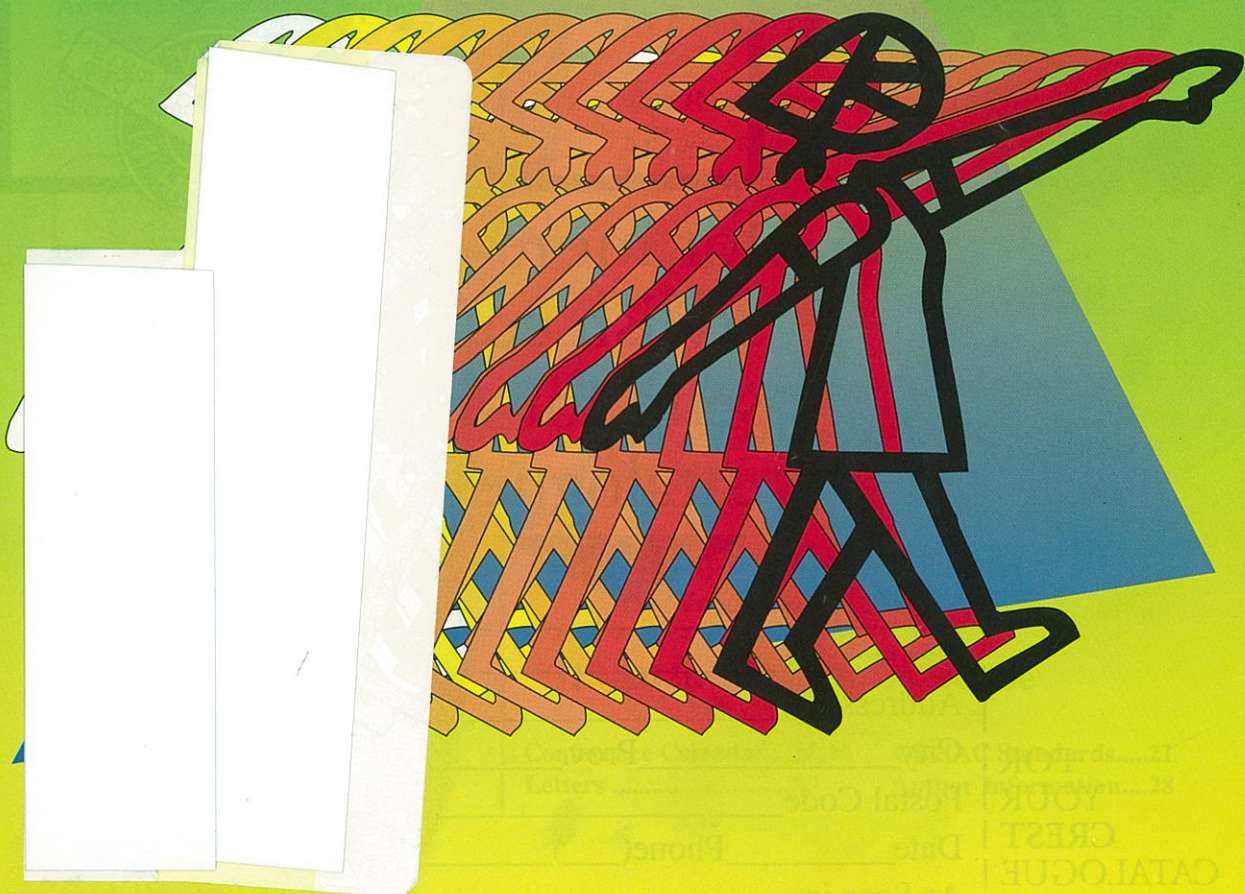


Canadian  
**Operating**  
**Room** Nursing  
Journal

Volume 10, Number 2, May/June, 1992

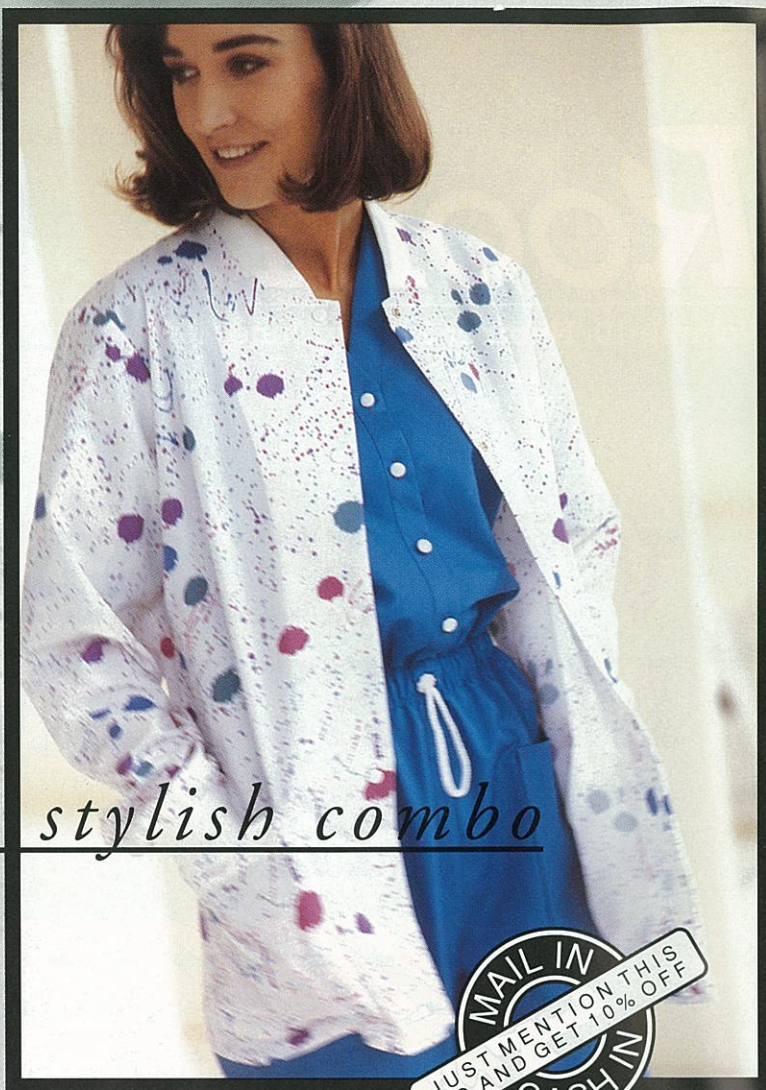
# WORKLOAD MEASUREMENT SYSTEM



FOR MORE INFORMATION  
CONTACT THE PUBLISHER  
DATE OF PUBLICATION  
CATALOGUE  
CLIP & MAIL

**CREST**<sup>®</sup>  
The Uniform Company

**Lac-Mac**  
LIMITED 



*stylish combo*



for more  
stylish combos  
send for our  
catalogue

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_\_  
Postal Code \_\_\_\_\_  
Date \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
As Seen in \_\_\_\_\_



Lac-Mac Limited  
425 Rectory Street  
London, Canada  
N5W 3W5  
(519) 432-2616  
Fax 1-800-461-0001

# Canadian Operating Room Nursing Journal

Published for the Operating Room Nurses  
of Canada by Health Media Incorporated.

Volume 10, Number 2, May/June, 1992

## Contents

### Editorial Staff:

**Editor:** Agnes Forster  
**Legal Writers:** L.E. and Fay Rozovsky  
**Editorial Board:**  
**Hilda Gatchel, R.N., (Chairman)**  
Head Nurse, Operating Room,  
Oshawa General Hospital, Oshawa, Ont.  
**Loretta Thomas - Aasen**  
Weyburn, Saskatchewan  
**Sandra Betts**  
Saint John, New Brunswick  
**Geraldine McEvoy**  
Montreal, Quebec

### Advertising and Subscriptions

Ron Forster  
Publisher & Advertising Manager  
Sherri Cannon - Subscriptions Manager

Canadian Operating Room  
Nursing Journal,  
14453 29A Avenue  
White Rock, B.C.  
V4A 9K8

Phone: (604) 535-7933  
FAX: (604) 535-9000

Subscription Rates:    1 Year   2 years  
Canada                    \$ 16.00 \$26.00  
United States            \$ 22.00  
Other Countries        \$ 26.00  
Single Copy orders     \$ 5.00  
Add GST @ 7% to all orders. R102310323  
Canadian Operating Room Nursing Journal is in-  
dexed in *Index Medicus*, the Cumulative Index to  
Nursing and Allied Health Literature.  
I.S.S.N. No.-0712-6778  
Publications Mail Registration No. 5934

- 5    **What's in the Future for ORNAC ?**  
By Gloria Stephens, ORNAC President
- 6    **ORNAC - Johnson & Johnson  
Bursary Fund for OR Nurses**
- 7    **Development of an Operating Room  
Workload Measurement System**  
By E. Friedberg, L. O'Reilly & J. Theriault
- 11   **The Regulated Health Professions Act**  
Keynote address of the ORNAO  
By Pat Mandy, R.N., B.A., M.P.A.
- 13   **Value, Venture, Vision**  
BCORNG Annual Conference Report
- 19   **Questions on Sterile Technique  
Can Lead to Study and Research**  
By Margueritte Martin, R.N., B.Sc.N.
- 22   **Principles of Aseptic Technique**  
By Wanda Oliver, R.N.
- 31   **An Invitation to Subscribe**

Conference Calendar....26,30    ORNAC Standards.....21  
Letters .....25                    Author Information....28

# What's in the Future for ORNAC ?

By Gloria Stephens

The time is here again to make sure everyone is informed as to the issues, current activities and future projects that ORNAC Executive, Board and Committees are actively working on.

During the recent ORNAC Executive and Board meeting held in Toronto, April 11 and 12, 1992, Jackie Waisman of Red Deer, Alberta was elected President-Elect. Jackie is Nurse Manager OR/RR of the Red Deer Regional Hospital Centre. She also holds the ORNAC Executive position of Vice President and will continue in this role until June '93. We all welcome Jackie to this new position.

As in all organizations success cannot be anticipated unless we know where we came from, where we are now and where we wish to be in the future. It is clear to the membership where we came from, especially after reading the *Communique* of 1991. Where do we wish to be, as an organization, in the future?

The Executive and Board struggled with this question for two days. There still is a considerable amount of work to do on a Strategic Plan but at least we managed a healthy start. Drafts of philosophy and mission statements were developed, goals and objectives were prioritized. Ideas were numerous but funding was a stumbling block to many projects, at least for the immediate future. Decentralization seemed to be a common thread throughout the meeting but, as just mentioned, availability of funds must first be considered before plunging head on into a program of decentralization. As soon as the philosophy, mission statements, goals and objectives are completely agreed upon, this information will be published in the *Canadian Operating Room Nursing Journal*

Two day-long Board meetings, once a year, create an almost unmanageable agenda where decisions

may be made without time to consider all sides of the issue. Therefore, an investigation may be done to see if two meetings a year would be feasible.

ORNAC is continuing to actively pursue the installation of OR nursing knowledge and clinical experience into the Basic Nursing Education programs. Considerable lobbying will take place with University Schools of Nursing and CNA. ORNAC's Position Statement will once again be distributed throughout Canada to people in strategic positions. Special invitations have been sent to Executive Directors of University Schools of Nursing and the President of CUNSA to attend our Board meetings. CNA's Executive Director will also be invited.

There is a great urgency throughout Canada for ORNAC to be pro-active in developing the "Expanded Role of the O.R. Nurse". With changing technology, financial restraints and lack of properly educated O.R. personnel, the traditional role of the O.R. nurse must be guarded. At the same time, to prepare ourselves for future trends the ORNAC Research Committee has received the Board's mandate to explore and recommend ways and means to expand the traditional roles of O.R. Registered Nurses. These expanded roles may encompass the RN First Assistant, Assistant to Anaesthetist and Pre and Post Op Assessments. The committee is developing an important national questionnaire, so it would benefit all OR nurses to answer promptly. If we don't act quickly then we will be in a position of only reacting to someone else's plans. The research committee will be working cooperatively with Physician/Surgeon, Anaesthetists groups, CNA, and as well, consulting with researchers.

Almost hand-in-hand with the above concerns are  
*(continued on page 6)*



## A sign of the times.



ColdSpor has hit the streets and is rapidly becoming the disinfectant/sterilant of choice where efficacy and speed are critical. After all, time is important when it comes to patient care.

**- Superior Cleaning plus Fast Disinfection / Sterilization -**

- MetriZyme, a unique, fast acting liquid enzymatic detergent, dissolves organic solids on instruments and equipment prior to disinfection/sterilization.
  - ColdSpor kills all vegetative organisms, including TB in just 12 minutes at room temperature (1:20 dilution), sterilizes in 10 hours (1:5 dilution), and makes quick work of HIV-1 in a mere 30 seconds.\*
- When every minute counts, count on MetriZyme and ColdSpor, a sign of the times!

ASEPSIS HOTLINE INFORMATION 1-800-841-1428

\* See HIV Bulletin #7. MSDS, Testing and Efficacy Data on file.



the *Standards for Patient Care in the Operating Room*. The previously published professional (1986) and technical (1988) standards will be amalgamated in the next, soon to come, edition. This edition will also have a section "Competencies of the O.R. Registered Nurse".

To assist in validating the registered nurses presence in the operating room, once again, the certification process will be investigated. ORNAC Board foresees many advantages for having certification available to our members. In the near future there will be more concrete information to report.

There is a void among our peers and the public in general, as to the actual role, functions and the amount of critical, complex knowledge and skills an O.R. registered nurse requires, in order to function effectively and efficiently in giving care to the surgical patient. It is up to us to 'sell ourselves', to actively promote our valuable presence in an operating room as the patient's advocate and to maintain standards of patient care. It is important to reach the public school system as well as other health care personnel and the public in general. ORNAC will do its part through a Public Awareness committee but the most important ingredients for success is you - the membership. Start now by making plans for O.R. Nurse Day on Nov. 14 or the week thereof.

Another concern for ORNAC is the process of handling waste and the management of waste in operating rooms. We will be working cooperatively with industry and governments on this issue.

ORNAC has developed a strong relationship with CNA and will play an active role at the annual CNA meeting in Saint John, NB, this June where many of these issues will be discussed and acted upon.

Please refer to the 'Conference Calendar' within this Journal for dates and details on several important upcoming O.R. conferences.

ORNAC is very involved in promoting Operating Room Nursing on many fronts and the success of this involvement depends on the support of all Provincial Executives, but most importantly the success depends on each member of an O.R. organization. This membership must grow. If each of you recruited one more nurse, think of our strength? Your input counts and no matter how small, it is very much appreciated. As the saying goes: "A chain is as strong as its weakest link". Let's pull together on all our projects. Be pro-active!

---

*Gloria Stephens is President of the Operating Room Nurses Association of Canada, and the Clinical Instructor, St. Paul's Hospital, Vancouver, B.C.*

## Bursary Fund for OR Nurses 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 for the ORNAC/Johnson&Johnson Fund

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

# Development of an Operating Room Nursing Workload Measurement System

By Elaine Friedberg, Lila O'Reilly & Jo-Ann Theriault

## Introduction

After the Ottawa General Hospital became one of the test sites for the Canadian MIS Project in 1985, we began to introduce retrospective "Workload Measurement Systems" (WLMS) in nursing and diagnostic service departments. At this time Specialty unit WLM systems, inclusive of the Operating Room system, were in developmental stages. We decided to proceed with the systems implementation program, assuring compliance with retrospective requirements.

An important factor in play at this point was that we had recently obtained approval to proceed with the introduction of an Operating Room (OR) computerized Scheduling System. In developing the functional requirements for the selection of scheduling system software, we clearly defined a necessity for a system with architecture which was sufficiently flexible to permit inclusion an OR WLMS.

What follows is a description of the development of a WLMS in conjunction with the 1990 implementation of an automated Operating Room Scheduling System .

## System Development

A development committee, whose members included the Nursing Director of Critical Care, the Operating Room Charge Nurse, the Operating Room Clinician and the Quality Assurance Coordinator, was formed to begin work on the system development. The committee was later expanded to include the Operating Room Scheduling System Project Coordinator. We decided that the typical activity based system would not be appropriate since OR nursing is largely influenced by non nursing functions. A literature search on OR WLMS revealed very limited applications available to assist in our project. The National

Hospital Productivity Improvement Program had recently published the "Operating Room Workload Measurement System and Staffing Methodology". This document was reviewed in detail. It did not provide information on how this methodology and resulting system related to the MIS Guidelines. In 1986 the MIS project produced a guide to the implementation of the above system in accordance with MIS guideline criteria. As very little information about OR workload measurement systems was available, we were left to create our own unique system.

We determined that we should define case and nursing functions carried out in the OR, and should sort these into categories of work described in the MIS guidelines.

We recognized that the OR system would have to meet some minimal criteria. It would have to be responsive to the MIS guidelines meeting both the global and departmental dimension requirements. This system had to be user friendly and require minimal time to maintain, and moreover, it had to provide valid and reliable data in a timely fashion.

## Authors:

Elaine Friedberg, B.Sc.N., MHA, is the Quality Assurance/Education Coordinator at the Ottawa General Hospital. Her responsibilities include the development and maintenance of workload measurement systems for the Department of Nursing.

Lila O'Reilly, B.Sc.N., is the Nursing Director in the Critical Care/Ambulatory Care Program at the Ottawa General Hospital.

Jo-Ann Theriault, R.N., is presently the Charge Nurse of the Eye Institute of the Ottawa General Hospital. Formally she was the Operating Room Scheduling System Project Coordinator.

Two major areas of classification were required to achieve our goal of utilizing what we saw as a matrix approach to the system design. We needed to classify OR nursing activities into the major categories of nursing, related, support and other support care, as defined by the MIS Guidelines. We also needed to classify all Operating Room surgical cases and anaesthesia procedures into groupings based on complexity and thus time based components. These classifications would provide the framework for our system.

Nursing activities for which standard times would be employed were defined. These activities include the following:

- Nursing Care**
  - Admit patient to the bay
  - Ready supplies
  - Set-up case
  - Admit the patient to the OR theatre
- Related Care**
  - Nursing time allocated per case that is associated with the functioning of the unit in general
- Support Care**
  - Case specific
  - Transfer patient to the Operating Room
  - Assist with positioning
  - Clean-up
- Support Other**
  - Nursing time allocated per case that is associated with activities that could be carried out by other personnel

Time study tools were developed and staff were taught to complete them. Nursing staff carried out the time studies to determine the standard nursing care and support care times related to each case. The data were analyzed and standard times assigned for eleven surgical specialties and three sub-classifications within each specialty.

The case classification activities involved input to the system of approximately 1200 procedures and indicating a category for each procedure of A, B, or C. The A, B and C category indicates the degree of complexity; and thus time required, on average, to provide for essential OR nursing functions of case preparation, clean-up, patient admission, induction and discharge.

In addition to the above mentioned time studies, nurses were asked to carry out studies to determine the time factors for related care and other support.

The MIS guidelines divide personnel into unit-producing (those personnel whose primary function is to provide patient care - MIS guidelines, 1985) and

non unit-producing categories. Studies were carried out to determine what proportion of time the clerks and attendants spent carrying out unit-producing activities. As well, the time factor to admit the patient to the Operating Room bay was determined from data collected in these studies. Analysis of the data revealed that clerical time was 25% unit-producing, while attendant time was 30% unit-producing.

Once the standard times were developed, we decided that the system should be tested. Nursing workload per case would be calculated in the following manner:

<b>Nursing care =</b>	
<b>Admit Patient to the bay</b>	standard time
<b>+ Set-up Case &amp; Admit Patient to Operating Room theatre</b>	standard time
<b>+ Intra-operative time</b>	real time
<b>+ Related Care</b>	standard time
<b>+ Support Care = Case Specific</b>	standard time
<b>+ Support Care - other</b>	standard time

At what point would the intraoperative time begin? It was decided that for the first scrub nurse the intraoperative time would be calculated starting with the patient prep and concluding with the end of the procedure. For the first circulating nurse the intraoperative time would start when the patient entered the theatre and end when the patient left the theatre. If at any time there was more than one scrub or circulating nurse involved in the case, the time they were in the room within the above stated time frames would also be calculated.

### Pilot Study

One of the purposes of conducting the pilot study was to ensure that the system did not double count activity times. This was a distinct possibility, since there is an overlap of activities in the Operating Room. An example relates to clean up, which can begin before the procedure ends.

To conduct the pilot study and to accurately calculate the intraoperative time, the following time elements were required, namely when:

- patient entered the theatre
- prep started
- procedure ended
- patient left the theatre
- each scrub and circulating nurse entered and left the theatre

Initially, there were concerns related to the collection of information from the OR record. Although this record was adequate for current needs, it did not facilitate documentation of all the actual times required to complete the pilot study. A revised OR record, designed to facilitate accurate recording of the actual times, was introduced just prior to implementation of the computer system.

Staff undertook to collect actual case times from each OR theatre and each service using a prototype of the new OR record. Initially, the project coordinator was present in the theatres during the actual cases to collect the data. This was very time consuming; however, it proved to be beneficial, since it allowed the coordinator to test the new OR record, meet staff, explain new systems that were being implemented, and serve as an "ambassador of change".

Data from the evening and night shifts were retrieved retrospectively from the OR record. Staff collaborated in the data collection process and endeavoured to diligently record all the required times, on the current OR record.

Data, collected on approximately 450 cases and encompassing all services, were analyzed; and productivity was calculated. It was known that there were times when no cases were taking place in the OR. It was therefore concluded that there should not be a productivity of more than 100% in any 24 hour period. This was confirmed by the data, since the calculated productivity, although high, was always less than one hundred per cent. Because of the consistently high productivity scores however, there was still concern that some of the standard times may have been too generous. A process of validation of standard times was undertaken. We identified that standard times for two services required adjustment.

### Computer Applications

The software purchased for the OR scheduling system did not include a workload measurement component. Software modifications were defined and incorporated to facilitate our WLMS, inclusive of computer screen design corresponding to the elements of the OR record.

As indicated previously, our system contained a predefined database of procedures classified by service and workload measurement category of A, B & C. As a result, there would be little workload data input entered by the data entry clerk. When the scheduling clerk would enter a procedure into the system, the workload measurement standard times would auto-

matically be assigned to that procedure. If a case had more than one procedure associated with it, the workload for the case would be determined from the procedure with the highest numeric value.

Consequently, for each post-operative case entered, the system calculated the hours worked, by adding the standard times as predefined, to the actual times. Actual times were calculated by the system using the intraoperative staff times. The system would default the intraoperative times from the information entered off the OR Record.

- the 1st scrub nurse's times, equivalent to:
  - the PREP START and END of PROCEDURE times.
- the 1st circulating nurse's times, equivalent to:
  - the PATIENT ENTERED THEATRE and PATIENT LEFT THEATRE times.

The default times could be overridden. Only additional, or relief nurses participating in the case had their real times, as recorded on the OR record entered by the data entry clerk.

A number of concerns were identified almost immediately when we began to actually produce workload reports. The first problem identified was one of the software. The calculation of workload time for a case that ran across midnight, thus covering two calendar dates, was inaccurate and produced workload times of more than 24 hours per case. This fault was subsequently rectified by the vendor company.

The second problem was one of data entry, related to clerical compliance and the obvious learning phase which influences accuracy levels. Written reference material resolved this problem.

### Change

The new OR record was a major change associated with the introduction of the workload measurement system as well as the computerized scheduling system. Collaboration and cooperation of the team in designing the new record produced good results. The new record was comprehensive and easy to use, followed the sequential course of the case and the screen sequence and formats. The significant change for nurses was that they must now record the times they enter and leave the case. The new record provided for capture of information needed to generate not only workload measurement reports, but many other OR management reports which were actually the initial requirement of the system.

### Concluding Thoughts

Our system became operational in May, 1991 and

is functioning well. With the implementation phase complete, a number of things became evident.

1. For the OR nurses, the system is easy to use, the major impact being the accurate entry of their in and out times on the OR record of each case. Inservice sessions introducing the system, prevented any major problems.

2. Although the Ottawa General OR workload measurement system is one component of an automated OR management system, it can nonetheless be introduced as a stand alone manual system. The many calculations to be done however, can be time consuming. During the pilot phase the OR computer system was not yet installed and data collected were analyzed using a P.C. and a spreadsheet package. This process seems to be a viable alternative for an institution that does not have a computerized OR Management System.

3. The reporting capability of the system is most flexible. It is now possible to generate reports of the total workload generated per case, as well as per service, by specific days or by week. To further enhance the system and to facilitate the calculation of productivity ratios, the OR Management System with its workload measurement units will have to be linked to the actual staffing information in the payroll system. In addition, case specific information from the OR will have to be integrated to data generated from the Global dimension reporting system so that total costs per case can be determined.

4. Even without the enhancements, the system has produced almost immediate benefits. As we began to analyze the data we saw which services and cases were utilizing the greatest number of nursing resources. As more data are collected nursing will have the information to determine the cost and effect of the expansion or reduction of various types of specialties or services. In addition, nursing will be able to assess the manpower costs and effects of any increase or reduction of different types of OR procedures. Data to assist the manager to make informed decisions is now readily accessible.

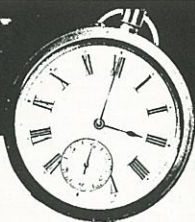
#### References

Management Information Systems Project, *Guideline for Management Information Systems in Canadian Health Care Facilities - Nursing Inpatient Services*. Ottawa: 1985

National Hospital Productivity Improvement Program, *Operating Room Workload Measurement System and Staffing Methodology*. Ottawa: National Health and Welfare, 1985.

MIS Project *Guide to Implementation of the "National Operating Room Workload Measurement System and Staffing Methodology"*. Ottawa: 1986

Where Every  
Moment Matters



## OR NURSES

*How would you like to  
have the potential to  
earn over \$40,000 your  
first year in the Wake  
Medical Center System?*

It can be done! If you are an OR nurse with at least one year of experience whose approach to patient care focuses on excellence and is built on the premise that every moment matters, we invite you to join our team of OR nurses today.

We will reward you with:

- **\$3,000 sign-on bonus**
- **\$2,000 bonus for straight 3-11 shift**
- **\$4.25/hour shift differential for 3-11 shift**
- **Interviewing and relocation assistance**
- **Generous career progression and tuition reimbursement.**

Wake Medical Center's multi-hospital system includes a central campus 560-bed regional referral and teaching facility, and smaller division hospitals located in several nearby communities, including a new 80-bed acute care hospital in Cary, N.C.

To find out more call or write today: (COLLECT) (919) 250-8146, Nurse Recruitment, WAKE MEDICAL CENTER, P.O. Box 14465, Raleigh, NC 27620-4465.

 **Wake Medical Center**

An Equal Opportunity Employer

# The Regulated Health Professions Act

By Pat Mandy, R. N., B.A., M.P.A.

## The Keynote Address to the Operating Room Nurses Association of Ontario

Our places of work, our health care system, in fact our whole world is in the midst of major unrest and change. No one knows for sure where it will all end. Sometimes we feel like Ogden Nash when he said, "Progress may have been good at one time, but it's gone too far."

At times we feel threatened or overwhelmed. We must not let this happen. We have choices and these choices will allow us to influence the constant change that surrounds us. Change will happen in spite of us. It is up to us to establish our role.

The Ministry of Health in Ontario is now establishing its role as one of leading and managing change in the health care system. The government is encouraging partnerships among those concerned with health and health care and is requiring new accountability from consumers and providers.

Change within hospitals will be a prerequisite for survival...the era of unlimited resources and unchecked growth of expenditures and services has ended. We once had an unlimited budget in health care and we exceeded it.

The pressures for change are not only financial. Numerous studies have demonstrated that different models of health care delivery can more effectively meet the needs of the consumer. It has also been demonstrated that the balances and linkages between the various institutions and agencies can and should be used to make the best use of the health care dollar.

The adjustment for nursing in this environment will be significant. Although the system shifts are in keeping with the fundamentals of our profession's beliefs, many nurses will need to learn new skills and approaches to practice. This takes place in a climate where there is a high emphasis on competence and

growing demand for public accountability. Nursing will have to redesign its role and responsibility if it is to meet the needs of society.

The government has given health care reform a very high priority. Just some of the legislation currently under review or at some stage of its development, includes the regulated health professions act and the 22 accompanying profession specific acts, the public hospitals act, the independent health facilities act, the advocacy, consent to treatment and substitute decision acts and the cancer treatment act. With little exception, the new legislation reflects a strong direction of public or consumer choice and involvement, as well as encouraging partnerships amongst health care providers and a team approach to health care.

We are about to have new health professions legislation in Ontario and it offers the nursing profession an enormous challenge.

One of the challenges of the regulated health professions act will be the development of collaborative and cooperative, rather than competing relationships with other health care providers and the public.

However the greatest challenge for nursing will be reaching agreement within the profession.

*One day a group of nurses were given the opportunity to meet with God and ask her some questions. One*

#### Author

Pat Mandy, R.N., B.A., M.P.A., is Director of Nursing, Henderson Division, Hamilton Civic Hospitals, Hamilton, Ontario. This address is an abridged version of her keynote address which compliments and supports the opinions expressed in the keynote address to the B.C.O.R.N.G. three days earlier, (See page 14).

nurse asked "Do you think that nurses will ever be recognized for their true economic worth to society?" God answered, "Yes, but not in your lifetime." The next nurse asked, "Do you think there will ever be a cure for cancer?" God replied, "Yes, but not in your lifetime." The third nurse then asked, "God do you think there will ever be agreement among all the nursing organizations in Ontario?" "Yes," said God, "but not in my lifetime."

Each of our nursing organizations have a different mandate. It is difficult to succeed in making a point with government or the public when there is conflict or disagreement amongst nurses about what that point should be. We must learn to acknowledge our differences and find those issues that bind us together, in order to strengthen our positions.

The regulated health professions act has acknowledged major change in the health system with the inclusion of 22 professions in the act. This is a remarkable shift from 1974 when the number of professions regarded as capable of self-regulation was five. One of the challenges is: that the new legislation will involve overlapping scopes of practice. When we think of overlap or conflicting areas of practice, we tend to think of the traditional professions such as medicine, occupational therapy, dietetics, midwifery and so on.

Increasingly, however, treatments considered somewhat on the fringe, such as acupuncture, transcendental meditation, yoga, and therapeutic touch, are increasingly becoming the mainstream. More nurses are becoming associated with these approaches and incorporating them into their practices. The adjustment to new approaches with an open mind can be uncomfortable - how are we as professions going to react? We must remember that minds are like parachutes...they only function when they're open.

The regulated health professions act redefines how health care providers are regulated. Instead of licensing professions, it licenses or controls, specific acts. At the same time it increases public involvement. The thrusts of the legislation are openness, quality care, consumer choice, public protection and the freedom for evolution of professional roles.

This is the legislation that will provide the framework for nursing for the next many years.

This new legislation will challenge all of the professions to demonstrate effectively what they do best. It promotes evolution among and within professional groups and it recognizes the reality of a multidisciplinary health care system where the practice of the various professions will overlap. Successful

implementation of the legislation will require new approaches as well as open communication and collaboration amongst the professions. Professionals must work together with no group assuming either a subservient or superior role. This equality will be difficult for some professions to accept.

### Nurses want autonomy

Nurses want nursing to become an autonomous profession. They want to work cooperatively as equal partners with other health professionals, e.g. pharmacists, dentists, physicians, physiotherapists. Note that physicians are not singled out. In an increasing number of hospital settings, nurses feel free to confront and even challenge other professions on issues of patient care. They view certain aspects of care as within their domain, and make decisions about patients without first consulting the attending physician.

In operating rooms, nurses are identifying their independent roles. When I worked in the operating room, nurses charted very little. Today, nurses are demonstrating their responsibility and accountability for patient care by documenting the patient's problems and responses, as well as recording nursing's activities.

These changes have not been and will not be problem free. O.R. nurses work closely with physicians all of the time. Many physicians are reacting to the increased autonomy of nurses with feelings ranging from puzzlement to confusion, and not infrequently to feeling of betrayal and anger.

Physicians for the most part did not perceive nurses to be subservient in the first place and are thus confused by their efforts to gain equality.

It is not unusual for those in power to be oblivious of the fact that those under them may feel oppressed. It will take some courage and creativity but difficulties in the nurse-doctor relationship can be worked out. Patients depend on the knowledge of both professions for their safety.

The regulated health professions act can facilitate the changing roles. The broad scope for nursing in the act, allows nurses to carry out a wide range of activities in a variety of settings. The use of nurses as primary caregivers is an obvious door which is open to us. I had not related this opportunity to operating room nurses until I read the ORNAC Position Statement on "the operating room nurses' role in primary health care" in the Nov/Dec, 1991 issue of *Canadian Operating Room Nursing Journal*. It noted that while

(continued on page 24)

# Value Vision enture

The 13th Biennial Meeting  
of the British Columbia  
Operating Room Nurses  
Group (BCORNG)  
April 9 - 11, 1992  
Vancouver, B.C.



Program planning committees are careful about the creation and selection of an appropriate theme for their conference. They give due consideration to current issues, tensions and practices within their specialty. These days OR nurses are experiencing new pressures to change both personally and professionally, and these pressures reflect the world around us which is changing at a speed heretofore unmatched in history. The theme of the 13th biennial conference of the British Columbia Operating Room Nurses Group, "Value, Vision and Venture", was chosen because it describes important characteristics of perioperative nursing in the 1990's.

Marnie Simon, President of the BCORNG welcomed 295 OR nurse delegates from across the province in her opening remarks and introduced the conference theme. **Value** implies worth, deserving of merit; **Vision** suggests having a view, or perspective, or outlook; **Venture** insinuates movement or change, or an adventure. Strengthening of these qualities will enhance personal and professional growth.

She then presented the BCORNG 1992 "Recognition Award for Perioperative Nursing". The recipient was Gloria Stephens, current president of ORNAC, and a past president of BCORNG (1972-74). Gloria received the award for her contributions in Nursing Practice and Nursing Education, as well as her contribution to the BCORNG. From its inception in 1966, Gloria has been one of BCORNG's most active members. Her extensive work on Standards for Perioperative Nursing at the provincial and national level is recognized with this award. Gloria is a frequent speaker - three World OR Conferences, numerous national presentations, and is very active on the provincial and regional scene.

**Above Photo:** Gloria Stephens, (left) recipient of 1992 BCORNG Recognition Award for Perioperative Nursing with Marnie Simon, President, B.C.O.R.N.G.

**Photo below:** B.C.O.R.N.G. Past Presidents received special plaques recognizing their service to the provincial group. (Standing left to right) Jean Kerr, Lorna Murphy, Margaret Mellan and Susan Knoll. (Seated left to right) Marnie Simon and Joan Flower (the First President).



### Past-Presidents Honored

Also honored during the conference were BCORNG past presidents - Joan Flower, the first president, (1966-68); Jean Kerr, (1974-76); Margaret Mellan, (1982-84); Susan Knoll, (1986-88), Lorna Murphy (1988 to 90) and Marnie Simon, (1990-92). Each past president was presented with a commemorative plaque in recognition of their service to BCORNG.

Barbara Greenlaw in her keynote address to the BCORNG weaved a motivational message on the conference theme Value, Vision, Venture, describing the challenges facing nurses in the 90's. She drew on her own experiences and adventures (getting lost in a storm while hiking in the jungles of Thailand) to illustrate the need to call upon one's personal adventures and successes to fuel one's sagging confidence. The Thailand hike and her other adventures are the character building episodes she can draw on to build confidence and help her venture forth in her personal and professional life. She encouraged the nursing delegates to similarly recall their past adventures and successes when courage is needed.

The following is a slightly edited and condensed version of her keynote address which offers many illuminating pointers and sign posts to assist the OR nurse on that journey, that venture, into the future.

## Value, Venture, Vision

(Keynote address)

By Barbara Greenlaw, R.N., B.N., M.A.  
Education Consultant, RNABC.

When I try something new or venture forward on a new plan or career change I go back and reflect on my past adventures. If I can cross a 100 foot gorge on little more than ropes and sticks, I can go into a meeting with my colleagues and present a controversial idea. If I can run through a forest fire with a full pack on my back, I can deal with a conflict with another professional. If I can survive a week long hike in the jungle of the Amazon, I can venture forward with a new plan for a course or a curriculum. Past experiences give us the strength, confidence and fortitude to venture out again.

To venture does not require courage alone, one must also have something to believe in, something that has value. Nurses value caring, commitment and competence. Patricia Benner's work has been very significant to our understanding of the need to value competence. In her book *From Novice to Expert* she speaks at length on how nurses achieve competence and excellence in their practice.

Benner has a vision of what nursing could be in Chapter 13 of her book entitled "*The Quest for a New Identity and New Entitlement in Nursing*". She draws

from the literature a list of the benefits that people want from work: opportunity, recognition, the desire to do a good job and self-fulfilment through meaningful work. The nursing profession can meet all these psychological requirements. She notes that nurses are not recognized even though they have responsible, significant roles. Benner goes on to say that "Entitlement, recognition and rewards commensurate with knowledge, skill and responsibility, however are possible in nursing." She then discusses her vision of how the system must be restructured to make these changes happen.

I have found Benner's vision appealing and it has helped shape my own views. However, I am not recommending Benner's vision above all others - rather I want you to focus on your own vision.

Recall for a moment what your vision of yourself was when you chose nursing. What did you see yourself being and doing as a nurse? We need to take time out to reflect, to update our vision. We sometimes think that having a vision is the work of administration or the Board of whatever.

You may recall or know nurses who are visionary. Ladies with a vision are essential. Every vision started with someone, and grew. Think of John F. Kennedy who had a vision of a man on the moon. Think of the Fathers (and Mothers) of Confederation who had a vision of Canada from "sea to shining sea". Canadians had a vision of universal health care and created the Canada Health Act. Nurses had a vision of speaking out and they created the *Canadian Nurses Association*. Nurses with a vision for OR nurses created the BCORNG. (*Rumour has it at RNABC that the OR nurses are a well organized group and get what they want. I should take lessons from your organization.*)

Our challenge is to clearly articulate our vision. By listening and explaining our goals and aspirations as nurses we will articulate a shared vision for nursing. First shared by ourselves and then by the health care system and society. Many nurses lament that we don't really know who we are as a profession, that we can't describe our unique role. We do know - it's deep within us who we are. We must find it and describe it.

Peter Serge in his recent book *The Fifth Discipline* speaks at length about having a shared vision. But he only addresses this after he discusses what he terms "personal mastering", related to competence in nursing. Personal mastery includes continuous self-development and learning. Clarifying personal vision is an ongoing practice required by those who achieve or hope to achieve personal mastery. Keeping the vision

uppermost in our mind is not the only requirement. Seeing the current reality for what it is, is essential. In fact, Serge believes that the difference between our vision and the current reality causes a creative tension. You might call it anxiety or the approximate step on the learning curve when learning really happens. He advises us to use that creative tension to get what we want. He also acknowledges that the current reality and creative tension can become overwhelming leading to inaction or apathy. Is this what is happening to our vision of Canada? To Medicare? Does this happen in our day to day problems and crisis in nursing?

### Learn to articulate your vision

What shall we do? How do we venture forward? How do you take your personal vision and develop it into a shared vision? By articulating your own vision and by reading what others have said. By listening to what others say. Through writing in your newsletter and journals you can develop the vision and then keep it clearly in mind. And always remember to keep your sense of adventure and humour.

Besides keeping your sense of humor, keep your sense of direction and watch for opportunities. We are currently in a time of dwindling resources, changes have to be made. We are warned that health care is in a crisis. At the RNABC recently the B.C. Minister of Health, Elizabeth Cull, spoke to nurses about her vision and direction for health care. She supported nurses' desire to change the system.

The Minister spoke of their view of the future role for nurses. She believes that nurses will play a stronger advocacy role for patients - this is already an area of strength for OR nurses. She sees nurses being empowered to take control. Nurses will have a major role in bringing primary health care to B.C. But she emphasized that nurses will continue to be the human face of the health care system. The caring role that we value was recognized.

She reviewed the strategic plan for the Ministry of Health with the primary direction called Quality Management or Quality Care, and predicted nurses will be able to use the Quality Improvement approach to their advantage to achieve better care for patients.

This is an opportune time for nurses to speak out - to share their vision. To be heard we must articulate and be persistent. When you have the opportunity to speak for nursing - to speak of what you do and its importance - do it. It is time for nurses to venture forth. We need to look at creating an environment that is conducive to what we do and our vision for the future.

Serge speaks of institutions becoming learning organizations. The emphasis is on the continuous learning and development of the individual and the team. Learning organizations support shared visioning through partnerships. As well as personal mastery he speaks about team learning which takes practice. As OR nurses you are working as part of a team but have you learned to learn as a team? Interesting ideas for you to critique.

Jenniece Larsen and Alice Baumgart in their book *Canadian Nursing Faces the Future* speak of nursing futures. When I first saw the plural of future I was perplexed - as it didn't seem to fit with the notion of a shared vision. But as I read this work it reinforced the idea that while we have a broad vision for nursing there will still be room for the individual perspective. Larsen and Baumgart claim that the future is created "by men and women of vision, conviction and will." They go on to say and I quote:

*"Creating futures requires the confluence of these three qualities. Vision is the most obvious. To create a future one must have some sense of the shape and texture of this brave new world. Such a vision must be able to be conveyed to others. It must resonate with the present (Serge calls this creative tension). It must build from what we know to what we believe, from what we live with to what we hope for (or in other words coming from our values). A vision, no matter how radical, must in the end seem feasible. Creating futures necessitates conviction. One must have a vision, grasp it with conviction, and hold it under fire. Will is closely related to conviction but differs in one fundamental element. Conviction is the private expression of belief; will requires conviction but adds the dimension of being public.*

Larsen and Baumgart then go on to discuss the difficulties of making change or creating a new future in the bureaucratic setting where nurses practice. They speak of the problem solving approach to change and they refer obliquely to a shared vision. I think that until we have developed a strong, shared vision that we will not succeed. Examine and develop your personal vision with commitment and will, then with your colleagues develop a shared vision of nursing.

This conference provides you the opportunity to reflect on your vision. You have stepped out of the current reality of your work. You have given yourself the time to develop what Serge would call personal mastery. Time to value yourselves and your profession. You will also have the opportunity to reaffirm your group's vision of "improving the quality of



**1992 Conference Planning Committee** - Top row left to right (standing) Gwen Gordon, Helen Calveley, Maryn Strzelecki, Gloria Stephens, Ellen Schrod, and Marion McEwan. Seated left to right: Mary Raikes-Tindle, Emily Shuya, Fran Gaudreau, Faye Meuser, Linda Ward, Susan Wynne, and Sue Kerr.

nursing care to patients". We are in a critical time in nursing and in health care in this country. We have a responsibility to our patients and to ourselves to do the right thing. Think of your vision and hold on to it. Find the means through problem solving, learning organizations or other approaches that have succeeded in the past, and then venture forth!

**References**

- Baumgart, Alice and Larsen, Jenniece. 1988. *Canadian Nursing Faces the Future*. Toronto, C.V. Mosby.
- Benner, Patricia. 1984. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, Ca: Addison-Wesley Publishing Co.
- Serge, Peter. 1990. *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday.

**The Official Opening of the Exhibits**

Helen Calveley, Exhibits Committee, Steve Moniz, representing the Exhibitors; Mary Raikes-Tindle, Chairperson, Exhibits Committee; and Marnie Simon, President BCORNG. ▼



**Sharing Power  
The Healthy Hospital Project  
By Barbara Burke, Vice President,  
Nursing, St. Paul's Hospital.**

Many hospital professionals have expressed serious dissatisfaction with many facets of their hospital working environment, and prior to this current recession, this dissatisfaction was the leading cause of the high turn rates in nursing. One hospital has embarked on a three-year project to strategically transform their troubled institution into a "Healthy Hospital".

Barbara Burke, the Vice President of Nursing at St. Paul's Hospital in downtown Vancouver, described the first year of the power sharing strategy. The project is designed to turn the hospital from a state of

Faye Meuser, the Planning Committee Coordinator; Terry Murphy - Howmedica; and the Planning Committee secretary Mary Strzelecki (Standing left to right) at the "Get Acquainted" Wine and Cheese Party sponsored by Howmedica. ▼

chaos and deteriorating employee-management relations into a healthy environment characterized by groups of people working together effectively. Ms. Burke described the process as slow and painful, but at the end of its first year with a steering committee in place the project can proceed and offer other hospitals guidance in establishing their own healthy hospital project.

St. Paul's is a 560-bed teaching hospital treating patients from a wide strata of socio economic backgrounds. Nearby neighborhoods include a large geriatric and gay population and it is the closest hospital for thousands of people working and visiting the downtown core.

Ms. Burke described the 1982 cut-backs as similar to today's funding restrictions causing workloads to be increased, education budget slashed and support departments decimated. What started as short term challenges became a way of life. Nursing turnover rates ran as high as 35%, she said.

"Aids became epidemic during this period. Other hospitals in Vancouver backed away from serving Aids patients. St. Paul's, because of its roots in Catholic traditions, became the hospital for the care of Aids patients. Some health care workers....left the hospital. The strain on the staff was increasing with no evidence of internal activities to help deal with the building pressures."

People were refusing to work in the Emergency which handles about 45,000 cases a year. Stabbings, drug overdoses and other emergencies characteristic of a downtown area in a major port city contributed to the workload. Add to these pressures labour unrest and strikes and the result is an unhealthy hospital.

**One year into the Project**

"We now understand the long term impact of our approach to budget cut-backs in the early 1980's. By focusing every available dollar on direct patient care, we neglected the health of our  
(continued on page 18)



**The Unicorn Night.** After a day of lectures and exhibits delegates to the BCORNG conference wine, dine and dance.



Dr. Walter F. Schlech III of Halifax was a conference speaker and dinner guest. He is shown with members of the conferenc committee.

**Photo below:** Gwen Gordon of the Conference Committee and an nursing colleague at the Unicorn Night.



own hospital organization. Staff had a difficult time coping and our top down decision making processes only made things worse.

- We've also learned that union involvement right from the beginning is critical. If we had the opportunity to start the process over, we would involve the unions much earlier. Getting started is tough enough. Initiating the process without union involvement from the conceptual stage makes the journey even more difficult.

- A project of this nature is going to have hospital wide impact. I believe the B.C. nurses union provincial office was correct in insisting on the involvement of the other unions.

- Since the beginning people have observed the lack of any medical staff representation on the steering committee. Our medical advisory committee chairman has now agreed to participate along with another physician. It is too early to gauge any impact of this move.

- We've also learned that you need to be prepared for the people involved to spend a lot of time together. Senior management people need to be seen as strong supporters of the initiative and to allocate sufficient time to the program.

- Union and management people use a different jargon. There was a lot of time spent talking to each other, not realizing our communication differences.

- It took our committee a long time to overcome the "we can do it ourselves syndrome". (A reluctance to use outside consulting services to help the steering committee develop into an effective team was tolerated too long). Properly facilitated retreats played a large role in enabling the steering committee to achieve their progress to date.

- Finally, not only are resources within the hospital's communications department scarce, they may not be trusted initially by union participants. It took our committee a long time to understand the need for a first class communication program. We hired a firm with specialists in employee communication to handle this specific task.

### Three things to remember

If I could leave only three things to remember from this presentation that will help, they would be:

1. Protect the long term health of your organization even in the face of downsizing and restructuring.
2. Work together with employees, unions and all levels of management to create solutions.
3. Keep the faith ... the early days can be tough. ■

## Major Topics and Speakers from the BCORNG conference to be featured in upcoming issues:

### Are You Safe Handling Wastes

By Dr. Walter F. Schlech III, M.D., Assistant Professor of Microbiology and Community Health and Epidemiology, Dalhousie University, Halifax.

Infection control practices in the Operating Room, including body substance precautions, were reviewed incorporating the most recent guidelines from the Centre for Disease Control.

### Everyday Dilemmas

By Patricia Rodney, R.N., M.S.N., Nurse Education Consultant, Vancouver.

This session was highly rated as O.R. nurses frequently face serious ethical dilemmas in their practice. Ms Rodney expanded the O.R. nurses' understanding of the ethical questions facing nurses and suggested strategies to help in dealing with these dilemmas.

### Painless Presentations

By Robert Goodall, M.A. of the B.C. H.A.

Delegates learned how to plan and prepare a presentation, establish a comfortable relationship with the audience and how to organize a presentation logically and effectively. The use of audio-visual aids and technique to encourage audience participation were also covered.

### Synthes Lecture/Demonstration of Femoral Rods and Cannulated Screws

By Carole Griffiths, R.N.

The latest developments in the application of intramedullary rods and cannulated screws in the treatment of fractures was presented. It is hoped the presenter will submit this for the journal's September Orthopaedic Special Issue.

### Doctor's Office: Can You Hold?

By Dr. S. Larry Goldenberg, M.D.

A new treatment of female incontinence by collagen injection was described. The urologist focused on female and geriatric incontinence and the etiology of incontinence in the male. Only two or three centres in Canada have experimented with this new procedure and so far successful results have been impressive. We will be hearing more about this treatment in the Fall.

(Continued on page 27)

# Questions on sterile technique can lead to study and research

By Marguerite Martin R.N., B.Sc.N.

## Introduction

Operating room nurses should constantly assess aseptic protocol. Relevant to this, current and changing practices must be backed by valid and reliable rationale. (Murray and Zentner, 1975).

## Who Said What and Why?

As a staff nurse are you given credible rationale for change? Are there questions you want to ask about sterile technique and asepsis? If you start asking questions you will be participating in change processes toward optimal technique and safe nursing care. One reason is that decisions and practice based on reliable rationale produce accountability. This accountability is demonstrated in nursing care as one is able to explain and back-up reasons for decisions and procedures. Should your questions lead to research, remember that any study must enlist the guidance of a qualified person, educated in planning, conducting and critiquing research.

## Start Somewhere

There are many issues we could consider. Let us begin with a few basic topics as they relate to the operating room:

1. Wearing apparel,
2. Masks,
3. Jewellery,
4. Perfumes and
5. Food

### 1. Wearing apparel

Starting at the top, hats should cover the hair. An individual who persists in not covering his or her hair could be influenced by this simple demonstration. Randomly culture a hair from a volunteer's head. The

resulting growth of microorganisms would provide persuasive data.

Research that meets nursing science criteria supports maximal skin and shoe covering for operating room personnel. Studies (Davis 1985) recommend wearing O.R. scrub pants with ankle closures. These studies condemn dresses and sleeveless suits as being ineffective in preventing skin scale contamination.

Relevant to this, remember that the infection rates are in direct proportion to the number of persons in the operating room. Furthermore, the traffic or movement of the persons increases the infection risks. Considering this, shoe covers are practical preventative tools that prevent soiled shoes acting as transfer vehicles for microbes. Jean Davis, an independent hospital asepsis consultant, advocates the use of shoe covers. She suggests, "Shoe covers do reduce the lateral transfer of debris, therefore, should be used."

### 2. Mask

Hawthorne 1981 demonstrated that cloth masks do not filter respiratory secretions. Disposable masks should be used and handled by the ties when removed.

### 3. Jewellery

There is the long lasting practice of wearing neck chains and ear rings in the operating room. These are

## Author

Marguerite Martin is a staff nurse in the operating room at Civic Hospital, North Bay, Ontario and is currently the elected representative to The College of Nurses of Ontario for Northeastern Ontario. She has worked in O.R.s in Naniamo, B.C. and Winnipeg, Manitoba. Marguerite received her B.Sc. N. in 1984 from Laurentian University in Sudbury.



ULTRAMED

Presents...

## STERILE PROCESSING

"Just in Time"™



### NOW... A sterile instrument for each patient procedure every time.

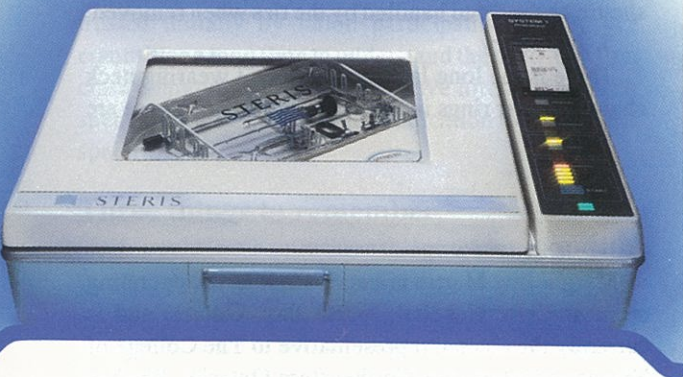
A single standard of practice... standardized, documented sterile processing which is safe for your instruments.

A single standard of care... availability of sterilized instruments for each patient procedure.

STERIS SYSTEM 1™ permits you to safely sterilize instruments which you are currently disinfecting between patient procedures. Even heat sensitive rigid and flexible scopes, cameras, and microsurgical instruments can be safely sterilized and ready for use in the standard 20 minute cycle.

STERIS... guaranteed sterilization every time and Just In Time for each patient procedure.

Environmentally safe and selected by hospitals across the U.S. as the preferred standard of practice.



# STERIS



50 Steeles Avenue East, Suite 15, Milton, Ontario L9T 4W9  
(416) 878-4400 Tor: (416) 826-4866 Fax: (416) 878-5044

a source of infection because they create skin cell chaffing. To prove this point, drop a chain or an earring on a culture plate, incubate, and watch the microbes grow.

#### 4. Perfumes

Another conventional grooming practice for O.R. personnel to consider as a source of infection is the use of scented cosmetics. The chemical structure of perfumes is designed to perfuse mini droplets through the air. Perfumes are effective vectors to spread microorganisms. Further considerations are that patients/clients and other staff may be allergic to perfume or nauseated by it.

#### 5. Food

Each operating room suite has the rule that there is to be 'no food or beverage' in the operating room. This produces a dilemma. Long surgical procedures deem that staff require nourishment, but they can not leave the surgical room. The reason for the 'no food or beverage' rule is relevant to basic microbiology. Foods act as transfer media, cell nutrients and wicks to support microbial residue and rebound growth.

### You Can Do Something

If you have questions or concerns, you could suggest a research group be started in your staff development programme. This group could identify problems and find answers through research. Often, a literature review will provide enough reliable and valid data for accountable decisions.

Nurses should strive to effect change with optimal aseptic technique and safe nursing care in mind. This means that decisions are based on proven scientific information. With solid rationale, operating room nurses can sell management on the importance of research to back policies and practices.

### Conclusion

Costs of nosocomial (hospital acquired) infections and litigations must be considered. Furthermore, management, will be supportive of efforts toward optimal asepsis because infections prolong hospitalization. The costs of post operative infections are phenomenal, both to patient suffering and dollars, (Donald 1985). Another consideration supporting efforts towards optimal asepsis is the potential for patients to sue because of nosocomial infection. (Ritter, 1986).

These factors may be driving forces for managers to welcome input from staff nurses. If you have concerns about sterile technique or nursing care, suggest to your unit manager that a research committee be

formed, study one segment of infection control management, or write an article.

### Bibliography

- Crow, S., Taylor, E., Nurses' compliance with aseptic technique, *AORN Journal*, May, 1983, 37:6, pp.1066-1072.
- Cruse & Ford, The Epidemiology of Wound Infections: A 10 Year Prospective Study of 62,939 Wounds, *Surgical Clinics of North America*, 60 (Feb.80), 27-40.
- Garner, S., Control of Surgical Nosocomial Infections, *AORN Journal*, July, 1978, 28:1 pp.148-158.
- Mauldin, B.C., Need for Basic Aseptic Technic, *Point of View/Ethicon*, 1982, Vol. 19, No.3, pp. 10-11.
- Schultz, J.K., Microbiological Sampling, *AORN Journal* fe. 1981, 33:2, pp. 224-225.

### ORNAC Recommended Standards

The Recommended Standards for Operating Rooms in Hospitals, as established by the Operating Room Nurses Association of Canada, are available for sale

#### Recommended Standards

@ \$12 per copy

#### Recommended Technical Standards

@ \$20 per copy

Cheques and money orders should be made payable to:

The Operating Room Nurses Association of Canada. Postage will be added.

Direct your orders with a return address to:

Shirley Hemerling, Operating Room  
Kelowna General Hospital,

2268 Pandosy St.,

Kelowna, B.C. V1Y 1T2

Telephone Orders: (604) 861-5945

FAX Orders: (604) 862-4250

# Principles of Aseptic Technique

By Wanda Oliver

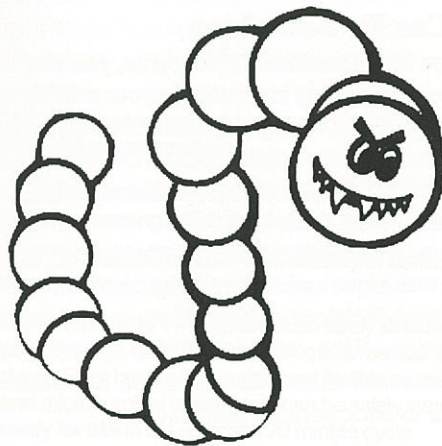
The following is a lighthearted reminder to all nurses that asepsis is a priority in the operating room in order to ensure the safety and well being of our patients.

Our aim in the O.R. is to prevent contamination of the open wound, isolate the operative site from the surrounding physical environment and create and maintain a sterile field in which surgery can be performed safely.

*Hi...my name is 'Bugsy Bacteria' and I am representing the great world of the Perilous Pathogens! We live on your skin, in the air, in your hair, under your nails, on clothes, and tabletops etc. etc. etc. You, the nurse, can now have the honor of being our friends! Great! See, we are pretty hungry and feeling lonely and we know that as caring, giving human beings, Nurses would love to help us! All you need to do, is help us to get into a big, fat juicy incision line, so that we can get some grub and multiply a few billion or so!! Sounds easy so far? Never mind those with their asptic garbage! Here's how you can help. All you have to do is:-*

1. *Open a package where the sterility date has expired or the chemical indicator hasn't changed.*
2. *Keep one cuff of your gown uncovered by your glove or just turn your back on your sterile field.*
3. *Drop your suction or cautery beyond the sterile boundary and then pull them back into your sterile field.*

4. *Let unsterile personnel touch, reach over, or lean over your sterile field.*
5. *Perforate your glove - even if you don't think it's okay, leave your glove on. I can go through small holes!*



*So - anyhow - these are a few hints ok. You get the idea! So.. be a sport and help us Bacteria to live a better life in the world of infection.*

## Author

Wanda Oliver is Staff Nurse, Operating Room, St. Paul's Hospital, Vancouver, British Columbia.

**A**-is for the Autoclaves - be sure you know how they work! Inadequate sterilization leaves a lovely place for Bacteria to Lurk.

**S**-is for Scrubbing - the rule says five and three. Remember... germs are invisible; not something you can see.



**E**-is for Everyone you care for - and know you've done your best. Be proud that your patient is number 'one' here in the west.

**P**-is for Protecting and guarding your sterile field. When medical staff come too near... your job is to make them yield!!!

**T**-is for Technique - Please watch what you do. A repellent doesn't always mean the water won't soak through.

**I**-is for Incision - We must keep it clean. For if the patient ends up with an infection - I'm sure he'll be very mean.

**C**-is for Contamination - in the O.R., it is a 'Taboo'. Please try to prevent this in whatever that you do.

**T**-is for Transmission - of 'Bugs', it's easily done. Don't let those surgeons tell you how your sterile field should be run.

**E**-is for Enforcing - the rules of Aseptic Technique. For allowing any of them to be broken - certainly isn't very 'chic'!

**C**-is for the Circulator - who must keep a good lookout. Be sure the things you open are sterile without a doubt.

**H**-is for Hearing what we have to say. We hope that you'll remember this - each and every day.

**N**-is for Nosocomial - we need not say much more. No one wants a Hospital infection knocking on their door.

**I**-is for Impeccable - be this, for the Patient's sake. When they're asleep, they don't have choices like they do when they're awake.

**Q**-is for Questioning - it is your right to do. Any item that may be unsterile, can be replaced in a moment or two.

**U**-is for Us All to put ourselves in the patients shoes. They have put their trust in the decisions that we choose.

**E**-is for our O.R. Environment - it's a responsibility we all must share. A job well done ensures a Patient that his Nurses really did CARE!!



(Continued from page 12) operating room nurses have traditionally not been involved in the provision of initial health care services, the clinical practice of operating room nurses is developing into a perioperative practice.

This is only one example of many that demonstrates that we can increase the numbers and types of nursing practitioners. It won't happen unless we are prepared to take an active role in marketing our skills and credibility to the public and to our employers.

Unregulated auxiliary workers are another expanding force in the workplace. They usually are persons with less training than professionals, but who perform related functions. Some examples are health care aides, surgical assistants and various equipment technicians. With increased technology and an expanding aging population, the kind and numbers of auxiliary workers are growing rapidly. In many cases, they are performing functions within the scope of the practice of nursing. This may be the area of greatest conflict in the workplace, as the balance between the fiscal constraint and safe, effective health care is reconciled.

The environment in which we practice is ready for nurses to assume a leadership role. In the ministry of health document, "*Deciding the Future of Our Health Care*" it is identified that one of the new directions of the ministry of health is... "to enhance the overall status of nurses in the health care delivery system and to improve their working conditions."

The Public Hospitals Act was amended in 1989 to ensure nurses were represented on decision-making hospital committees.

For many years, operating room nurses have been proactive and involved in guiding and influencing change in the system. The Operating Room Nurses Association of Canada and the OR Journal are well established. They provide a means of communication on a nation-wide basis. The collective efforts of the group provide leverage, credibility and objectivity that can have a much higher impact and a greater chance of success than that of individual efforts.

The OR nurses groups and their associations, provincially, regionally and nationally, are vehicles that can be used to examine the role that nurses want to have in operating rooms and in the broader area of perioperative care.

How can nurses take advantage of the opportunities open to them by the regulated health professions act? Because each situation is unique, it is difficult to list activities or skills and the conditions under which activities can be performed or roles can be expanded.

Individuals and special interest groups are better able to identify what it is they want to be able to do independently or in conjunction with other regulated health professionals.

ORNAO is in an excellent position to be an advocate for O.R. nurses, to identify the issues and to facilitate expansion of roles.

The College of Nurses wants input on the development of the regulations for the controlled acts in nursing act. The college also wants input on what authorized acts in the practice of other professions should be formally delegated to nurses. The college needs to hear from O.R. nurses.

In addition, your O.R. colleagues would like some assistance in exploring the opportunities for expansion of the role of the operating room nurse. Be innovative and creative. Dare to dream. Remember a goal is only a dream with a date on it.

Nursing practice advisers at the College of Nurses are available for consultation and to assist in interpretation of standards and the new legislation. I asked one of the advisers to look up all of the issues raised in relation to nursing practice in the operating room. There were only six issues raised in the last three years. Three of those related to the role of nurses who are expected to act as surgical assistants. The others related to R.N. vs R.N.A. as circulating nurse, O.R. skills as added nursing skills, sanctioned medical acts and the role of the O.R. nurse as patient advocate. All of the questions have been better addressed by operating room nurses. The "Recommended Standards for operating room nursing practice" that were developed by the Operating Room Nurses Association of Canada (O.R.N.A.C.) and the position papers that are developed by the Canadian and provincial associations provide much better direction for nurses practicing in the operating room.

If it is not in place already, a legislative review committee should be established by ORNAO to review the many acts that are currently at various stages in the legislative process and to identify those that will have a direct impact on operating room nursing. You would then be in a position to make recommendations and to lobby in order to influence change to be in the best interest of O.R. nurses. The most urgent legislation to be addressed, because of timeframes, is the regulated health professions act.

(Editors note: ORNAO established a legislative committee at this conference.)

On an individual level, all jobs provide some opportunities for choice and career enrichment, even

within the constraints of union or management policy. For example, you have some leeway in deciding how you are going to do your work or in determining work priorities. You may also have some control over what work you can delegate. You may be able to get involved in new projects. You can volunteer for committees or new assignments.

You can make your job more interesting by learning more about your hospital or organization. How does the operating room fit into the overall programs and mission of the hospital? What are the hospital's centres of excellence? Where does the planning and decision making take place? Where does your hospital fit into the health care system as a whole?

You have to position yourselves to take advantage of the opportunities now opening, and remember, there is strength in numbers.

Nurses have made progress in the past few years in seeking and identifying a place for themselves in the

health care system. Recent enviro-nics polls have identified that nurses are the most trusted profession. We have a head start. We can take advantage of our good standing with the public and government.

We only need leadership and individual will to take advantage of the opportunities that are open to us. We need to be involved in the political process. We are limited only by our own creativity and determination.

The challenge for O.R. nurses is to be prepared to benefit from and change with the health care system in Ontario. It takes motivation to change. It takes knowledge to change. But mostly it takes courage to change. Nurses, physicians and all health care professionals must have the courage to discard obsolete roles, pay attention to role and relationship changes and be responsive to changing needs. I know from personal experience that O.R. nurses have the motivation, the knowledge and the courage to help shape their future. All you need is the vision. The responsibility is yours!



## Letters to the Editor

It has now been almost two years since our patient, Lianna, first became ill and underwent the major surgeries we wrote about in the March/April 1991 issue. (Aboud, Diane and Williams, Jan, *Gas Gangrene, Part 1 & 2*, Canadian Operating Room Nursing Journal, 9(1), 11-15.) At that time, Lianna had been diagnosed with Crohn's Disease and sent home. She was re-admitted one month later (April 24, 1990) with profound anaemia. Her WBC dropped to 0.9 during that week. She woke on the morning of May 1, 1990, with severe pain in her left thigh. She had a mid-thigh amputation after a diagnosis of 'gas gangrene' was made. She had a colectomy the following day for extensive Crohn's Disease.

We have kept in touch with Lianna during her crisis and rehabilitation over the past 22 months. From May to August of 1990, nurses and doctors at the pediatric hospital focused on eradicating the Clostridium, which was detected by regular cultures from an open area on the stump. They did many surgical debridements over this time period.

During the three months prior to her discharge from hospital, Lianna was able to drive a car. That allowed her to return to high school and to travel to the hospital once a day for assessment and dressing changes. In October, 1990, she was discharged from hospital and began receiving home care.

In February, 1991, Lianna had surgery to close the colostomy. (In the article we stated she had a permanent ileostomy. This was incorrect. She had 20 cm of colon remaining which allowed for re-anastomosis).

In mid-April, 1991, Lianna received her permanent prosthesis. She had difficulty adapting to her new limb. By summer it was replaced with a new prosthesis. She is still undergoing physiotherapy but is adapting well to her new limb. Lianna's positive way of dealing with her amputation enabled her to speak with and counsel other young amputees while she was a patient in the pediatric hospital.

Lianna hopes to be able to play soccer again some day. She had been a top athlete in this sport. In the meantime, she is coaching ten-year-olds.

Many victims of gas gangrene don't survive; Lianna did. Today she is completing her first year of Commerce at the University of Ottawa.

Operating room nurses rarely have the opportunity for the in-depth patient follow up and contact which we have experienced with Lianna. Her courage and zest for life inspired all who cared for her.

**Diane Aboud, R.N.,  
Operating Room,  
Riverside Hospital,  
Ottawa, Ontario.**

# Conference Calendar

## 1992

### The Atlantic Operating Room Nurses Conference

Theme: "Caring In The Age of Technology"  
**September 21 - 23, 1992**  
C.P. Prince Edward Hotel in Charlottetown  
(See ad elsewhere in this issue)

### The Saskatchewan Operating Room Nurses' Group

Theme: "Changes, Challenges and Choices"  
7th Annual Conference  
**September 25 - 27th, 1992**  
Ramada Renaissance, Saskatoon, SK  
(See ad elsewhere in this issue)

### Operating Room Nurses Association of Hamilton and District

Sponsoring a one day Conference in Burlington at  
the Holiday Inn on **October 17, 1992.**  
Inquires may be directed to:  
Helen Friend, Reg. N.  
c/o St. Catharines General Hospital  
142 Queenston Street,  
St. Catharines, Ontario. L2R 7C6  
Phone: (416) 684-7271 Ext: 5561

### Operating Room Nurses of Alberta Association

1992 Conference  
**October 21 - 24, 1992**  
Capri Centre, Red Deer, Alberta  
Theme: O.R. Nurses and Colleagues:  
"Sharing the Harvest"  
(See ad elsewhere in this issue)

## 1992

### Newfoundland and Labrador Operating Room Nurses Association

13th Provincial Conference  
**October 22 - 24, 1992**  
Glynmil Inn, Corner Brook, NFLD  
Contact Margaret Howe or Connie Stratton  
Western Memorial Regional Hospital  
P.O. Box 2005,  
Corner Brook, NFLD A2H 6J7

## 1993

### Quebec City, Quebec -13th National Operating Room Nurses Conference

**June 6th - 11th, 1993 .**  
Theme: "Global Vision of Care, Guide in the  
Midst of Automation".  
(See ad elsewhere in this issue)

### World Conference of Operating Room Nurses - VIII - September 6-10, 1993

**Adelaide, Australia**  
ORNAC has decided the same mountie shirt and red  
hat will be the official Canadian dress at this Aus-  
tralian World conference. The costumes are still  
available for sale. Announcements will be made in  
the Journal and Provincial newsletters.

## 1994

### Operating Room Nurses of Ontario

3rd Provincial Conference  
**April 25 - 27, 1994**  
Ottawa Congress Centre, Ottawa, Ontario.

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

**June 2 - 4, 1994**  
Contact: Trish Allen, 4108 - 14th St.  
Vernon, B.C. V1T 8B9  
Phone: (604) 542-2418

(BCORNG Speakers - Continued from page 18)

### Out of thisWorld: The Spine in Space

By Dr. Peter Wing, M.B., M.Sc.,  
and Lark Susak, R.N., B.S.N.

An investigator working with a NASSA microgravity  
team talked about how to get research projects into  
space. The UBC research group is studying changes in  
the spine associated with back pain in the astronaut.  
An experiment using stereophotographic techniques  
was conducted on board the Discovery in January this  
year. An entire issue of the Journal could be devoted  
to those space experiments, especially the work being  
done by Dr. Roberta Bongard on nausea and several  
other neurological experiments.

### Anaesthetic Drugs of the 90's

By Dr. John Dolman, M.D.

Diprivan...midazolam...alfenta...the many new drugs  
in use today offer more options to physicians and  
patients. It is important for O.R. nurses to keep up to  
date with these drugs and how they make anaesthesia  
safer and more tolerable in terms of risks, benefits and  
side effects. We hope to present this as a full article.

### In Control

By Dr. Jennifer Cant, B.Sc. M.D. and Lynne Maxwell,  
R.N., M.S.N.

Intravenous Patient Controlled Analgesia (PCA) is  
a boon to post-operative pain management! The  
speakers described how two Vancouver hospitals,  
one large and one small, have implemented and man-  
aged this service. Lynne Maxwell has agreed to write-  
up her presentation for September, specially geared  
to the OR nurse.

### Personality and Conflict: Venturing Beyond Muddling Through

By Dr. Brian Little.

The wrap-up speaker addressed the problems and  
perplexities of daily life explaining why individuals  
differ in their need for stimulation, sedatives and  
structure; why some health professionals are crash,  
bang, wallop workers while others are perfectionist  
snails; why some see their lives as half full and others  
half empty, and why some of us want tons of intimacy  
and others just wish to be left alone. He examined why  
we often drive each other to distraction.

## Being an OR Nurse can get you a great view. Of the Golden Gate Bridge.

Become an OR Nurse at Mt. Zion Medical  
Center of the University of California, San  
Francisco and you'll not only enjoy the extraor-  
dinary sites and cultural diversity of one of the  
world's most beautiful cities, you'll also enjoy:

- being a part of the University of California  
statewide hospital system
- state-of-the-art technology in your area of  
expertise
- a variety of educational programs and paid  
educational leave
- an on-staff OR nurse educator
- licensure assistance for experienced OR nurses
- the option of fully paid healthcare coverage
- an active clinical ladder

As part of the University of California, San  
Francisco, you'll practice in an environment  
which offers world-renowned technical  
resources, yet still enjoy the close-knit atmo-

sphere of our 246-bed hospital. Currently, we are  
expanding our operating services from seven  
suites to ten. We need your expertise in these OR  
specialties:

- cardiology
- ortho/neuro spine
- head & neck
- urology
- oncology
- ophthalmology
- gynecology
- general surgery

Find out more about both the enormous  
professional and personal opportunities awaiting  
you at Mt. Zion Medical Center. Call Elly Krause,  
Nurse Recruiter, COLLECT at (415) 885-7877, or  
send your resume to her attention at Mt. Zion  
Medical Center, 1600 Divisadero St., San  
Francisco, CA 94115, U.S.A. AA/EOE/MFHV.

**MtZ Mount Zion**  
Medical Center of UC San Francisco

## Instruments de Mir

is seeking Sales Representatives with operating room nursing experience in the following Provinces:

- British Columbia
  - Alberta
  - Saskatchewan
  - Manitoba
  - Quebec

We specialize in supplying hospitals with trocars, laparoscopes, arthroscopes and other laparoscopic surgical instruments.

Mail or fax your c.v. to:

**Instruments de Mir**  
320A Victoria Avenue  
Westmount, Quebec  
H3Z 2M8

Telephone: (515) 484-2909

Fax: (514) 484-4431

At Synergy, our goal is to become Canada's premier nurse placement service. We provide our nursing clients with the information and support they need to make an informed decision about relocation, which means a better solution for everybody.

**"If working as a nurse  
in the U.S. is your  
goal ... then Synergy  
is your best solution."**

When you come to Synergy, our knowledgeable staff will guide you through each step of the process. We have a wide variety of US locations to choose from in both **general and cardiovascular operating rooms**; large or small facilities.

Whether you seek a full time position or short term assignment, we can help. Each position offers a unique and attractive salary and benefit package. Relocation assistance, educational reimbursement programs, clinical ladders and promotional opportunities all make these positions well worth considering.

So put us to work for you and we'll help you explore all the options. Call toll-free today 1-800-667-5499

**SYNERGY**

**VANCOUVER, BRITISH COLUMBIA**

'PROMOTING CANADIAN NURSING PROFESSIONALS ...  
INTERNATIONALLY.'

AT SYNERGY, WE WORK FOR YOU.



Recruitment and Immigration Specialists, Inc.

## How to submit an article

The Canadian Operating Room Nursing Journal is intended to serve the information needs of perioperative nurses in hospitals and clinics throughout Canada. Readers include staff nurses, technicians, head nurses, nursing supervisors, coordinators, clinical instructors, directors of nursing and many other speciality nurses including post-anaesthetic recovery room nurses. The journal is peer-reviewed and published quarterly by Health Media Incorporated under the aegis of the Operating Room Nurses Association of Canada (ORNAC). Manuscripts are reviewed by the editorial board members appointed by ORNAC, and when necessary by outside experts. Submissions are invited on new surgical techniques, descriptions of new technologies or advising of new programs and educational material. Selection is based chiefly on the following criteria: originality, timeliness and relevance to the needs of the journal's readers.

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

1. An abstract summarizing the article.
2. An autobiographical statement that includes the author's full name, current title and academic qualifications. e.g. Jane M. Smith, RN., M.N.; is head nurse, Thoracic Surgery Unit, General Hospital, Perth, ON.

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

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

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

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

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

Address all correspondence to:

**The Editor,**  
**Canadian Operating Room Nursing Journal**  
c/o Health Media Inc.  
14453 29A Avenue  
White Rock, B.C., V4A 9K8 FAX:604-535-9000

# CARSEN

The full-line Endoscopy Company

# OLYMPUS

A world leader in Endoscopic technology

## THE LAPAROSCOPIC CHOLECYSTECTOMY SYSTEM:

### Laparoscopic cholecystectomy...the leading edge in the management of gallstones

Removal of the gallbladder through a laparoscope is an exciting new alternative to traditional surgery. As a minimally invasive procedure, it offers a number of advantages, including shortened hospitalization and recuperation time, minimal scarring, and reduced cost.

### Carsen is your one source...a sophisticated technical resource for laparoscopic cholecystectomy.

Carsen provides the total system, which includes the Olympus OES II laparoscopes, a comprehensive line of operating instruments, insufflation and irrigation capabilities, and superior video technology.

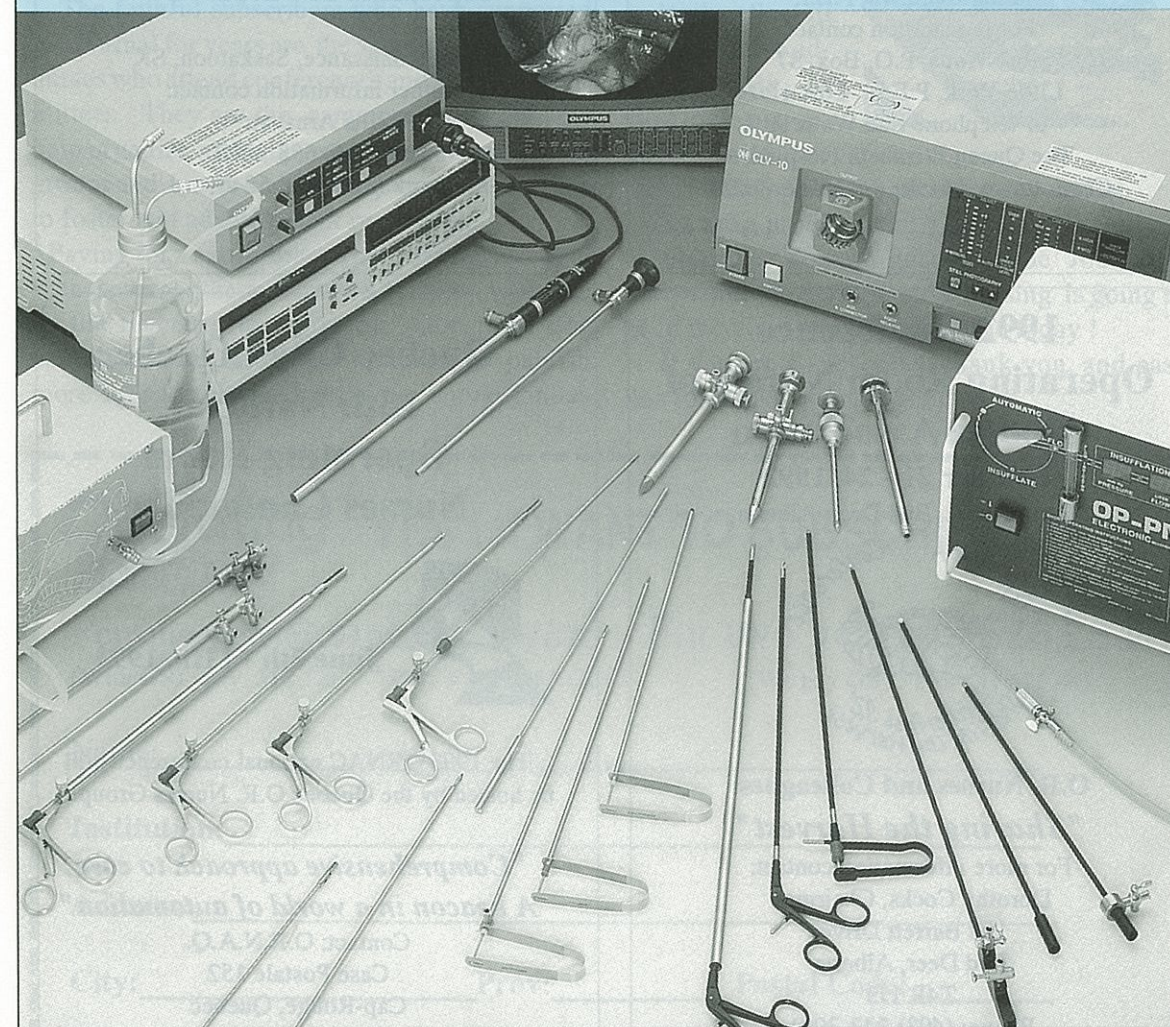
### Images free of distortion and up to 29% larger

New Olympus OES II laparoscopes have improved optics. Images are free of distortion and up to 29% larger—a very important advantage when performing laparoscopic abdominal surgery.

### Removable eyepiece for streamlined video capabilities

The OES II laparoscope features a removable eyepiece. This enables direct video connection when using the AR-1D coupler, reducing weight and providing more convenient handling.

For more information, call your one Olympus Laparoscopic Cholecystectomy source... Carsen.



**CARSEN GROUP INC.**

**MEDICAL INSTRUMENT DIVISION**

151 TELSON ROAD, MARKHAM, ONTARIO L3R 1E7

Tel: (416) 479-4100 • Fax: (416) 479-1610

## The Atlantic Operating Room Nurses Conference



### "Caring In The Age of Technology"

September 21 - 23, 1992

C.P. Prince Edward Hotel  
Charlottetown, P.E.I.

For registration contact:  
Rae Watts, P.O. Box 87

Little York, P.E.I. C0A 1P0  
or telephone Rae Watts at

The Queen Elizabeth Hospital,  
Charlottetown, Phone: (902) 566 - 6231

## The Saskatchewan Operating Room Nurses' Group



presents

### "Changes, Challenges and Choices"

7th Annual Conference

September 25 - 27, 1992

Ramada Renaissance, Saskatoon, SK

For further information contact:

Phyllis Arnst at:

home (306) 653-1480

work (306) 664-5240

## 1992 Conference Operating Room Nurses of Alberta Association

October 21 - 24, 1992

Capri Centre, Red Deer, Alberta



O.R. Nurses and Colleagues:

### "Sharing the Harvest"

For more information contact:

Dorothy Cocks, Chairman

152 Barrett Drive,

Red Deer, Alberta

T4R 1J3

Phone: (403) 343-3081

## Quebec City - Quebec 13th National Operating Room Nurses Conference



June 6th - 11th, 1993

The 1993 ORNAC national conference will  
be hosted by the Quebec O.R. Nurses Group.

### "Comprehensive approach to care: A beacon in a world of automation"

Contact: O.R.N.A.Q.

Case Postale 152

Cap-Rouge, Quebec

G1Y 3C7

# Survival.....

If the *Canadian Operating Room Nursing Journal* is to survive, we need your paid subscription.

A committed group of over 1,000 nurses has supported this Journal since its inception in 1983.

Advertising, especially in these austere times, does not provide sufficient revenue to sustain a high quality publication. The Journal needs paid subscribers to survive and expand.

In spite of directives from ORNAC to support the Journal and promotions in the provincial association newsletters, we are not building the circulation base we need to survive and excel.

The faithful subscribers who have supported the Journal for years are the same committed OR nurses who attend conferences and serve on committees. They are the same professionals who help organize meetings, support their provincial groups and donate hundreds of hours of their time to foster and advance their profession.

Paying for a subscription (not sharing a Journal with several others in the OR lounge), will give us the revenues to report on more than one conference per issue, the revenues to publish more manuscripts and promote more confer-

ences. Your paid subscription will help in publishing all the new and exciting programs and directions ORNAC's Board and committees are investigating, such as the Expanded Role for the O.R. Nurse.

We need the support of **all perioperative nurses** to venture into this decade and truly reflect all the innovative advancements in surgical procedures and the many developments underway in nursing.

You are a professional. You cannot afford not to subscribe. You can guarantee the Journal is as dynamic as perioperative nursing is going to be in the years ahead. Subscribe today!

If you are a subscriber, thank-you, and pass this form on to a colleague.



Canadian  
**Operating Room Nursing Journal**

**YES! I WANT TO SUBSCRIBE.**

For one year @ \$16  plus GST For two years @ \$26

(With GST pay \$17.12)

GST # R 102310323

(We pay GST. You pay \$26.00)

Name: \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mail your cheque today payable to the Canadian Operating Room Nursing Journal, with your name and address, and postal code. Mail to: 14453 29A Avenue, White Rock, B.C. V4A 9K8

# A Case That's Hard To Beat!



STERION\* Sterilization Container Systems from Surgikos Canada Inc. provide sterility assurance by eliminating damage due to handling and storage. These sturdy containers hold sterilized instruments safely and securely until ready to use. STERION Systems are an excellent quality assurance measure—soiled instruments are returned for decontamination inside a closed, protective device. Let Surgikos Canada Inc. show you the case that's hard to beat...STERION Sterilization Container Systems. For more information write or call Surgikos Canada Inc., Peterborough, Ontario.

Ontario call: 1 - (800) - 461-7693 All other provinces : 1-(800)-461-1441

*Johnson & Johnson*

MEDICAL PRODUCTS

