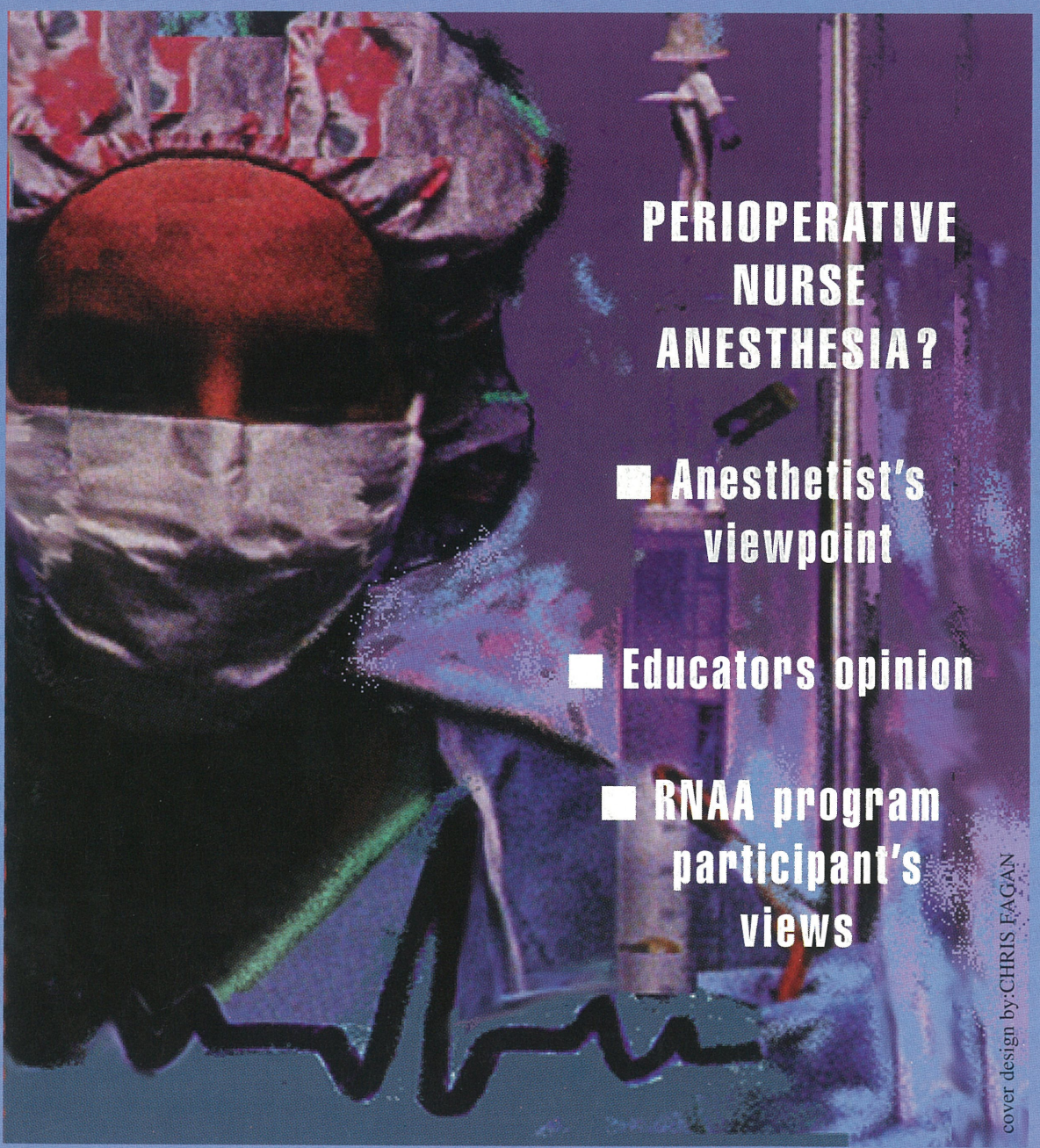


# Canadian **Operating Room** *Nursing Journal*

Volume 12, No. 2, May/June, 1994



## **PERIOPERATIVE NURSE ANESTHESIA?**

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## Is The Nurse Still Needed In Anesthesia?

By Dr. Ian White

The health care industry is experiencing extremely unsettled times and all health care professionals are profoundly affected. Health care is responsible for approximately 33% of most provincial budgets and expenditures and represents approximately 9.6% of the Gross Domestic Product (GDP). Health care costs have continued to increase two to four percent above the increase in GDP despite the "cut backs" instituted by governments over the past several years. If governments are to reduce the deficit, without increasing revenues from taxes, they are obliged to reduce overall expenditures and health care, then, will be a prime target.

In the face of these pressures, the health care environment has become increasingly complex and difficult. Over the last two to three decades there has been a move away from the bedside by most physicians, reducing their direct contact with the patient. This has been caused by the increase in the medical knowledge base and the increased use of technology with less opportunity for physicians to have direct contact. Therefore, physicians have transferred increasing responsibility to 'Health Science Professionals.(HSP)

At the same time there has been increasing specialization by both MD's and HSP's. These pressures have resulted in a shift in the interface between the HSP's and MD's in the patient care continuum. This extends to both the diagnostic and therapeutic areas of patient care, and these changes have occurred by both active and passive processes.

### Present Scope of Practice

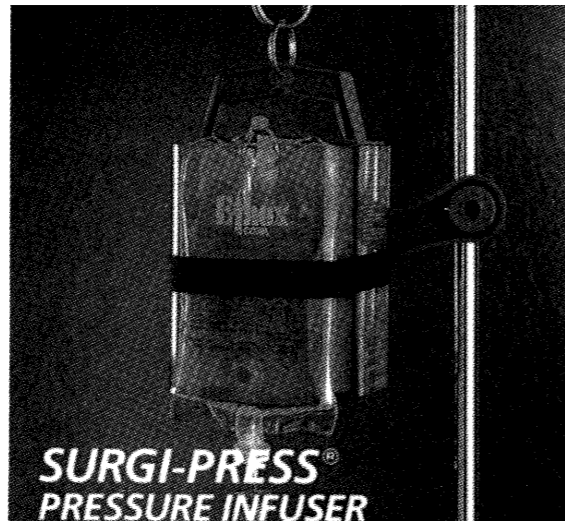
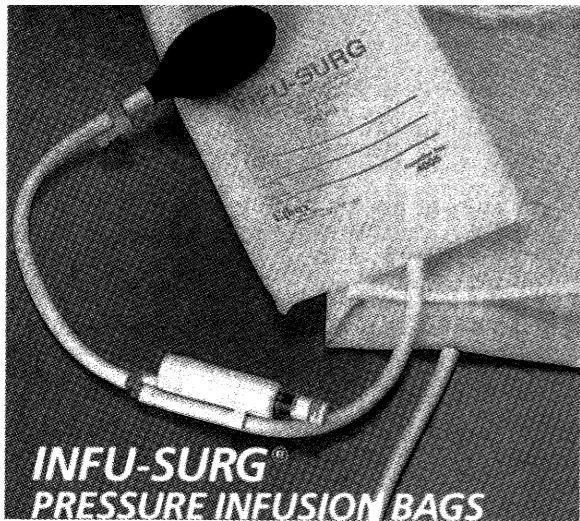
Nursing is associated with Anesthesia in many different ways. There are also many different regional and hospital variations in this interface which make generalizations difficult. However, the conventional interface between nursing and the physician has been restricted to a nursing preoperative assessment, assisting the anesthetist with induction of anesthesia and during the intra-operative phase, in 'crisis' management, accompanying the patient to the recovery room and in monitoring the patient during the recovery process prior to discharge to the ward.

### Future Practice and Pressures

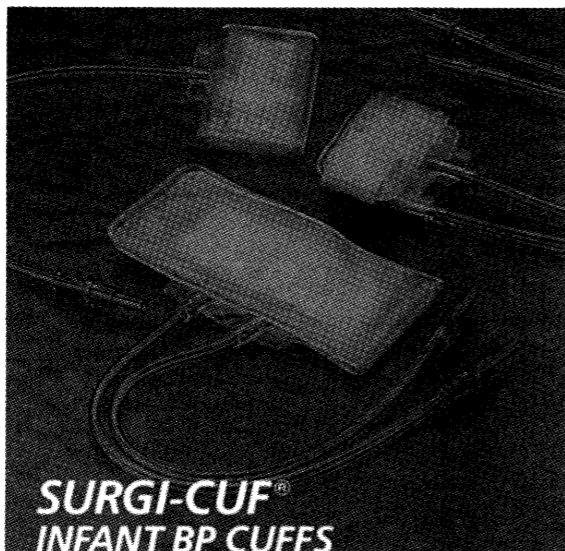
The pressures exerted by government are to reduce health care expenditures by reducing overall expenditures, de-institutionalize health care by moving health care to the community, and move spending from illness care to wellness care. In the face of these

### Author

Dr. Ian White, M.D., FRCP(C), is an executive member of the Canadian Anesthetists' Society and a staff Anesthetist at St. Boniface General Hospital, Winnipeg, Manitoba. This is a synopsis of Dr. White's views as presented during ORNAC's 13th National Conference, June, 1993 in Québec City. See also the views of Nurse Clinician Gloria Stephens and Jack Kress, R.N., Nurse Clinician, other panel members.



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pressures we have an increasingly complex technological environment, and an increased need to maintain and improve standards and quality of care within this reduced funding envelop. It is unlikely that the caseload volume will change significantly. We will have to do more with less. Not only do more, but do better!

How can anesthesia respond to these pressures and how do the health science professions fit into the picture? Anesthesia has to move out of the safety of the operating room and deliver care in the community. They must strive to reduce the time spent by patients in hospital by reducing the effects of anesthesia in the post-op period, by reducing nausea and vomiting, by reducing post-operative myalgias, and in particular, reducing post-op pain. In addition, the anesthetist has to better assess patient suitability for surgery and for resource allocation, (i.e. does the patient need to be admitted, will they need special care) they also have to ensure that patients have received optimal care and have not experienced untoward complications from anesthesia and surgery (quality care, quality management). Do health science professions have a place in this changing patient care environment? Absolutely!

**What lessons can we learn from other Health Science Professions ?**

**Neonatology**

Over the years the medical profession has had difficulty recruiting appropriate physicians to work in neonatal intensive care units around the clock. This was identified by the Canadian Society of Respiratory Therapists(CSRT) four to five years ago. An advanced diploma program has been created for health science professions with the transfer of delegated acts such as chest tubes and arterial catheterization. This dual entry model (nursing and respiratory therapy) is in its infancy, but appears very successful. It has built on the skills of both professional groups adding to those skills not present and enhancing those already in place to improve the quality of patient care.

**Clinical Perfusion**

This group of health science professions was developed in the late 1970's. Initially certification was obtained through the American College of Clinical Perfusion who set the standards, accredited the programs and administered the final examinations. Entry into this profession was from respiratory therapy,

representing 75%; nursing, representing 20% and about 5% from other HSPs. Again the programs built on the skills of both groups, supplementing where appropriate.

The Canadian Perfusionists identified in the late 1980's that they would have to set up their own society to oversee the functions of accreditation standards and certification in the national context. This group was unwilling to have one of several organizations (nursing or respiratory therapy) oversee this process and therefore an independent "Society" has been created. There are, however, only two programs in the country and only 150 perfusionists. This makes independent assessment, national certification etc., very difficult and very expensive. Probably not sustainable in the long term.

**Midwives**

I will probably get into big trouble for discussing this group of health science professionals, but I will because I think there are lessons we (as a medical profession working with health science professions) can learn. This group is midwifery, in particular, as it is being developed in Ontario.

In the 1970's there were many attempts by the nursing profession and others to dialogue with the medical profession in respect to midwifery. The medical profession essentially said "No". We don't need to. We can do it all ourselves thank you very much and walked away. The desires of health science professions were still there and became more intense. Through the late 1980's the medical profession became less interested in obstetrics, family physicians stopped doing obstetrics and an increased number of female physicians entered the professions with different expectations. At the same time the "midwife" became more active, gained public support and as a part of the reform of Regulated Health Care Act, 1991, became an independent College of Midwives with an independent scope of practice that includes both home and hospital patient care. I won't discuss the pro's and con's of this, suffice to say I have worked with Midwives extensively in the past. I probably learned more obstetrics from midwives than anyone else, but I regard what has happened in Ontario as a failure. The medical profession has lost, the nursing profession has lost, the government has lost, costs will increase, and the patient has lost. Increased home deliveries can only increase the neonatal mortality rate. Canada has the lowest rate in the world.

This experience identifies two messages:

1. All the health professions and government need to work together
2. We don't need to create new professions, we need to build on what we have.
3. We need to concentrate on team work and patient central care.

#### Where does this leave us for the future?

1. We have a group of highly motivated, well trained health science professionals (nursing and respiratory therapists) that are committed to assisting anesthetists in their professional activities.
2. The Canadian Anesthetists Society has described the duties of the "Anesthesia Technician" which concentrates on O.R. activities.
3. There are extensive changes in health care underway, particularly in institutional care and they are directed to reducing human resources. Therefore, we must do more with less.
4. The care of all patients will move from the hospital to the community. Anesthesia care will be no different. There will be an increased need for outpatient assessment of patients and follow up of patients. This will require appropriately trained health science professionals.
5. Technology and the aging population will place increased demands on anesthesia services for appropriate maintenance of equipment (in house where possible to contain costs).

#### How can we meet these demands ?

Clearly the anesthetists requires assistance in the performance of his/her duties. The extent of those duties are expanding, pre-anesthetic clinics, consultation clinics, pain clinics (acute and chronic), post anesthesia recovery and follow up, equipment maintenance and in university centres, research. Certainly a broad area of responsibility in addition to the conventional wisdom of assisting the anesthetists in the O.R. with preparation, induction, maintenance, recovery and transfer to PARR. Can all these duties be met within the current resource pool?

Yes! We don't need to create a new specialty group. We have the basic skills in both the nursing and respiratory therapy professions. We can build on those basic skills to meet the broad needs of patient care and the anesthesia profession.

The reasons that this project has not moved ahead is the "fear" of the product, i.e. nurse anesthetists. By

that I mean independent, non-physician practitioners providing unsupervised anesthesia delivery, similar to the CRNA in the U.S.A.

This model is seen as a threat by all of the professional groups, but governments, e.g. Manitoba, sees this model as a way of delivering care in remote areas, as an alternative in an area where physician recruitment is difficult and at reduced costs.

I, and almost all other anesthetists, together with those senior nursing and respiratory therapists do not support this thrust. However, until this 'fear' is dealt with nothing will move ahead in the area of post diploma anesthesia assistants.

#### What can we all do?

- (1) Work together

The professions of nursing, respiratory therapy and anesthesia need to clearly identify the need for an anesthesia assistants with a dual entry model.

- (2) Develop curricula and examinations that will build on skills already obtained by respective professions.

These skills would be obtained where possible, while remaining in the workforce.

- (3) Clearly defined roles need to be identified.

- (4) Lay to rest the threat of the nurse anesthetist. ■



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# The RNAA Program Enhances the OR Team

By Jack Kress, R.N.

Working in the operating room (OR) requires the expertise of numerous specialties involved in perioperative patient care. This is especially true for a tertiary care hospital which provides a broad spectrum of patient care services. As reflected in the St. Boniface General Hospital (SBGH) mission statement, the goal of the hospital is to promote excellence and high quality patient care.

The complex and demanding practice of anesthesia is further influenced by a number of factors such as; a technological explosion; increased patient acuity; expanding ambulatory surgery; and greater patient expectations of convenient quality care in the face of fiscal restraint and health care reform. These factors have accentuated the need for more education and alternative methods of implementing perioperative patient care.

At the present time in Canada, anesthetists rely on OR nurses and/or Respiratory Technicians for additional support with patient care. A number of issues regarding anesthesia support in perioperative patient care need to be addressed. They include: the importance of dedicated assistance in the OR; the lack of specific educational programs in the field of anesthesia for the present assistants; enhanced perioperative patient care to include more of the pre and post operative phases; and, the need to bridge the communication gap between anesthesia and nursing.

The advanced knowledge and skills that the OR nurses require have not been taught in the basic nursing programs. Traditionally, OR nurses have acquired their skills and expanded their knowledge through

continuing education programs and self directed learning. OR nurses must enhance their knowledge and skills in order to effectively assist the anaesthetist. Areas of study should include the induction and maintenance of anesthesia, as well as physiology, monitoring techniques and technology.

Basic nursing education provides the knowledge of biological, physical and psychological sciences with nursing theory as the basis for assessment, diagnosis, planning, intervention and evaluation in the promotion and maintenance of health. It is these basic nursing strengths coupled with OR and/or critical care experience that provides a solid foundation for an expanded nursing role.

To explore the feasibility of this role, a one year pilot project was developed at SBGH. Following approval of the Department of Anesthesia and Nursing Division, the Registered Nurse Anesthesia Assistant (RNAA) program was initiated. This program was developed by Dr. R. Friesen, Associate Head, Department of Anesthesia, in collaboration with G. Boughen RN, BN, Assistant Director, OR Nursing.

#### Author

Jack Kress, R.N., Perioperative Nurse Clinician, has completed the Registered Nurse Anesthesia Assistant Program at St. Boniface General Hospital, Winnipeg, Manitoba. This article is a summary of his presentation in a panel discussion at ORNAC's 13th National Conference in Québec City last June. See also the articles by Anesthetist Dr. Ian White and Nurse Clinician and educator, Gloria Stephens.

## The RNAA Program

The purpose of the program was to augment the OR nursing expertise with specific anesthesia education so that the RNAA would be better able to assist the anesthetist in meeting the needs of the individual patient. The candidates were seconded from the OR nursing staff at SBGH. Desirable attributes which were sought in the program applicants included being familiar with the dynamics between anesthesia and nursing, as well as possessing specific expertise in OR nursing.

The objectives of the RNAA program were to acquire technical as well as clinical evaluation skills related to the provision of anaesthetic services. This was accomplished through a structured, one year training program, and through a variety of educational venues. Attendance at medical undergraduate cardio-respiratory clinical skills workshops; Nurse Clinician - CVT pathophysiology; attendance at anesthesia resident seminars and staff rounds; didactic lectures; and one-on-one staff anaesthetist preceptorships. The components totalled for 1,346 hours.

The didactic lectures consisted of thirty-one (31) topics all related to the provision of anesthetic services. Examples included: Advanced Physiology, Topics dealing with a cardiac patient for non-cardiac surgery, or diabetes and renal impairment implications for anesthesia. Assessment skills to identify a potential difficult airway, or Anesthetic considerations with pre-existing disease processes, such as Rheumatoid Arthritis. Technical skills, in establishing regional anesthesia, or utilization of equipment in a variety of airway management techniques. In Pharmacology, to become familiar with the action and interaction of the more common intravenous and inhalational anesthetic agents. In addition, we were made aware of the potential hazards and employed safety features used in dealing with electricity and compressed medical gases, as they pertain to workplace and patient safety. It was a concentrated labor-intensive venture to fulfil the objectives and goals of the program.

Evaluation of the candidates progress was by a written examination, formal research paper presentation and clinical skills evaluation.

## Outcome

The outcome, we believe, has been quite positive. The knowledge and experience acquired during this process has allowed the RNAA's role to expand be-

yond the OR suite. This expansion has facilitated a greater participation in the multidisciplinary approach to perioperative care. The RNAA's practice profile involves five major areas: (1) Medical/Nursing Rounds: attending anesthesia rounds twice weekly, and presenting at nursing rounds monthly; (2) Post-Operative follow-up, quality assurance and research utilize approximately fifteen percent (15%) of our practice. The remaining eighty-five (85%) is divided between the (3) preop assessment clinic, (4) clinical practice and (5) education. The RNAA within the intraoperative clinical practice, as a skilled and knowledgeable practitioner, will provide nursing care for the high risk or acutely ill patients and this skill will impact on patient care with decreased induction times and as a positive anesthesia/nursing liaison. Following the patient's intense and stressful induction of anesthesia, the RNAA is able to assist in other theatres as requested. This allows for maximum utilization of the role to provide assistance for more than a single slate of patients.

The RNAA has been instrumental in the development and implementation of a preoperative assessment clinic where the RNAA initiates preoperative assessments under the direction of a staff anesthetist. The clinic will provide, on an outpatient basis prior to surgery, the preoperative assessment, patient education and preparation normally done once surgical patients are admitted to the hospital. It is then possible to admit patients for surgery on a same day basis. The clinic's major focus is its mandate to reduce duplication and inappropriate laboratory testing, and reduce the hospital length of stay.

The need to broaden the educational background and skill level of OR nurses has been identified. Enhancing the knowledge base of the support staff will also strengthen the OR team. The RNAA will develop and implement educational opportunities dealing with anesthesia concerns. These include workshops for OR nurses; regular in-servicing of OR staff; anesthesia attendant training program; and informal information sharing during clinical practice.

In keeping with the educational direction of SBGH, the RNAA role has evolved to encompass that of a nurse clinician specializing in meeting the needs of patients undergoing anesthesia. The title 'Perioperative Nurse Clinician' was chosen to reflect the responsibility for providing clinical nursing care pre, intra and post operatively to surgical patients undergoing an anaesthetic procedure.

The new OR facility at SBGH has two additional

patient care areas. One is the Preoperative Holding Unit for preparation and supervision of surgical patients. The other is the induction rooms which will be used for anaesthetic patient preparation including insertion of invasive lines, establishment of regional blocks, as well as monitoring of patients. Plans for staffing and utilizing these areas are presently being developed with the RNAA role in mind.

By participating in the RNAA program, the Perioperative Nurse Clinician provides a strong positive link between the members of the Department of Anesthesia and perioperative nursing. This will enhance their ability to meet the clinical needs of the surgical patients.

## Summary

The need to expend the energy and resources on such an expanded nursing role as the RNAA has been identified. In the midst of health care reform and

fluctuating staffing levels, there is a need to capitalize on their assistance for patients requiring complex and high risk anaesthetics.

The RNAA has been an integral part in the preoperative assessment clinic which has streamlined patients assessments and enhanced resource utilization. The focus has been to maintain the present activity level and standards with fewer health care dollars.

In the future, through development and implementation of educational programs, OR nurses will become more aware of anesthesia related concerns and increase their proficiency for efficient and safe patient care. Also, strengthening the knowledge base of the support staff will enhance OR team work and trust.

We must continue to strive to create valuable new roles for nurses which will utilize their educational preparation and skills and provide quality client care in the most cost-effective manner. ■

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# Perioperative Nurse - Anesthesia

By Gloria Stephens

Over the last five years the Operating Room Nurses Association of Canada (ORNAC) has become increasingly concerned with the proliferation of roles within the surgical team previously filled by the operating room registered nurse. The quality of patient care is perceived at risk and the erosion of the operating room nurse's role, with subsequent reductions in nursing positions, is viewed with distress.

Perioperative nursing has distinct, interchangeable roles; scrub nurse and circulating nurse. The parameters of these roles are clearly defined in the published ORNAC Standards (1993), describing patient care preoperatively, intraoperatively and postoperatively.

Changes have been occurring rapidly in all sectors of the health care system in Canada, but most markedly in the specialty of surgery. The increased complexity of surgery, a proliferation of new techniques that can be performed in ambulatory care settings are perhaps the most profound changes. Health care dollars have been steadily declining in acute care and administrators are looking at saving money by employing a less expensive level of health care workers in the operating room.

Recently a College in one of our Canadian provinces attempted to establish a course for the Circulation Nurse, but ORNAC managed to stop such a development.

There is ambiguity amongst nurses, (other than OR nurses), administrators and even educators about the need for the RN in the operating room.

To become a registered nurse today the entrance to any program is University requirements, and to become a registered nurse (in most Provinces) the requirement for the year 2000 will be a degree.

Over the years there has been a gradual transfer of medical function and responsibilities from physician

to nurse, and the operating room nurse has been assisting the anesthetist in many ways for many years.

Therefore it is right and fitting that the educated, experienced nurse who is already prepared and experienced in providing routine and emergency care to the surgical patient throughout all the phases of care from preparation to immediate postoperative care, fulfills this vital role and function - the role of Perioperative Nurse - Anesthesia.

One of the oldest specialty nurses in North America is the OR nurse. ORNAC is in no way promoting the concept of nurse anesthetist, but it is strongly and enthusiastically promoting the advanced role of the Perioperative Nurse - Anesthesia.

Years ago when there wasn't such a "push" in the OR, the circulating nurse (CN) could get the set-up done, bring the patient in and then assist the anesthetist. This role was assumed by the CN and included some technical aspects, but it was primarily to provide nursing care and assist the anesthetist during the critical periods of induction and the reversal of the anesthesia.

The anesthetists are now requiring more technical expertise in their assistants and instead of seeking to increase the level of skill and knowledge of the OR nurse, other avenues are being considered. This re-

## Author

Gloria Stephens is Nurse Clinician, Operating Room, St. Paul's Hospital, Vancouver, B.C., and the Immediate Past-President of the Operating Room Nurses Association of Canada. This article is part of the panel presentation on the Advanced Nursing Role at ORNAC's 13th National Conference in Québec City.

moves the nurse from the traditional role, thus depriving the patient of much needed direct nursing care.

Another factor and a common concern is the ever present pressure of time and push to rush cases through the OR in order to increase the numbers of surgeries performed. Expediency rather than quality care often is the goal. Nurses are being forced to abandon the humanizing nursing activities which are often not perceived as necessary by physicians and administrators.

## OR Nurses must speak out and tell the world about their scope of practice

It is high time that we as caring nurses speak out. It is our responsibility to tell the world our scope of practice. There is such a lack of knowledge about what nurses do in the operating room. People who do not understand the role are easily persuaded that other levels of workers are as effective, often losing sight of the fact that nurses will still be required to do the job during shifts when these other individuals are not present. OR nurses are regularly called upon to help with cases, often complex emergency cases. A potentially unsafe and inefficient system could be introduced.

There is a problem for recruitment and retention of nurses throughout Canada. It is the thought that the perceived limited scope, within the clinical aspects of the position, could be a contributing factor.

The opportunity for the 'expert' nurse to expand roles and education to include the suggested advanced activities could provide a much needed opportunity for career laddering within the specialty of perioperative nursing.

This position could be that of an operating room nurse specialist. Such an expert and versatile nurse would be a member of the health care team and could provide not only technical expertise but an advanced level of nursing care for the surgical patient.

There is obviously a growing need for an assistant to the anesthetist because of the quantum leaps in equipment technology, new drugs, and monitoring devices which occur almost daily. The OR nurse may have a knowledge gap in the above mentioned areas, but with additional educational programs and meeting a pre-established entrance criteria, without much effort, could be the most appropriate person to fill the position of assistant to the anesthetist.

There are presently many formal OR nursing pro-

grams across the country which already have this advanced anesthesia technology included in their curriculum. One problem we face is that not all ORs in Canada have as a selection criteria that potential staff must be a graduate of a post basic program.

The knowledge, skills and judgement of the Perioperative Nurse-Anesthesia would be acquired through an educational program combining organized instruction and clinical practice.

The ORNAC Board has investigated this subject and debated regional views vigorously. Results of the recent National Survey included data to give the ORNAC Board a clear mandate to continue pursuing this concept.

The ORNAC Board endorsed the Research committee to actively continue to pursue this advanced role with all the various stake holders.

ORNAC's definition for the position of Perioperative Nursing Practice - Anesthesia:

"The operating room registered nurse practices advanced perioperative nursing in anesthesia. The increasing complexity of anesthesia compels a higher level of expertise than was previously required of the circulating nurse. The operating room nurse with advanced perioperative nursing education functions collaboratively with the anesthetist during the preoperative, intraoperative and postoperative phases relating to anesthesia".

What the OR nurse brings to the position is an education base with the following:

- University entrance;
- Broad base of knowledge from the sciences, nursing and the humanities;
- Many nurses are already graduates of a post basic OR program; and,
- Years of surgical experiences.

The registered nurse as assistant to the anesthetist practices advanced perioperative nursing. The advanced perioperative nurse functions during preparation for induction, maintenance, and reversal of anesthesia. This role may include the following:

- maintenance and assembly of anesthetic equipment;
- comprehensive assistance to the anesthetist;
- increased responsibility for patient monitoring; and,
- participation in quality assurance of anesthesia practice.

These duties would not be additional to the already busy shift of the circulating nurse but would be a designated position under the Nursing Department and in cooperation with the Anesthetic Department. Details of a job description require further study.

The ORNAC Standards (1993) provide an excellent background of the duties already performed by the circulating nurse in relation to anesthesia, for example:

**Standard #1** - "Perioperative nursing practice requires knowledge from nursing, the sciences and the humanities".

**Standard #3** - "Perioperative nursing practice requires nurses to be professionally responsible and accountable".

**Clinical Standard #4** - "The operating room nurse facilitates a safe, smooth induction for each surgical patient".

### \* Competency 2 : Provides Physical Patient Care The Circulating Nurse Role

The circulating nurse is competent to:

2.1 review, identify and assess the physical status of the surgical patient.

2.2 adjust the standard nursing care plan to meet the specific needs of the patient.

2.3 establish priorities of patient care specific to the needs of the patient and the surgical procedure.

2.4 provide resources necessary for the surgical team to function efficiently.

2.5 provide physical comfort measures specific to each surgical patient in relation to vital functions, warmth and positioning, using supportive equipment and/or devices.

2.6 remain with the patient and provide appropriate care during the admission, pre-induction and induction period.

2.7 provide continuous, astute observation of the surgical team throughout the operative phase while meeting their needs with minimal time delays.

2.8 monitor and evaluate the physical well-being of the patient throughout the perioperative period to prevent potential impairment or injury.

\*Recommended Standards for Nursing Practice, ORNAC, 1993.

2.9 re-evaluate the patient's physical status in the immediate postoperative period.

2.10 provide and assist with procedure/devices required to complete patient care following the surgical procedure.

2.11 assist in the physical patient transfer and postoperative positioning to prevent injury and facilitate the recovery.

2.12 observe for and respond appropriately to complications and unexpected events during the surgical procedure.

2.13 document any and all unusual incidents with appropriate follow up action.

### Scrub Role

The scrub nurse is competent to:

2.14 apply knowledge, skills and techniques of the procedural steps of the intended surgery.

2.15 set priorities and expedite an efficient sterile set up prepared for each specific surgery.

2.16 protect the patient from physical injury resulting from unsafe practice.

2.17 observe and provide appropriate response to complications and unexpected events during the surgical procedure.

2.18 perform count procedure with the circulating nurse and account for all items in the sterile field.

2.19 display knowledge of instrument(s) and equipment used for procedures.

2.20 act as the patient's advocate during surgery.

We have been saying that OR nursing is a career for persons desiring power, status, opportunities and job satisfaction. We also have said that we must feel proud of what we do - be an inspiration to others.

The social and economic changes that we face today presents us with challenges never before thought of. Success will only be guaranteed if and when we decide to innovate, create new ideas and systems and take new risks. We must look upon the advanced role in a positive way and not concentrate on the possible barriers. Yes, by all means consider every aspect and keep seeking out solutions. ■

# Yes, I Want to Walk to the OR

By Anne Porteous & Judi Tyndall

## Introduction

The health consumer of today is a changing dynamic force. Clients are becoming more involved with their health care. Clients choose to have surgery, and that choice makes the consumer an active participant

## Abstract

The health consumer of today is a more active participant in his or her health care. Although clients may require surgery, many of them do not consider themselves as being ill preoperatively. Health care professionals have a tendency to place the client in a dependent, ill role upon entering the health care facility. At this health care facility, clients are given the choice of either walking to the operating room, or going by stretcher. Studies found in the literature suggest that personal control is central to the reduction of clients' stress-related signs and symptoms. Nurses need to encourage client participation and assist the client to take control over those factors that are controllable. Utilizing King's (1981) conceptual framework, active client participation in mutual goal-setting, decision-making, and interactions to achieve the mutual goals in relation to health care is encouraged. All clients who attended the Preadmission Assessment Clinic were potential participants for this study. On the day of surgery, clients were asked by the nurse if they would prefer to walk to the operating room or go by stretcher. The majority of clients chose to walk to the operating room. The choice made by many of the clients is consistent with the findings in the literature stating that clients need a sense of control in what is often perceived as an uncontrollable environment.

in his or her health. Although clients may require surgery, the majority of them do not think of themselves as being ill preoperatively. Why should nurses ask these "well" clients to accept a "sick" role upon entering a health care facility?

The clinicians from the Operating Room (O.R.) and the Preadmission Assessment Clinic (P.A.C.) thought that giving clients the choice of walking the short distance to the operating room would promote client wellness. By having a choice, the client may perceive the surgical experience as less threatening and give more control to the client. Studies suggest that a sense of control is important in decreasing a client's stressful reactions to invasive medical procedures (Johnson, Fuller, Endress, & Rice, 1978; Padilla et al., 1981; Watkins, Weaver, & Odegaard, 1986). In order to determine a client's desire to walk to the O.R., a questionnaire was developed which is available from the authors on request.



Anne Porteous



Judi Tyndall

## Authors

Anne Porteous, R. N., B.Sc.N., M.S.N. (candidate), is Nurse Clinician, Preadmission Assessment Clinic; and Judi Tyndall, R. N., is Nurse Clinician, the Operating Room, both at the Hamilton Civic Hospitals/Henderson Division, Hamilton, Ontario.

## Literature Review

The level of control that a client has over his or her personal situation usually diminishes upon entering a hospital. Studies found in the literature suggest that personal control is central to the reduction of clients' stress-related signs and symptoms (Langer & Rodin, 1976; Gibson, 1991). Neither of these studies gave clients the option of walking to the operating room.

A literature search did not reveal any information and/or research studies regarding clients walking to the operating room. Using a qualitative methodology the authors wanted to discover the following: a) Did clients like being given the choice of walking to the operating room?, b) Was the client satisfied with the choice that he or she made preoperatively?, and, c) What reason(s) were given for the client's choice to either walk or go by stretcher?

According to Gibson (1991), there is a need for health care professionals to surrender some of their control and adapt to a more collaborative client-nurse relationship. The attitude that the nurse knows what is best for the client can only foster dependency. Nurses need to encourage client participation and assist the client to take control over those factors that are controllable.

## Theoretical Framework

Nursing practice at this health facility is provided within the framework of King's (1981) theory of goal attainment. Theory is useful in that it depicts events or aspects that are essential for understanding the client's world (Chinn & Jacobs, 1987). The focus of King's model (1981), is the nurse-client interaction within a systems approach. Active client participation in mutual goal-setting, decision-making, and interactions to achieve the mutual goals in relation to health care is encouraged (King, 1981).

King's model of nursing incorporates three dynamic interaction systems - personal, interpersonal, and social - which lead to development of a theory of goal attainment (King, 1981).

### Personal Systems

The personal system incorporates concepts such as perception, and self. King (1981) views clients as open systems, interacting and exchanging matter, energy, and information with the environment. 'Self' is an integral part of one's human experiences. Positive experiences tend to enhance the self; negative experiences may render the self in need of assistance.

King (1981) states that the health care environment

may threaten the client's self by eliminating control over decision-making. Surgical clients often experience a loss of control which may threaten the self. Clients do not live in vacuums. They are continually being bombarded by all sorts of internal and external stimuli. This combination of stimuli dramatically affects their response to the environment (Hames & Dayle, 1986).

Surgical intervention may be perceived by clients as a threat. Consequently, anxiety may reach levels that would be detrimental. Some studies suggest that high levels of anxiety correlate with poor physical recovery (Jamison, Parris, & Maxson, 1987). Nursing studies have indicated that the psychologically prepared client will have a better postsurgical recovery than those who are psychologically unprepared (Hartfield, Cason, & Cason, 1982).

The client may become overwhelmed with anxiety related to such factors as the perceived threat to life, the complexity of the disease and its methods of treatment and an unfamiliar environment. The inability to control events may initiate a sense of powerlessness. This loss of control may affect the client's ability to make short and long term adjustment to illness (Scott, 1983).

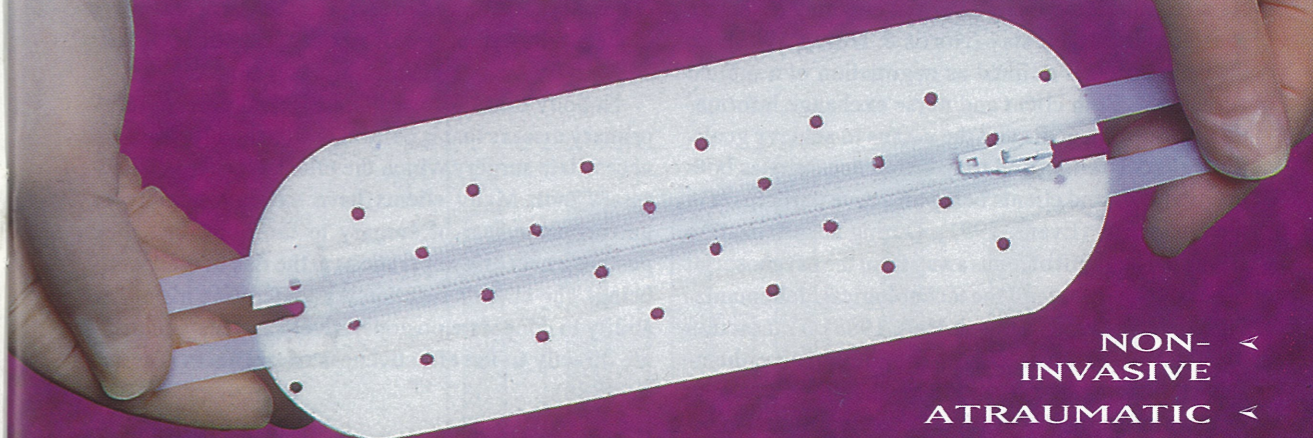
In order for a client to try to maintain the 'self', a sense of control is needed. However, the expertise and knowledge of health care professionals create inequities in power and control between professionals and clients. According to Gibson (1991), clients who perceive some degree of control viewed the surgical experience as positive, while those with limited control felt negative. Lack of control is a recurrent theme in clients' discussions of the surgical experience. Nurses and other health care professionals need to relinquish some of their control and empower their clients to make health care decisions (Gibson, 1991).

### Interpersonal Systems

The interpersonal system is understood by examining such concepts as communication, transaction, and role. Communication, whether verbal or nonverbal, should facilitate interaction between individuals in the environment. According to King (1981), an individual's perceptions and 'self' influence communication patterns and style. Communication occurs when the sender accurately conveys his or her message to the receiver, to achieve mutual understanding.

There is incongruence between the perceived rights and responsibilities of clients and health professionals in three major areas: control, roles, and communica-

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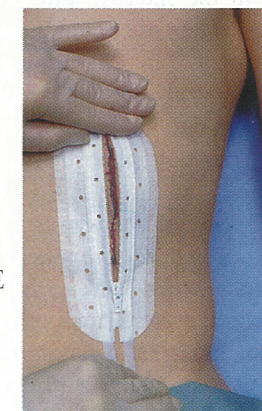
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tion. Professionals tend to assume control with minimal input from clients. There is also a tendency for health professionals to place the client in a 'sick' role. As a result clients feel powerless and may assume a passive role in their stay (Norris & Hoyer, 1993).

Transaction is defined as negotiation of a mutual agreement. Both client and nurse exchange information to agree on goals and the means to achieve goals. Mutual goal-setting and transaction necessitates both hospital staff and clients being an active participant in the interaction (Evans, 1991). During hospitalization there may be a shift of focus away from the psychosocial needs of clients toward the technological, dehumanizing aspects of care (Allen & Hall, 1988). Transaction does not occur when clients do not perceive themselves as having a responsibility in their care. The lack of transaction may be attributed to the hospital environment, stress, and the relinquishing of control to health professionals (Pinch & Spielman, 1990).

The goal of nursing "is to help individuals maintain their health so they can function in their roles" (King, 1981). Health implies continuous adaptation to stress "in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living" (King, 1981). The authors believe that giving a person a choice helps the person to maintain some control and contributes to health promotion rather than health dependency.

### Social Systems

The third component of King's (1981) conceptual framework is the social system. King (1981) defines social system "...as an organized boundary system of social roles, behaviors, and practices developed to maintain values and the mechanisms to regulate the practices and rules" (p.115). Nurses and clients as individuals belong to more than one social system. Each one is influenced by expectations emanating from their own family social system. They are both strongly influenced by their respective work environments.

Nurses are in a familiar work environment and familiar routine while functioning in the hospital environment. Hospitalization can be a frightening experience for clients. Nursing staff may increase the client's sense of helplessness by trying to do everything for him or her and by describing the hospital rules and regulations as if the client no longer had any right to make decisions about his or her own care.

Hospitalization is a threatening situation that may cause the client to feel as though he or she is at the

mercy of a vast impersonal institution. His or her physical being is placed in the care of others whom he or she may never have met before. The stresses the client faces are many and real, and the client may react to them with symptoms of anxiety (Lipkin & Cohen, 1992).

Nobody looks forward to a surgical procedure. A primary disease that is painful or life-threatening may necessitate surgery which the client accepts as a necessary evil. Many clients have extreme anxiety or unreasonable fear of surgery to the point that they postpone necessary operations at the risk of their well-being. The client's reaction will determine his or her ability to cooperate postoperatively and may contribute directly to the effectiveness of treatment (Sterns, E., 1988).

### Study Population

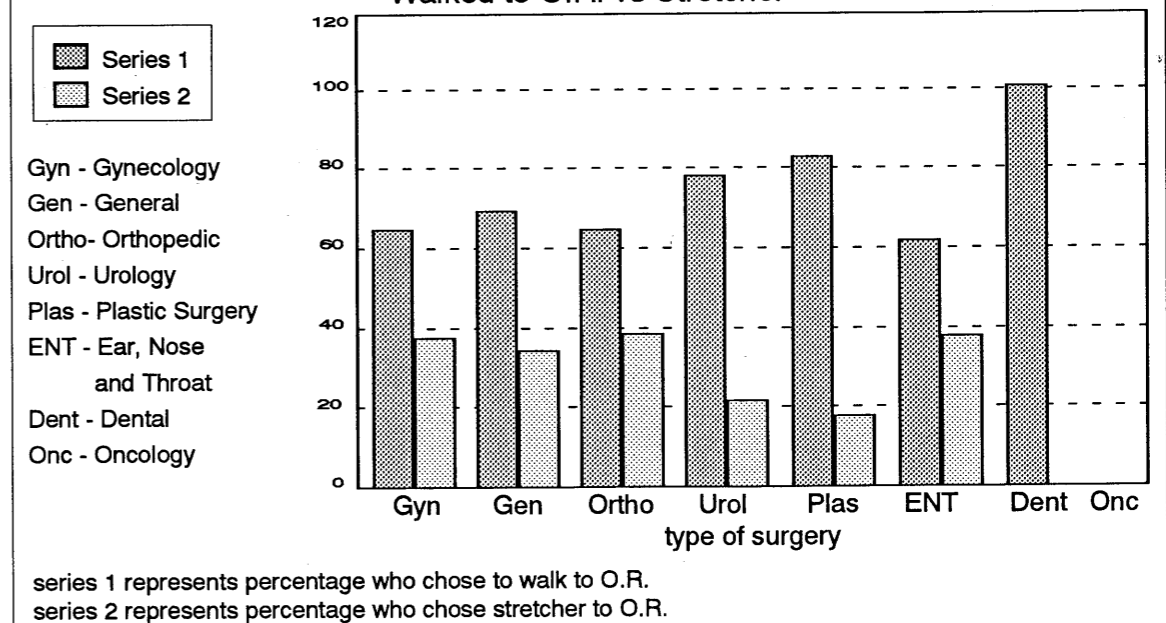
The study population consisted of all preoperative surgical clients attending the P.A.C. at a large university-affiliated teaching general hospital. Clients can be seen in the clinic up to two weeks before their scheduled date of surgery. There are fifty-four surgeons who utilize the clinic's services, representing general surgery, gynecology, oncology, orthopaedics, ears, nose and throat, urology, dental, and plastic surgery. Approximately thirty-five clients are assessed in the clinic daily.

The majority of surgical clients who come to this institution are admitted the same day as their surgery. However, there are some clients who are admitted prior to their surgery. All clients who attended the P.A.C. and were to be admitted the day of their surgery, were potential participants. Clients who were to receive preoperative sedation or who identified a physical limitation e.g. fractured leg, were excluded from answering the questionnaire.

### Methodology

The operating room, located at the north end of the Same Day Surgery (SDS) hallway, is approximately 126 feet from the SDS admitting area. The P.A.C. is located at the south end of SDS hallway. Clients were seen in the P.A.C. three to fourteen days prior to their day of surgery. The idea of being given a choice to walk to the O.R. or going by stretcher was introduced to the client during this visit. The nurse in the P.A.C. conducting the assessment explained to the client that a choice of either walking to the operating room or going by stretcher would be given to the client on the morning of his or her surgery. Clients were reassured

**Minor Surgeries**  
Walked to O.R. vs Stretcher



that their choice would not influence their care while in the hospital, or their surgery.

On the day of surgery, a nurse asked for the client's preference, and then escorted the client to either a lazy-boy chair or a stretcher in the admitting area of SDS. The client received the questionnaire and was asked by the nurse to complete the first two questions. The questions were: 1. Do you want to walk to the Operating Room? If yes, why did you choose to walk, or if no, why do you not want to walk? and, 2. Do you want to go by stretcher to the Operating Room? If yes, why did you choose to go by stretcher, or if no, why do you not want to go by stretcher?

The nurse then placed the questionnaire on the client's chart. All clients received the usual preoperative care as per hospital policy. This care included: having the client change into a hospital gown, slippers, and housecoat; starting an intravenous and administering any medications ordered by the surgeon (these medications are usually antibiotics, as the majority of clients no longer receive preoperative sedation); completing the O.R. checklist; revising information obtained in the P.A.C.; reinforcing and/or initiating client education; and ensuring the client's safety by making him or her comfortable and placing the nursing callbell within reach of the client.

Whether walking or going by stretcher, all clients were accompanied by a porter to the Patient Receiving

area in the operating room. The operating room nurse accompanied the client to the O.R. theatre, a distance of approximately 178 feet to theatre one, and 85 feet to theatre six. After arriving in the O.R. theatre, the O.R. nurse recorded the client's response to the last question from the questionnaire, "Were you satisfied with your decision to walk (or go by stretcher)?" A computer number was assigned to the completed questionnaire by the O.R. nurse. The completed questionnaire was then placed in a sealed box for the O.R. nurse clinician to retrieve. To ensure confidentiality questionnaires were kept in the O.R. nurse clinician's filing cabinet to which she alone had access.

### Results

There were 250 questionnaires administered over a five week period. Ninety (36%) of the questionnaires were incomplete and therefore, excluded from the study. Some clients did not answer all the questions; some gave conflicting answers such as answering 'yes' to both questions regarding preference to walk or go by stretcher; some questionnaires did not have a computer number assigned.

The study population consisted of the following clinic services: general surgery (15%), gynecology (38.5%), oncology (1%), orthopaedics (11%) ears, nose and throat (7%), urology (18.5%), dental (1%), and plastic surgery (8%). The study population repre-



These feet have just put in ten miles taking blood, giving needles, calming an emergency patient, and filling in for another nurse who called in sick.

Logiparin™ (Tinzaparin Sodium Injection) is a new low molecular weight heparin (LMWH) for DVT prophylaxis that only has to be administered once daily.<sup>1</sup> As well, Logiparin™ requires no PT or APTT monitoring.<sup>1</sup> This can make a significant difference to hospital staff who are trying to keep up with today's challenges of providing optimal patient care with fewer resources.

**LOGIPARIN™ TAILORED TO BODY WEIGHT.**

Logiparin™ is the first LMWH to help simplify DVT prophylaxis by offering a convenient dosing regimen that tailors dosage to individual body weight for general and hip replacement surgery patients.<sup>1</sup>

**PROVEN EFFICACY.**

A double-blind, multicentre trial showed Logiparin™ 50 Xal U/kg body weight to be as safe and more effective than placebo in patients undergoing total hip replacement surgery.<sup>2</sup>

As well, in a multicentre, double-blind study of 1290 patients, Logiparin™ 3500 Xal U was shown to be as effective as unfractionated heparin in general surgery.<sup>3</sup>

**A CONVENIENT NEW STEP IN PROPHYLAXIS THERAPY.**

While the risk of DVT in surgery is high,<sup>4</sup> prophylaxis with LMWH has been shown to reduce the risk of thromboembolism.<sup>5</sup> Logiparin™ is effective, generally well tolerated and easy to use. In terms



**LOGIPARIN™ CAN HELP**

of efficacy, safety and convenience, Logiparin™ is in step with your needs today.

Most common side effects of Logiparin™ (>1/100) include hematoma at injection site (uncomplicated) and transient increase in aminotransferase levels (not clinically relevant).

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 Low Molecular Weight Heparin






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**Logiparin**<sup>TM</sup>  
Tinzaparin Sodium Injection

**NAME OF DRUG**  
Logiparin<sup>TM</sup> (Tinzaparin Sodium Injection)  
(Low Molecular Weight Heparin)

**THERAPEUTIC CLASSIFICATION**  
Anticoagulant/Antithrombotic Agent

**ACTION AND CLINICAL PHARMACOLOGY**

Logiparin<sup>TM</sup> (Tinzaparin Sodium Injection) is a low molecular weight (LMW) heparin, produced by enzymatic depolymerization of conventional heparin from porcine mucosa. It possesses antithrombotic activity mediated through antithrombin III.

The pharmacokinetics of Logiparin<sup>TM</sup> after a single subcutaneous injection have been studied in clinical trials by the measurement of plasma levels of Xal activity, IlaI activity and APTT activity.

	Xal activity	IlaI activity	APTT activity
Absorption T <sub>1/2</sub> after s.c.	199.5 min.	256.7 min.	
Bioavailability	90.1%	66.8%	
Elimination T <sub>1/2</sub>	81.9 min.	71.3 min.	35.3 min.
Apparent volume of distribution	4.0 l	10.9 l	4.0 l
Time for peak activity	4-6 hours	4-6 hours	

The plasma level of Xal activity may only be used as a measure of the amount of Logiparin<sup>TM</sup> (Xal active molecules) in plasma. It is not recommended as a tool for monitoring treatment efficacy with Logiparin<sup>TM</sup>.

Results from clinical trials with Logiparin<sup>TM</sup> indicate that there is a close relationship between plasma levels of Xal activity and body weight. This indicates that dosing according to body weight is the best way to obtain precise dosing.

**INDICATIONS AND CLINICAL USE**

Logiparin<sup>TM</sup> (Tinzaparin) is indicated in the management of the prevention of postoperative venous thromboembolism in patients undergoing hip replacement surgery.

Logiparin<sup>TM</sup> may be used in the management of the prevention of postoperative venous thromboembolism in patients undergoing general surgery who are at high risk of developing postoperative venous thromboembolism.

(SEE PRECAUTIONS: SELECTION OF GENERAL SURGERY PATIENTS)

Postoperative administration of Logiparin<sup>TM</sup> does not preclude other prophylactic modalities including physical and mechanical methods of adjunct therapy.

**CONTRAINDICATIONS**

- Logiparin<sup>TM</sup> (Tinzaparin), must not be administered by intramuscular injection due to the risk of hematoma. Where possible, intramuscular injections should be avoided in patients during anticoagulant treatment.
- Allergy and hypersensitivity to Logiparin<sup>TM</sup> (Tinzaparin); acute or subacute septic endocarditis; major blood clotting disorders; history of thrombocytopenia or in patients in whom an *in vitro* platelet - aggregation test in the presence of Logiparin<sup>TM</sup> is positive; active gastrointestinal ulceration; uncontrolled severe hypertension; generalized hemorrhage tendency and other conditions/diseases involving an increased risk of hemorrhage.

**WARNINGS**

LOGIPARIN<sup>TM</sup> SHOULD BE USED WITH CARE IN PATIENTS WITH SEVERE LIVER OR KIDNEY INSUFFICIENCY, UNCONTROLLED ARTERIAL HYPERTENSION OR A HISTORY OF GASTROINTESTINAL ULCERATION.

**EXPERIENCE WITH CHILDREN AND USE DURING PREGNANCY OR LACTATION**

There is currently no clinical experience with Logiparin<sup>TM</sup> in pregnant women and children. In two clinical studies performed in pregnant women during second trimester using Logiparin<sup>TM</sup> in a dose of 35-40 Xal U/kg, no transplacental passage of Xal and IlaI activities was demonstrated.

Logiparin<sup>TM</sup> should not be used in pregnant women and in children unless the therapeutic benefits to the patients outweigh the possible risks to the fetus and the patients.

It is not known whether Logiparin<sup>TM</sup> is excreted in breast milk of nursing mothers. Mothers receiving Logiparin<sup>TM</sup> should avoid breast-feeding.

Logiparin<sup>TM</sup> contains sodium bisulphite, which may cause allergic reactions including anaphylactic symptoms and life threatening or less severe asthmatic episodes in certain susceptible people.



IN STEP WITH YOUR NEEDS

The overall prevalence of sulphite sensitivity in the general population is unknown. Sulphite sensitivity is seen more frequently in asthmatics than in non-asthmatic people.

**PRECAUTIONS**

Logiparin<sup>TM</sup> should not be administered by intramuscular injection due to the risk of hematoma. Where possible intramuscular injections should be avoided in patients during anticoagulant treatment.

Logiparin<sup>TM</sup> should be used with caution in conjunction with drugs which affect either platelet function or the coagulation system (i.e., salicylates, vitamin K antagonists and dextran).

**LABORATORY TESTS**

Clinical trials with Logiparin<sup>TM</sup>, in the dosages recommended, have not been associated with clinically significant bleeding. A fall in thrombocyte counts has been observed yet no direct association to Logiparin<sup>TM</sup> has been identified.

As a precautionary measure, platelet counts should be determined prior to the start of treatment with Logiparin<sup>TM</sup> and, subsequently, twice weekly for the duration of treatment. An *in vitro* platelet-aggregation test in the presence of Logiparin<sup>TM</sup> should be performed in patients with a history of heparin-induced thrombocytopenia. In case of negative results, treatment with Logiparin<sup>TM</sup> may be instituted but the patient must be closely monitored and platelet counts determined at least once daily. A positive result contraindicates Logiparin<sup>TM</sup>.

In the case of minor bleeding, the drug should be postponed or withdrawn. When serious bleeding requires reversal of Logiparin<sup>TM</sup>, protamine sulfate (1% solution) by slow infusion will neutralize Logiparin<sup>TM</sup>. The effect of protamine sulphate should be monitored by the APTT. (For more information, please see SYMPTOM AND TREATMENT OF OVERDOSAGE.)

**Selection of General Surgery Patients**

Logiparin<sup>TM</sup> may be used as an adjunct in the prevention of postoperative venous thromboembolism in patients undergoing general surgery who are at high risk of developing postoperative venous thromboembolism.

General surgery patients, who have one or more of the following risk factors, are at high risk of developing postoperative venous thromboembolism: Previous venous thromboembolism; varicose veins; obesity; heart failure; malignancy; previous long bone fracture of lower limb; bed rest more than 5 days prior to surgery; predicted duration of surgery more than 30 minutes; age 60 years or above.

**Drug Interactions**

There has been no clinical experience with the possible interaction between Logiparin<sup>TM</sup> and other drugs other than ASA (Acetylsalicylic Acid). No evidence of an interaction between Logiparin<sup>TM</sup> and ASA on the Xal or IlaI activities was found. The bleeding time increased on the combined treatment in 7/8 subjects as expected with regard to the ASA intake, though no significant influence on the platelet aggregation was found.

Logiparin<sup>TM</sup> should be used with caution in conjunction with drugs which affect either platelet function or the coagulation system (i.e., oral anticoagulants, inhibitors of platelet aggregation, nonsteroidal anti-inflammatory agents, preparations containing acetylsalicylic acid, vitamin K antagonists and dextran).

**ADVERSE REACTIONS**

Hemorrhage is the main complication that can result from Logiparin<sup>TM</sup> treatment. However, the clinical trials with Logiparin<sup>TM</sup> in the dosages recommended have not been associated with hemorrhage to any clinically significant degree.

**Frequent reactions (>1/100)**

General: Hematoma at injection site - uncomplicated  
Liver: Transient increase in aminotransferase levels - not clinically relevant

**Less frequent reactions**

Skin: Rash - uncomplicated

**Rare (<1/1000)**

General: Allergic reactions (has not been reported)  
Blood: Bleeding - clinical relevance depends on the site and severity of bleeding  
Thrombocytopenia - clinical relevance unknown

**SKIN**

Minor adverse events, such as bruising, wound hematoma, and injection site hematomas, have been noted to occur to a varying extent in all clinical studies. In addition, rashes have been reported in a few cases after administration of 3500 Xal U once daily.

Logiparin<sup>TM</sup> alone or in combination with aspirin was well tolerated with only occasional bruising at the injection site seen.

**LIVER**

As with conventional heparin, a significant but transient increase

of the liver transaminases has been noted following administration of Logiparin<sup>TM</sup> in doses of 50 Xal U/kg b.w. once daily, as well as in higher doses. The increased levels of liver transaminases observed in the Logiparin<sup>TM</sup> studies were most probably induced by the treatment. The conclusion agrees with observations made in association with treatment using heparins. The exact mechanism associated with the increased levels of liver transaminases has not been fully elucidated. However, no consistent irreversible liver damage has ever been demonstrated due to this known heparin effect.

Clinical studies have suggested that the transaminase increase seems to be dose dependent and requires more than three days of treatment to appear. Following the administration of Logiparin<sup>TM</sup> in a dose of 150 Xal U/kg twice daily, however, all subjects showed increased plasma levels of AST and ALT from a mean of 17.8 to 128.5 U/ml and 19.3 to 257.0 U/ml respectively. These elevations correspond to a seven to twelve fold increase as compared to the post-study evaluation performed within seven days of study completion. Transaminase levels normalized within two weeks of the last dose of Logiparin<sup>TM</sup>.

In summary, Logiparin<sup>TM</sup> administered in doses of 50 Xal U/kg b.w. once daily, and 150 Xal U/kg twice daily, for five consecutive days results in markedly increased but reversible liver transaminases levels (especially ALT). Normalization of these levels occurred within two to four weeks. Clinical studies involving administration of standard heparin in doses up to 10 000 IU given i.v. every six hours or s.c. in doses of 5000 IU every eight hours or twice daily, have yielded the same effect.

**SYMPTOMS AND TREATMENT OF OVERDOSAGE**

Bleeding is a symptom of Logiparin<sup>TM</sup> overdose. In recommended doses, there should be no need for an antidote but in the event of accidental administration of an overdose, protamine sulphate should be given. There is no clinical experience with overdose, but studies in animals indicate that the dose of protamine sulphate required to neutralize the hemorrhagic effects is greater for Logiparin<sup>TM</sup> than for unfractionated heparin. The effect of protamine sulphate should be monitored by the APTT. Excess bleeding is not seen in animal experiments when the APTT is brought within the normal range. If transfusions are required, fresh frozen plasma is preferred.

In the case of minor bleeding, the drug should be postponed or withdrawn. When serious bleeding requires reversal of Logiparin<sup>TM</sup>, protamine sulfate (1% solution) by slow infusion will neutralize Logiparin<sup>TM</sup>. No more than 50 mg should be administered, using a very slow i.v., during a 10-minute-period. Each mg of protamine sulfate neutralizes approximately 100 IU Logiparin<sup>TM</sup>.

**DOSE AND ADMINISTRATION**

Prevention of postoperative venous thromboembolism in General Surgery patients:

- Logiparin<sup>TM</sup> 3500 Xal U given by subcutaneous injection two hours before surgery followed by 3500 Xal U once daily for 7-10 days.

Prevention of postoperative venous thromboembolism in Hip Replacement Surgery patients:

- Logiparin<sup>TM</sup> 50 Xal U/kg b.w. given by subcutaneous injection two hours before surgery followed by 50 Xal U/kg b.w. once daily for 7-10 days.

**PHARMACEUTICAL INFORMATION**

**DRUG SUBSTANCE**

The active ingredient, Logiparin<sup>TM</sup>, is derived from Heparin Sodium USP by controlled enzymatic depolymerization, which results in low molecular weight heparin with a peak maximum molecular mass of 4500 ± 1500 Daltons.

**STABILITY AND STORAGE RECOMMENDATIONS**

The preparation should be stored at 15-25°C.

**AVAILABILITY OF DOSAGE FORMS**

Logiparin<sup>TM</sup> is available as aqueous solution containing benzyl alcohol and sodium bisulfite.

Presentation: Logiparin<sup>TM</sup> Injection 10,000 Xal U/ml; 2 ml vial. Each pack contains 5 vials.

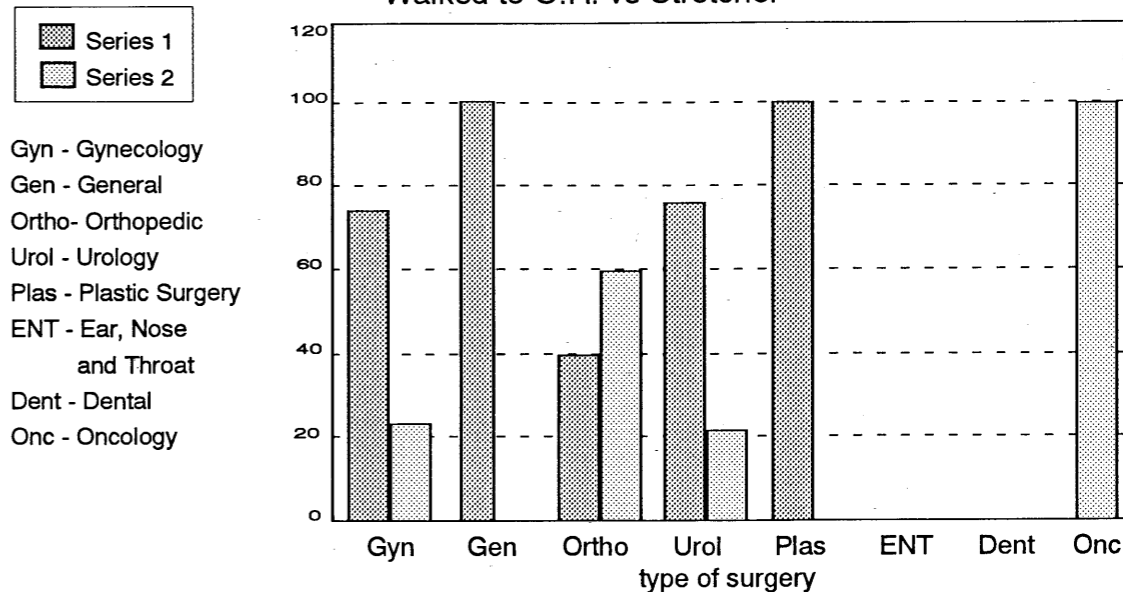
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**Major Surgeries**  
Walked to O.R. vs Stretcher



series 1 represents percentage who chose to walk to O.R.  
series 2 represents percentage who chose stretcher to O.R.

sented 37% male clients and 63% female clients. Although one of the purposes of the questionnaire was to determine the number or proportion of clients who desired to walk to the operating room, it was interesting to note that the age range of the clients willing to walk was 18-81, with the average age of 40 years (mode 37; median 45). For the clients who preferred to go by stretcher, the age range was 20-76, with an average age of 46 years (mode 24,30,66; median 47).

Of the 160 clients who completed the questionnaire (representing a 64% return rate) 111 preferred to walk (69%) and 49 (31%) preferred to go by stretcher. Eighty-three of the 111 (75%) wanted to walk because they were healthy, did not feel sick, and felt more in control. Four clients had had the choice of walking to the O.R. for previous surgeries and enjoyed the experience. Some clients stated that they would be less nervous if they could walk.

Of the 111 clients who preferred to walk, twenty-three (21%) were booked for major surgery and eighty-eight (79%) were booked for minor surgery. Of the 49 clients who preferred to go by stretcher, 10 (20.4%) were booked for major surgery and 39 (79.6%) were booked for minor surgery. Figure 1 and Figure 2 represents the study population, the preference to walk or to go by stretcher to the O.R., and the surgical classification. In this hospital the classification of

major surgeries includes such cases as total joint replacements, nephrectomies and total abdominal hysterectomies. Submucous resections, laparoscopies, inguinal hernias and breast biopsies are classified as minor surgeries. A complete list is available from the authors.

Of the 111 clients who preferred to walk, two, (1.8%) were not satisfied with their choice. The reasons given by the two clients were that he or she became uncomfortable waiting, and also that he or she would have felt more pampered on a stretcher. One hundred and nine or 98.2% of the clients were satisfied with their decision to walk to the O.R. The reasons they gave were: able to walk, not sick, felt better, less like a sick person, felt more in control, in control until the last minute, felt that I could better keep my dignity.

Of the 49 clients who went by stretcher, one (2%) was not satisfied. The reason given was that due to preoperative sedation the client had to go by stretcher but would have preferred to walk. The remaining 48 clients were satisfied with their decision stating reasons such as: more comfortable, too nervous, pain, easy way, free ride, and lazy.

**Limitations**

Uncontrolled extraneous variables in this study included the time between the client being seen in the

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clinic and the scheduled date of surgery. As previously stated, clients could attend the P.A.C. 3-14 days prior to their day of surgery. This allowed some clients more time to think about their choice of walking or going to the O.R. by stretcher. A potential limitation was that all nurses who worked in the P.A.C., S.D.S., and the O.R. were involved in the study. This variation could raise concern for extraneous variables in the nurses influencing the client's choice. The nurse may not have agreed with giving clients the opportunity of walking to the O.R. The manner in which the nurse approached the client could also have been a factor influencing the client's choice. For example, if the nurse was in a hurry, the nurse may have had a negative tone to her voice which may have influenced the decision made by the client.

### Conclusion

On the basis of the findings from this study, we conclude that given a choice, the majority of surgical clients prefer to walk to the O.R. immediately prior to both major and minor surgeries as opposed to going by stretcher. Our results are consistent with the findings in the literature that clients need a sense of control in what is often perceived by clients as an uncontrollable environment.

Areas for future investigation would be to focus on the outcomes postoperatively. For example, does the client who perceives more control preoperatively experience a shorter hospital stay? A randomized control trial, which would provide for a higher level of evidence, would also provide for the application of stringent statistical tests.

### Acknowledgements

Ms. Joan Eagle, B.Sc.N., M.N, M.Sc. Nursing Research Coordinator, Hamilton Civic Hospitals/Henderson Division.

Staff from Preadmission Assessment Clinic, Same Day Surgery and Operating Room, Hamilton Civic Hospitals/Henderson Division.

Sandy Silk, Jennifer Bowen and Loreen Hodgins.

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# Research Committee Activities

By Loretta Thomas-Aasen

The Ottawa Congress Centre, just five minutes from Parliament Hill, was the setting for The ORNAC Research Committee's Spring board meeting, April 23-24, 1994. The meeting was held in conjunction with the ORNAC Board meeting and the Operating Room Nurses of Ontario Annual Conference.

Members of the committee met on two separate occasions during our visit to Ottawa. Present were:

L. Thomas-Aasen, Chair, (SK); Gloria Stephens (BC); Judi Tyndall (ON); and, Shirley Thorn (MB).

Meeting highlights include: • A twenty minute video titled "Research - You Can Do It" was purchased for use by ORNAC.

• Jack Kress of Winnipeg and Gloria Stephens of Vancouver are now serving as consultants to the ORNAC Research Committee.

• The Spanish red and grey display board accented with lights was presented to the board members. The research posters completed by CTR and Associates, Vancouver graced the display board perfectly. We will be exhibiting at the 1995 ORNAC National Conference. Remember to stop by and visit our display.

• Organizers of the International Research Conference May 4-6, 1994 were pleased to receive a donation from ORNAC for one graduate student to attend the Vancouver conference.

• A skills list for Perioperative Nursing Practice - Surgery will be developed for presentation at a future board meeting.

• The Committee is seeking funding for the performance of perioperative nursing practice research; letters have been circulated.

• The Research Committee working in collaboration with the Certification Committee will be circulating the national operating room nursing Certification

survey questionnaire in the coming months. Watch your mail box and participate as your feedback is important to us! (See Certification article - page 28).

## Perioperative Nursing Practice - "Surgery"

The operating room registered nurse practices advanced perioperative nursing in surgery. The increasing complexity of surgery compels a higher level of expertise than was previously required of the scrub nurse. The operating room nurse with advanced perioperative nursing education functions collaboratively with the surgeon during the preoperative, intraoperative and the postoperative phases, relating to the surgical intervention.

## Perioperative Nursing Practice - "Anesthesia"

The operating room registered nurse practices advanced perioperative nursing in anesthesia. The increasing complexity of anesthesia compels a higher level of expertise than was previously required of the circulating nurse. The operating room nurse with advanced perioperative nursing education functions collaboratively with the anesthetist during the preoperative, intraoperative and postoperative phases, relating to anesthesia.

• Scope of Perioperative Nursing Practice - to be revised by the Research Committee and presented to the board at the October 29-30, 1994 board meeting in Toronto, Ontario.

• Research Committee members were pleased to meet with executive members of the Canadian Nurses Association on Friday, April 22/94, at CNA House, Ottawa regarding the maximization of our role(s) as operating room nurses. Indeed, this meeting was very productive and insightful for our association.

• Canadian Anesthetists' Society (CAS) Task Force meetings were held on March 19th and April 16/94 respectively. A skills list for the Anesthesia Assistant was developed for a number of clinical areas. The Task Force report will be presented at the Society's

annual meeting in June, 1994, in Edmonton, Alberta. Future Research Committee meetings will be decided after this meeting.

• For her many contributions to the Research Committee, a special gift was presented to Gloria Stephens on behalf of the ORNAC Research Committee members.

Our next Research Committee meeting is scheduled for October, 1994. If you have any questions please contact:

**Loretta Thomas-Aasen**  
**Chair, ORNAC Research Committee**  
**# 9 McLelland Bay**  
**Weyburn, Sask. S4H 2V3**  
**Phone (306) - 842-6991**  
**Fax (306) - 842-4453**



ORNAC Research Committee Members - (Left to right - Standing) Donna Prokopczak (Alberta), Judi Tyndall (Ontario), Shirley Thorn (Manitoba), Gloria Stephens, (British Columbia). (Left to right - Sitting) Loretta Thomas-Aasen (Saskatchewan), and Marnie Simon (British Columbia). Missing is Jack Kress (Manitoba)

# Certification For Perioperative Nurses: Answering Your Questions

By Leslie Anne Patry, R.N., B.Sc.N.

The nurses attending the recent Ontario Operating Room Nurses Association conference in Ottawa this year were tremendously enthusiastic about their specialty and the opportunity for professional certification.

As the Certification Coordinator for the Canadian Nurses Association (CNA), I had the opportunity to attend this conference and meet many Perioperative Nurses from across Ontario and Canada. You may have been one of the many who dropped by the CNA booth to pick up information or to talk about the upcoming certification for perioperative nursing.

Many nurses have questions regarding the certification credential, the application process and the development of the examination. This article will answer the most commonly asked questions and provide up-to-date information about certification for Perioperative Nursing in Canada.

## What is CNA certification?

The certification program for nursing specialties promotes excellence in nursing and recognizes nurses who have met the national standards of their specialty. The CNA is the only organization offering this national credential in Canada. You can earn this credential by meeting specific eligibility requirements and passing the specialty examination.

## Why should I become certified?

Certification gives you the opportunity to show your peers and clients that you are committed to nursing in your specialty and enhances your qualifications. With the growing number of nurses earning the credential (estimated 2500 in 1995), employers have begun recognizing the added value they gain from employing certified nurses.

Nurses have expressed many reasons for obtaining the credential. An occupational health nurse had this to say:

"I love my job and I wouldn't want to be doing anything else", says Elizabeth Valenta, RN, BScN, CCOHN(C), an occupational health nurse with the Ontario Ministry of Labor. "You need to be the best you can be, and being certified helps me to do this."

## How often are the Certification examinations offered?

The CNA certification examinations are offered annually. The first certification examination for perioperative nursing will be offered on June 7th, 1995 with a subsequent exam in January, 1996 and every January after that.

## I've ordered my candidate application package, but have not yet received it?

We have received requests from thousands of nurses from across Canada. We have worked hard to put together a candidate package that meets their needs. If you have ordered a package, it will be on its way very soon. Remember, you have lots of time to apply, the deadline for application for the June, 1995 exam, is January 31, 1995.

We have also heard comments about the paperwork involved in the application process and have responded by developing a new process for 1995.

## Author

Leslie Anne Patry, RN, BScN, is the Certification Coordinator at the Canadian Nurses Association.

## Is there information available to help me prepare for the examination?

Included in the candidate information package is a description of the practice area, some general information about the areas of knowledge and skills to be tested on the exam, and a bibliography.

At this time, CNA and perioperative nurses from across Canada are just beginning the task of developing the certification examination. In early 1995, the **Blueprint for the Perioperative Nurse Certification Examination** will be available for purchase from the CNA publication/sales department. This document provides detailed information about the certification examination including a complete list of competencies to be tested. An order form for the Blueprint is included in the candidate application packages.

## How can I get involved in the development of the examination?

We welcome involvement from all interested perioperative nurses from across Canada, working in all aspects of the specialty. Just send us your request to participate in examination development and we will send you a nomination form to complete. On receipt, your name will be added to our list of participants.

## How long is the certification credential valid?

Once you pass the exam, your certification credential is valid for five years. During this period of time, you will be able to use a designated mark of your specialty after your name. In order to maintain the credential, it is necessary to hold current nurse registration/licensure in Canada.

## How do I recertify?

Recertification requires that you meet eligibility requirements and there is an option to recertify by earning 100 hours of continuing education activities in perioperative nursing during the five year certification term or by writing the certification examination.

## In what other specialty areas is certification available?

In 1995 the CNA Certification Program will be expanding to include certification for nurses working in the following seven specialty areas: Critical Care; Emergency; Nephrology; Neuroscience; Occupational Health; Perioperative; and Psychiatric Nursing.

Nurses who are interested in obtaining a candidate package or other information about the program can contact the CNA certification program by mail, telephone or fax as indicated below.

Certification Coordinator  
Canadian Nurses Association  
50 Driveway  
Ottawa, Ontario, K2P 1E2

Phone: (613) 237-2133 Fax: (613) 237-3520  
Toll-free phone: 1-800-450-5260

## Certification in Nursing Specialties

Join the growing number of Canadian nurses who are earning the Canadian Nurses Association (CNA) certification credential in one of the following nursing specialties:

Emergency	<b>NEW for '95</b>
Nephrology	Critical Care
Neuroscience	Perioperative
Occupational Health	Psychiatric

### Application Deadlines:

September 15, 1994  
(January 31, 1995 for Perioperative  
Nursing only)

Exam dates: January 18, 1995  
(June 7, 1995 for perioperative nursing only)



Contact:  
Certification Coordinator  
Canadian Nurses Association  
50 Driveway,  
Ottawa, Ontario,  
K2P 1E2  
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### Annonce

Le comité de traduction de l'A.I.I.S.O.C. recrute des membres pour la révision de documents traduits afin de fournir aux infirmiers et infirmières de langue française, les mêmes informations que reçoivent leurs consoeurs et confreres de langue anglaise. Dans le but de respecter cette mission, nous sommes a la recherche de personnes désireuses de donner bénévolement de leur temps pour la bonne interprétation des documents. Veuillez adresser vos coordonnés a:

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Lévis, PQ  
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### Announcement

The translation committee of ORNAC recruits members for the revision of translated documents to provide French speaking nurses, the same information received by their English colleagues. For this purpose and to respect our mission, we are researching nurses desirous to give their time benevolently for the good interpretation of documents. Please address your coordinates to:

**Mariale Lapierre**  
34-302 rue Thibault  
Lévis, PQ  
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### Gloria Stephens named YWCA Woman of Distinction

**Vancouver.** Gloria Stephens, Past President of the Operating Room Nurses Association of Canada, was honored, along with seven other British Columbia professional women, at the 11th annual YWCA Women of Distinction Awards in late May.

Gloria received the honor in the category of education, training and development. The award marked her career as a nurse clinician whose primary focus has been on teaching and professional development. She developed the OR education program at St. Paul's Hospital in Vancouver, and was active in the collective bargaining process for nurses, providing leadership to foster better labor relations. She was instrumental in developing the first Essential Services Manual in the provinces and is well known across Canada in her work with ORNAC - especially her involvement in the published Professional and Technical Standards for OR Nurses.

Kim Campbell, former Prime Minister of Canada, was honored for her contribution in communications and public affairs.

### The Johnson & Johnson Drake - Thompson Editorial Award

Judy Tyndall, RN, Nurse Clinician, (photo left to right) Sue Smith, RN, Resource Nurse, and Alaine Young, Nurse Manager, Operating Room, Henderson General Hospital, Hamilton Ontario, are winners of the annual editorial award sponsored by Johnson & Johnson Medical Products. Their article "Do You Have a Latex Allergy Protocol?" was published in this journal Vol.11, No.3, Sept/Oct., 1993. The cash award of \$3000, will be shared by the three winners. The cheque and commemorative plaque were presented by Dave Patterson, Vice Pres., Marketing, Johnson & Johnson Medical Products, at the Ottawa Conference Centre during the 3rd Provincial Conference of the Operating Room Nurses Association of Ontario, in late April.



The 16th annual conference of the Operating Room Nurses Association of Alberta (ORNAA) takes place in Lethbridge, Alberta, October 19-22, 1994. The committee has been at work for over a year planning a great social and educational conference. ORNAA Planning Committee (Back row, left to right: ) Lauri Basso, Secretary; Sue Ball, Registration; Bev Ripko, Exhibitors, Gail Kiefuik, Registration; Barb Willis, Treasurer; Roz Kranzler, Program; and Sharon Freel, Social. (Seated: front row left to right) Jane McClain, Conference Vice Chairman and President of the ORNAA, Gloria Nemecek, 1994 Conference Chairman and Pat Petersen, Publicity. (See page 34 for conference details.)

### The Operating Room Nurses Association of Canada 14th National Conference



May 8 - 12, 1995  
Vancouver Trade & Convention Centre  
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*Watch for more information and details in the September/October, 1994 issue of this Journal*





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# New Brunswick presents Lifetime Memberships

By Lynne C. McLaughlin,  
Chairperson, NBORN Lifetime & Honorary Membership Awards Committee

The New Brunswick Operating Room Nurses presented Lifetime Memberships to two OR nurses, and a special award to a surgical supplier at their Spring Institute in Moncton, N.B. The NBORN is celebrating its 20th anniversary this year. (See the History of the group on page 36).

The first Lifetime Memberships were presented in 1992 at the Spring Institute. Recipients at that time were three Charter Members - Barbara Smith, Fredericton, NB; Marietta Finlay, Saint John, NB; and Alene Forsythe, Moncton, NB. This year's recipients were Isabel Delano and Joan Donald. An Honorary Membership was award to Robert (Bob) Purdy.

## Isabel Mary Delano honored with Lifetime Membership

Isabel graduated from the Miramichi Hospital School of Nursing in 1947. Even then she had the "Operating Room Fever" and two years later completed a Post Graduate Course in Operating Room at the Montreal General Hospital.

Isabel then returned to the Miramichi Hospital as Operating Room Supervisor, with one of her many duties being responsible for the student nurses Operating Room Training.

For eight years from 1953 to 1961, Isabel worked part-time but returned to O.R. Nursing on a full time basis in 1961. She always liked challenges and in 1988 left as O.R. Supervisor to open the new Day Surgery Unit at the Miramichi Hospital

Isabel was a founding member of NBORNG. She served as Treasurer for a number of years and attended all the Spring Institutes and General Business Meetings. To quote one of her colleagues "Her entire life has been dedicated to Nursing and the betterment of her fellow humans".

For her 30+ dedicated years to O.R. Nursing, NBORN bestow upon her a Lifetime Membership.

## Joan Donald honored with Lifetime Membership

Joan Donald graduated from the Victoria Public Hospital School of Nursing in 1961, then went on to complete a post-graduate course in Operating Room Technique & Management in 1962 at the Royal Victoria Hospital in Montreal.

She received her B.Sc.N and Masters degree and is currently the Director of Nursing at the Sackville Memorial Hospital. Although not directly involved with perioperative nursing at present, Joan has worked in the Operating Room for many years as a staff nurse, educator, and Assistant Director of Nursing.

She has served on both the Provincial and National Executives and is past president of ORNAC. She was chairperson of the ORNAC Standards Committee which developed the "Recommended Standards of Operating Room Nursing Practice" published in 1988, and a member of the Technical Standards Committee which published in 1988. In 1990 Joan won the Johnson & Johnson Editorial Award for her article "Promoting O.R. Education" published in this journal, (Vol. 8, No. 1, Feb., 1990).

The NBORN presented Joan with a Lifetime Membership Award in recognition of her dedication and outstanding contributions to Operating Room Nursing in the province and in Canada.

## "Mr. Suture" is an Honorary Member

An honorary membership was awarded to Bob Purdy, Fredericton, N.B., recently retired from Ethicon Sutures (Johnson&Johnson Medical Products). Every OR nurse in the province knows Bob and his willingness to support the NBORN in any way possible. He was known as "Mr. Suture" and always took on extra duties to assist all the OR nurses in the provinces as a trusted friend and technical advisor. NBORN expresses its thanks to Bob on behalf of all OR nurses and wishes him well in his retirement years. ■

# CALENDAR

## Operating Room Nurses Association of Alberta

16th Annual Conference

October 19-22, 1994

Lethbridge Lodge Hotel  
Lethbridge, Alberta  
(403) 328-1123  
Toll Free 1-800-661-1232

Theme: **Standing Tall in the Winds of Change**

Program Content Outline:

Keynote Address by **Professor Joan Keyes** on "Professional Survival". "Living Wills and Dependent Adults", speaker - **W. Petersen, B.A., LLB.** "Self Esteem - Power for a Women" by **Professor Joan Keyes.** "Women's Wellness" by **Wilma Winter.** "Computers in the OR, Especially Rural Hospitals", by **Mary Knight.** "The Future of the RN in the OR" by **Muriel Shewchuk.** "Certification" by **Anna Kristoff.** "The Waterworks" by **Dr. W. Shields,** a Lethbridge Urologist. "Regionalized Anesthetic" by Lethbridge Anesthetist **Dr. G. Milman.** "Advanced Nursing Practice" by **Sharon Balkan.** Other Topics: Latex Allergies, Menopause, Basic Skin Care, Stepping Out in Style and Relax, Recharge and Enjoy. Closing Address: "Job Loss, Hope and Opportunity", speaker **Gordon Colledge.**

Social Events:

**Opening Gala Wine & Cheese**  
at the Galt Museum

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Italian Canadian Club - Transport Provided  
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at the Lethbridge Lodge

Contact: **Gloria Nemecek, Chairman,**  
Box 122, Picture Butte, Alberta. T0K 0V0  
(403) 732-4667

## 25th Provincial Conference Operating Room Nurses of Quebec

Explosion of Knowledge  
September 28-29-30, 1994

Tuesday, September 27, 1994

18:30 to 21:00 Welcome, Preregistration and  
Annual general meeting (election)  
20:00 Wine and Cheese party.

Wednesday, September 28, 1994

Registration  
7:00 - 8:00 Breakfast  
8:15 Opening ceremony  
8:30 - 9:30 Opening speech  
Keynote Guest Speaker  
10:00 - 11:00 Round table discussion about the  
nurse's role as first assistant in the OR  
with **Mrs Louise Bouffard, O.I.I.Q.**  
**Mr. Claude Marcil, MD, LLB,** a  
Director of Nursing and a member of pilot project.  
11:00 Opening of exhibits.  
14:00 - 15:00 Nursing research  
15:00 - 16:00 Continuing, quality improve  
**Mrs Jocelyne Beaumier**

Thursday, September 29, 1994

7:00 - 8:00 Breakfast  
8:30 - 9:30 The new civil code and the OR  
nurses - **Mrs Alexandrine Cote**  
10:00 - 11:00 Adjustment to changes;  
Myth or a reality?  
Working schedule. Resistance to change.  
**Mrs Sylvie Vandal**  
14:00 - 15:00 Sterilization: Abolishing the CFC's  
**Mrs Helene Julien**  
15:00 - 16:00 Breast cancer  
**Mrs Rosemonde Mandeville**

Friday, September 30, 1994

7:00 - 8:00 Breakfast  
8:30 - 9:00 Nursing promotion, individual  
participation **Mrs Rita Lussier**  
10:00 - 11:00 to be determined  
14:00 - 15:00 Stress management - **Abel Edmond**

Saskatchewan Operating Room Nurses Group  
Workshop and Annual Meeting

October 15th, 1994

St. Paul's Hospital, Saskatoon, Sask.  
Guest Speaker: **Noela Inions**  
(Nurse - Lawyer)

Hamilton & District Operating Room  
Nurses' One day Workshop  
October 22, 1994

White Oaks Racquet Club, St. Catharines, ON  
Contact: **Chalene Smith**  
Milton District Hospital  
(416) 878-2383

## 20th Atlantic

Operating Room Nurses Conference

October 23-26, 1994

Saint John Trade & Convention Centre  
Saint John, New Brunswick

Exhibitors contact:

**Sandra Betts**  
993 Seacliffe Drive  
Saint John, NB. E2M 3G1  
(403) 732-4667

## OR Bursary

The Canadian Nurses Foundation (CNF) is pleased to announce the CNF/Ansell Medical Baccalaureate Award. This award of \$1800 is available to operating room nurses pursuing Baccalaureate studies on a full or part-time basis.

CNF grants approximately \$150,000 per year to nurses pursuing further education and up to \$75,000 per year to nurses pursuing research related to nursing and/or health care. By providing awards and research grants, CNF encourages nurses to maintain the high standards for which Canadian nurses are known.

For an application form or information regarding any of our awards, please contact:

The Canadian Nurses Foundation  
50 Driveway, Ottawa, Ontario K2P 1E2  
Telephone: (613) 237-2133 Fax: (613) 237-3520

CHICA-Canada  
1994 National Conference  
Chateau Halifax,  
June 20-23, 1994

Site of Sessions and Exhibits  
- St. Mary's University  
Sponsored by the Infection Control  
Association of Nova Scotia,  
A Chapter of CHICA-Canada.

Contact **Pauline Robins, Registration Chair**  
Ocean View Manor, PO Box 130,  
Eastern Passage, N.S.,  
B3M 1M4  
(902) 465-6020

ORNAC '95

14th National Conference

May 8-12, 1995

Vancouver, BC

World OR Conference

September, 1995

Sponsored by the AAORN

Hamburg, Germany

ORNAC '97

15th National Conference

Ontario

OR Bursary

The Johnson & Johnson Medical Products Bursary is offered to financially assist members of the Operating Room Nurses Association of Canada (ORNAC) in furthering their education in areas that will enhance perioperative nursing practice.

Applications (available from your Provincial Presidents) are invited by ORNAC for the Johnson & Johnson Medical Products Bursary for 1995. Submit your application to:

**Elizabeth A. Kent**  
Chairman, Awards Committee  
54 Foley Court  
Fredericton, N.B.  
B3B 2R8

# 20th anniversary for New Brunswick OR Nurses

By Corina Balcom, President NBORN

The New Brunswick Operating Room Nurses held their 8th Annual Spring Institute in Newcastle, N.B., April 29 and 30, 1994, attended by 95 members and 21 exhibitors. The Education day concluded with the election of officers for the 1994-1996 term. Next year's Institute will be held in Edmunston, N.B.

1994 marks the 20th Anniversary of the New Brunswick Operating Room Nurses Group. To commemorate the milestone, a booklet on the history of the group was presented to the members.

The history of an organized operating room nurses group in the Atlantic region starts as early as 1963. At that time Study Groups were organized and by 1965 a group of interested nurses met periodically to share ideas and concerns related to operating room nursing.

In June, 1974 an organizational meeting for a Provincial OR nurses association was held at The Moncton Hospital, at that time it was decided the group would become a sub-committee of the Nurses Association of New Brunswick (NANB). It would be open to any graduate or registered nurse interested in supporting its objectives.

Due to the demographics of the Province, the membership was divided into six regions, based on the existing regions defined by the New Brunswick Nurses Union. Each region would be represented by a regional presiding officer (RPO).

At the 1974 meeting the proposed number of yearly provincial meetings was set at two, one meeting held in the Spring and one in the Fall. The first Provincial Institute was held in Moncton, in November, 1974.

NBORNG is a member of the National Group, the Operating Room Nurses Association of Canada (ORNAC). This membership entitles NBORNG to be represented on the National Board of Directors by two members. The Province has been represented on the National Board since ORNAC's originated in 1983. The group is especially proud of one of its members, Joan Donald from Moncton, who served on the ORNAC executive from 1983-1991, and was president of ORNAC from 1988-1990.

The Constitution and By-Laws were first presented and approved in 1974 and have been revised several times. Continuing education for perioperative

nurses is provided through chapter meetings and provincial conferences. Some major accomplishments have resulted from this interaction. In 1975 a Clinical Interest group was formed to create standards for surgical counts. Another group, in the same year, was created to study hazards of anesthetic gases. Due partly to this group's efforts, all ORs are now equipped with scavenging systems.

Changes in nursing education in the 1970's resulted in students no longer being prepared in OR experience. In 1976 a NBORNG task force developed an OR/Recovery Room post-graduate program and recommended its implication. In 1978 a course was started at The Moncton Hospital, and later due to lack of provincial funding was discontinued. Today this program has been adapted by Sandra Poirier of the education department, as a self-motivating, modular program. In 1991 it was approved by NANB as a post-graduate course and is available to any OR nurse with a minimum of two years experience.

Also in the area of education, NBORNG endeavors to have perioperative nursing included in basic nursing education. Contacts with NANB and educators at the university and nursing school level in the Province have been some of the vehicles used in this educational upgrading attempt.

In 1990, ORNAC established November 14th as OR nurses day, as an organized effort to bring awareness of the unique experience of the operating room to others. In N.B. this day was declared by Ray Frenette, Minister of Health and Community Services. Members in their regional work areas celebrate this day in their own unique way.

Today NBORN is an active group with a total membership in 1994 of 174. With the many changes facing us in the health care system, NBORN is striving to maintain the position of the OR Nurse within the hospital. Keeping up with changes the members voted in 1994 to change the name to the New Brunswick Operating Room Nurses, dropping the word "Group"

Looking back we can be proud of what has been accomplished since 1974. Our continued net-working within the group will ensure our strength and influence in the future. ■

The New Brunswick OR Nurses honored Joan Donald (left) and Isabel Delano (right) with Lifetime Memberships at their Spring Institute this May. Robert (Bob) Purdy received an Honorary membership. See story on page 33 of this issue.



NBORN's new executive (1 to r) Linda Waye, Newcastle, Secretary, Nora Slater, Bathurst, Vice-Pres., (Seated (1 to r) Corina Balcom, Newcastle, President, & Helene LeBlanc, Moncton, Treasurer. ▼



ORNAC Board Members (photo below) in Ottawa, Ontario, April 23rd and 24th, 1994 for the Annual Spring Board Meeting. Back Row (left to right) Judi Tyndall (ON), Carole Starr (ON), Rosemary Moase (PEI), Jane Percy (PQ), Dahlia Robinson (AB), Corina Balcom (NB), Karen Steindel (MB), Josette Forest (PQ), Karen Schuster (MB).

2nd Row (left to right) Donna Farid (NS), Paula Dyer (PEI), Jane McClain (AB), Shirley Hemerling (BC), Lorraine Varner (BC), Angela LeMoine (NF), Lil Budden (NF), Shelly Zareski (NS), Phyllis Arnst (SK), Anna Kristoff, (SK).

Front Row - the ORNAC Executive (left to right) Hilda Gatchell, (Secretary), Vija Hay (Vice-President), Loretta Thomas-Aasen (President-Elect), Jackie Waisman (President), Gloria Stephens (Past-President), and Marlene Hill (Treasurer). Missing at the time of the photo - Elizabeth Kent (NB).



# Editorial awards provide cash for advanced nursing study

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

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

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

1. An abstract summarizing the article.
  2. An autobiographical statement that includes the author's full name, current title and academic qualifications. e.g. Jane M. Smith, RN., M.N.; is head nurse, Thoracic Surgery Unit, General Hospital, Perth, ON.
- All illustrations, graphs, tables, etc. should be clearly labelled and, if necessary, reference should be made as to where they are to be inserted in the text. The author should submit the original manuscript and two(2) copies for reviewers. A copy of the edited text will be

sent to the author for approval. If possible, submit a copy of your IBM-compatible or Macintosh disk.

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

Benjamin M. & Curtis, J. (1986). Ethics in Nursing (2nd ed). New York: Oxford University Press.

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

Share your knowledge, expertise and experience with your operating room nursing colleagues across Canada and those nursing in the U.S. and foreign countries.

Address all correspondence to:

**The Editor,  
Canadian Operating Room Nursing Journal  
c/o Health Media Inc.  
14453 29A Avenue  
White Rock, B.C., V4P 1P7  
Phone (604) 535-7933  
FAX: 604-535-9000**

Please allow six weeks for the acceptance and review of your manuscript. Authors will receive a letter from the publisher on receipt and a follow-up letter announcing acceptance and possibly some revisions suggested by the editorial review board.

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



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<sup>1</sup>Eubanks, S et al. Reduction Of HIV  
Transmission During Laparoscopic  
Procedures. Surgical Laparoscopy And  
Endoscopy Vol 3. No. 1, 1993.

<sup>2</sup>Baggish, M. S et al. Presence Of  
Human Immunodeficiency Virus DNA  
In Laser Smoke. Lasers In Surgery And  
Medicine 11:197-203, 1991.

<sup>3</sup>Fry, D. E.; Reduction Of HIV  
Transmission During Laparoscopic  
Procedures. Surgical Laparoscopy And  
Endoscopy Vol 3. No. 1, 1993.

<sup>4</sup>Data on File.

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