chosen stress. Not only do people give you their stress, not only are there some inevitable stresses out there, you then have the nerve to go out there and choose your stress. Frequently we forget that we made those choices. Some of us act as if somebody walked into our house, tied up our hands, tied our feet together, and rolled us out to the nearest School of Nursing and said, you will become a nurse.

We forget the choices that we have made. We choose where we work, colleagues, we really do choose. I am suggesting that you start relooking at some of the things that feel as if you have no choice, and take ownership of the fact that you are choosing to be in a certain place, period and time.

I have had some folks say, "well, I am going to go home, and I am going to tell those people where I work, that I choose not to be here". I said, well, there are some variables you might want to take into consideration, like how you are going to pay your rent or mortgage, put food on the table - some basics. So, if you don't want to be there, I suggest a planning process before you immediately make this announcement. It is called survival.

I am not in any way suggesting that you can immediately make different choices. I am saying that when you understand that you made a choice, you then have the power to say, there are other choices that I can make. And then you go into that Why, When, How, Where, that I gave you earlier about making a change. You go into that model. It is a very reasonable way to look at making a change.

So those are the three stresses. Now what can nursing do about stress vacation. I recommend you

vacate the mind. I am talking about vegetating, without being hooked up to a respirator. We have got to learn how to really vacate. Now some people say it is mountains, other people say it is oceans that relieve the stress. I have heard the rumour that a five star hotel with full room service can give you the same glow.

Nursing takes a lot out of you. Haven't you noticed? Make sure that you provide the healing. As you start thinking about vacations, make it real. Make it count. Don't wait for someone else to figure it out. Structure your own healing. Structure those things that feel good for you. That's a change to take from the mountain top. Do something good for yourself. That is a powerful move all by itself.

Conclusion

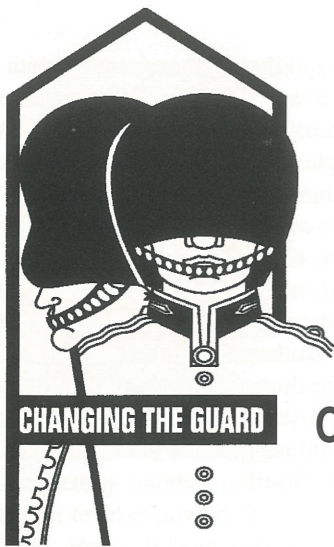
I hope I have given you enough clear, specific ideas of what you can do to manage change. Some things you can do for yourself. Some things you can do for the group of people that you work with.

Managing yourself is so important. Make sure you treat yourself well. Find ways to give yourself some breathing time. Some rest time in between that crazy place called work and that equally crazy place called home. Find ways to, I know, buy yourself some bedroom door locks - and use them. And tell those wonderful family members that you don't want to be interrupted for 45 minutes after you get off, unless they are dying and they have documentation.

We have got to make sure that we treat ourselves very well because my belief is that if we can treat ourselves better colleagues, we can then treat other nurses better. Oh, I know, I think the reason that we are so hostile at times with one another is that we are not treating ourselves very well at all, and that when we do treat ourselves very well, there is more energy to give to our patients, to give to our colleagues. I know there is nothing more important than the delivery of quality care. I also know you have got to have the energy and the power base to do it.

Change can be managed. Hallucinations can even be enjoyed. I see nothing wrong with a good hallucination every now and then, just don't have others around to diagnose it.

All of this can be managed if you are good to yourself in the process and so what I hope you take down from this particular mountain-top, is permission and support, to be absolutely, positively, good to yourself. From one nurse to another. ■



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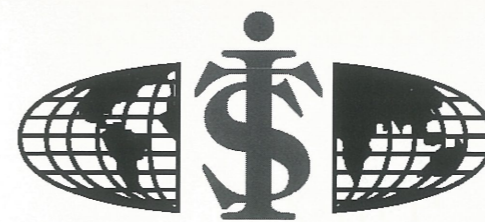
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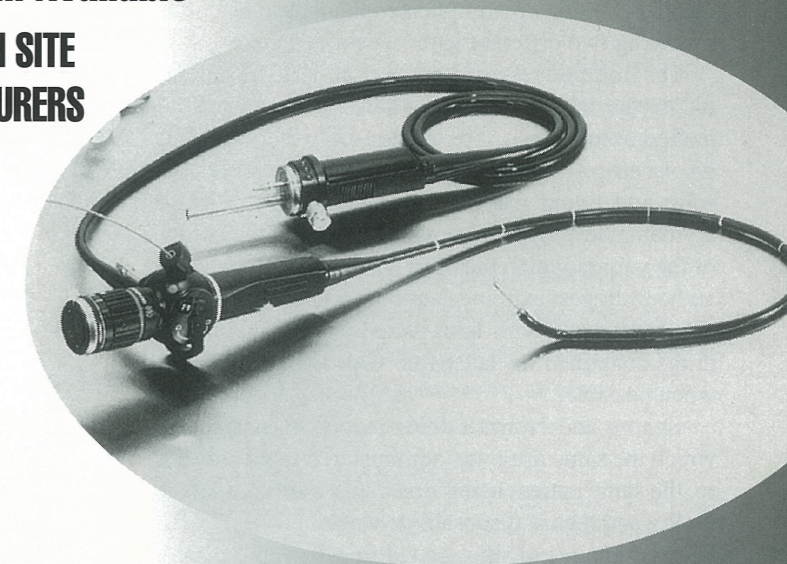
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Latex Allergy Update

Mary Knight Kubasiewicz, RN, MN, CPN(C)

Latex Allergy protocols have been developed and implemented in most operating rooms, and extensive product lists have been checked for latex content to ensure the delivery of safe patient care. While updating a latex allergy protocol, information was discovered which has implications for the way we deliver care for these patients. Reports in the literature document two recent cases in which the latex plunger in a plastic disposable syringe and the rubber stopper of a medication vial were implicated in allergic reactions involving two different latex-sensitive patients.

The first case report (Vasallo et al, 1995) discusses the events which occurred when a patient received methylprednisolone, preparation of which requires displacement of the rubber stopper separating the solid and liquid parts of the medication. Marked erythema developed within minutes along the course of the vein in which the drug was administered. The authors suggest extreme caution when using medication from vials with latex-based stoppers, and that drugs contained in latex-free vials should be used when possible.

Kearns and Norris (1996) report an instance in which the same drug was administered intravenously to the same patient using first a glass syringe in the O. R., and then a disposable syringe in the P.A.C.U. Within minutes of the second injection, the patient developed an urticarial rash on the forearm proximal to the injection site. The authors concluded that as the drug had already been given uneventfully through the same injection site, the latex syringe plunger was implicated as the source of the allergen.

Recommendations for Practice

The above case reports suggest it is prudent to avoid the possibility of such reactions, especially as the allergic response is triggered by a water-soluble protein that occurs naturally in latex (Young et al, 1992).

Many institutions have already incorporated the use of glass syringes and recommended the avoidance

of puncturing rubber stoppers in medication vials in their latex protocols. Additional precautions which should be taken for latex sensitive patients are:

1. Whenever possible, *minimize* the use of drugs which have rubber stoppers. Pharmacy can identify alternate products, and a small supply of some of the more common medications can be kept with the latex-free supplies.

2. Use only non-latex disposable syringes in the care of latex-sensitive patients. While glass syringes are one option, they are not easy to use for intramuscular injections. In addition, the recommendation that regular syringes can be used *provided the contents of the syringe are injected immediately* poses problems in unit-dose facilities and also when used with syringe pumps, e.g. patient-controlled analgesia pumps. The use of non-latex disposable syringes eliminates these issues. These syringes are readily available on the market, and may already be carried by your local supplier.

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The author wishes to acknowledge Carol Neil, Operating Room Instructor, Foothills Hospital, Calgary, Alberta, for sharing information.

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