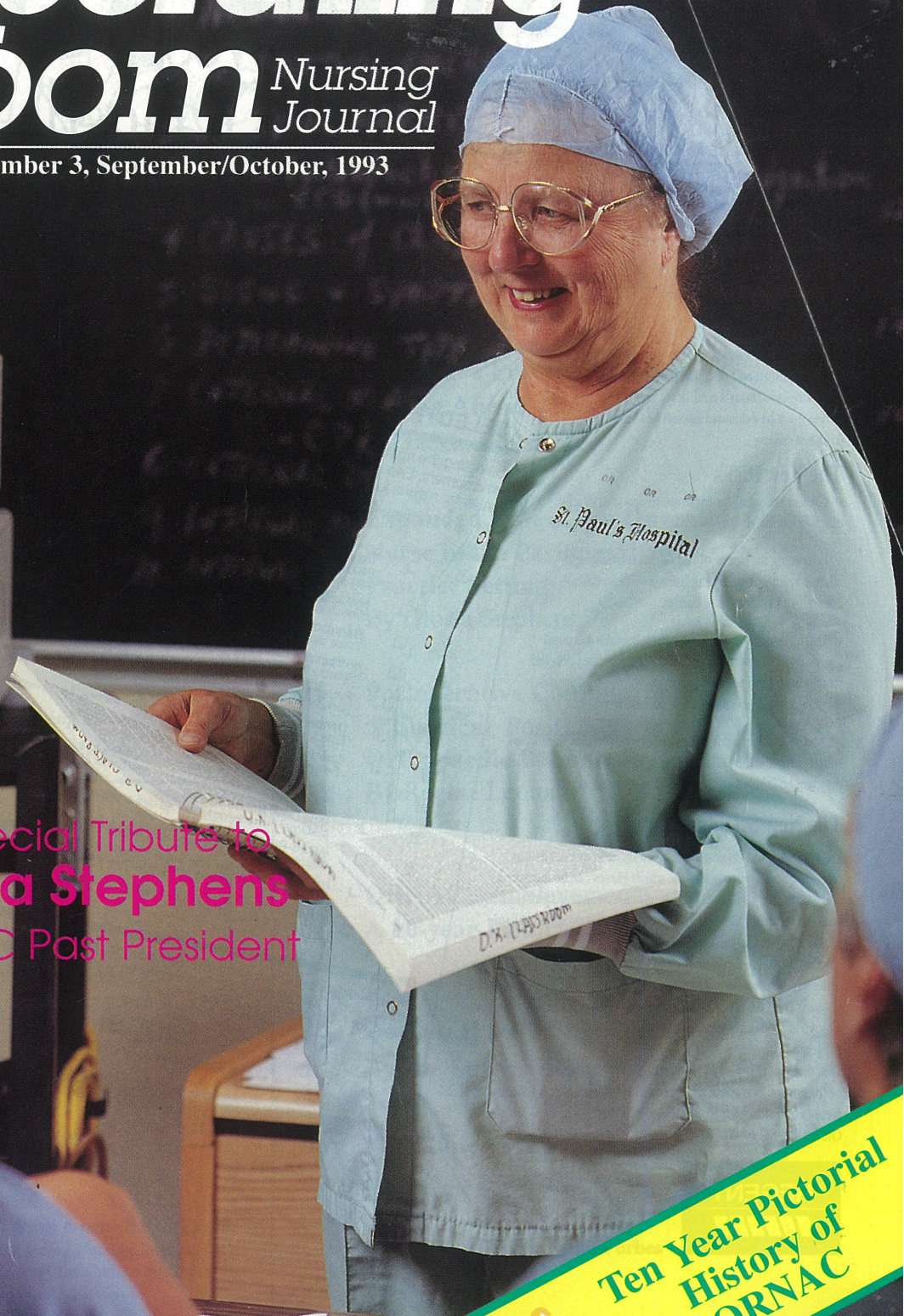


# Canadian Operating Room Nursing Journal

Volume 11, Number 3, September/October, 1993



A Special Tribute to  
**Gloria Stephens**  
ORNAC Past President

Ten Year Pictorial  
History of  
ORNAC



October, 1993



## Spring Ahead - Fall Back

By Jackie Waisman

Once again, the fall season is upon us. Our busy lives seem to get even more hectic as fall kicks off the start of school, social activities, a return to full workloads and the list goes on. For most of us, fall also signals a time change on our clocks - Spring Ahead - Fall Back. ORNAC faces the same time clock in the 90's. Is this the time to move ahead or fall back? Tough decisions for us all!

ORNAC is presently facing some very challenging and exciting issues, including: •Lobbying for OR Experience in Basic Nursing Programs; •RN's as First Assistant to Surgeon; •RN's as Assistant to the Anaesthetist; and •Certification; all of which have been discussed for a number of years and recently have gained tremendous momentum. These major issues demand a lot of volunteer time. Members of your associations, both provincially and nationally, must gather and assimilate volumes of information, share this information in an effort to establish a consensus across Canada, then await your feedback before presenting a national plan on behalf of all perioperative nurses.

As Canadians, and especially as health care workers, we watch and listen to hear how our health care system is being realigned and recreated. Concurrently, while decisions and revisions are being made to our total health care system, ORNAC must make decisions on the Association's direction and focus. Herein lies the dilemma, do we spring ahead or fall back?

At the recent ORNAC board meeting in Québec City, held in conjunction with the ORNAC National Conference, I had the opportunity and pleasure of being part of a very motivated group of ORNAC members who have a great vision for your association. ORNAC was celebrating its tenth anniversary and reflecting on how it all began, where we are today and what is our vision for the future. Our focus was and remains - meeting membership needs.

As I browsed through past issues of the *Canadian Operating Room Nursing Journal*, I came across a President's Message written by the first president of

ORNAC, Valerie Shirreff. In her message Val, writes of the formation of ORNAC and the objectives which were determined in April, 1983. She wrote:

"For many of us, this was the realization of a dream after many years of hard work, sacrifice and dedication to a cause. The creation of this association, however, is only a beginning, albeit, an historical and propitious one. Now, it must be nurtured through its formative stages, sustained and nourished until it has a strong and vibrant past with which to grow upon. In other words, as operating room nurses, it is your's and my task, together and as members of a professional fraternity, to guide it to maturity".

The tenth anniversary marks a time in the association's growth to take a safety check and determine which issues require time and commitment from our membership. We have made it through those formative stages and today we have a strong and vibrant association. By addressing the current issues we are following through with the visions of those representing ORNAC in 1983, we are guiding the association to maturity. It is time for ORNAC to "Spring Ahead" and as for the "Fall Back"- let's leave that to only the time pieces in some provinces!

Until next time...remember, "You are the wind beneath my wings".



Jackie Waisman is President of ORNAC, effective, June, 1993. She is the Nurse Manager, Operating Room and Recovery Room, Red Deer Regional Hospital Centre, Red Deer, Alberta.

Don't forget. . .

to order your  
free  
uniform catalogue

1-800-461-0033



THE DISCOVERY COLLECTION

Lac-Mac Limited, 849 Dundas Street, London, Canada N5W 2Z8  
(519) 432-2616 Fax 1-800-461-0001

# Expanded Role of the Operating Room Nurse In The Perioperative Practice Setting

By Gloria Stephens, Chairman, Research Committee, ORNAC

## Background

The project was initiated in response to a mandate from the ORNAC Strategic Planning session of April, 1992 to investigate "The Expanded Role of the Operating Room Nurse and to set up the future direction for perioperative nursing".

## Rationale

Changes in job functions and categories of workers within the OR environment are occurring because of advancing technology, financial restraints and the ever increasing complex surgical procedures. As a result of these real and potential changes it became evident that current practices and opinions of the future role of the perioperative nurse be established.

## Principle Investigators:

• G. Stephens (BC) Chairman • M. Simon (BC)

## Co-investigators:

• G. McEvoy (PQ) • D. Prokopczak (AB)  
• S. Thorn (SK) • J. Tyndall (ON)

## Potential Outcomes

- The potential outcomes of the survey included:
- indication of action to take with respect to expanding the OR nurses' role in perioperative nursing,
  - suggestions as to required/optional education opportunities,
  - indication of current practice,
  - indication of need to increase membership in ORNAC,
  - indication of action to take with respect to recruitment and retention of nurses to the specialty of operating room nursing,
  - data obtained to be used to develop goals and strategic plans, contributing to the profession of nursing.

## Basis of the questionnaire

The basis of the questionnaire was derived from the ORNAC Recommended Standards of Nursing Practice (Professional, Clinical & Competencies). In addition, some concerns (not limited to the following) expressed during discussions of the Strategic Planning Session at the April Board meeting in Toronto, 1992: were considered:

- the necessity to determine the "scope of nursing practice" in the operating room,
- circulating nurse's role having the potential of being reduced in scope and authority in view of alternate health care workers being employed,
- promote the need for continuing education for operating room nurses,
- after career laddering for experienced operating room nurses.

## Purpose

The purpose of the survey was to determine the current nursing practice of operating room nurses in Canada and to determine if there was any interest/support from OR nurses to promote an expanded role of both the circulating and scrub nurse.

## Methodology

Questions were designed to elicit information about current perioperative practice in the three phases of the perioperative period.

Demographic information was sought about the respondents, including: education, OR nursing experience, age and sex, workplace size, surgical services, operations performed and staffing.

Respondents were asked to envision the future role of the operating room nurse and give their opinion on expanding the role of the circulating nurse to that of

Assistant to the Anaesthetist and scrub nurse to First Assistant to the Surgeon.

The questionnaire was divided into four major sections:

- #A - OR facilities and personnel
- #B - OR registered nurse responsibilities
- #C - perioperative activities undergoing change
- #D - future trends

Consultation throughout the project was provided initially by research experts Barbara Greenlaw, RN, MN, and Heather Clarke, RN, PhD, (RNABC Research Consultant and UBC nursing faculty). Ongoing consultation was provided by Dr. Clarke and the research team at 3M.

The questionnaire was pilot tested with the following people completing and critiquing the questions:

- Dr. Heather Clarke, RNABC research consultant
- 3M Canada research team
- Judith Oulton (Executive Director of CNA)
- Dr. White (President, Canadian Anaesthetist Association)
- ORNAC Executive
- ORNAC research committee members

## Selection of Respondents

361 hospitals across Canada were surveyed. Hospitals were selected at random from a list of all Canadian hospitals with more than 100 beds. 75% were selected from each Province, which eliminated the possibility of regional distortion. Surveys were sent to operating room head nurses/managers with the intent that they would respond on behalf of their staff.

## Key points in the data analysis:

### 1. Sample:

It was reported that the response rate of 44% provided high statistical validity to the survey.

The following is a Provincial and hospital size breakdown of the sample:

- |                         |                         |
|-------------------------|-------------------------|
| •35% - Ontario          | •4% - Saskatchewan      |
| •25% - Quebec           | •3% - Newfoundland      |
| •14% - British Columbia | •3% - Nova Scotia       |
| •6% - Alberta           | •3% - New Brunswick     |
| •6% - Manitoba          | •1% - Prince Edward Is. |
| •29% - <250 beds/hosp   | •50% - 250-500 bedshosp |
| •13% - 501-800 beds     | •3% - 801-1000 bedshosp |
| •5% - 1000 beds/hosp    |                         |

Of significance was the fact that 75% of the responses came from the highest populated Provinces of Ontario, Quebec, and British Columbia. The majority of the hospitals are located in the city, and perform 170

operations per/week and have less than 500 beds.

Approximately 74% of the OR staff are ORNAC members and appear to be mostly situated in the mid-sized hospitals. Interestingly hospitals of over 1000 beds sampled had the lowest percentage of ORNAC members (50% vs. 74% average) and the least number of staff with OR post graduate education. The overall average being 17% with post graduate education.

OR Managers with an average of 21 years experience in OR and over 30 years of age made up 84% of the respondents. Of these 29% had taken post basic OR programs; approximately six months in length. The highest level of education of the respondents broke down to: 64% - diploma, 29% - BScN, 3% - non-nursing degrees, 4% - Masters level. (Manitoba & Quebec show significant high percentage of respondents with their baccalaureate degree in nursing).

## 2. Findings - Current Practice:

Twenty six questions were asked with regard to the OR nurses' general, preoperative, induction, interoperative, and immediate postoperative responsibilities in both the circulating and scrub nurse roles. Respondents agree, that 67% of the time, the OR nurse was solely accountable.

## General Responsibilities

- promoting and maintaining standards of practice 84%
- complying with legal requirements 83%
- identifying and rectifying unethical practices 56%
- exemplify role model characteristics 87%

Quebec views the induction differently. They appear to utilize respiratory technicians more than other provinces - to assist the Anaesthetist and provide support care to the patient during induction, and this phase is to be a shared responsibility unlike other provinces that believe the induction activities is solely the circulating nurse's responsibility.

The circulating nurse provides comfort measures in relation to vital functions 98% and is with the patient 78% at induction. The OR nurse (88%) receives, identifies and admits the patient to the operating room.

Combinations of many OR staff members are found to be responsible for the anaesthetist equipment. For recording activities and drugs during a cardiac arrest (Circulating Nurse 56%, Respiratory Technician 4%). The Circulating Nurse was found to be primarily responsible for the anaesthetic equipment (>50%).

The survey showed that the circulating nurse did

not have primary responsibility to monitor the anaesthetized patient (<60%) the exception being in the case of the monitoring local anaesthesia (96%).

92% do not have a designated RN whose role it is to assist the anaesthetist. Of those, 25%, received extra training from an organized anaesthetic program and 88% from on the job training.

The majority, 53%, indicated that the scrub nurse performs a surgical assistant's function when additional assistance is required and only when there is no surgical assistant available. This would not be considered a "transfer of function". 89% reported the scrub nurse was expected to perform both roles consecutively.

### 3. Vision on Future Roles:

The polls appeared to be split when asked if the respondents could envision an expanded role for the scrub and circulating nurse.

66% indicated that they could see an expanded role for the scrub nurse to include that of RN First Assistant. Respondents stressed the importance of advanced education and experience and this should be a separate function not shared with other responsibilities.

54% envisioned an expanded role for the circulating nurse to that of First Assistant to the Anaesthetist. Again, advance education was stressed on the fact that this should be a separate function of the circulating nurse. Some respondents felt they were presently fulfilling this task.

The most popular affiliation responsible for preparing operating room nurses to assume these functions are educational institutions.

75% of the respondents agreed that there will be an increased role for the nurses in the operating rooms of Canada over the next five to ten years.

## Survey Of Each Section

### Section A: Operating Room Facilities and Personnel Highlights:

78% of the hospitals that responded are located in the city with the majority utilizing between 250 and 500 beds per hospital. The majority, 36%, will use an average four to five operating room theatres on weekdays between September and June. (This is very dependent on the size of the hospital). Approximately 31 operations are done per day, or 170 per week on average.

The OR staff nurse most often alternates between scrub/circulating (98%) nurse duties. 86% of the hos-

pitals reported that OR nurse assists the Anaesthetist and 50% of the hospitals have their staff nurse work in the recovery room, relieve for managerial positions (55%) and do other duties such as cleaning, supplies, leader, etc. (50%).

95% of the respondents were female. It should be noted here that the Provinces of Nova Scotia and Quebec, as well as, the smaller Hospitals, have the highest ratio of males.

### Section B: Operating Room Registered Nurse Responsibilities:

This section is divided into the following sections:

General

Preoperative Phase: Circulating Nurse

Induction Phase: Circulating Nurse

Intraoperative Phase: Circulating Nurse

Intraoperative Phase: Scrub Nurse

For the most part respondents agreed that the nurse has responsibility for these activities. This section will only touch on the exceptions worth noting.

#### a. Preoperative Phase: Circulating Nurse

The overall outcome indicated that 48% of Circulating Nurses perform preoperative patient assessments. 80% of circulating nurses receive, identify and assess patients. 36% of the respondents agreed that the circulating nurse is accountable for preparing individual perioperative nursing care plans. Another 36% agreed that they *should be* responsible.

Similar results are found for the Circulating Nurse's obligation for participating in perioperative patient teaching as above. 14% currently are participating in perioperative family teaching. 35% feel they should be responsible for this and 30% are sharing this with other staff. This sharing is found mainly in larger hospitals - 30%.

#### b. Induction Phase: Circulating Nurse

Analysis shows that 55% of the hospitals are sharing the responsibility for preparing and maintaining anaesthetic equipment.

53% of the hospitals in Quebec indicated that assisting the Anaesthetist during induction is a shared responsibility. The remaining provinces feel that this is only the Circulating Nurse's obligation.

#### c. Intraoperative Phase: Circulating Nurse

Half of the respondents felt that the responsibility of monitoring the physical wellbeing of the patient throughout the perioperative period is shared whereas the other half felt it lies solely with the Circulating

Nurse. 87% of the time the Circulating Nurse is responsible for providing resources in order to accomplish the operative procedure. The Circulating Nurse evaluates the patient care outcomes and 82% of the time communicates the information to other members of the health care team.

#### d. Intraoperative Phase: Scrub Nurse

With regard to preparing and maintaining the technical equipment for surgical procedure, 60% responded that this responsibility was solely the Scrub Nurse's. Another 34% responded that this role is shared.

### Section C: Perioperative Activities Undergoing Change

Bio-Psycho/Physical Assessments are usually done on admission to the OR in the (Holding Area). Pre-surgery area 20% of the respondents indicated doing this assessment in a combination of ways: in a pre-admission clinic, on the wards the day before surgery, on the admission to the OR. Quebec had a large percentage respond that they do not do this assessment.

Before surgery most patients are assessed (76%). Only 6% responded that only inpatients are assessed.

44% of the hospitals do not use care plans. 40-50% of the respondents in British Columbia, New Brunswick, and Ontario as well as the large hospitals use "Standard Nursing Care Plans".

The OR registered nurse is found (88%) of the time to receive, identify, and admit the patient to the OR. The Anaesthetist, Respiratory Technician and Receptionist rarely ever are responsible for this. It should be noted that the Anaesthetist does receive, identify and admit 40% of the time in hospitals that have greater than 1000 beds.

A response of 54% indicated that Circulating Nurse administers medication for intravenous use. With exception, a large majority of the respondents within the provinces of British Columbia, Manitoba, Nova Scotia and PEI indicated that this activity is not performed by the Circulating Nurse.

81% responded that the Circulating Nurse would not administer anaesthetic agents intravenously.

Although the majority of the responses indicated that the Circulating Nurse would record the narcotics use by the Anaesthetist in the drug register, by 52%, the other 40% indicated negatively. (Alberta, Nova Scotia, Saskatchewan and mid-size hospitals held the majority in the No answer). The remainder of the questions asked with regard to the Circulating Nurse's

anaesthetic responsibilities were answered positively. 69% of the time narcotics are dispensed by the Circulating Nurse and 79% apply monitoring devices, equipment to patients.

76% of Circulating Nurses assist the anaesthetist during induction. The Circulating Nurse provides comfort measures in relation to vital functions 98% of the time.

Similarly, 40% of the respondents use a combination of the Circulating Nurse, Respiratory Technician, and Nursing Aide along with other staff to prepare and maintain the anaesthetic equipment. In exception, 52% of the responses in Quebec use a Respiratory Technician only, and 60% of the responses in Saskatchewan use only a Circulating Nurse.

When asked if the Circulating Nurse has primary responsibilities for monitoring the anaesthetized patients, the answers were fairly negative. Exceptions: 47% of the respondents in small hospitals indicated that the Circulating Nurse has primary responsibility only when the Anaesthetist is absent (eg. Alberta, New Brunswick, Nova Scotia, Ontario). 66% answered "always" when asked if the Circulating Nurse has the primary obligation during local anaesthesia and records findings.

Not surprisingly, 92% answered No when asked if the hospital has a designated Registered Nurse whose role it is to assist the Anaesthetist. (42% in Manitoba answered Yes). Of the remaining 8% who answered Yes only 25% have nurses who received extra training from an organized Anaesthetic Program.

The Circulating Nurse is usually chosen as being primarily responsible for assisting the Anaesthetist (67%):

- to perform specific duties during extubation/conclusion,
- to record the activities and drugs given during a cardiac arrest/emergency situation,
- to accompany the anaesthetist and patient to the recovery room.

Larger hospitals use a combination of the Circulating Nurse (60%), respiratory technician (10%), nursing assistant, along with Residents, Orderlies, OR Technicians, RN Anaesthetic Assistants, and RNs to assist the Anaesthetist during extubation/conclusion of the anaesthetic. 40% of the respondents in Quebec use a combination of the Respiratory Technician and Circulating Nurse to make available and record the equipment, drugs, etc. during a cardiac arrest. Resident, surgeons and orderly, along with the Circulating Nurse, Respiratory Technician (4%) and Nursing

Assistants are used in larger hospitals to accompany the Anaesthetist and patient to the recovery room.

76% responded that both verbal and written charts are used as a means of communication for patient information between the Circulating Nurse and the recovery staff.

Greater than 80% of the responses indicated that the Scrub Nurse has responsibility in observing and reporting activities that could cause injury. 88% indicated the Scrub Nurse is responsible to observe and respond to complications.

Most hospitals agreed, (53%), that the Scrub Nurse performs both roles when additional assistance is required and when there is no surgical assistant.

89% agreed that the Scrub Nurse would perform Scrub Nurse functions as well when performing surgical assistant activities. 96% responded that this would not be considered a "Transfer of Function" and only 25% agreed that when formulating the "Transfer of Function" activities, operating room nurses were involved in the decisions (ie. small hospitals).

#### Section D: Future Trends Highlights

66% agreed that they could envision an expanded role of the Scrub Nurse to include that of RN First Assistant.

Only 54% responded that they could see the Circulating Nurse expand its role to that of RN First Assistant to the Anaesthetist. Alberta, British Columbia, New Brunswick, Nova Scotia, and PEI were provinces that responded negatively to this question.

75% agreed that there will be an increase in the role of nurses in the operating rooms of Canada over the next five to ten years.

Comments for an increased role are:

- advances in technology have dictated an increase of the role (ie. laproscopic surgery),
- increased awareness of legalities have developed, therefore, nurses will play a greater role as patient advocates (decentralization),
- aging population will impact,
- increased regulation,
- expand to paramedical fields of anaesthetics and surgery,
- patients will be discharged at a faster rate, giving more time for patient teaching on an outpatient basis,
- as recent cutbacks become more evident, the role of the RN in the OR will expand (new roles will be developed),
- no longer a narrow vision as an instrumentalist, thus going to see a greater role of nursing specialists,

- professional autonomy.

Comments for a decreased role are:

- financial constraints,
- scrubbing will be deleted,
- flattening organization,
- the OR technician brings good value with a more reasonable salary,
- fewer procedures are being covered by OHIP, thus the number of cases will reduce, thus fewer staff,
- nurses are not going into OR nursing as there are few training programs (not part of the basic training, therefore, not attracted to it)

#### Quotations worth noting:

1. "I believe that the OR nurse's role in Canada is continually growing. This is due to high risk points, modern technology, legislated acts, as well as legal implications".

2. "I envision the OR nurse as a strong patient advocate, a resource person for the surgeon, a specialist in a particular area of surgery and as a teacher/educator of OR nursing practice..."

3. "The role will change dramatically as we move into minimal access surgery, computerization, greater access to patient care information and our ever changing technology. The decreasing health care dollars and aging population will impact and challenge our future dramatically. We must be pro-active, flexible, and prepared to meet the needs of our patients in the context of the complexities of our uncertain future".

A second survey restricted to staff nurses was conducted during the National OR Conference in Quebec City, June, 1993. The results of this survey will be published in a future issue of the Journal. As well, there will be periodic reports on what will be transpiring with regard to the "expanded role" for the operating room nurse.

#### Acknowledgement

The ORNAC Research Committee wishes to thank all facilities who give time for the respondents to answer and return the questionnaire on time, and as well, thanks to all respondents for completing the survey so well.

We are grateful to the 3M Canada Company for their practical and timely support for the project.

Aspecial thanks to research consultants Dr. Heather Clarke and Barbara Greenlaw.

Thanks to the ORNAC Executive and Board for their valuable input, support and encouragement throughout the project.

# Postoperative Complications of Surgical Positioning in the Elderly Orthopaedic Patient

By Regina Leonard

Population demographics indicate that the number of elderly persons in our society is increasing. The elderly share a number of commonalities, including health problems. At present the number of elderly who are accessing the health care system is high compared to other age levels. These clients are requiring more health care treatments, are costing more and are taking a longer time to recover and to exit from the hospital system. The number of elderly who are receiving surgical procedures is increasing (Jackson, 1988). This is especially true in the speciality of Orthopaedic surgery where arthroplastic joint replacement and reduction of hip fractures is becoming quite routine. The elderly are also having surgery for limb, shoulder and back injuries and disease processes.

Positioning for a surgical procedure may jeopardize, compromise or disrupt the integrity of the body systems. The systems most frequently affected by the surgical positioning are the peripheral neural, musculoskeletal, integument, respiratory and cardiovascular. The focus for this paper will be on the complications affecting the peripheral neural, musculoskeletal and integument systems. Risk factors present a challenge to the surgical team for all patients. Patients incur some effects from the surgical

positions, albeit most of the effects will be minor, expected and transient. Each patient is a unique individual and although some patient needs are universal, there are concerns and problems specific to each patient and at each age level.

The elderly, as a group, pose higher surgical risks than the younger population. They are often physiologically and psychologically compromised, have less body fat and muscle tissue to cushion bony prominences, have a slower and sometimes compromised vascular system, have less physiological reserve, are slower to heal and are less responsive to treatment protocols than younger patients. The elderly have decreased tissue perfusion, their health status is often lower, they frequently suffer from more than one medical condition and they may be on multiple medications. They may have impaired communication ability due to medical condition, nutritional status, medications, and the dependent nature of unfamiliar surroundings.

The elderly arthritic patient poses problems in accommodating to the surgical demands on the musculoskeletal system. The obese manifest problems with poor tissue perfusion, a larger expanse of tissue and an uneven distribution of body weight on the OR table. Fatty tissue has decreased vascularity and resiliency which may enhance breakdown of tissue (Iverson, 1988). The aged have decreased skin thickness, vascularity and healing capacity. They have diminished ability to respond to physical and emotional stress and to return to a pre-stress level of

#### Abstract

This paper addresses the elderly population from the perspective of physiological and anatomical changes which occur throughout the aging process. Recommendations to enhance elderly patient wellbeing throughout the perioperative experience are given including achieving integrity of the body systems, positions used for surgery, and actual and potential problems which may occur as a result of prolonged positions.

#### Author

Regina Leonard, RN, BScN, MEd, has experience as an OR clinician, manager and educator. She is presently Coordinator of the Licensed Practical Nurse-OR Technician Program, Royal Alexandra Hospitals, Edmonton, Alberta.

wellness. Recovery takes longer (Latz,1987). Other contributing factors which may impede integrity are the actual age of the patient, the presurgical health status, number of associated medical conditions and overall nutrition (Barangan,1990).

The problems, concerns and precautions for the elderly are different from those of the younger middle aged adult. The complications in the aged differ mostly in their likelihood of occurrence, not so much in the type of complication (Jackson,1988, Latz,1987). The complications of positioning in the OR are similar to those of any unconscious patient (Sullivan, 1985).

### Surgical Positions

All disease and rehabilitative states involve some degree of immobility. The function of all body systems is directly or indirectly enhanced by changes in the body position (Milde, 1988). The objectives of surgical positioning are to provide safe administration of anaesthesia, to provide optimal surgical access, to provide patient safety and comfort, to maintain systems integrity and to maintain patient dignity (Leonard, 1992). The position that a patient is in for surgery is decided by the surgeon and based on the procedural access required. The three most common orthopaedic positions used are supine, prone and lateral. Modifications in these positions occur as per the surgical need. For example a modified supine is used for the hip fracture patient and an exaggerated prone, in the kneeling position, is often used for spinal surgery. See Table 1 for summary of positions, procedures and considerations.

Throughout the literature two main complications are identified as resulting from surgical positioning. They are pressure sores and peripheral nerve injuries. Other, noted but not as frequent, complications are deep vein thrombosis and compartment syndrome. Back pain, stiffness in the limbs and neck, muscle aches and bruising were also identified as expected and transient occurrences from surgical positioning.

### Pressure Complaints

It has been shown that 3 to 5% of all hospital patients get pressure sores and skin ulcers. From 12 to 66% of surgical patients get ulcers (Marchette et al, 1991). The etiology of the pressure ulcer is associated with the length of the procedure, decreased perfusion and to vascular surgery. Ulcers may not show till 1 to 3 days post-operatively. There is a likelihood that these ulcers are O.R. related (Scott, 1992). Operating room acquired ulcers are believed to develop from deep to superficial layers. The pressure is believed to originate on the bony prominence in the OR whereas it develops from skin inward in the unit patient (Vermillion, 1990). Immediately post-op the skin may be

red and intact. Within 24 hours bruising appears. Up to 6 days later a sacral or other area lesion may manifest itself (internal to external breakdown). Pressure time may include the preoperative, intraoperative and post-operative patient times. Contributing factors to pressure sore development are moisture, skin shear, negativity (layers of cloth between the patient and the mattress), heat, and patient nutritional status (Scott, 1992).

Risk factors include negativity, increased metabolism, pressure, shear, time, and anaesthesia (Campbell, 1987). Stretching of muscles can lead to vessel rupture and risk of skin breakdown. Skin pressure decubiti occur from an uneven distribution of body weight which leads to poor- perfusion. Tissue perfusion is a critical factor in pressure sore formation and prevention. Patient blood pressure is a factor as the lower the patient's blood pressure the lower the force required to cause pressure sores (Sullivan, 1985). In the O.R. the patient's pressure is often kept artificially low for the duration of the surgical procedure thus increasing patient susceptibility to pressure injury. In addition, heating pads may be used. These can increase the metabolic need at the pressure points on the pad.

Pressure injury vulnerability increases with length of procedure. In operations longer than 2 hours the probability of pressure injury is stated to be as high as 66%. The chances increase dramatically in the diabetic, the vascular compromised, the hypotensive, the alcoholic, the obese and the elderly (Sullivan, 1985). Fatty tissue is susceptible because of decreased vascularity and resiliency. The sacrum, ischial tuberosity, heels, and malleolus are the most common pressure injury points. Moving and turning the patient frequently preoperatively, intraoperatively and postoperatively may prevent damage (Iverson, 1988). The elderly patient's skin condition and limitations in movement are noted and considered when positioning the patient on the operative table. Adequate supports to accommodate physiological and anatomical changes are applied where appropriate (Jackson, 1989).

Major factors in predicting skin ulcers in surgical patients are age, tissue vascularity, and time on the operating room table (Kemp, et al, 1990). Trauma, ischaemia, compression, low arterial pressure (Pa), high venous pressure (Pv) and blood flow interruption all lead to skin ulcer potential. There may be compromise after one (1) hour if tissue pressure is greatly increased (Slye, 1991).

Factors influencing the elderly patient's recovery include age, presurgical health, medical condition,

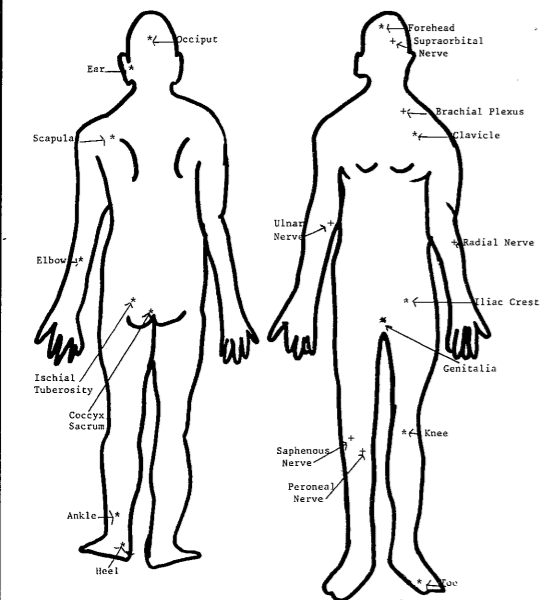
Table 1.  
Positions, Procedures and Considerations

Position	Procedures	Considerations	Comments
Supine	Extremities Shoulder Pelvis Anterior Body	-Brachial plexus injury from arm abduction > 90 -Radial, Medial, Ulnar Nerve injury -Saphenous, Tibial, Peroneal Nerve Injury -Popliteal Compression -Pressure sore injury to occiput, scapula, vertebrae, olecranon, sacrum, coccyx, etc. Skin pressure injury is the most common complication in the emaciated elderly, the obese, diabetics, and hypotensives. -Lumbar back pain may occur as a result of muscle and ligament relaxation. -Elevation of shoulder may lead to strain on the spinal column and the brachial plexus.	Stretching or compressing the nerve impedes the arterial blood supply to the nerve. This may lead to motor/sensory loss to arms, hands, shoulders, legs or feet. Venous thrombophlebitis may occur from compression. Patient's arms are well padded at the side or secured on arm boards. Head is in straight alignment with rest of body, and legs are secured with thigh strap.
Prone	Spinal Posterior Body	-Brachial plexus -Shoulder dislocation -Popliteal compression -Skin pressure to iliac crest, knees, toes, ears, face, female breasts, and male genitalia -Low blood flow	Shoulders must be supported, face placed in a face mask or carefully positioned to protect the eyes and ears. The clavicle to iliac crest is supported for diaphragm and lung expansion and the abdomen remains free from pressure. The arms are abducted with elbows flexed, palms down.
Prone kneeling	Spinal	-Knee pressure -Obese at high risk	Most of the weight is on the knees so careful padding is required. Some redness and tenderness can be expected post-op.
Lateral	Hip Shoulder Spinal Ankle	-Peroneal nerve -Ear, eye injury -Ankle pressure -Greater trochanter compression, -Neck discomfort -Brachial plexus -Radial artery obliteration	Patient may be placed in a bean bag or may be positioned with pillows, and/or a body frame such as McGuire support frame.
Fracture table	Hipfracture	-Perineal pressure -Foot constriction -Shoulder pain -Brachial plexus -Fracture site -Sacral pressure -Shearing of affected leg/hip -Genital compression	Peripheral nerve damage is rare with this position. Sacral skin breakdown is a big concern, as is genital injury. Feet are placed in traction boots, perineal post is used to help secure the patient in place and the arm on the operative side is secured over the patient's chest.

Compilation of material by R. Leonard (1993)

**Table 1**  
**Potential Body Part Injury**  
**in Surgical Positioning**

\*Common Pressure Points + Peripheral Nerves



Compilation of material: R. Leonard, 1993

nutritional status, medications, etc. Pressure sores can be avoided by altering the patient's position and by passive exercise. Baragan, 1990 notes that few patients recover fully from major hip pinning. For those who do, it takes a long time.

### Peripheral Nerve Complaints

Patient positioning for surgery may result in peripheral nerve complications. Peripheral nerve damage is usually due to a mechanical force which causes a disruption to the perfusion of the nerve causing ischaemia and sensory and motor loss to a dependent body part.

The degree of injury is proportional to the severity and the duration of the compression of the compression. The duration plays the most critical role. A constant, low pressure will likely cause more damage than an intermittent heavier pressure. The damage may be transitory or permanent. The pressure may be from an external source such as surface pressure or from an internal source such as bone or muscle. The longer the nerve and the more superficial it is, the

greater the chance of injury from an external force (Sullivan, 1985).

Muscle relaxants increase the strain on muscles and nerves. Prolonged stretching of muscle can lead to localized pain, numbness and tingling (Walsh, 1993). Postoperative complaints of numbness, tingling and bruising not associated with the surgical procedure can frequently be traced to intraoperative positioning (Sullivan, 1985). Anaesthetic agents decrease perfusion to bone and tissue and block nerve impulses. Patients can not respond to disruption in normal anatomical position and body alignment while they are in the anaesthetized state.

Brachial plexus injury is the most common injury in the supine position. It may occur from abducting the arm greater than 90 degrees, compression of the plexus by muscle or bone, or from overstretching the patients head to one side. Nerve damage to the upper extremity may occur from compression of the nerve or from misplacement of the arm. The ulnar nerve is a concern in the emaciated and elderly as it can be easily injured from OR table pressure (Sullivan, 1985, Leonard, 1992). Peroneal nerve damage can occur from the lateral positioning of the patient. This is the most common complication of lateral positioning and affects the leg that is resting on the operating table. See Tables 1 and 2 for surgical positioning considerations and injury potential.

Compartment syndrome refers to a compression of nerves, vessels and other associated structures within a fascial envelope. This syndrome is not commonly associated with surgical positioning but it can occur in the legs if they have been in stirrups for a lengthy time or in the resting arm of the patient in lateral position. The forearm and the leg are most often affected by a trauma induced compartment syndrome, because of the small compartments in these areas. Signs of compartment syndrome are hyperaesthesia, weakness, pain on passive stretch, muscle tenseness, increased skin surface pressure. The complication of a fat embolism is most common in pelvic, femoral, tibial, and rib fractures but may occur from any untreated fracture within 24 to 48 hours post fracture (Slye, 1991). Fat embolism and deep vein thrombosis are critical emergencies in the orthopaedic patient. For further information see the attached bibliography for literature.

Eye pressure, supraorbital nerve damage, facial nerve damage, and ear trauma may occur from placement of the head in the face rest or pillow. Urinary retention may be attributed to the anaesthetic, pain or bedrest and may be caused by the oedema of the spinal cord column or from nerve injury (Bryant, 1992).

### Documentation

The Operating Room Nursing Record includes documentation of the patient's position for surgery, a listing of the equipment used to position the patient and any deviations and unusual occurrences from the norm. This record provides a reference to the patient's surgical experience and will assist the nurse in assessing the patient's postoperative complaints. Awareness of the position used during surgery can alert the postoperative unit nurse as to potential problems and assist in the identification of patient concerns, thus enabling the nurse to provide effective measures in patient care.

### Recommendation

The unit nurse and the O.R. nurse need to work as a team in order to provide continuity of care to the patient. Communication is important and essential between the unit staff and the Operating Room staff. In addition to a full preoperative nursing report the unit nurses should report to the O.R. staff any limitations or discrepancies noted in the postoperative care of the patient, complications identified, concerns related to patient care, and any trends noted in the postoperative patient period. The unit nurse and O.R. nurse may wish to observe in each other's areas the types of care provided and thus internalize the rationale for procedures and elderly patient wellbeing.

### Summary

Caring for the elderly patient is becoming the norm on the orthopaedic nursing units. Knowledge of the elderly patient's physiology, limitations, aging process, normal expectations and wellness outcomes is essential in order to give effective nursing care. The elderly patient is not an older version of the middle aged patient. The elderly have unique problems, conditions and needs. The operating room experience for the elderly is more traumatic than for the younger or middle aged patient. A longer recovery time is required for these patients.

Surgical positioning of the elderly should be completed by knowledgeable and skilled operating room personnel. Patients are positioned such that surgery, anaesthesia, patient comfort and dignity can be efficiently, effectively and safely accomplished. The position is dependent on the surgical access required. The elderly patient's limitations are considered and consideration is given to the physical and physiological state of the patient.

Complications can and do occur as a result of surgical positioning. The likelihood of complications is higher in the elderly. The two main complications discussed in this paper were pressure sores and peripheral nerve injuries. The astute operating room and unit nursing team members strive to assess patient needs and to plan and implement safe patient care. Evaluation regarding the elderly patient's concerns and issues is required on an ongoing basis. Communication is essential to providing optimal care.

### References

- Baragan, J. (1990, September-October). Factors that influence recovery from hip fracture during hospitalization. *Orthopaedic Nursing*, 9(5).
- Bryant G. (1992, July). When your patient needs back surgery. *RN*, 55(7).
- Campbell, K. (1989, May-June). Pressure point measures in the operating room. *Journal of Enterostomal Therapy* 16(3).
- Iverson-Carpenter, M.S. (1988, March). Impaired skin integrity. *Journal of Gerontological Nursing*, 14(3).
- Jackson, M.F. (1988, January). High risk surgical patients. *Journal of Gerontological Nursing*, 14(1).
- Jackson, M.F. (1989, October). Implications of surgery in very elderly patients. *AORN Journal*, 50(4).
- Kemp, M., Keithley, J., Smith, D. & Morreale, B. (1990, October). Factors that contribute to pressure sores in surgical patients. *Research in Nursing and Health*, 13(5).
- Latz, P.A. (1987, August). The elderly patients: perioperative nursing implications. *AORN Journal*, 46(2).
- Leonard, R. (1992, November-December). All the right moves: Positioning the patient in the O.R. *Canadian Operating Room Nursing Journal*, 10(4).
- Lopez, J. & Silva, I. (1988, December). Shoulder arthroplasty a diagnostic and therapeutic tool ... home study program. *AORN Journal*, 48(6).
- Marchette, L., Arnell, I. & Redick, L. (1991, Nov.-Dec.). Skin ulcers in elderly surgical patients in critical care units. *Dimensions of Critical Care Nursing*, 10(6).
- Milde, F. (1988, January). Impaired physical mobility. *Journal of Gerontological Nursing*, 14(3).
- Scott, S., Mayhew, P. & Harris, E. (1992, August). Pressure ulcer development in the Operating Room: nursing implications. *AORN Journal*, 56(2).
- Slye, D. (1991, March). Orthopaedic complications: compartment syndrome, fat embolism and venous thrombosis. *Nursing Clinics of North America*, 26(1).
- Sullivan, D. (1985, July-August). Complications from intraoperative positioning. *Orthopaedic Nursing*, 4(4).
- Vermillion, C. (1990, February). Operating room acquired pressure sores. *Decubitus*, 3(1).
- Walsh, J. (1993, February). Postop effects of OR positioning. *RN*, 56(3).
- Walsh, J. (1993, February). Diagrams used in Table 1: *Positions, Procedures and Considerations*.

**Members of ORNAC:**

On behalf of all the staff of Caresen Group Inc., I am pleased to offer our congratulations on the occasion of the 10th Anniversary of the Operating Room Nursing Association of Canada and the Canadian Operating Room Nursing Journal.

Over the past 10 years there has been remarkable technical and clinical achievements. We take great pride in having been a partner with ORNAC, working together in many of these achievements.

We look forward to the years ahead, and our continued close association. As always, we offer our total commitment to provide you with superior products, exceptional service and in-depth product training and maintenance seminars.

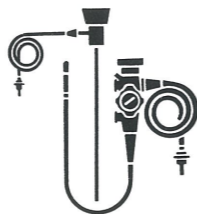
**Congratulations !**

Yours very truly,



W. Vella  
Senior Vice President

**THE FULL-LINE ENDOSCOPY COMPANY**



**ORNAC's 1st Board (1983-1986) at ORNAC's 1st National Conference, Jasper, 1994**  
*Seated Left to Right: Margaret Doyle PE, Muriel Shewchuk, AB, Shirley Hemerling (Treasurer) BC, Ann Robinson (1st Vice) PQ, Val Shirreff, ON, (President), Joan Donald, NB( 2nd Vice), Dorothy Orr, AB, (Sec/National Liaison), Bernie Francis, NS, Deborah Roberts, PE. Standing Left to Right: Ann Hayes, ON, Jane Malach, MB, Lynn Taylor, NB, Margaret Archibald, NS, André Walsh, PQ, Catherine Schlosser, MB, Donna Farid, NF, Sylvia Humphries, NF, Carol Rolfe, AB, Karin Henderson, BC, Darlene Stuttard, SK.*

**ORNAC's Achievements and Activities  
A 10 -Year Pictorial Retrospective**



ORNAC's 1st President Valerie Shirreff and 1st Secretary, Dorothy Orr raise the flag bearing the ORNAC logo. The flag was a gift from the National Exhibitor's Advisory Committee. The logo was designed by Jocelyn Patenaude of Montreal in 1985. Photo below: Gloria Stephens presents Valerie Shirreff her personal gift of two enlarged ORNAC logo impressions on permanent plaques.



**Above:** Muriel Shewchuk, chairperson of the 1984 Jasper National Conference presents Valerie Shirreff the ORNAC gavel, a gift from the Operating Room Nurses Association of Alberta.  
**Below:** The National Exhibitor's Advisory Committee - 1st Executive - (l to r) Lorne Flower, Valerie Shirreff (ORNAC President) Bernie Saul and Bob Bothwell.





**1986-1988**

**The 1986-1988 ORNAC National Executive and Board of Directors:** Standing - left to right: Karin Henderson, B.C.; Susan Knoll, BC; Lorna Murphy, BC; Deborah Roberts, PE; Catherine Schlosser, MB; Lynne McLaughlin, NB; Judy Wheeler, NB; Pat Harris, NF; Margaret Hayes, SK; Penny Gael, PQ; Carol Rolfe, AB; Marge Ensminger, AB. Standing - center: Carol Starr, ON; Darlene Stuttard, SK; Margaret Doyle, PE. Seated - left to right: Ann Hayes, ON.; Shirley Hemerling, BC; Joan Donald, NB; Val Shirreff, ON; (President); Ann Robinson, PQ; Dorothy Orr, AB; Sylvia Humphries, NF.

**ORNAC's Achievements and Activities  
1983 - 1993**

**ORNAC Board 1988 -1990 . Seated(l to r) :** Loretta Thomas-Aasen, SK; Sandra Betts, NB; Muriel Shewchuk, AB (Outgoing-Secretary); Carol Lenox-McDougall, ON, (Vice Pres.); Joan Donald, NB, (Immediate Past Pres.); Gloria Stephens, BC, (President); Carole Starr (Treasurer); Heather Arsenault, PE; Shirley Taylor, NF. **Standing:** Jackie Waisman, (Vice Pres.), AB; Carole Belanger, PQ; Lorna Murphy, BC; Marne Simon, BC; Marlene Hill, PE; Penny Gael, NS; Anne Hughes, NF (Secretary); Judith Wheeler, NB; Ann Robinson, PQ, (Outgoing Past-Pres); Geraldine McEvoy, PQ; Audrey McFaden, MB; Mary MacAdam, NS; Linda Bobinski, ON; Sharon Balkan, AB; Hilda Gatchell, ON; Eva Marie Lessing, MB; Darlene Stuttard, SK.



**ORNAC Executive and Board 1991- 1993 -Banff, Alberta, September, 1991**



*Gloria Stephens, 1st recipient of the Isabelle Adams Award, presents the award to Valerie Shirreff in 1990. Looking on is Sharon Corbie, Toronto, (far left) and ORNAC Past President Joan Donald, (far right)*



*Isabelle Adams, left) presents the 1993 award to Jacqueline Craig of Montreal. Looking on is Muriel Shewchuk of Calgary, the 1991 award winner of the "Isabelle Adams" Award for Excellence in Perioperative Nursing".*

ORNAC recognizes the major contributions of Isabelle Adams, a Montreal OR nurse who was instrumental in the foundation of a national organization which was to become ORNAC in 1983. The recognition is in the form of "The Isabelle Adams Award for Excellence in Perioperative Nursing". The award honors exceptional perioperative nurses.

The first award of "The Isabelle Adams Award for Excellence in Perioperative Nursing" was presented to **Gloria Stephens** at the 1988 ORNAC Conference in Vancouver, BC. Gloria was one of the original founding members of the BCORNG and has just completed her term as president of ORNAC. See "Tribute" page 38 of this issue. In 1990 the award was presented to **Valerie Shirreff**. Two weeks following the presentation, Valerie died at the Mississauga Hospital after a long and courageous battle against cancer.

Shirley Shewchuk of Calgary was the 1991 recipient and Jacqueline Craig of Montreal, was the 1993 recipient.

**ORNAC Executive and Board 1991- 1993 - Québec City, June, 1993**



# Just Add MDT.



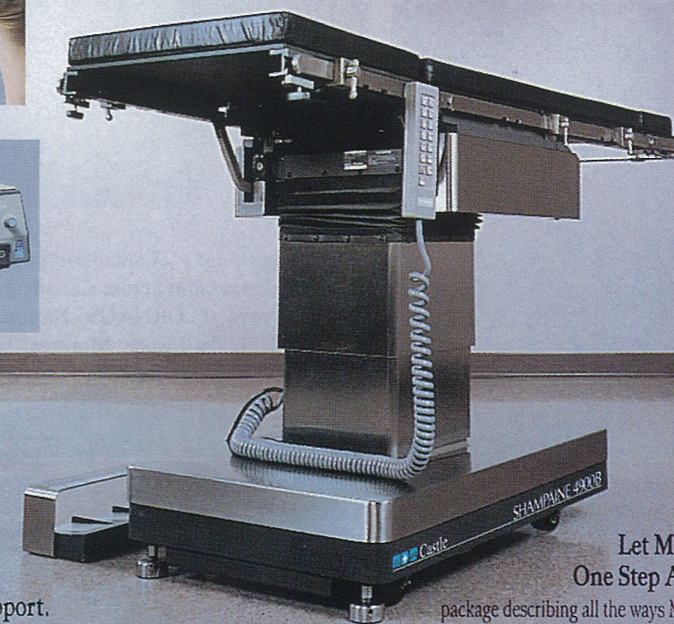
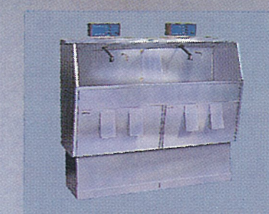
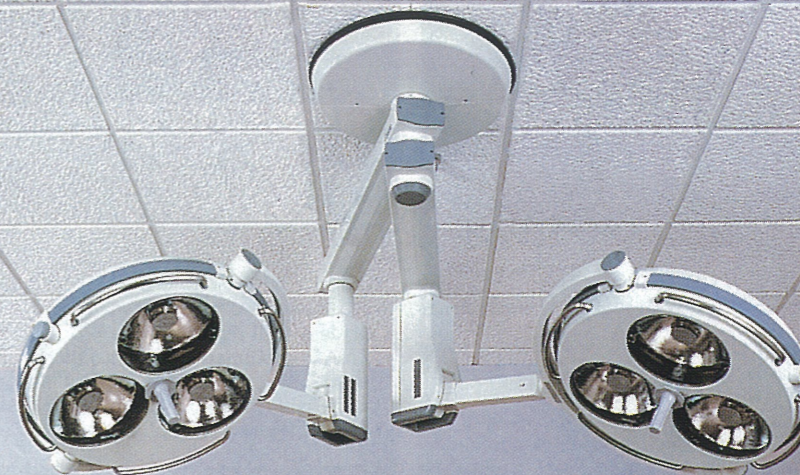
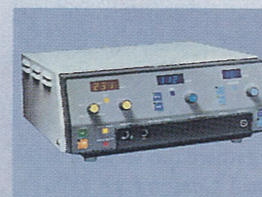
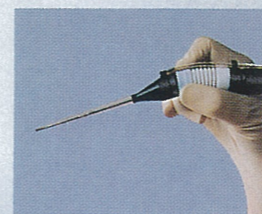
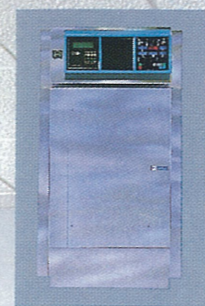
**Brilliant Control. Brilliant Flexibility. Castle Champagne Tables and Castle Lights.** For optimal performances, demand total flexibility. It's yours with the Castle® 2000 Surgical Lights and the Castle Champagne Series 4000 Surgical Tables. Choose track or center-point mounted lights in six and three-pod configurations. Castle Champagne Surgical Tables can be easily configured to handle both your routine and special procedures.

**You're On Electrosurgery's Cutting Edge With Bovie.** The Bovie® X-10 ESU with the new APRM system adds a new level of safety to your surgical procedures. It automatically senses whether the return electrode is correctly attached to the skin surface. If it isn't, the unit shuts down automatically to prevent burns. The Bovie® X-10i delivers high performance in a totally isolated unit.

And the Bovie CSV is still unmatched for its dependable coagulating performance. **Stay In Front With Bovie Aspirators.** For surgical procedures requiring high precision, choose the Bovie Ultrasonic Aspirator. The PZT (plumbeous zirconate titanate) tip converts electrical energy to mechanical energy so efficiently that bulky cooling lines are eliminated for easier handling. Plus it meets the most stringent safety codes for electrical OR equipment.

**Stay A Step Ahead For All Your Processing.** Castle sterilizers deliver the flexibility of flash sterilizing with extremely dependable performance, high volume productivity and easy operation. Castle warming cabinets and Castle-Forge® scrub stations, cabinets, and consoles deliver trouble-free operation in space-saving, easy-maintenance designs.

# And You Are One Step Ahead All Over Your OR.



**We Keep You A Step Ahead With World Class Product Support.**

All MDT equipment comes with our long-term commitment to service. You can pick the plan that fits your needs—from spot service to regularly scheduled maintenance inspection to an all-inclusive plan, available wherever you are in North America.

And nobody knows your MDT equipment better than MDT Product Support Technicians. Their training never stops. They're kept abreast of the latest repair techniques for simple or complex problems. That's how they keep you one step ahead for equipment maintenance.

**Let MDT Keep Your Surgical Suite One Step Ahead.** We'll send you an information package describing all the ways MDT works to keep you One Step Ahead in your OR. Call: (800) 387-3341, FAX: (416) 629-8875  
Or write MDT Canada Limited  
2740 Matheson Blvd. E. #2  
Mississauga, Ontario L4W 4X3



**MDT**  
Technology for Life



A major undertaking by ORNAC in 1983 was the creation of a National Standards Committee with (left to right) Gloria Stephen, (BC); Muriel Shewchuk, (AB); and Joan Donald, (NB), the chairperson. They are shown with the 1986 publication (French and English) of "Recommended Standards for Operating Room Nursing Practice, Quality Assurance Audit", which later was referred to as "The Professional Standards".

In 1988 the committee under the chair of Gloria Stephens published "The Recommended Technical Standards". In 1993 both documents were revised and published in one volume with a section on "Competencies of the OR Nurse".



Canada is well represented at World OR Conferences with ORNAC appointed speakers and hundreds of delegates. Hawaii, 1982; The Hague, 1985 (Photo above); Singapore, 1987; (Photo below) Vienna, 1989; Vancouver 1991 and Adelaide, Australia, September, 1993.



Right hand page - A small sampling of Board Members and OR nurses from across Canada gathered to work hard and play hard at ORNAC's National Conferences from 1983 to 1993, in Jasper, Montreal, Vancouver, Toronto, Banff and Québec City.

Photo left: Vienna, 1989. Photo below: Vancouver, 1991





**The 1st Winner - 1984 - Joanne Teskey**, Sunnybrook Medical Centre, Toronto, for "O.R. Preceptors Promote Competence" 1 (2), April, 1983. Presenter: Bill Clarke, at that time president of Surgikos Canada, one of the family of Johnson & Johnson Medical Products.



**1988 - Mary Knight-Kubasiewicz**, Edmonton, for "Controlling Anaesthetic Gas Exposure in PACU" 5 (2), April, 1987, (centre photo with Dave Paterson). She won a second award in **1992** for "Problem Solving in Perioperative Nursing" 9(2) May/June, 1991. (Photo right with Bill Morin)



**1985 - Jean Savickis**, The Hospital for Sick Children, Toronto, for her article "The Separation of Conjoined Twins" 2(4), Sept., 1984. (right) Dr. T.M. Gorrie

### Editorial Award

In 1983 with the inaugural edition of the *Canadian Operating Room Nursing Journal*, Surgikos Canada committed an annual \$2,500 award to recognize Canadian nurses who contribute to the advancement of perioperative nursing knowledge. The Johnson & Johnson Editorial Award is now \$3,000 and also serves as a memorial to Chris Drake and Greg Thompson, who died in an air crash in Cincinnati, Ohio in 1983. The Editorial Awards Committee was established under the chairmanship of Muriel Shewchuk, Alberta.



**1990 - Theresa Markowski**, Hotel Dieu, Kingston, Ontario, for "Sanctioned Medical Acts in the OR" 7(4), September, 1989. (photo above)

**1989 - Donna Prokopczak**, Edmonton, for "Computers in the Operating Room", Vol. 6, No. 6, December, 1988. Photo not available.

**1991. Joan Donald** (photo left) for her "Promoting O.R. Education" 8,(1), Feb., 1990. Presenter: J&J pres. Arn McLean

(Below) **1989. Sharon Ball**, Toronto, for "Laser Safety: Using the Co<sub>2</sub>, Argon and Nd:YAG Lasers" 4 (2) April, 1986.

**1986 - Jerry Rudney**, Winnipeg, "Ultrasonic Percutaneous Lithotripsy" 3 (1) February, 1985. (Photo below)



# TRANSPAK™

**NEW**  
Helps meet  
OSHA  
Standards



## TAKES THE EDGE OFF HANDLING SHARPS

*The new TRANSPAK™ from Riley Medical helps meet the OSHA requirements for the handling, storage and recovery of reusable sharps exposed to blood-borne pathogens.*

- durable polymer can be autoclaved, washer/sterilized or used with cold sterilizing solutions
- three convenient sizes for different applications
- clear top lets you see contents; no unnecessary handling
- removable, east-to-handle drainage tray

**CLASSIC**  
*Surgical*  
(EAST)  
L T D.

1-800-268-2202  
(Ontario)

**HEAD OFFICE**  
#13 - 13478 78 Ave.  
Surrey, B.C.  
V3W 8J6  
(604) 590-2200  
Fax: (604) 590-5300

**CLASSIC**  
*Surgical*  
L T D.

1-800-663-6575  
Western Canada

# Do you have a Latex Protocol ?

By Sue Smith, Judi Tyndall & Alaine Young

An allergy to latex is unlike a drug allergy. Latex is such a common element within our environment that it becomes very difficult to isolate. Allergy to latex is frequently underestimated and not seriously considered as a risk by many health care professionals. Latex allergy can result in a life threatening situation, therefore it is the responsibility of all hospitals to develop a latex policy and protocol.

The F.D.A. recommends these safety measures:

- Include questions about latex sensitivity in taking general histories of patients, particularly for surgical, radiology, spina bifida patients, and for health care workers being treated as patients. Questions about itching, rash or wheezing after wearing latex gloves or inflating a balloon may be useful. Patients with positive histories should have their charts flagged.

- If latex sensitivity is suspected, consider using devices made with plastic or other alternative materials.

- If an allergic reaction does occur and latex is suspected, advise the patient of a possible latex sensitivity and consider immunologic evaluation. Advise patients to tell health care workers about latex sensitivity and to consider wearing a medical identification bracelet.

In communication from the Director of Health and Human Services, it is stated that the Food and Drug

Administration (FDA) will soon publish in the Federal Register (FR), regulations requiring the labels of certain medical devices to declare latex content.

The regulation will require all medical devices which contain natural rubber latex, which comes directly or indirectly in contact with the body, to state on the principal display panel: "This Product Contains Natural Rubber Latex". Manufacturers may expand on this statement should they believe additional information on allergic reactions is desired. For example, the Agency would have no objections to the following wording: "This product contains natural rubber latex which may cause allergic reactions in some individuals".

The FDA and Health & Welfare Canada are looking at the use of terms such as "hypoallergenic" on latex containing medical devices such as gloves. The term "hypoallergenic" is inconsistent and misleading with respect to latex containing products.

Ansell states in their June '93 "Source to Surgery" that the term "hypoallergenic" refers to any manufacturer's gloves or device which passes a specific evaluation test. Ansell has suggested that possibly an alternative label of "low irritant" be used. We agree that an alternative name be given to these gloves because not all people with irritant/contact dermatitis are allergic to latex. For this category of personnel these gloves often resolve their problems. They do not need to use



Authors: (Left to right) Sue Smith, R.N., is a Resource Nurse in Laser, Gynecology and Oncology; Judi Tyndall, R.N., is a Nurse Clinician; and Alaine Young, R.N., is a Nurse Manager, Operating Room, Hamilton Civic Hospitals, Henderson General Division, Hamilton, Ontario.

## Abstract

In the November/December 1992 issue of the *Canadian Operating Room Nursing Journal* our submission titled "The Unsuspected Allergy" discussed the issue of a patient with latex allergy. This follow up document lists our hospital protocol, provides a company product list and information on latex gloves and the employee.

a non-latex or vinyl glove.

The Latex Protocol (Appendix 1) at the Henderson General Hospital (Hamilton Civic Hospitals) encompasses the following:

1. **Pre-op admission screen:** on the booking request form patients are asked about patient/family history of latex sensitivity, (this form is filled out in the doctor's office).

2. **Once the patient is identified/suspected of being latex sensitive:**

- Admitting, Pre-op Clinic and OR are notified
- procedure is booked in the OR suite with the laminar air flow system

3. **On Admission:**

- latex allergy band is given (patient encouraged to get a medic-alert bracelet)

- ward notified and signage for room and bed given (to warn other departments ie: lab, dietary, MDU)

- latex allergy box is obtained from CSR and stays with patient throughout hospital stay

- latex allergy box contains the hospital protocol for latex allergy patients and lists latex-free items to be used with patient (i.e. silicone catheters, non-latex gloves, oxygen equipment, latex-free tape, temp probes, etc.)

4. **O.R.**

- O.R. has its own latex box (Appendix 2) and nursing care plan (See November/December 92 O.R. Journal) for latex allergy patients.

- an extensive product evaluation list (Appendix 3) is included in the O.R. box for cross-checking during operative procedures.

Now that our hospital has successfully established a protocol for the safety of the latex allergy patient, our present goal is to educate the staff in appropriate use of latex gloves in order to reduce their risk of latex sensitization.

## Are You At Risk ?

The concern surrounding the subject of HIV and Hepatitis has led to increased glove use by health care workers. The result is that in many health care facilities gloves are being worn without conscious thought of possible consequences of such action. Only one-half of the gloves worn by nurses are used for patient care activities involving exposure to blood or body fluids. The inappropriate wearing of gloves for charting, handling of dietary trays or direct patient care not involving body substances, places the health care worker at a significantly higher risk of developing latex sensitivity due to constant exposure to latex. Nurses are clearly over using gloves for patient care activities that do not warrant glove use. Research study data indicates that O.R. nurses have a 10-14% incidence of latex positive reaction. The percentage of nurses with latex sensitivity is constantly increasing hospital-wide.

A health care worker with possible latex sensitization may initially show symptoms which could include irritation, contact urticaria, wheezing or rhinitis. These health care workers should contact Employee Health Services and initiate investigation which may include testing. The easiest, most inexpensive testing method is the skin prick test. This test gives quick results and is highly sensitive, however, one must be aware that the test may precipitate a full blown anaphylactic reaction and should only be carried out in an environment where resuscitation equipment is readily available.

## Do Gloves Give A False Sense of Security ?

Do nurses have a false sense of security in wearing bulk gloves? Research supports that latex bulk gloves worn 1-2 minutes have a 10% leakage, while gloves worn 3-5 minutes have a 55% leakage. The quality of latex gloves varies according to the manufacturer's processing. Recent evidence indicates that gloving may not assure complete protection against microbial contamination to the hands of the wearer (Reingold, Kane & Hightower, 1988; Weiss et al. 1988). This data is consistent with research by Korniewicz et al. (1990) which indicates that gloves do provide a barrier, but are not completely impermeable, particularly under in-use conditions. It is imperative that a conscientious handwashing technique be adhered to after glove removal to ensure that viral particles are removed. Handwashing cannot be overemphasized in that it is also important to the removal of any latex powder proteins left on the skin.

Sterile glove processing and testing can also be manufacturer related. The results from research indicates that variables such as the amount of stress and duration of use have vast implications in maintaining the integrity of the gloves and are correlated with leakage rates. The life span of glove effectiveness can be altered by chemicals, petroleum-based hand cream, temperature, ultraviolet light, ozone and water; therefore, hospital personnel must take care not to store gloves near fluorescent lights, direct sunlight, x-ray equipment, air conditioners or open chemicals. Rotating of glove supplies must be closely monitored.

When purchasing gloves, statistical information should be supplied by companies on glove processing and testing methods used. Products should also contain literature provided by the manufacturer but carried out by independent research firms.

## Switch to Vinyl ?

With increasing numbers of health care workers becoming sensitive to latex, is a total switch to vinyl a viable alternative? Gloves made of polyvinyl chloride (vinyl) are less flexible and less durable than latex. Latex offers nine times the barrier protection as compared to vinyl, thus showing vinyl to be of limited usefulness in high-risk, heavy usage situations. For example, in scrubbing in surgery. In research labs, using the watertight testing method, when vinyl gloves were punctured they did not reseal and had a higher defect rate (4.1%) as compared to latex gloves (2.7%). At a high stress use level, 63% of vinyl gloves leaked bacteriophage as compared to 7% of latex gloves used (Korniewicz - Leakage of Virus, 1988). All these factors indicate that at the present time, no glove offers 100% protection. Gloves do not protect workers against needle sticks which can be a mode of hepatitis and HIV transmission. Attempts should be made to reduce, control, or eliminate latex exposure to avoid sensitization of more workers.

These points should be considered in our practice:

- employees are urged to be inoculated with the Hepatitis vaccine
- appropriate use of gloves to comply with body substances/universal precautions
- education on transmission of HIV/Hepatitis
- handwashing after removal of gloves
- never reuse gloves
- use of non-powdered gloves to reduce airborne latex proteins, absorbed on the powder
- encouragement of workers with other atopic allergies or contact dermatitis to wear vinyl or plastic gloves under latex gloves or where practical and appropriate, wear non-latex gloves
- when purchasing gloves, consideration should be given to gloves with low extractable protein levels and low levels of known rubber sensitizers.

## Conclusion

The next decade should show continued research and possible alternatives to the problem of latex sensitization. Increased consumer and manufacturer awareness is the first step to serious consideration and resolution to this problem. Latex allergy can not be underestimated by the health care professional, both for the protection of the patient and themselves.

## Acknowledgement

The Authors wish to thank all the companies for their cooperation in this project. The prompt response with information was greatly appreciated.

## Bibliography

- ACAI Interim Recommendations to Health Professionals and Organizations, March 1992.
- American Health Consultants, Glove Precautions Spur Latex Reactions In Patients, Staff, July 1992, Vol. 19, No. 7, pp 89-92.
- Ansell, Source to Surgery, June 1993.
- Beezhold, D.H., Latex ELISA for Antigenic Proteins, 1992, Volume 61/No. 2, pp 77-81.
- Gonzalez, E., Latex Hypersensitivity: A New and Unexpected Problem, Hospital Practice, February 15, 1992.
- Kelly, K., Management of the Latex Sensitive Patient, Source to Surgery, Jan. 1993, Vol. 1, Issue, 1, 3.
- Korniewicz, D.M., Effectiveness of Glove Barriers Used in Clinical Settings Med Surg Nursing, 1992, 1:1:29-32.
- Korniewicz, D.M., Kerwin, M., et al., In Use Comparison of Latex Gloves in Two High Use Units - Surgical Intensive Care and AIDS, Heart and Lung, Jan. 1992, 21:1:81-84.
- Korniewicz, D.M., Laughon, B.E., et al, Integrity of Vinyl and Latex Procedure Gloves, Nursing Research, May/June 1988, pp 144-148.
- Korniewicz, D.M., Laughon, B.E., et al, Leakage of Virus Through Used Vinyl and Latex Examination Gloves, Journal of Clinical Microbiology, April 1990, Vol. 28:4, pp 787-788.
- Leynadier, F., Xuan, T.T., et al., Allergenicity Suppression in Natural Latex Surgical Gloves, Allergy 1991:46:619-625.
- Ontario Ministry of Labour, Industrial Health and Safety Branch, Report on Latex Allergy, May 1993.
- Ownby, Dennis, M.D., Critical Care Lecture, Hamilton, Ontario, May 4, 1993.
- Stehlin, D., When Rubber Rubs the Wrong Way, FDA Consumer, September 1992:21.
- Turjanmaa, K., Laurila, K., Rubber Contact Urticaria, Contact Dermatitis 1988:19:362-367.
- Zbitnew, A., Green, K., et al, Vinyl vs Latex Gloves as Barriers, Journal of AIDS, 1989, 2:201-204.

## APPENDIX 2

### LATEX ALLERGY BOX - OR

- Sterile gloves (Tactylon)
- Vinyl bulk gloves x 1 box
- Glass syringes x 5
- Plastic ambu bag and mask X 1
- Opsite & Tegaderm x 2
- Meditrace discs x 2
- Med-Fx suction tubing x 1
- #16, #18 100% silicone catheter
- Dermicel tape x 2
- Tourny (Webril underneath)
- Yankauer suction x 2
- Vinyl oxygen connector x 1
- Mallinckrodt E/T tubes (6.5 -8)
- O'Neil urinary catheter (in&out)

## APPENDIX 1

Departments of Nursing (Manual : Nursing Policy and Procedures,  
Hamilton Civic Hospitals-Henderson Division.

POLICY #03  
PROCEDURE X  
Date: Aug. 1992

### TITLE: Protocol For Patients with Known Latex Allergy

- 1.0 PURPOSE:** To decrease risk for anaphylactic reaction secondary to exposure and sensitization to latex
- 2.0 RELATED PROCEDURE(S).** - none
- 3.0 EQUIPMENT:**

#### Latex Allergy Box

##### Contents:

- Vinyl Bulk Gloves
- Non-latex Sterile Gloves
- 100% Silicone Foley Catheters sizes 14,16
- Glass Syringe
- Glass thermometer
- Plastic Ambu Bag and Mask
- Dermicel Tape/ Micropore Tape
- Opsite, Tegaderm
- Sign Indicating Latex Allergy patient
- Webril
- Yankauer Suction (Oral Suction)

Location: CSR

Ordering: CSR

#### NOTE: Other items which are latex free include:

- Suction tubing
- O<sub>2</sub> masks and tubing including Nasal
- PPM II Venti-mask
- O'Neil In and Out Catheter
- Enema kit
- Chlorhexadine pre-op sponge
- Dietary tray
- Hospital mattress
- Ivac Tympanic Temperature Probe
- Rectal tube
- Razor

#### 4.0 PROCEDURE

- 4.1 If a patient has a severe latex allergy (ie respiratory problems), a private room is recommended.
- 4.2 Teach patient regarding protocol and latex allergy.
- 4.3 Obtain latex allergy box for any known allergies and leave in patient's room.
- 4.4 Post sign over patient's bed.
- 4.5 Ensure patient has red allergy armband on.
- 4.6 Take patient's Temperature using a glass thermometer or IVAC Tympanic Temp. Probe
- 4.7 Take patient's blood pressure using Webril beneath the BP cuff.
- 4.8 Wear sterile non-latex gloves for sterile treatment
- 4.9 Wear vinyl bulk gloves for unsterile treatments involving body substances precautions.
- 4.10 Use O'Neil Catheters for Intermittent patient catheterizations. Use Silicone Foley for Indwelling patient catheterizations.
- 4.11 Use Dermicel to tape IV access.
- 4.12 Use Opsite or Tegaderm for dressings.
- 4.13 Use glass syringes for all injections.
- 4.14 Monitor patient for symptoms of an allergic reaction.
- 4.15 If patient is to be transferred or sent for tests (ie Lab), notify the receiving dept. of the patient's allergy.
- 4.16 Send latex allergy box with patient to receiving dept.(ie Lab)

#### RATIONAL/SPECIAL INFORMATION

Indicates to all staff the patient has latex allergy.

IVAC Oral temperature probes contain latex.

The bladder of the blood pressure cuff contains latex.

Regular hospital gloves sterile and unsterile contain latex.

Red rubber and foley catheters contain latex.

Micropore contains latex.

Disposable syringes contain latex.

Re: 4.14:

**Signs & Symptoms:** hives,wheals, pruritus, swelling of soft tissue involving hands, face, lips, tongue.  
**Severe Symptoms:** bronchoconstriction, asthmatic breathing, hypotension and syncope

#### 5.0 DOCUMENTATION:

- Initiate and document nursing diagnosis, goals and interventions for latex allergy
- Document any allergic reactions

#### 6.0 RESOURCE PERSONS:

Operating Room Clinician, Surgical Clinician,  
Operating Room GYN Resource Nurse

Review: \_\_\_\_\_

Revise: \_\_\_\_\_

Appendix 3

COMPANY (mfg. and/or distb.)	PRODUCT	PRODUCT CODE	LATEX CONTENT N = NO, Y = YES	COMMENTS
ABBOTT	-Decanting Set	1721	N	
	-Transpac Transducer - single	42606	N	
	-Transpac Transducer - double	42592	N	
	-Transpac Transducer - triple	42591	N	
	-Catheter Irrigation Set	6536-980	N	
	-T.U.R. Y Set	6543-980	Y	-in terminal (latex) segment
AMERICAN HOSPITAL SUPPLY	-Airway: Bardex Nasopharyngeal (Robertazzi Mode)	C055528-32	Y	
	-Catheters: - 24Fr. 3way, 30CC - 18F.	C0167124 EUF03391	Y Y	
	-Drains: Jackson Pratt	all sizes	N	-silicone
	-Fogerty Inserts	VCV5071	Y	
	Suction: - Control suction	S3014, S3010, S3008	Y	
	- Tubing 144"	70-8144	Y	
	- Tubing 72"	70-8072	Y	
	-Yankauer	C0034870	N	
	-Thoraklex Chest Drainage	C0077000	N	
	-Urine Collection Bag	40-0020	Some	
	-Urine Collection Bag	P4084	Some	
AMSCO CANADA INC.	-Table pads for 1080, 2080 and 3080 O.R. tables		N	
ANSELL	Gloves: Sterile Surgeons "Dermaprene"	Size 8 - 8506	N	Neoprene material
ARROW MEDICAL PRODUCTS INC	-Arrow Introducer Kits	HG-09800	Y	-latex in hemostasis valve
ARROW INTERNATIONAL	-Silic catheter	SS-14701	N	
	-Injection Caps	IC-14703	Y	-latex in diaphragm of cap
	-All balloon catheters	all codes	Y	-latex balloon
	-Heimlich valve connecting tube		Y	
	*O' ring on Percutaneous Sheath		Y	
	introducer valve casing		Y	
	*O' ring on CathGard		Y	
	-Johans Adapter Cap		Y	
	-Heimlich valve - Internal flutter valve		Y	
	-Hemostasis valve in Perc. Sheath Introducers		Y	
	-Syringe plunger Cap		Y	
	-Raulerson Syringe valve		Y	
	-Emergency Infusion Device spring wire guide seal		Y	
	-Hand-Off Thermolulution Cath. tubing seal		Y	
	-Pneumo thorax Kit	AR-01500	Y	
	-Injection Cap	IC-14703	Y	
ARBOR MEDICAL	Hydrophobic Filters (proximal)	121	N	Virgin Polypropylene
ARTEC INC.	Airways: Berman, Guedel and colour coded Guedel	all sizes	N	-thermoplastic
ARS (Assoc. Respiratory Services)	Non-rebreathing Valve	414-0200-100 series	N	Polycarbonate & Silicone
AUTOSUTURE	-Surgiport III: 15mm disp trocar	179032	Y	internal seal
	-Autosuture stapling products	all other codes	Y	
AVION MEDICAL	All respiratory disposables (O <sub>2</sub> masks, nasal cannula, etc.)		N	medical grade plastic
BARD	-Airways: Bardex Nasopharyngeal	055528 to 055532	Y	
	-Catheters: -ureteral R&L	136405 R&L	N	
	-Drains: DAVOL Lg & Med	0034610	N	
	-Hickman Catheters (Davol)	FR-60035-2 & FR-60016-2	N	
	-Percutaneous Introducer Kits	60146	N	
	-T-tubes (Davol)	all sizes	Y	
	-Simpulse Irrigation Unit		Y	latex diaphragm
	-Stone Baskets	039340, 039330	N	
	-Suction: Yankauer (Davol)	0034870	N	
	-Urinary Drainage Bag 4 Litre	153509	N	
	-Urolase Laser Fiber	350000	N	
BAXTER (AHS Specialities) American Hospital Supply)	VIP Swan Ganz catheter 7.5	EH93A-831-7F	Y	latex balloon
	-Airways: nasal	C055528-C055532	Y	
	-Asepto syringe	F7525	Y	
	-Catheters:			
	- 3 way, 30cc 24FR.	C0167L24	Y	
	-18 Fr.	EUF03391	Y	
	-Drains:			
	Jackson Pratt	all sizes	N	Silicone
	Chest- Thoraklex	CC077000	N	
	-Fogerty inserts	VCV5071	N	Insert is latex
	-Suctions: Control suction	S3014/S3010/S3008	N	PVC material
	-Suctions: Tubing	70-8144 / 70-8072	N	PVC tubing, *connector is latex
	Yankauer	C0034870	N	
	- Urine Collection Bags:	40-0020 and P4084	Y* and Y*	*in sample port only
	-Anaesthesia Filter: Transparent	19406-107	?	
	-Anaesthesia System: Circle	19408-329	?	
	-Blood/Fluid Warming Sets	DWC-100	?	
	-Converters Sleeves	589	Y*	*in elastic band
	-CVP Manometers	4338A	?	
	-Converters drapes and gowns	all products	?	
	-Feeding Tubes	71030B / 71032B	N	PVC Material
	Gloves: Sterile Surgeon's "Elastyren"	all sizes	N	Styrene Butadiene Block Polymer
	-Ommaya Reservoir	NL850-1270	?	
	-Oxygen tubing, crush resistant vinyl tipped 7'	P0013202	N	
	-Urometric TUR Series Set	JC4006	N	
	-Sodium Phosphate and Biphosphate Enema	20306-010	N	

BENTLEY LABS	-Straight Connectors 1/4x1/4	C-120S	N	
BIOMET	Filter system	631030	?	
	Filter Insert	631050	?	
BECTON-DICKINSON	Gloves: -sterile surgeon's "Neolon"	all sizes	N	Neoprene
	- Bulk vinyl-Truetouch	482207, 482205, 482003	N	Vinyl
	-Needles	305198/305196/305176/ 305156/5144	N	polypropylene hub
	-Spinal needles	5183/5184/5148/5161 5181/5149/5180	N	polypropylene hub
	-PRN adaptor	388171	Y	latex port
	-syringes	9574/1604/1625/ 9588/9685	Y	glass
	-Shurt: LeVEEN	8542	N	
BOSTON SCIENTIFIC (BEEJAY MEDICAL)	Medtech Greenfield Vena Cava Filter, Carriers and access.	50-100/200/600/526	N	
	-Pulmonary Cytology brush (Microvasive)	50-328/300/301/537, 50-312/314/335	N	
	Stump socks - post op sock	1600	N	
CAMP INTERNATIONAL	Sweatbands - Stackhouse	RS-102	N	Orlon/Lycra Blend
CANADA MICROSURGICAL CONCORD-PORTEX	-Airways: Clear disp.	330011	N	
	-Humid Vent Portex Filter	580011	N	
COOK (Canada) Inc.	Catheters:			
	-3 Fr. Radial Artery Catheter	C-FMS-301-RA	N	
	-CVP: single lumen	C-PUM-501J-PRG	N	
	- Triple lumen	C-U-TLM-701J	N	
	#5 right yellow whistle tip	022105	N	
	#5 left yellow whistle tip	022205	N	
	Stent: Ureteral Pigtail-	133624S17	N	
	Silicon 6Fr. 24Cm			
	Uteteral Pigtail-	133624S17	N	
	Silicon 6FR. 28CM			
	Stent: ureteral Pigtail			
	Softflex 6fr. 24CM	039624	N	
	6fr. 25CM	031625	N	
	6fr. 26CM	039626	N	
	6fr. 22CM	039622	N	
	7fr. 22CM	039722	N	
	-Ureteral Brushes 5fr. 80CM	040000	N	
	-Ureteric open end Pollack 5fr	021305	N	
	-Handle for baskets	059200	N	
	-Torcan blue Catheter -Cobra visceral	BPS 6.5-3865N-NS-C3	N	
	-Angiographic catheter	P.50M-38-65-M-45-0	N	
	-Angiographic cath. TM high Flo torque control cobra visceral	HBP5.5-38-65-M-NS-C3	N	
	-Angiographic multi-purpose	HBP5.5-38-65-M-6S-MPA N	N	
	-Stylette catheter #14fr	066514	N	
	25cc balloon-Raye nephrostomy			
	-Smith Percutaneous Endopyelotomy	084712	N	
	stent set #12fr. catheter with 7 FR.stent			
	-Ureteroscopy Balloon Catheter	078354	N	
	-Amplatz renal Dilator Set	075000	N	
	-Teflon Catheter	T80-38-88-0 NS ARD	N	
	-Teflon Cath. Short 10fr.	075010	N	
	-Nephrostomy tract dilator set	077030	N	
	-Percutaneous Nephrostomy set	PNS-1	N	
	-Guide Wire- straight teflon coated (.38x145)	638433	N	
	-Guide Wire- curved teflon coated (.38 145.3)	638414	N	
	-Beneton (.38 x 145)	638487	N	
	-Liposuction tubing	TLST100	N	
COLLAGEN CORPORATION	Alveoform Biograft	5201BS/5201BC/5201CS, 52001CC?	Y*	
CRITICAL ASSIST GROUP	Level 1 - IV fluid warming set	D50	?	*injection port only
DAVIS & GECK	-Pre Op Scrub Brushes	8001-04	?	
		8019-04	?	
	-Sutures	all types	?	
	-Valtec Anastomosis Rings	all sizes	?	
DEVON	Lite Gloves	3611, 3612	N	
DOW CORNING	all DOW orthopaedic products		N	
DUMEX	Gloves: sterile surgeon's "TASTYLON"	all sizes (i.e. 41060)	N	
	-Sponges: Opake 4 x 8	4967S	N	
	-Laparotomy tapes 18 x 18	1213	N	
	-Laparotomy tapes 18 x 24	1272	N	
	-Laparotomy tapes 18 x 36	1293	N	
DYNETECH LIMITED	Medex 3way & stopcock with 6" line	MX436-60	N	
FUTURMED	-Falope Seal	000782-3	?	
	-Flat Red Seal	000758-7	?	
	-O-ring	100441	?	
	-Berkley plastic Adaptor	00220-51	?	
	-Berkley Collection Bottle	54389	?	
GENERAL ELECTRIC MEDICAL	Patient mover	E63228BA9	?	
GRAPHIC CONTROL	-Medtrace Pellet electrode	1801	Y	
	-Pellet electrode	F91	Y	
HOLLISTER LIMITED	-Ident-A-Band (clear)	6748	N	
	-Ident-A-Band (red)		N	
	-Loop Ostomy Gasket	7345	N	
	-Loop Ostomy Bridge	7767	N	
	-Wound Drainage Collector with Barrier	9773	N	
HOWMEDICA	-Cerclene Partridge Plates & Straps	6108-8-170	N	
		6610-3-320	N	
	-Moore's Head Replacement	6808-2-00	N	
	-Nallet Head Replacement	6809-2-001	N	
	-Mallet Head Replacement	6809-2-003	N	
	-Mixing Bowls	6201-3-400	N	
ICN CANADA LTD.	Scarlion silicone Surg-I-Loop	8-93-79 8-93-81	N	
	Scarlion silicone Surg -I-Loop	8-93-77	N	

IVAC				*in Y injection site	COMPANY	PRODUCT	PRODUCT CODE	LATEX CONTENT Y = Yes N = No	COMMENTS
	-Universal Set (pump cassette)	52073	Y*						
	-Universal Set	52053	N						
	-Infusion Set: Primary universal	C50087	N						
	-Disp. probe cover for mod.2090	P90	N						
	- tympanic thermometer								
INGRAM & BELL	-Falope Ring Procedure Kit	00719250	N	Silicone band	MALLINCKRODT (cont)	-left tube with carinal hook with CPAP	95852	Y	
	-Maxitherm Blankets	SZ2276 / SZ2274	N			-Warmtouch Patient Warming System	503-0810	Y	
INSTRUMENTARIUM	Washers: 10 mm. Silicone	CEV-110J	?		MEADOX MEDICALS, INC	(Carequit Blanket)			
	- 8 mm. Silicone	CEV-108J	?		(BRENT SURGICAL)	-Veri soft str. Cooley Dacron	234420	N	
	- 5 mm. Silicone	CEV-105J	?		MEDITEK	Tube Graft			
	-5 mm. W/3mm hole Sil.	CEV-103J	?			-Action Pressure Management Pads		N	
JOHNSON & JOHNSON	-Ethicon Mechanical Stapling	all products	N		MEDICAL MART	-Hytape 1"	358-10	?	
	-Ethicon endosurgery products	all products	N			-Surflo I.V.cannulas	16,18,22	?	
	-Ethicon Sutures	all products	N		MILES	-Cutter Blood Bags		N	
	-Ethicon Hemostasis products	all products	N		OHMEDA	Probe Materials: Oximeter		N	housing C-Flex
	-Drapes: Surgikos Barrier Packs and gowns	all products	N			-Flex II:		N	window: Acrylic
	Tape: Dermicel	H-5382,5382,5383	N			-Black:		N	housing: Acrylic
	Dermiclear	H-5248,5250,5254	Y			-Ear Probe:		N	window: Acrylic
	J&J Waterproof tape		N					N	Diffuser: PVC
	Gloves: - Dispos-A-Glove	3168,3128	N					N	Cover & housing: ABS
	-ALLERGUARD synthetic surgical glove		N					N	Stabilizer: Polyethylene
	-Vein Strippers Diap.	634031	N					N	Cover: vinyl
J & J (CRITIKON)	-Mask: Barrier		N		OLYMPIC MEDICAL	-Soft Probe:		N	Pillow & pad: silicone
	-Dura-cuf complete inflation system	2830-2835	Y			-Grey Probe:		N	polyvinylchloride
	-Dura-cuf BP cuffs	2699,2697,2698,2770	Y		O-TWO SYSTEMS	Olympic Vac Pac (patient positioner)		N	beads are styrofoam
		2771,2774,2778,2779			INTERNATIONAL INC.	-Resuscitation Face Masks	02FM4999,02FM5000	N	polyvinylchloride
		2780,2781,2782,2783						N	
		2790,2795,2796,2791						N	medical grade PVC
		2281,2283,2285,2287	Y					N	medical grade PVC
	-Disposa-cuf complete inflation system	2341	Y		PICKER INTERNATIONAL	Cushion Tabletop Hydrojet III	333108	?	
	-Reusable bulb and valve	2659	Y		PREFERRED MEDICAL PRODUCTS	-Spinal procedural tray	2534	N	
	-Disposable bulb and valve	4600	Y			-Continuous epidural Tray	1016	N	
KENDALL CANADA LTD.	-Jelco Intermittent Injection cap	50024	N			-Epidural Catheter	100	N	
	Underpad	69019	N		RUSCH-PILLING	-Rectal tubes (soft rubber)	436700	Y	
	Combine Pad ( unsterile)	507587,27044X	N		INTERNATIONAL	-Rectal tube (PVC)	sterile 22 55 00	N	
LABORIE	-Washers	ST 27040G	N			-Rectal tube (PVC)	sterile 23 58 00	N	
(R. Laborie Surgical Ltd.)	-Resectoscope Cutting Loops	ST 27072NS	N			-Facemask with hook ring	3101	Y	latex-neoprene overdip
	-Nephroscope Caps	ST 277550A series	N			-Ureteral Connector	3365-00	Y	
	-Nipples	ST 27502	N			-Intertech Filtered Heat & Moisture Exchanger	002835	N	
	-Leur lock connector	ST 27024YL	N			-Teeth Guards	50-2276	N	PVC
	-gasket	ST5.0/2.6/1.8 series	N			-Pilling Esophageal bougies (Mahoney,Hurst)		Y	
	-Caps	ST 27080E,FA,GA,HA	N			-Bougies Mahoney Style-100% silicone	size 20:50-7968 to size 60:50-7988	N	
	-Calcutript Probes	PT495NL,NB,etc.	N		RICHARDS	Microscope Drapes	89-0005	?	
	-Light Cables	PT 495SSL 35/50	N		SANCELLA INC.	Excel pants	07686,etc.	N	
	-Light Cables (Orange)	FE851	N		SHERWOOD MEDICAL INDUSTRIES	-Salem Sump Tube	8888-2649-86	N	Lycra & Dorlastan
	-Fishie Clip (FEMCARE)	001	N			-Saratoga Sump Drain	8888-5305-27	N	
LES INDUSTRIES (FANNY) LINVATEC	Reducer		N	Titanium and silicone Formaldehyde Acetate		-Medicut Cannula	8888-1002-14	N	
	-Drape: for camera	9707	N			-Thoracic Catheter Series	8888-5705-xx	N	
	-light cords		N			Celestine tube	8888	Y	
	-Hemoclips	523800,523860,523870	N		SIMS	Myringotomy tubes:	140028	N	
	-Electrodes:		N		SMITH & NEPHEW	-Shepard Grommet		N	
	-Hook electrode	115630	N			-Feuerstein	140250	N	
	-spatula electrode		N			-Richards T	240071	N	
	-Menisectomy basic kit	9737B	N			- ENT long & short term		N	
	Instrumentation:		N			implant products.eg.middle ear prosthesis		N	
	-all Sensatec Instruments	all sensatec inst.	N	Kynar(black insulation on laparoscopic inst.) silicone silicone		-Dressings:		Y	latex in adhesive
	Washers: for chole lap. instr.	110001,110002	N			-Elastoplast dressing including elastic Adhesive Bandages	All codes		
3 M CANADA INC.	-Action Wrap (self-adherent)	110010,110006	Y			-Hypafix		N	
	-AVI Infusion Sets		Y			-Airstrip	all sizes	N	
	-Coban & self Adherent Wrap		Y			-Melolite	all sizes	N	
	-Incheque Sterilization Indicators	1201,1202	Y			-Drape: Opsite Incise Drapes	all sizes	N	
	-3M Arthroscopy Fluid Control system Tube Sets	83091, 83100	Y			-Microdrape	89-0005	Y	blue rubber band-latex
	-Tape: 3M Autoclave Steam Tape	1222,1224,1255	Y			-Soft guard Barrier, Soft & Secure	1163-04	N	
	-3M Autoclave Tape for disposable Wraps	1255	Y			-Gloves: Surgeon's & Specialty		Y	
	-INDEX ETO Indicator tape		Y			-Cut Resistant		N	
	-3M Particulate Respirator	1814	Y		SORIN CANADA	Shiley/Sorin tracheostomy tube		N	
	-Red Dote Electrodes	2230-2265,2270,2271	Y			Sorin embolectomy catheters		Y	latex balloon latex covered tip
		9630,9640,9641	Y					N	
		1071	Y					N	
	-Steri-Drape (Urological drape with finger cot)		Y					N	
	-Tape: Micropore	all codes	N		STEVENS	-Surgifix Sizes 1-B	641-010191027		
	-Transpore	all codes	N			-Urinary leg bag			latex straps
	-Dressing: Tegaderm		N			-Ultra thin disposable gloves	635-014-200		
	-Mesk skin Closure	1556	N			-Instrument marking tape	175-N-800	?	
	-Masks: ASEPTEX Surgical Masks	1800,1812	Y			-Esmarch bandages	377-5610-08	?	
MALLINCKRODT MEDICAL	TRACHEAL TUBES:		Y			-Cystocath suprabubic drainage system	600-330-12	N	silicone elastomer
	-cuffed Intermediate Hi-Lo	86448	N			Bardex Catheters			
	-Oral Rae Preformed	86201	N			-20 fr. 5cc 3-way whistle tip	666-132V	Y	
	-Nasal Rae Preformed	86214	N			-20 fr. 30cc 3-way	666-125RV	Y	
	-uncuffed trach tubes	86224	N			-22 fr. 30cc 3-way	666-125RV	Y	
	Broncho - Cath	85887	N			-24 fr 75cc 2-way	666-0113-24	Y	
	-Gentle Flow Suction Catheter	85898	N			-26 fr 75cc 2-way cath	666-0113-26	Y	
	-Hi-Lo General Purpose Temp. Sensor	90104	N			-16 fr 5cc 2-way council cath	666-196V	Y	
	-Satin-Slip Intubation Stylet	85865	N			-18 fr 5cc 2-way council cath	666-196V	Y	
	-Hi-Lo Trach.tube with Lanz pressure regulating valve	96107-5.0mm	Y	enclosed-latex balloon to inflate cuff		-20 fr 5cc 2-way council cath	666-196V	Y	
	-Broncho cath:	96117-10.0mm	Y			-22 fr 5cc 2-way council cath	666-196V	Y	
	-Endobronchial tube with the CPAP SYSTEM	Right-85815 Left-95880	Y	contain standard latex anaes.circuit breathing bag		Malecot Rusch 4-Wing			
						-20fr	180415800	Y	red latex
						-22fr	180415800	Y	red latex
						-24fr	180415800	Y	red latex

COMPANY	PRODUCT	PRODUCT CODE	LATEX CONTENT Y = Yes N = No	COMMENTS	
STEVENS (cont)	5cc 2-Way Tieman Coude				
	-18fr	866-102L	Y		
	-18fr	866-102V	Y		
	-20fr	866-102V	Y		
	-22fr	866-102V	Y		
	-24fr	866-102V	Y		
	Fbley Catheter	866-174V	Y		
	-20fr	866-174V	Y		
	-22fr (inactive item)	866-174V	Y		
	-24fr	866-174V	Y		
	-22fr 30cc 3-way	866-167L	Y		
	-24fr 30cc 3-way	866-167L	Y		
	-20fr 30cc 2-way	866-166L	Y		
	-22fr 30cc 2-way	866-166L	Y		
	-24fr 30cc 2-way	866-166L	Y		
	-26fr 30cc 2-way	866-166L	Y		
	Ureteral Olive Tip Cath				
	-#4	866-13655	N	polyurethane	
	-#5	866-13655	N	polyurethane	
	-#6	866-13655	N	polyurethane	
	Ureteral spiral Tip				
	-#4	866-375-04	N	polyurethane	
	-#5	866-375-05	N	polyurethane	
	-#6	866-375-06	N	polyurethane	
	#24fr 75cc 3-way catheter	866-125-75	Y		
	Cone Tip Occlusion Cath				
	-8fr	866-138008	N	polyurethane	
	-10fr	866-0380	N		
	-12fr	866-0380	N		
	-3fr Whistle Tip	866-036103	N		
	-4fr Whistle Tip	866-036104	N		
	-6fr Whistle Tip	866-036106	N		
	-7fr Whistle Tip	866-036107	N		
	-8fr Whistle Tip	866-036108	N		
	-5fr (grey) Whistle Tip	866-136405	N		
	-Adaptors Ureteral Catheter	140000	N		
	Woven Filiform 12" Straight				
	-Size 2	866-021902	N	woven dacron	
	-Size 4	866-021904	N	woven dacron	
	-Size 6	866-021906	N	woven dacron	
	Spiral Woven Filiforme 12"				
	-Size 4	866-022104	N	woven dacron	
	-Size 6	866-022106	N	woven dacron	
	-size 5	866-022105	N	woven dacron	
	Electrodes:				
	-Green Ball Tip 8FR.	229-CET107K	N		
	-Orange Ball Tip 7FR.	229-CET107R	N		
	-Blue/Brown Ball Tip 8FR.	229-CET107K	N		
	-Green Cone Tip 8FR.	229-CET107A	N		
	-Orange/Yellow cone Tip 7FR.	229-CET107A	N		
-Blue Cone Tip 8FR.	229-CET107A	N			
-Yellow Ball Tip 24FR.	229-U247B	N			
-Yellow Knife Tip 24FR.	229-U247A	N			
-Black Loop 27FR.	229-U310R	N			
-Black Knife Tip 27FR.	229-U247A	N			
Stone Extractor #5 (5 wire)	180-341801-5	N	teflon shaft		
Filiform Tip					
Nasal splints	N-3916SA/MA/A	N			
-Bowls, Mixing	206-550	?			
-Cylinders, Carbide	1360-000				
-Nozzles, Str. Femoral	206-512	?			
-Pressurizers, Cancellous	206-518	?			
-Pressurizers, Prox. Femoral	206-526	?			
Caps for external fixation	394.97	N	Delrin		
tubes					
-Curette, Curved 10mm	360600	N			
-Curettes, " 8 to 14	20317 etc.	N			
-Collection Set, Vacurette 3/8"	326976	N			
-Mapleson D Circuit	TM1003	?			
-Anaes. Filter	TM1002	?			
-Sigmoidoscope, disposable	53130	?			
Washers: (WOLF)	all codes	N	HTV Silicone Rubber		
VALLEYLAB CANADA	all electrourgical products	all codes	N		
VITAI	Laryngeal Mask		N		
XOMED-TREACE	-Nasal Splint, External	15-28120	N		
	-Nerve Locator	8262015	N		
	-Acetabular Liners	67 _SERIES	N		
	-Bone Cement	1102 SERIES	N		
	-Castelli Membrane	10-12015	N		
	-Cereilage Wiring System	1292-81	N		
	-Dermacarriers	2195-012-00	N		
	-Harris Femoral Pressurizer	5069-12	N		
	-Hemovac Kit 1/2"	2550-002-10	Y*	*in anti-reflux valve	
	-Hemovac Kit 1/4"	2550-004-10	Y*	*in anti-reflux valve	
	-Hemovac Collection Bags	1550-50-10	N		
	-Innertube for Reamers	1428-005	N		
	-MGII Articulating Surface	51 _Series	N		
	-MGII Poly Patella	51 _Series	N		
	-Miller Cartridge Kit	5069-52	N		
	-Nozzle, 12" Flexible	5069-54	N		

## Bursary Fund

Sponsored by ORNAC and Johnson & Johnson

### 1. Purpose of the Fund

To financially assist ORNAC members in furthering their education.

### 2. Factors Influencing Assistance Available

1. Other financial assistance requested and / or granted.
2. Previous bursary funding granted by ORNAC.
3. Length, place and content of educational program.

Note: Financial assistance is not available for salary replacement.

### 3. Application Process

1. Fill out application form and submit an application form to ORNAC.
2. Reference letters- two, (2) from most recent employer which states the applicant's professional competence and experience, (ORNAC will request the reference).
3. Reference letter should address applicants potential to succeed in the program.
4. Submit autobiographical to include career accomplishments, education, goals.
5. Proof to be submitted of registration for the program.

### 4. Responsibility of Applicant Receiving Funding

1. Signed contract to be returned to ORNAC Executive within 30 days of receipt of contract, otherwise funding will be withdrawn.

#### Criteria For Selection

1. Applicant must be a member of a provincial group for minimum of three (3) years.
2. Primary employment focus - the Operating Room Nursing ( staff, education, administration).
3. Applicant has actively participated in their respective Provincial Group and/or with ORNAC. Applicant's participation to be listed & submitted with application form.
4. References (2) indicate the applicant promotes professionalism, is responsible and accountable, and has potential to succeed.
5. Applicant's future plans at the completion of the program must include perioperative nursing.

\*Perioperative nursing defined in (Rules & Regulations) Information Manual.

For more information or to apply for the Bursary Fund please contact ORNAC's Awards Committee Chairperson:

**Muriel Shewchuk**  
 Director of Nursing, OR/RR/Surgery  
 Foothills Provincial General Hospital,  
 1403-29 Street N.W.,  
 Calgary, Alberta  
 T2N 2T9

## Calendar

1994

Operating Room Nurses of Ontario  
 3rd Provincial Conference - April 25-27, 1994.

"Personal Commitment + Professional  
 Collaboration = Capital Gains"  
 Ottawa Congress Centre, Ottawa, Ontario.

Exhibit Chairperson: Carole Starr  
 Fax: 1-705-876-5105  
 Bus Phone (705) 743-2121

B.C.O.R.N.G. 14th Biennial Conference

June 2nd to 4th, 1994

VERNON, B.C.

Contact: Trish Allen,  
 4108 -14th St., Vernon, B.C.  
 VIT 8B9 Phone: (604) 542-2418

ORNAC -14th National Conference  
 Vancouver, May 8-12, 1995

ORNAC -15th National Conference  
 Ontario, 1997.

Purchase the 'New' ....



ORNAC

"Recommended Professional  
 and Clinical Standards"

for Operating Room Nursing Practice.

This document is a combination of the 1986 and 1988 publications and includes a new section on competencies of an O.R. nurse.

The Standards may be purchased for  
**\$35**

(includes handling) payable to:

The Operating Room Nurses Association  
 of Canada.

Send order, cheque and a return address to:

**Carole Starr**  
 39 Terraview Heights  
 Peterborough, Ontario  
 K9L 1M7



**Canadian Operating Room Nurses Association of Canada  
Executive and Board of Directors - 1993**

**President**

Jackie Waisman  
Nurse Manager, OR,RR  
Red Deer Regional  
Hospital Centre  
Red Deer, AB

**President-Elect**

Loretta Thomas-Aasen  
Nursing Unit Manager,  
OR/PACU/CSR/ER  
St. Joseph's Hospital of  
Estevan, Estevan, SK.

**Past President**

Gloria Stephens  
Nurse Clinician  
St. Paul's  
Hospital  
Vancouver, BC

**Vice President**

Vija Hay  
President ORNAO  
Nurse/Manager, OR/RR/DS  
Queensway Carlton,  
Ottawa, ON

**Secretary**

Hilda Gatchell  
Nursing Unit Mgr.,  
Surgical Suite,  
Oshawa General  
Hosp., Oshawa, ON

**Treasurer**

Marlene Hill  
President ORNPEI  
OR, Queen Elizabeth  
Hospital,  
Charlottetown, PEI

**Provincial Representation - 1993**

**British Columbia**

Shirley Hemerling  
BCORNG President  
Operating Room  
Kelowna General Hosp.  
Kelowna, B.C.

Lorraine Varner  
Kelowna General  
Hospital  
Kelowna, B.C.

**Saskatchewan**

Anna Kristoff  
President SORNG  
Clinican Nurse Educator,  
Staff Nurse,  
Regina General Hospital  
Regina, SK

Phyllis Arnst  
St. Paul's Hospital,  
Saskatoon, SK

**Ontario**

Judi Tyndall,  
President-Elect ORNAO  
OR Clinician  
Henderson Div., Hamilton  
Civic Hospital, Hamilton.

Carol Starr  
Unit Supervisor, OR  
Peterborough Civic  
Hosp., Peterborough ON

**Quebec**

Jane Percy  
President, SO/OR  
Operating Room  
Queen Elizabeth Hosp.  
Montreal, PQ

Josette Forest  
President Elect, SO/OR  
Ste.Foy, P.Q.,

**New Brunswick**

Elizabeth Thompson  
President, NBORNG  
OR, Dr. Everett Chalmers  
Hospital, Fredericton, NB

Corina Balcom  
Pres.Elect.NBORNG  
OR, Region 7 Hospital  
Corporation, Newcastle, NB

**Nova Scotia**

Donna Farid  
NSORNG President  
Victoria General Hosp.  
Halifax, NS

Shelly Zareski  
NSORNG President-Elect  
Operating Room  
Isaac Walton Killam  
Hospital, Halifax, NS

**Newfoundland**

Angelia LeMoine  
President, N&LORNA  
Western Memorial  
Regional Hospital,  
Corner Brook, NF

Lillian Budden  
Pres-Elect, N&LORNA  
OR, Dr. Charles A.  
Janeway Hospital,  
St. John's, NF

**Prince Edward Island**

Rosemary Moase,  
Vice President, ORNPEI,  
Prince County Hospital  
Summerside, PE

**Alberta**

Jane McClain  
President ORNAA  
Lethbridge Regional  
Hospital,  
Lethbridge, Alberta

Dahlia Robinson  
President-Elect ORNAA  
OR Clinical Coordinator  
University Hospital  
Edmonton, AB

**Manitoba**

Karen Schuster  
President- MORNA  
Seven Oaks General  
Winnipeg, MB

Karen Steindel  
President-Elect MORNA  
Operating Room  
Children's Hospital  
Winnipeg, MB

**DEROYAL**  
**SURGI MATE**<sup>TM</sup>  
SURGICAL ACCESSORIES

**HAVE WE GOT A MATE FOR YOU!**

**NeedleMate!**  
Needle counters - the most complete selection available with different product styles and types for everyone. Foam Strip, Magnetic or Combination.

**SkinMate!**  
Surgical Skin Markers - prep resistant, non-toxic ink. Available in Standard and Fine Tip.

**CauteryMate!**  
Electrosurgical Tip Cleaner

**InstruMate!**  
Magnetic Instrument Pad

**SurgiMate Vessel Loops!**

**SurgiMate Suture Boots!**

**DEROYAL**  
INDUSTRIES OF CANADA, INC.

An Affiliate of DeRoyal Industries, Inc.  
108 Woodbine Downs Blvd. #1A  
Etobicoke, Ontario M9W 5S6  
1•800•458•0865  
FAX 416•798•2046

# Tribute to Gloria Stephens

## Immediate Past President of ORNAC

By Agnes Forster

If space allowed, many operating room nurses could be singled out as exceptional practitioners, or teachers, or association members, and honored accordingly for their many hours of dedication to the development and enhancement of perioperative nursing. But, Gloria Stephens stands out, in large measure because of the sheer volume of her services, accomplishments and the many awards recognizing her contributions over the years. I believe she must be acknowledged in this anniversary issue in a special tribute as she steps down as president of ORNAC. It is important for organizations to record their history and she has been significantly involved in many of the advancements in perioperative nursing, especially since the inception of both ORNAC and this Journal.

Gloria has been deeply committed as an educator and association board member in program development and practice standards development, within her hospital as well as at a provincial and national level. She was a member of first ORNAC Standards Committee and later, as chairman of the National Standards/Education Committee, her committee published the "Recommended Technical Standards" in 1988. In 1993, her committee published the combined Professional and Technical Standards. Also under her chairmanship her committee published "Approval of Post Basic Operating Room Nursing Standards" in 1988.

She has been impressively active in highly public ways, for example as President of ORNAC from 1990 to June of 1993, and just as often in private, quietly behind the scenes, in some tedious, exacting and time consuming undertaking.

I am not an intimate friend, but I have grown to admire her over the past decade as a gifted communicator, a woman of great warmth and generosity and most especially as an educator. Her legions of students offer unsolicited admiration and many of them have been encouraged to write articles in the journals. Many have successfully done so. She herself is a lifelong learner and uses all the new toys and innovative techniques available to educate in the classroom, at conferences, in her speeches, in videos, and across Canada for the teleconferencing projects.

She is one of the most frequently published authors in this Journal's history, and probably the record holder for conference presentations to OR nurses across Canada and as a Canadian rep around the world.

Gloria started work at St. Paul's Hospital, Vancouver as Team Leader (in charge) Neuro, Ortho, Plastic Surgery. She has specialized in thoracic surgery and in her early nursing days in Halifax was a public health nurse. In 1960, she assisted in developing the Open Heart Program at St. Paul's and scrubbed on the hospital's first open heart procedure.

As the Nurse Clinician in the 560-bed teaching hospital in downtown Vancouver, a position she has held since 1972 she was responsible for the development and implementation of their six-month Operating Room Nursing Education Program offered twice a year. St. Paul's program was one of the first programs to receive "accreditation" by RNABC 1974.

In addition she also conducts inservice and orientation programs for all levels of staff at St. Paul's, including OR staff, surgical ward nurses and interns.

Gloria Stephens is a role model for all OR nurses and educators. She is strongly rooted in operating room nursing practice and through her unique and creative educational approaches she has transformed perioperative nursing in many areas. She is committed to excellence in nursing and has labored on hundreds of committees, over endless reports, manuals, and publications.

She has served with distinction at all levels of OR associations. She served as founding member and later as president of the British Columbia Operating Room Nurses Group (BCORNG) 1970-72.

We cannot list all her achievements, all her memberships and publications, but we list some of her major awards.

### Awards

1992 - British Columbia Operating Room Nurses "Award of Excellence";

1990 - Registered Nurses Association of B.C. "Award of Excellence in Nursing Education";

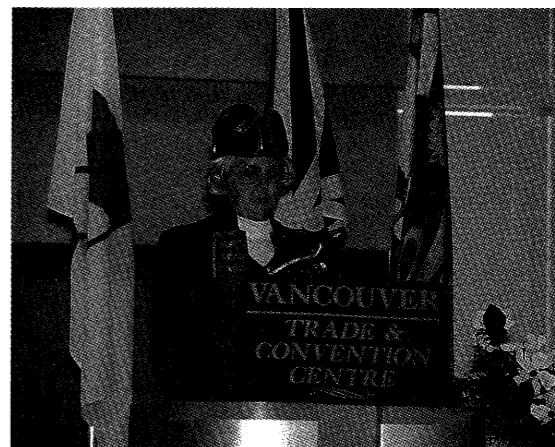
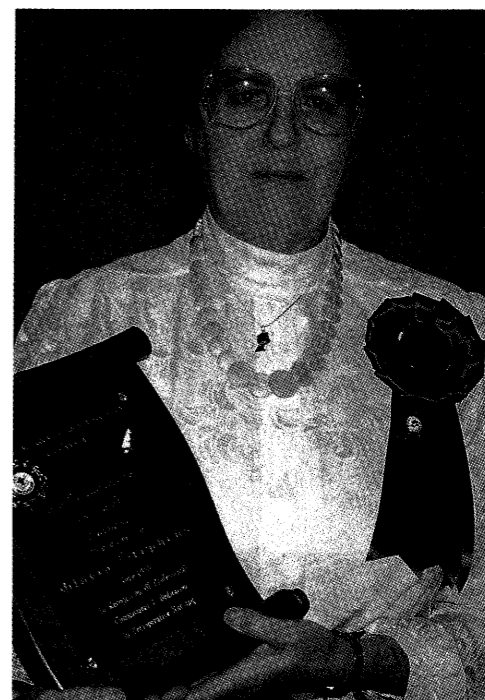
1988 - Operating Room Nurses Association of Canada (ORNAC), "Isabelle Adams Award for Excellence in Perioperative Nursing";

1987 - Registered Nurses Association of B.C. "Award of Excellence in Nursing Practice"; and

1973 - RNABC Vancouver chapter - "Innovative Nurse Award for writing the first *Standards of Operating Room Nursing Care*".

Currently, as immediate past-president of ORNAC, she is the chairperson of the Research Committee and has one article in this issue and another awaiting publication. Gloria, we all look forward to working with you, reading your informative and inspirational works, and following your future achievements.

On behalf of all our readers, we thank you.



**Top Photo** - Gloria Stephens receiving the British Columbia Operating Room Nurses "Award of Excellence". Marnie Simon, (right) BCORNG president (1992) presents the award.

**Middle Photo** - In 1988, the first recipient of the Operating Room Nurses Association of Canada "Isabelle Adams Award for Excellence in Perioperative Nursing".

**Lower Photo** The lighter side of Gloria was demonstrated in 1988 as ORNAC's National Conference Coordinator in Vancouver. She wore her "Captain Vancouver" outfit to both promote the successful conference in a year earlier, and while hosting its 1,400 registrants.

MICRO-TOUCH\* LATEX SURGICAL GLOVES

# Trusted Protection. Now More Sensitive.

MICRO-TOUCH Surgical Gloves have long been the leading brand. Now they're more sensitive, flexible and comfortable.

• **SENSITIVITY**

Advanced latex formula provides greater tactile sensitivity.

• **PROTECTION**

Look for the Johnson & Johnson stamp of quality on every glove. It's your assurance of superior protection.

• **FLEXIBILITY**

Low modulus latex formulation reduces hand fatigue.

• **COMFORT**

Curved fingers and adequate finger length make movement easy.

• **PLUS ...**

**NEW PACKAGE**

Impervious poly material minimizes latex deterioration, clear seal turns opaque if compromised and thumb notch makes opening easier.



*Johnson & Johnson*

MEDICAL PRODUCTS

1421 LANSDOWNE STREET WEST, PETERBOROUGH, ONTARIO K9J 7B9  
WESTERN & ATLANTIC PROVINCES: 1-800-668-9045 • ONTARIO: 1-800-268-5577 • QUEBEC: 1-800-668-9067

\*Trademark