CANADIAN
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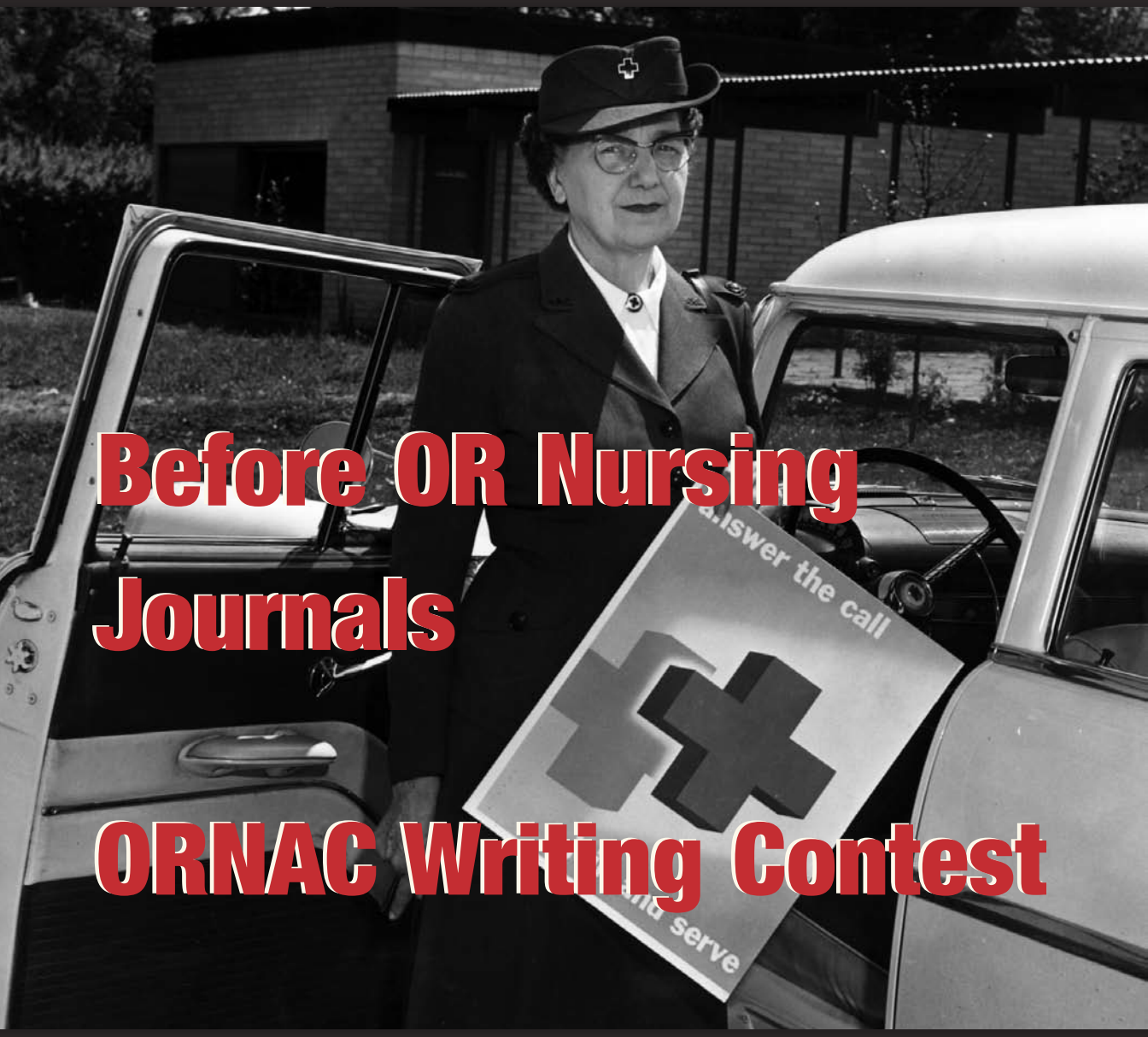

Before OR Nursing Journals

ORNAC Writing Contest

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President's Message

'The difficulty lies, not in the new ideas, but in escaping from the old ones'
Keynes, 1935, cited by Dzik-Jurasz, 2006

Many of us are creatures of habit. We prefer the comforts of the predictable to the discomforts of the strange: the route we drive to work, the stores we shop at, the parking spot we select. We tolerate change but we'd like it to be on our own terms. But, change is almost constant in the "new normal" state of life, and there is no escaping it.

In the President's message, March 2010, I asked each ORNAC member to connect with their local, provincial, and/or national perioperative groups and share opinions/ideas for future changes of the association. The opinions/ideas/critical reviews/etc. will be a vital component of the strategic meeting of the ORNAC Executive and representatives from each province scheduled for late August in Ottawa. This meeting is a proactive decision and will provide the opportunity for innovative change to enhance our association. Also, I am hopeful that a synergy between all facets of ORNAC: individual perioperative nurses, the provinces and the association as a whole, will be a second outcome as the development of effective relationships with all team members is key to "implementing" effective change.[1]

Please refer to the ORNAC in a Nutshell, provided by ORNAC Secretary Sue Styles, from the May 2010 Board meeting (see pg 26) for an overview of the activities and accomplishments of your association. As outlined, I have participated in a variety of national and international meetings with our global perioperative nursing partners. I have noticed that the associations and organizations, ORNAC included, provide the forum for collective interactions that can overcome nursing care challenges. This will continue to be a priority for ORNAC while we reflect on the significance of ORNAC today, and determine the direction of tomorrow.

Of course, I offer a challenge to each of you as the "essence" of ORNAC. If all perioperative nurses choose to unite and benefit from collective interactions, and the power of an association, we can move the group in the direction that we want. I ask you to contemplate the foundation of ORNAC: the philosophy and the mission, vision, and value statements as you respond to the questions: "What's in it for me?", "What's in it for us?" and, more importantly, "What's in it for our patients?"

I welcome your comments and can be reached at **president@ORNAC.ca**.

Wishes for health and happiness to you.

Bonnie W. McLeod

References
1. 1. Dzik-Jurasz, Debbie, (2006). Supporting Sustainable Change. *Nursing Management*, 13 (4), p. 26-29.

Bonnie W. McLeod, RN, BScN, MN, CPN(C), is Clinical Nurse Educator - Perioperative, Fraser Health Authority, Ridge Meadows Hospital site, the ORNAC representative on the Canadian Patient Safety Institute, and the past Chair of the ORNAC Standards committee.

Mot de la president

« La difficulté repose non pas dans les nouvelles idées, mais dans le fait d'échapper aux anciennes »

Keynes, 1935, cité par Dzik-Jurasz, 2006 (traduction libre)

Nombre d'entre nous avons nos petites habitudes. Nous préférons le confort de ce qui est prévisible à l'inconfort de l'inconnu : le chemin que nous prenons pour nous rendre au travail, les magasins où nous faisons nos achats, le stationnement que nous choisissons. Nous tolérons les changements, mais nous aimons qu'ils soient selon nos termes. Les changements sont cependant presque constants dans les nouveaux rangs sociaux normaux et nous ne pouvons y échapper.

Dans le message de la présidente du mois de mars 2010, j'ai demandé à chaque membre de l'AIISOC d'établir des liens avec leurs groupes de soins périopératoires locaux, provinciaux et/ou nationaux et d'échanger des opinions/idées pour des changements futurs à apporter à l'association. Les opinions/idées/comptes rendus/etc. feront partie intégrante de la réunion stratégique des membres exécutifs et des représentants de l'AIISOC de chaque province qui aura lieu à la fin août à Ottawa. Cette réunion représente une décision proactive qui permettra à des changements novateurs d'améliorer notre association. De plus, j'espère grandement qu'un effet de synergie s'opèrera entre tous les aspects de l'AIISOC, à savoir entre les infirmières et les infirmiers en soins périopératoires, les provinces et les association dans l'ensemble, étant donné que le développement de relations efficaces avec tous les membres de l'équipe est essentiel à la « mise en œuvre » efficace des changements.[1]

Veuillez vous référer à l'article L'AIISOC en bref, rédigé par la secrétaire de l'AIISOC, Sue Styles, à la suite de la réunion du conseil d'administration de mai 2010 (voir pages 26) pour un aperçu des activités et des succès de notre association. Tel que mentionné, j'ai participé à diverses réunions à l'échelle nationale et internationale avec nos partenaires internationaux en soins périopératoires. J'ai remarqué que les associations et les organismes, tout comme l'AIISOC, servent de groupes de discussion pour les interactions collectives pouvant aider à surmonter les défis auxquels font face les soins infirmiers. Cette activité demeurera une priorité pour l'AIISOC à mesure que nous réfléchissons à la portée de l'AIISOC aujourd'hui, et que nous en déterminons la direction future.

Bien sûr, pour terminer, je vous lance un petit défi, vu que vous êtes l'essence de l'AIISOC. Si toutes les infirmières et tous les infirmiers en soins périopératoires choisissaient de s'unir et de profiter des interactions collectives et de la force d'une association, nous pourrions diriger le groupe dans le sens que nous l'entendons. Je vous demande de réfléchir au fondement de l'AIISOC : à sa philosophie et sa mission, à sa vision de l'avenir, à ses valeurs, à ses prises de position en répondant aux questions suivantes : « Quels avantages y a-t-il pour moi? », «Quels avantages y a-t-il pour nous? »", et surtout, « Quels avantages y a-t-il pour nos patients? »

J'apprécie vos commentaires que vous pouvez m'envoyer en m'écrivant à **president@ORNAC.ca**.

Tous mes vœux de santé et de bonheur.

Bonnie W. McLeod

References

1. 1. Dzik-Jurasz, Debbie, (2006). Supporting Sustainable Change. *Nursing Management*, 13 (4), p. 26-29.

Bonnie W. McLeod, infirmière autorisée, BScN, MN, CPN(C), est infirmière clinicienne enseignante (périopératoire) à la Fraser Health Authority, Ridge Meadows Hospital, représentante de l'AIISOC auprès de l'Institut canadien pour la sécurité des patients et ancienne présidente du comité des normes de l'AIISOC.

CANADIAN OPERATING ROOM NURSING JOURNAL

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Editorial Contents

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Before OR Nursing Journals

AVANT LES JOURNAUX SUR LA PRATIQUE INFIRMIÈRE EN SALLE D'OPÉRATION : LES SOINS INFIRMIERS EN SALLE D'OPÉRATION DANS LES PAGES DE *THE CANADIAN NURSE*, DE 1940 À 1960

Auteure : *Alice Moszczynski, IA, B.Sc.Inf., M.Sc., candidate au doctorat (University of Alberta) CPN(C), est une infirmière soignante dans le bloc opératoire du Memorial Hospital, à Terrace en Colombie-Britannique. Elle est membre de la PRNABC et a été la rédactrice des procès-verbaux pour le conseil de l'association de 2006 à 2010. Elle est aussi membre de Sigma Theta Tau International, la Honor Society of Nursing (société honorifique de pratique infirmière).*

RÉSUMÉ :

L'association des infirmières et infirmiers du Canada (AIIC) valorise l'apprentissage à partir de l'histoire de la pratique infirmière pour offrir une perspective contextuelle afin de comprendre comment les événements antérieurs ont influencé les soins infirmiers actuels. Avant la publication des journaux sur les soins infirmiers en salle d'opération, le journal canadien sur les soins infirmiers, *The Canadian Nurse*, servait de ressource éducative et professionnelle pour le personnel infirmier travaillant en salle d'opération et les professionnels dont le travail était lié ou relié aux salles d'opération. Une étude historique des premiers numéros de *The Canadian Nurse* (d'abord publié en 1905) révèle un nombre important d'articles concernant les soins infirmiers en salle d'opération durant la période de vingt ans (à partir des années 1940) qui précédait l'existence des journaux spécialisés sur les blocs opératoires.

Le contenu était, pour l'époque, détaillé et instructif. Ce fut par ce journal que les infirmières et infirmiers de salles d'opération, en fait tous les infirmières et infirmiers au Canada, ont appris sur les nouveaux développements, les occasions d'emploi, les programmes éducatifs, les associations professionnelles et les accomplissements des personnes exerçant la profession. Les soins infirmiers en salle d'opération, comme spécialité isolée à croissance rapide, furent présentés à d'autres infirmières et infirmiers par le biais d'articles dans le journal *The Canadian Nurse*.

L'auteur remercie avec grandement Dre Pauline Paul.

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés (9e édition) de l'Association des infirmières et infirmiers de salles d'opération du Canada (AIISOC), juin 2009, section 1, p. 47 Norme 8.

BEFORE OPERATING ROOM NURSING JOURNALS: OPERATING ROOM NURSING IN THE PAGES OF *THE CANADIAN NURSE* 1940-1960

Author: *Alice Moszczynski RN, BSN, MSc, PhD candidate (University of Alberta) CPN(C) is a staff nurse in the operating room department, Mills Memorial Hospital, Terrace, BC. She is a member of PRNABC and served as recording secretary for its Board from 2006-2010. She is also a member of Sigma Theta Tau International, Honor Society of Nursing.*

ABSTRACT

The Canadian Nurses Association (CNA) values learning from nursing history to provide a contextual perspective in understanding how past events have shaped current nursing practice. Until the publication of operating room nursing journals, Canada's national nursing journal, *The Canadian Nurse*, served as an educational and professional resource for those nurses working in the operating room and for nurses whose work was related to, or connected with, the operating room. A historical review of early issues of *The Canadian Nurse* (first published in 1905) reveals a substantial amount of content related to operating room nursing in the twenty year period, beginning in the 1940s, that predated the existence of OR specialty journals.

The content was, for the time, both detailed and informative. It was through this journal that operating room nurses, indeed all Canadian nurses, learned about new advances, employment opportunities, educational programs, professional associations, and the achievements of those in the profession. Operating Room Nursing, as an isolated and quickly emerging specialty, was introduced to other nurses via items in *The Canadian Nurse* journal.

Before OR Nursing Journals

Before Operating Room Nursing Journals

Today's perioperative nursing publications are valuable communication tools that provide more than just information – they are also a vital communication tool for the profession. By raising awareness of relevant issues they facilitate dialogue between colleagues and create avenues for change. They provide a forum in which all nurses' voices can be heard and provide the opportunity to build shared understanding that leads to improvements in perioperative nursing. And, perhaps most importantly, they provide access to knowledge and understanding.

Many specialty nursing journals are relatively young in terms of publication years. The first American operating room nursing journal was published by AORN in 1963[1] and its Canadian equivalent (Canadian Operating Room Nursing Journal) was first published in 1983.[2] Prior to this, The Canadian Nurse, a widely read journal that has been published since 1905, served as a source of information for matters concerning all areas of nursing. This article is intended to share with the reader an historical perspective about the emergence of the specialty of perioperative nursing.

While the term 'perioperative' has recently been adopted to reflect the changing aspects of the specialty of operating room nursing, the commonly used term at the time was 'operating room' nursing. This term has been used throughout the article in order to maintain fidelity with the perspective of the time. Several items, addressing OR nursing, have been identified for discussion. They include post-graduate education, formation of associations, job recruitment, product advertising, journal articles, book reviews and personal correspondence. The review of these items provides a brief overview of OR nursing as seen in the pages of *The Canadian Nurse* (for the remainder of this article this will be referred to simply as the Journal).

Post-graduate education

In the 1940s post-graduate education was available to help prepare nurses for immersion in one particular specialty. At the time, OR Nursing was being reframed as its own specialty and hospital advertisements for post-graduate nursing courses began as early as 1941.[3] While these advertisements for Post-Graduate study placements were, initially, sporadic, they soon grew and by the mid '50s numerous postings appeared for post-graduate OR education in Canada as well as in the United States.[4] As time passed, these advertisements expanded to include information about stipends and benefits available to students as well as potential salaries and benefits upon graduation.[5,6] Other postings soon followed this format and became more detailed and competitive by description. While the Journal was a bilingual publication, English language postings were definitely in the majority (only one French language posting, from a Montreal Hospital, was included).[7] Post-graduate courses were initially described, rather generically, as courses in 'Operating Room Technique and Management' or 'Operating Room Technique and Supervision'. The option of further specializing, within the OR, became evident in 1960 with the appearance of an advertisement for a 6-month program in 'nursing care of the eye' at Wills Eye Hospital in Pennsylvania.[8] The appearance of American advertisements for education may indicate that the United States also struggled to obtain specialty-prepared nurses and therefore looked to Canada as a potential source of these

qualified nurses. Of further significance is the 1960 announcement that an Operating Room Technicians course was being offered in some Canadian hospitals.[9] This could be interpreted as an attempted solution to a staffing issue or it could signify the emerging debate, that continues today, in regard to the professional and technical status of the OR nurse.[10,11]

Operating Room Supervisors attend meeting to organize OR Nurses Group, Montreal 1956. Canadian Nurse V52(3) March 1956 p198.

Entry requirements to post-graduate OR courses included graduation from an accredited school of nursing, qualified graduate nurse status, and a period of nursing service was an occasional requirement. At the time it was standard for most of these programs to be administered by the hospital and so applications for post-graduate courses were submitted to the hospital Director of Nursing or Superintendant of Nurses. Bursaries for post-graduate education were also available from groups such as the Alberta Association of Registered Nurses and could have been utilized for OR courses.[12]

Operating Room Nursing Associations

While provincial nursing associations were formally organized and active by the 1920s (by 1924 each province in Canada had a provincial nursing organization)[13] the same could not yet be said for associations related to professional practice or specialty nursing. This changed in 1954 when Edmonton nurses proudly announced the formation of what, according to their announcement in the Journal, they believed to be the first in Canada – the Association of Operating Room Nurses.[14] This announcement was accompanied by a detailed description of the association's upcoming meetings which included a session on draping techniques and the viewing of a film about an operation to separate Siamese Twins. This offers the first published documentation in to what topics OR nurses were discussing, and prioritizing, at the time. The association also included a call to action for other provinces to form OR Nursing associations -- with a reminder that associations were already quite wide-spread in the United States.

In 1956, Quebec responded to the call with Montreal nurses at the Hôtel-Dieu Hôpital announcing the results of their meeting to form a provincial OR nursing association with its goal stated as:

"*to maintain the highest level of proficiency in this phase of nursing*"

and to:

"*bring the newest trends and developments in OR to the nurses.*"[15] (p.198)

The formation of these specialty nursing associations in different provinces seems to reflect the growing desire for a forum in which specific needs and interests of operating room nurses could be addressed. Operating room nursing was showing signs of being identified as different from general duty nursing.

Recruitment of Nurses

Job postings between 1940 and 1960 frequently specified the need for a surgical nurse or a nurse with surgical experience.[16,17] While these terms might be unclear and unfamiliar to us today, the Journal writings of the time outline the surgical nurse as a general

Continued on Page 15

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[1] Darouiche, R.O., Wall, M.J., & Kamal, M.F. et al. (2010). Chlorhexidine-Alcohol versus Povidone-Iodine for Surgical-Site Antisepsis. New England Journal of Medicine, 362, 18-26.

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PrPrecedex™ (dexmedetomidine hydrochloride for injection) is indicated for sedation of initially intubated and mechanically ventilated postsurgical patients during treatment in an intensive care setting by continuous intravenous infusion. The Precedex™ infusion must not exceed 24 hours.

Precedex™ has been continuously infused in mechanically ventilated patients prior to extubation, during extubation, and post-extubation. It is not necessary to discontinue Precedex™ prior to extubation. After extubation, the dose of Precedex™ should be reduced by half. The mean time of continued infusion is approximately 6.6 hours. **Precedex™ is indicated for sedation of non-intubated** patients prior to and/or during surgical and other procedures by continuous intravenous infusion for the following procedures:

- Monitored Anesthesia Care (MAC) with an adequate nerve block and/or local infiltration and
- Awake Fiberoptic Intubation (AFI) with adequate topical preparation of the upper airway with local lidocaine formulations.

Due to insufficient safety and efficacy data, Precedex™ is not recommended for use in procedures other than the two listed above.

Patients should be continuously monitored while receiving Precedex™. Caution should be exercised when administering Precedex™ to patients with advanced heart block and/or severe ventricular dysfunction. Because Precedex™ decreases sympathetic nervous system activity, hypotension and/or bradycardia may be expected to be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension and in elderly patients. In situations where other vasodilators or negative chronotropic agents are administered, coadministration of Precedex™ could have an additive pharmacodynamic effect and should be administered with caution. Because Precedex™ has the potential to augment bradycardia induced by vagal stimuli; clinicians should be prepared to intervene. Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Precedex™ is indicated only for sedation of initially intubated and mechanically ventilated postoperative patients recovering in a post-operative care unit or an intensive care unit. During the use of Precedex™ in an intensive care setting, the patients must be monitored continuously, particularly for their cardiovascular safety indicators. If Precedex™ were to be administered for more than 24 hours and stopped abruptly, withdrawal symptoms similar to those reported for other alpha-2-adrenergic agents may result. These symptoms include nervousness, agitation, and headaches, accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma. Precedex™ infusion must not exceed 24 hours.

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See prescribing summary on page xxx

Precedex™
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Prescribing Summary

Patient Selection Criteria

THERAPEUTIC CLASSIFICATION: Alpha$_2$-adrenergic agonist

INDICATIONS AND CLINICAL USE:

Intensive Care Unit Sedation

Precedex™ is indicated for sedation of initially intubated and mechanically ventilated postsurgical patients during treatment in an intensive care setting by continuous intravenous infusion. The Precedex™ infusion must not exceed 24 hours.

Precedex™ has been continuously infused in mechanically ventilated patients prior to extubation, during extubation, and post-extubation. It is not necessary to discontinue Precedex™ prior to extubation. After extubation, the dose of Precedex™ should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.

Conscious Sedation

Precedex™ is indicated for sedation of non-intubated patients prior to and/or during surgical and other procedures by continuous intravenous infusion for the following procedures:

- Monitored Anesthesia Care (MAC) with an adequate nerve block and/or local infiltration; and
- Awake Fiberoptic Intubation (AFI) with adequate topical preparation of the upper airway with local lidocaine formulations.

Due to insufficient safety and efficacy data, Precedex™ is not recommended for use in procedures other than the two listed above.

CONTRAINDICATIONS

Patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the Dosage Forms, Composition and Packaging section of the product monograph.

SPECIAL POPULATIONS

Pregnant Women: There are no adequate and well-controlled studies in pregnant women. Precedex™ should be used during pregnancy only if the potential benefits justify the potential risk to the fetus.

Labor and Delivery: The safety of Precedex™ during labor and delivery has not been studied. Therefore, Precedex™ is not recommended during labor and delivery including cesarean section deliveries.

Nursing Women: It is not known whether Precedex™ is excreted in human milk. Radio-labeled Precedex™ administered subcutaneously to lactating female rats was excreted in milk. Because many drugs are excreted in human milk, caution should be exercised when Precedex™ is administered to a nursing woman.

Pediatrics: There have been no clinical studies to establish the safety and efficacy of Precedex™ in pediatric patients below 18 years of age. Therefore, Precedex™ should not be used in this population.

Geriatrics: Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection in elderly patients, and it may be useful to monitor renal function **(see Dosage and Administration).**

Safety Information

WARNINGS AND PRECAUTIONS

General

Precedex™ should be administered only by persons skilled in the management of patients in the intensive care or operating room setting. Due to the known pharmacological effects of Precedex™, patients should be continuously monitored while receiving Precedex™.

Cardiovascular

Hypotension, Bradycardia and Sinus arrest: Clinically significant episodes of bradycardia and sinus arrest have been reported with Precedex™ administration in young, healthy volunteers with high vagal tone or with different routes of administration including rapid intravenous or bolus administration.

Reports of hypotension and bradycardia have been associated with Precedex™ infusion. If medical intervention is required, treatment may include decreasing or stopping the infusion of Precedex™, increasing the rate of intravenous fluid administration, elevation of the lower extremities, and use of pressor agents. Because Precedex™ has the potential to augment bradycardia induced by vagal stimuli; clinicians should be prepared to intervene. The intravenous administration of anticholinergic agents (e.g., glycopyrrolate, atropine) should be considered to modify vagal tone. In clinical trials, glycopyrrolate or atropine were effective in the treatment of most episodes of Precedex™-induced bradycardia. However, in some patients with significant cardiovascular dysfunction, more advanced resuscitative measures were required.

Caution should be exercised when administering Precedex™ to patients with advanced heart block and/or severe ventricular dysfunction. Because Precedex™ decreases sympathetic nervous system activity, hypotension and/or bradycardia may be expected to be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension and in elderly patients. In situations where other vasodilators or negative chronotropic agents are administered, coadministration of Precedex™ could have an additive pharmacodynamic effect and should be administered with caution.

Transient Hypertension: Transient hypertension has been observed primarily during the loading dose in association with the initial peripheral vasoconstrictive effects of Precedex™.

Treatment of the transient hypertension has generally not been necessary, although reduction of the loading dose infusion rate may be desirable.

Dependence/Tolerance

Precedex™ is not a controlled substance. The dependence potential of Precedex™ has not been studied in humans.

Endocrine and Metabolism

The available evidence is inadequate to confirm if dexmedetomidine is associated with significant adrenocortical suppression. The adequacy of the adrenocortical function should be individually assessed and managed.

Hepatic/Biliary/Pancreatic

Since Precedex™ clearance decreases with severity of hepatic impairment, dose reduction should be considered in patients with impaired hepatic function.

Renal

Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. **(see Dosage and Administration)**

Peri-Operative Considerations

Arousability: Some patients receiving Precedex™ have been observed to be arousable and alert when stimulated. This alone should not be considered as evidence of lack of efficacy in the absence of other clinical signs and symptoms.

Withdrawal

Intensive Care Unit

Precedex™ is indicated only for sedation of initially intubated and mechanically ventilated postoperative patients recovering in a post-operative care unit or an intensive care unit. During the use of Precedex™ in an intensive care setting, the patients must be monitored continuously, particularly for their cardiovascular safety indicators.

If Precedex™ were to be administered for more than 24 hours and stopped abruptly, withdrawal symptoms similar to those reported for other alpha-2-adrenergic agents may result. These symptoms include nervousness, agitation, and headaches, accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma. Precedex™ infusion must not exceed 24 hours.

Conscious Sedation

Withdrawal symptoms were not seen after discontinuation of short term infusion of Precedex™.

Patient Counselling Information

Precedex™ is indicated for short-term intravenous sedation. Dosage must be individualized and titrated to the desired clinical effect. Blood pressure, heart rate and oxygen levels will be monitored both continuously during the infusion of Precedex™ and as clinically appropriate after discontinuation.

- When Precedex™ is infused for more than 6 hours, patients should be informed to report nervousness, agitation, and headaches that may occur for up to 48 hours.
- Additionally, patients should be informed to report symptoms that may occur within 48 hours after the administration of Precedex™ such as: weakness, confusion, excessive sweating, weight loss, abdominal pain, salt cravings, diarrhea, constipation, dizziness or lightheadedness.

Intensive Care Unit Sedation

A total of 849 patients in the clinical studies were 65 years of age and over. A total of 242 patients were 75 years of age and over. In patients greater than 65 years of age, a higher incidence of bradycardia and hypotension was observed following administration of Precedex™. Therefore a dose reduction should be considered in patients over 65 years of age **(see Dosage and Administration).**

Conscious Sedation

A total of 131 patients in the clinical studies were 65 years of age and over. A total of 47 patients were 75 years of age and over. Hypotension occurred in a higher incidence in Precedex™-treated patients 65 years or older (72%) and 75 years or older (74%) as compared to patients <65 years (47%). Pre-specified criteria for the vital signs to be reported as adverse reactions are footnoted below Table 2 **(see Adverse Reactions)**. A reduced loading dose of 0.5 mcg/kg given over 10 minutes is recommended and a reduction in the maintenance infusion should be considered for patients greater than 65 years of age **(see Dosage and Administration)**.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Use of Precedex™ has been associated with the following serious adverse reactions:

- Hypotension, bradycardia and sinus arrest **(see Warnings and Precautions)**,
- Transient hypertension **(see Warnings and Precautions)**.

Most common treatment-emergent adverse reactions, occurring in greater than 2% of patients in both Intensive Care Unit and conscious sedation studies include hypotension, bradycardia and dry mouth.

Intensive Care Unit Sedation

Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. Overall, the most frequently observed treatment-emergent adverse events included hypotension, hypertension, nausea, bradycardia, fever, vomiting, hypoxia, tachycardia and anemia **(see Table 1).**

Conscious Sedation

Adverse event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Treatment-emergent adverse events occurring at an incidence of >2% are provided in **Table 2**. The most frequent adverse events were hypotension, bradycardia, and dry mouth.

Post-Market Adverse Drug Reactions

Hypotension and bradycardia were the most common adverse reactions associated with the use of Precedex™ during post approval use of the drug.

DRUG INTERACTIONS

Drug-Drug Interactions

Anesthetics, sedatives, hypnotics, opioids

Co-administration of Precedex™ with anesthetics, sedatives, hypnotics, and opioids is likely to lead to an enhancement of effects. Specific studies have confirmed these effects with sevoflurane, isoflurane, propofol, alfentanil, and midazolam. No pharmacokinetic interactions between Precedex™ and isoflurane, propofol, alfentanil and midazolam have been demonstrated. However, due to possible pharmacodynamic interactions, when co-administered with Precedex™, a reduction in dosage of Precedex™ or the concomitant anesthetic, sedative, hypnotic or opioid may be required.

Neuromuscular Blockers

In one study of 10 healthy volunteers, administration of Precedex™ for 45 minutes at a plasma concentration of 1 (one) ng/mL resulted in no clinically meaningful increases in the magnitude of neuromuscular blockade associated with rocuronium administration.

Cytochrome P450
In vitro studies in human liver microsomes demonstrated no evidence of cytochrome P450 mediated drug interactions that are likely to be of clinical relevance.

REPORTING SUSPECTED SIDE EFFECTS
Toll-free telephone: 1-866-234-2345 • Toll-free fax: 1-866-678-6789
Online at: www.healthcanada.gc.ca/medeffect
Regular Mail: Canada Vigilance Program, Health Canada
Postal Locator 0701C, Ottawa, ON K1A 0K9

Administration

Dosing Considerations
- Precedex™ should be used in only facilities adequately staffed and equipped for anesthesia, resuscitation, and cardiovascular monitoring.
- Precedex™ dosing should be individualized and titrated to the desired clinical response.
- Precedex™ is not indicated for infusions lasting longer than 24 hours.
- Precedex™ should be administered using a controlled infusion device with adequate precision.

Recommended Dose and Dosage Adjustment
Intensive Care Unit Sedation
- Precedex™ is indicated for post-surgical patients in an intensive care setting, e.g. in Post Anesthesia Care Unit or Intensive Care Unit.
- An assessment of the level of sedation and the need for Precedex™ should precede the initiation of Precedex™.
- Another intravenous sedative (e.g. midazolam or propofol) may be added if Precedex™ provides inadequate sedation at the highest recommended dose level.
- The need for Precedex™ continuous infusion post-extubation must be assessed individually.

If the continuous infusion is needed post-extubation, the infusion speed should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.
- Precedex™ use should not exceed 24 hours in an ICU setting.

A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.

Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of up to one mcg/kg over 10 to 20 minutes, if needed. For patients being converted from alternate sedative therapy a loading dose may not be required.

Maintenance: Adult patients will generally require a maintenance infusion of 0.2 to 0.7 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the desired level of sedation.

Conscious Sedation
- Based on the Ramsay and Observer's Assessment of Alertness/Sedation Scales, the loading infusion provides clinically effective onset of sedation 10 to 15 minutes after start of infusion.
- For use in Monitored Anesthesia Care, an adequate nerve block and/or local infiltration should be used.
- For Awake Fiberoptic Intubation, the upper airway should be topicalized with proper lidocaine formulations.

Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of one mcg/kg over 10 minutes. For patients over 65 years of age or those undergoing less invasive procedures such as ophthalmic surgery, a loading infusion of 0.5 mcg/kg over 10 minutes may be suitable.

Maintenance: The maintenance infusion of Precedex™ is generally initiated at 0.6 mcg/kg/hr and titrated to achieve desired clinical effect with doses ranging from 0.2 to 1 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the targeted level of sedation. Following the load in awake fiberoptic intubation, a fixed maintenance dose of 0.7 mcg/kg/hr is recommended until the endotracheal tube is secured.

Dosage Adjustment: Due to possible pharmacodynamic interactions, a reduction in dosage of Precedex™ or other concomitant anesthetics, sedatives, hypnotics or opioids may be required when coadministered. A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.

Administration
Precedex™ must be diluted in 0.9% sodium chloride solution to achieve required concentration (4 mcg/mL) prior to administration. Preparation of solutions is the same, whether for the loading dose or maintenance infusion.

Strict aseptic technique must always be maintained during handling of Precedex™.

To prepare the infusion, withdraw 2 mL of Precedex™ and add to 48 mL of 0.9% sodium chloride injection to a total of 50 mL. Shake gently to mix well. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Study References

1. "PRECEDEX" (Dexmedetomidine Hydrochloride for Injection) Product Monograph, December 8, 2009, Hospira Healthcare Corporation.

Supplemental Product Information

Clinical Trial Adverse Drug Reactions: *Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.* **Intensive Care Unit Sedation** Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. In these studies, the mean total dose was 7.06 mcg/kg (SD = 2.86), mean dose per hour was 0.51 mcg/kg/hr (SD = 0.39) and the mean duration of infusion of 15.6 hours (range: 0.17 to 29.08). Midazolam or propofol was used as the rescue medication for patients on Precedex™ or placebo. The population was between 19 to 83 years of age, 43% > 65 years of age, 73% male and 97% Caucasian. Treatment-emergent adverse events occurring at an incidence of >1% are provided in Table 1.

Table 1: Treatment-Emergent Adverse Events Occurring in >1% Of All Dexmedetomidine-Treated Patients in the Randomized Placebo-controlled Continuous Infusion Short-Term Intensive Care Unit Sedation Studies

Adverse Event	Randomized Dexmedetomidine* (N=387)	Placebo with Midazolam Rescue (N=181)	Placebo with Propofol Rescue (N=198)
Hypotension	28%	15%	10%
Hypertension	16%	13%	23%
Nausea	11%	9%	10%
Bradycardia	7%	3%	2%
Fever	5%	6%	4%
Vomiting	4%	6%	6%
Atrial Fibrillation	4%	4%	3%
Hypoxia	4%	5%	3%
Tachycardia	3%	7%	3%
Hemorrhage	3%	6%	4%
Anemia	3%	4%	1%
Dry Mouth	3%	2%	<1%
Rigors	2%	3%	4%
Agitation	2%	3%	3%
Hyperpyrexia	2%	3%	2%
Pain	2%	3%	1%
Hyperglycemia	2%	3%	1%
Acidosis	2%	<1%	3%
Pleural Effusion	2%	<1%	2%
Oliguria	2%	1%	<1%
Thirst	2%	<1%	<1%

*Data combined from studies conducted in post-surgical patients recovering in an ICU setting.

Conscious Sedation *event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Midazolam was used as the rescue medication for patients on Precedex™ or placebo. The mean total dose was 1.6 mcg/kg (range: 0.5 to 6.7), mean dose per hour was 1.3 mcg/kg/hr (range: 0.3 to 6.1) and the mean duration of infusion of 1.5 hours (range: 0.1 to 6.2). The population was between 18 to 93 years of age, 30% > 65 years of age, 52% male and 61% Caucasian. Treatment-emergent adverse events occurring at an incidence of >2% are provided in Table 2. Pre-specified criteria for the vital signs to be reported as adverse reactions are footnoted below the table. The decrease in respiratory rate and hypoxia was similar between Precedex™ and comparator groups in both studies.*

Table 2: Adverse Events with an Incidence >2% – Conscious Sedation Population

Body System/Adverse Event	Precedex™ N = 318 n (%)	Placebo N = 113 n (%)
Vascular disorders		
Hypotension[1]	173 (54%)	34 (30%)
Hypertension[2]	41 (13%)	27 (24%)
Respiratory, thoracic and mediastinal disorders		
Respiratory depression[5]	117 (37%)	36 (32%)
Hypoxia[6]	7 (2%)	3 (3%)
Bradypnea	5 (2%)	5 (4%)
Cardiac disorders		
Bradycardia[3]	45 (14%)	4 (4%)
Tachycardia[4]	17 (5%)	19 (17%)
Gastrointestinal disorders		
Nausea	10 (3%)	2 (2%)
Dry mouth	8 (3%)	1 (1%)

1 Hypotension was defined in absolute and relative terms as Systolic blood pressure of <80 mmHg or <30% lower than pre-study drug infusion value, or Diastolic blood pressure of <50 mmHg **2** Hypertension was defined in absolute and relative terms as Systolic blood pressure >180 mmHg or >30% higher than pre-study drug infusion value or Diastolic blood pressure of >100 mmHg. **3** Bradycardia was defined in absolute and relative terms as <40 bpm or <30% lower than pre-study drug infusion value. **4** Tachycardia was defined in absolute and relative terms as >120 bpm or >30% greater than pre-study drug infusion value. **5** Respiratory Depression was defined in absolute and relative terms as respiratory rate (RR) <8 bpm or >25% decrease from baseline **6** Hypoxia was defined in absolute and relative terms as SpO_2 < 90% or 10% decrease from baseline

Post-Market Adverse Drug Reactions *The following adverse reactions have been identified during post approval use of Precedex™. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.*

Table 3: Adverse Events Experienced During Post approval Use of Precedex™

Body System	Preferred Term
Body as a Whole	Fever, hyperpyrexia, hypovolemia, light anesthesia, pain, rigors
Cardiovascular Disorders, General	Blood pressure fluctuation, heart disorder, hypertension, hypotension, myocardial infarction
Central and Peripheral Nervous System Disorders	Dizziness, headache, neuralgia, neuritis, speech disorder, convulsion
Gastrointestinal System Disorders	Abdominal pain, diarrhea, vomiting, nausea
Heart Rate and Rhythm Disorders	Arrhythmia, ventricular arrhythmia, bradycardia, hypoxia, atrioventricular block, cardiac arrest, extrasystoles, atrial fibrillation, heart block, t wave inversion, tachycardia, supraventricular tachycardia, ventricular tachycardia
Metabolic and Nutritional Disorders	Acidosis, respiratory acidosis, hyperkalemia, increased alkaline phosphatase, thirst, hypoglycemia
Psychiatric Disorders	Agitation, confusion, delirium, hallucination, illusion
Red Blood Cell Disorders	Anemia
Renal disorders	Blood urea nitrogen increased, oliguria
Respiratory System Disorders	Apnea, bronchospasm, dyspnea, hypercapnia, hypoventilation, hypoxia, pulmonary congestion
Skin and Appendages Disorders	Increased sweating
Vascular disorders	Hemorrhage
Vision Disorders	Photopsia, abnormal vision

Compatibility with Other Fluids Precedex™ has been shown to be compatible when administered with the following intravenous fluids: Lactated Ringers, 5% Glucose in Water, 0.9% Sodium Chloride in Water, 20% Mannitol in Water. Dexmedetomidine has been found to be compatible with water solutions of the following drugs when administered via Y-site injections: thiopental sodium, vecuronium bromide, pancuronium bromide, glycopyrrolate bromide, phenylephrine hydrochloride. **Compatibility with Natural Rubber** Compatibility studies have demonstrated the potential for absorption of Precedex™ to some types of natural rubber. Although Precedex™ is dosed to effect, it is advisable to use administration components made with synthetic or coated natural rubber gaskets. **Incompatibilities** Precedex™ infusion should not be co-administered through the same IV catheter with blood, serum, or plasma because physical compatibility has not been established. Precedex™ has been shown to be incompatible when administered with the following drugs: amphotericin B, diazepam. **OVERDOSAGE** The tolerability of Precedex™ was studied in one study in which healthy subjects were administered doses at and above the recommended dose of 0.2 to 0.7 mcg/kg/hr. The maximum blood concentration achieved in this study was approximately 13 times the upper boundary of the therapeutic range. The most notable effects observed in two subjects who achieved the highest doses were first degree atrioventricular block and second degree heart block. No hemodynamic compromise was noted with the atrioventricular block and the heart block resolved spontaneously within one minute. Five patients received an overdose of Precedex™ in the intensive care unit sedation studies. Two of these patients had no symptoms reported; one patient received a 2 mcg/kg loading dose over 10 minutes (twice the recommended loading dose) and one patient received a maintenance infusion of 0.8 mcg/kg/hr. Two other patients who received a 2 mcg/kg loading dose over 10 minutes, experienced bradycardia and/or hypotension. One patient who received a loading bolus dose of undiluted Precedex™ (19.4 mcg/kg), had cardiac arrest from which he was successfully resuscitated. **STORAGE AND STABILITY** Store at controlled room temperature, 25°C (77°F) with excursions allowed from 15 to 30°C (59 to 86°F). [See USP.] **DOSAGE FORMS, COMPOSITION AND PACKAGING** Precedex™ (dexmedetomidine hydrochloride for injection) is a sterile, nonpyrogenic solution suitable for intravenous infusion following dilution. Each 1 mL of Precedex™ contains 118 mcg of dexmedetomidine hydrochloride equivalent to 100 mcg dexmedetomidine and 9 mg of sodium chloride in water. The solution is preservative-free and contains no additives or chemical stabilizers. Precedex™ (Dexmedetomidine Hydrochloride for Injection), 100 mcg/mL as the base is available in 2 mL clear glass vials (200 mcg/2 mL). Vials are intended for single use only.

Product Monograph available upon request at 1-866-488-6088 or at www.hospira.ca
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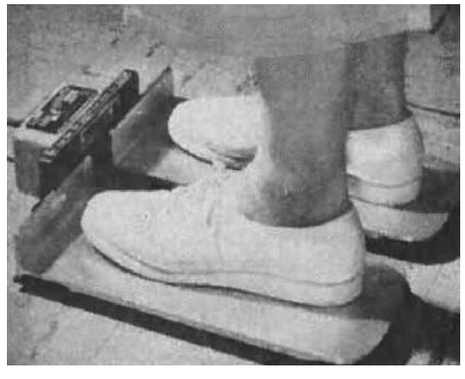
Before OR Nursing Journals (cont.)

duty nurse who worked in a pre- and post-operative surgical ward and who may also have had familiarity or experience with OR duties and procedures.[18] In addition to this unclear designation, there was a tendency, at the time, for nurses working in the OR and those on a surgical-focused patient care unit to both be identified as surgical nurses. The shift toward the recognition of an OR Nurse as one with specific OR education is shown in a 1941 advertisement requesting a 'nurse with OR training'.[19] It was not long before similar recruitment advertisements began to appear from hospitals in the United States.[20,21]

In the 1960s an advertisement from a Montreal hospital specified the need for 'OR Technicians'.[22] Advertisements were beginning to become more competitive and included information relating to wages & benefits; qualification differentials; preferential working hours; information highlighting the size and specialty of the hiring department; and equal opportunity declarations.[23,24,25] Mixed in with all of this information was the message of job portability and the allure and excitement of international travel and work opportunities. OR nursing as a specific type of nursing was now located internationally and as a result these nurses were no longer confined to Canadian soil.



"Lite-Rite" Shoe-Tester: used to test the static-charge conductivity of OR footwear. If the shoes were satisfactory, a light would come on. No light meant shoes had to be thoroughly cleaned and re-tested. Canadian Nurse V56(1) Jan 1960, p44.

During this time Canadian OR nurses were also being recruited from outside the country, with recruitment ads including job postings for OR nurses in countries such as England[26] and the US.[20,21] In addition they were being recruited and deployed by the Royal Canadian Army Medical Corps (RCAMC)[27,28], and knowingly risking their lives to be part of Canada's war-time military contribution during WWII and the Korean War.[29,30,31,32] Women were now more able to challenge their traditional standing in society and OR nursing was also developing in to a valued specialty that was growing in demand. Opportunities for employment were plentiful and competitive and OR nurses could choose from a multitude of well paid positions.

Product Advertisements

As early as the 1950s, nurses were able to keep up to date on the latest pharmaceuticals (both for general use and specific to areas of specialty such as the OR), by reading the "New Products Section" in the Journal. Information about new formulations included product descriptions, indications for use, and manufacturer information.[33]

As many surgical patients at the time did post-op recovery on the surgical unit (as the Post Anaesthetic Care Unit [PACU] was not yet firmly entrenched in the hospital system) pharmaceutical information would be relevant to both general nurses, working in the surgical unit, and to OR nurses.

Advertisements for products specifically related to the OR were, however, slower to appear in the Journal. In 1940 the items advertised were described in a generic and vague manner such as "surgical belts for fallen organs."[34] As products began to be developed specifically for use in the OR the advertisements became more focused on the end-user – initially the surgeon[35] and then eventually the OR nurse.[36]

The interest in advertising to the OR nurse became apparent by 1960 when numerous OR product advertisements appeared for products including dressings, sponges, and a device to

determine the static conductivity of OR footwear.[37,38,39,40,41] As these ads showcased products that were deemed to be time-saving for the OR nurse, rather than of use to the surgeon, it seems that advertisers were now intentionally advertising directly to nurses. This new type of advertising is further indication of the fact that OR nurses now had a stronger voice.

Journal Articles

The Canadian Nurse contained, between 1940 and 1960, numerous articles detailing pre- and post-operative care issues for patients undergoing specific surgeries. Articles were written by physicians, nurses, and student nurses and many described nursing activities that would, in today's world, be considered to be under the umbrella of perioperative nursing. The title of the article did not always indicate which nursing audience – the surgical or the OR nurse -- would benefit most from the information presented. Specific information in regard to medical conditions requiring surgery, anaesthesia, OR procedures, patient care, etc., was often woven in to articles. As a result, nurses would need to read all journal articles in order to ensure they obtained the information relevant to their specific area of practice.

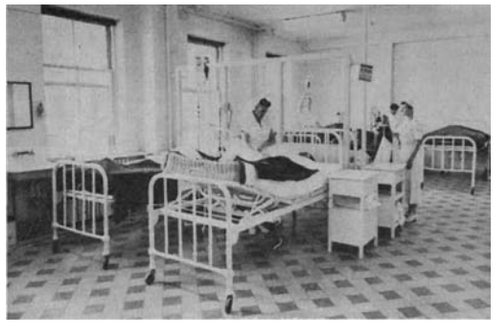
Reading all articles, and gaining insight in to various areas of practice, would certainly be of benefit to all nurses, especially those surgical nurses who were expected to assist in the OR as part of their regular work. While a surgical nurse's role would regularly include calculating the correct dosage and administering pre-op medication and completing the shave prep, enema, and skin prep their role could also include taking the patient directly into the OR and assisting the OR team in some capacity. It was in this context that the role of the surgical nurse was interpreted, and identified, earlier in this article.

To further illustrate the challenge of this role, a married nurse described, in *The Canadian Nurse*, her anxiety-ridden return to the workforce.[18] The return of Mrs. Chisholm to work is rather unusual, in itself, as married

Operating Room cap designed to meet the needs of operating room nurses, 1959. Canadian Nurse V55(5) May 1959 p429.

nurses did not, at the time, generally remain in the employ of hospitals. Mrs. Chisholm described her peripatetic duties over two days: admitting patients, preparing them for surgery, assisting in the OR, post-operative care on the ward, making beds, catheterizations, relieving on the maternity ward, looking after a fresh post-op tonsillectomy, boiling instruments, assisting with a delivery and post-partum care, and assisting with patients arriving by ambulance:

> "*False teeth out, hypodermic given. Now I wonder what I'm to do in the operating room. Hope I know where to find everything I'm asked for. Fasten patient down – do anything the scrub nurse asks you to…Tie up doctors' gowns…now they are starting…*"[18] (p.491)



Post-anaesthetic recovery room, Queen Mary Veterans' Hospital, Montreal, circa 1950. Canadian Nurse V46(6) June 1950 p467.

Then later she writes:

> "*A new patient admitted…Will I scrub?...If you'd paid attention in training you'd have known the procedure…Don't give a piece of silkworm for the peritoneum, or a round needle for the skin…Wonder if anyone notices how jumpy I am…There, it's all over. Now what were you worrying about? That wasn't much harder on you than your first tea.*"[18] (p.492)

Mrs. Chisholm's roles as a nurse on the surgical ward equated to what we would, today, consider to be the roles of a ward nurse, circulator and scrub nurse in the OR, a recovery nurse on the ward, and a float nurse… all in her first two shifts back to work after an absence from the hospital environment. The crossover of roles, between the surgical nurse and the OR nurse, in this unidentified hospital, are clear in Mrs. Chisholm's descriptions.

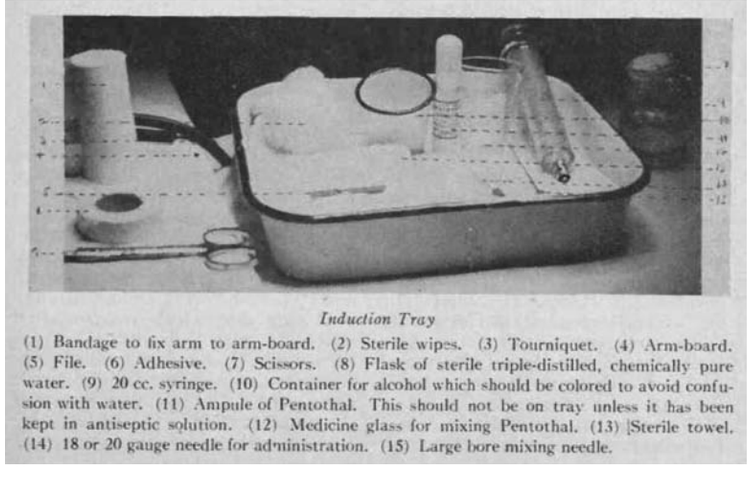
Descriptions of post-operative nursing care, at the time, often included a discussion of patient emergence from anaesthesia as well as the post-op recovery on the surgical ward.

At this time the PACU was not a reality in many hospitals. Yet the necessity for a separate post-anaesthetic care unit had been recognized and hailed as a safeguard in patient care as well as a way to prevent post-operative complications.[42,43,44]

One nursing sister described, in 1945, the set-up of a five bed PACU, including the requisite supplies and the duties of nursing sisters, and stressed that co-operation between departments was necessary for this unit to be effective.[42]

Two additional articles, arguing the case for a PACU, appeared several years later.[43,44] The recovery room was again identified as important to patient safety and as an exciting advancement in patient care. It stated that this type of unit was possible in any hospital and that there was no reason for hospitals to delay in the establishment of such a recovery room. It was noted, in addition, that patients who required prolonged ventilation as well as very ill patients who required constant supervision could be nursed in the PACU setting. This suggests that the PACU also functioned, at the time, as a quasi intensive care unit [ICU]. In a detailed article titled "Pentothal – The Nursing Approach"[45] it is noted that not all hospitals in Canada or the United States had an anaesthetic

Continued on Page 23



Induction tray for preparing pentothal solution, 1948. Canadian Nurse V44(5) May 1948, p351.

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Entries must be received by November 15, 2010 and should be submitted to awards@ornac.ca or mailed to Anita Esson **ORNAC** Awards Chair at 1769 Queen Street East, Sault Ste. Marie, ON, P6A 2G8.

AUTHOR ELIGIBILITY FOR THIS CONTEST IS AS FOLLOWS:

- Must be a perioperative registered nurse and active member of Provincial Perioperative Group/Association as of 31 March, 2010 as identified on the **ORNAC** National Database;
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THE WINNERS, AS SELECTED BY THE ORNAC AWARDS COMMITTEE, WILL BE NOTIFIED BY DECEMBER 15, 2010.

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Toute les soumission doivent être reçues au plus tard le 15 Novembre 2010, aux addresse suivantes: couriel, awards@ornac.ca ou par la poste à Anita Esson, présidente du comité des prix de **l'AIISOC** à 1769, rue Queen Est, Sault Ste. Marie, ON P6A 2G8.

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LES GAGNANTS, CHOISIS PAR LE COMITÉ DE PRIX DE L'AIISOC, SERONT CONTACTÉS AU PLUS TARD LE 15 DÉCEMBRE 2010.

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If you're interested in joining the CORNJ review panel, e-mail **journal@ornac.ca** for more information.

CORRECTION:

CORRECTION TO ORNAC STANDARDS 9TH EDITION

Section 3
page 138

8.4.2 Rationale

…. And the combined weight of the instruments and their container should not exceed 10 kg/22lbs (CSA Z314.3-09)

"GLORIA STEPHENS AWARD FOR EXCELLENCE"

The "Gloria Stephens Award for Excellence as an Educator of Perioperative Nursing" was established at the suggestion of Ms. Gloria Stephens. The $1,000 award, donated by Ms. Stephens, will be presented during National Conference years. It celebrates a nurse recognized by his/her students, peers, and managers as an outstanding educator and role model in the field of perioperative nursing.

For more information visit **www.ORNAC.ca**
and click on *Bursaries*, *Grants* & *Awards*.
Nomination deadline is January 15th, 2011.

"PRIX D'EXCELLENCE GLORIA STEPHENS"

Le Prix d'excellence Gloria Stephens à titre d'éducateur(trice) en soins périopératoires a été créé à la suggestion de Madame Gloria Stephens. Le prix d'un montant de 1 000 $, généreusement versé par Madame Stephens, sera remis lors de la conférence nationale annuelle. Il vise à reconnaître un infirmier ou une infirmière qui a été identifié(e) par ses étudiants, collègues et superviseurs comme une(e) éducateur(trice) exceptionnel(le) et modèle de rôle dans le domaine des soins périopératoires.

Pour de plus amples renseignements, veuillez visiter **www.AIISOC.ca** et cliquer sur le lien Bursaries, Grants, & Awards. (disponible en anglais seulement) ***La date limite des candidatures est le 15 janvier, 2011.***

UPCOMING EVENTS / EVÉNEMENTS SUIVANTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

Alberta	Red Deer	October 20-23, 2010
Saskatchewan	Regina	September 18, 2010
Quebec	Montreal	November 9-12, 2010
Newfoundland & Labrador	Gander	September 23-25, 2010
25th Atlantic Conference	Charlottetown, PEI	September 26-29, 2012

ORNAC CONFERENCES *www.ornac.ca*

22nd National	Regina, SK	May 8-13, 2011
23rd National	Edmonton, AB	May 5-10, 2013

INTERNATIONAL CONFERENCES

AFPP (www.afpp.org.uk)	Harrogate, UK	October 10-15, 2010
AORN (www.AORN.org)	San Antonio, TX	March 13-17, 2011

BEFORE OR NURSING JOURNALS (cont.)

recovery room. As a result, all nurses needed to be knowledgeable in "recovery supervision" and the associated care duties on the ward.

An article about tonsillectomy[46] outlined the sequence of anaesthetic agents used for general anaesthesia: inhalation divinyl ether followed by open drop ether, nitrous oxide and oxygen, and sodium pentothal or curare. After patient intubation, general anaesthesia was maintained with ether. The article described, in detail, the immediate post-op care on the nursing ward regarding patient positioning and emergence from anaesthesia. It was noted that if nurses followed the author's recommendations for recovery then suctioning equipment would not be required. The detailed writings about anaesthetic considerations, in this and many other articles, provided nurses on the surgical ward, in the OR and (where instituted) in the PACU with valuable information necessary for safe and successful post-operative patient care.

Many OR related articles were also written by nursing students, usually following a surgical observation or an assigned clinical rotation. Many students' articles focused on the necessity, and benefit, of a clinical OR rotation experience and the importance of ensuring that the OR experience remain a part of general nursing education.[47,48,49] Several technical writings, including descriptions of ligature and suture material, accompanied by hand sketches, were also published. This information helped prepare the surgical nurse for what to expect with post-op wound healing.[50]

Articles written by the clinical educators of the time seem to support a similar approach to curriculum development as far as the recommended length of the clinical experience, the year in which it should occur, the role of the student, the value of maintaining this experience as part of the nursing program, and whether the OR nursing position should be considered general nursing or a specialty.[51,52] These writings demonstrate that the perceptions of educators versus the perception of hospital administrators, in regard to OR nursing experience as a required component of basic nursing education, were becoming polemically opposed.

The realities of war were not ignored by the writings of nurses. In 1943 readers were introduced to disaster planning, preparing for a blitz,[53] setting up an OR for plastic surgery,[54] and the dilemma of a rubber shortage in regard to acquiring hospital supplies.[55] This article was of particular interest as it alerted nurses to the supply and demand challenges that were facing everybody during war time. There was a particular shortage of rubber goods, as raw rubber was unable to be procured from Singapore due to the Japanese invasion, and nearly all hospital supplies – such as gloves, tubing, needles, and scalpels – were being re-used during this time period. Nurses were advised on how to prolong the life of these supplies. A scalpel blade sharpening and reconditioning service was touted as a resource that leading surgeons were very happy with:

> "*The cost of sharpening and reconditioning these blades is less than one half of the original cost of possibly the best-known detachable blade. Surely this is real conservation of metal and labour.*"[55] (p.951)

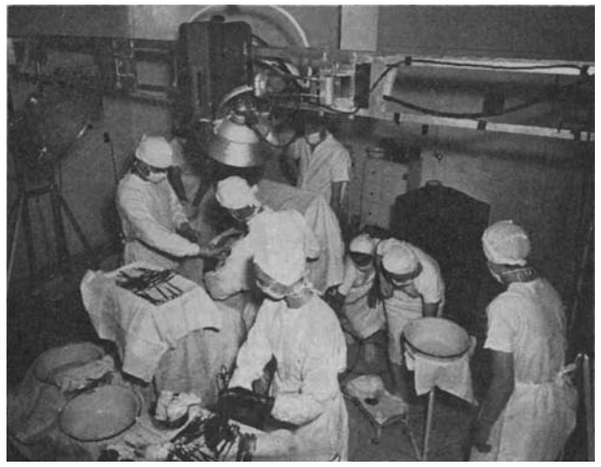
Careful resource management was now introduced as yet another element of the role of the OR nurse.

The articles published relating to surgical issues served two purposes:

1. general nurses were educated about OR practices. This was important if they were expected to work, at times, in the OR and to deliver immediate post-op care to the patient on the ward; and
2. OR nurses were kept up to date regarding advances in their areas of interest.[56,57,58,59]

Issues outlined for the OR nurse included the advantages of a central tray room, or central dressing room, in the hospital. In addition to learning about the overall concept of what we today call the Central Processing Department (CPD) or Central Sterilization Room (CSR) department, nurses learned about equipment sterilization and methods. Over the years, these writings became more OR-focused and included topics such as infection control,[60,61] educational qualifications,[62] fire in the OR,[63]

open heart surgery,[64] hypothermia,[65] and the use of live television as an educational medium for remote locations.[66]



New teaching technique: the first surgical operation, a coccygectomy, to be televised in Canada, 1949. Canadian Nurse (V45(9) Sept 1949 p679.

Nursing research with a specific focus on the operating room was introduced in an article in 1960.[67] The article is based on the author's research toward a Master's degree in nursing and attempts to address the issue of the importance of the operating room experience as a requirement in basic nursing education. The publication of nursing research in the Journal is significant, as it meant that the Journal was now being used as a mode of dissemination for scientific findings, not just for descriptive articles or those based on individual experience. Engaging in research allows nurses to question current practice within a particular context and demonstrates advanced nursing practice. With the publication of such research, the Journal could now be used as a forum for discussion amongst nurses in regard to pertinent research findings and the enhancement of nursing practice.

An interesting feature of *The Canadian Nurse* articles from 1949 through to 1951 was the inclusion of an 'estimated reading time' in minutes and seconds. Journal editors noted that they included a 'reading time' in response to nurses saying they were too busy to read the articles. Their point was made when, at the end of one year, they announced that the total reading time for all articles was 12 hours and 13 minutes. The practice of including estimated reading times was discontinued shortly afterward.[68]

Book Reviews, News Notes, and Correspondence

A "Book Review" section was a regular feature of the Journal during the 20 year period being reviewed in this article. The section included reviews of books on topics that included surgical nursing, anaesthesia, OR supervisor work, and OR nursing.[69,70,71,72,72] Books on surgical nursing were focused more on the ward nursing of surgical patients, rather than the OR aspect. Of note is the fact that several books reviewed in the '50s and early '60s [74,75,76] are still used as textbooks in perioperative nursing programs today -- albeit in updated and revised formats.

Book reviewers were nurses and physicians alike. The format of these reviews was not consistent in that they could be very succinct with limited information or very detailed and highly informative. Book reviews offered a way to learn about new books and topics that were relevant to nurses' practice. As the books could have been published anywhere in the world, the reviews also provided Canadian nurses with insight in to the OR practices and nursing issues in other countries.

In order to promote nurses' educational activities and personal accomplishments the names of nurses enrolled in post-graduate OR programs, along with the name of the hospital offering the course and the nurse's place of residence or employment, were published in the Journal.[77] Information about nurses who were on leave from their position, along with the reason for their temporary absence, was also noted.[78,79] While this information kept everyone who read the Journal apprised of their colleagues' activities, it may have also provided a stimulus to encourage other nurses to further their education.

Continued on Page 29

ORNAC in a Nutshell – Spring 2010

Submitted by: *Sue Styles, ORNAC Secretary*

The ORNAC Board of Directors Meeting and ORNAC Members' Semi-Annual General Meeting was held in Toronto on May 8th and 9th, 2010.

- The ORNAC Board of Directors/Members presently comprises five executive members, two representatives from each province and a representative from each of ORNAC's affiliate groups (CORL, RNFANC, and PNEC). ORNAC appreciates and encourages the membership collaboration that some provinces have with the Yukon, Northwest Territories and Nunavut and is highly interested in further enhancing these connections and the connection of all of Canada's perioperative registered nurses.

- ORNAC President Bonnie McLeod, warmly welcomed all executive and board members, and introduced new board members Anita Esson (ON representative) and Tracie Scott (PNEC president) as well as Quebec observer Line Michaud. Bonnie rapidly set the tone and focus of the meeting with a review of the 8 steps of "Improve Your Practice Environment" (www.nurseone.ca).

- The planning process for the ORNAC National conference is evolving. ORNAC deems the conference planning changes necessary to minimize liability risk, ensure broad representation of the status of perioperative nursing practice, and ensure cost effectiveness while retaining the unique character of each national conference locale.

- The 2011 ORNAC national conference in Regina SK, May 8-11th is less than one year away! The 2011 ORNAC national planning committee, the Prairie province of Saskatchewan and the city of Regina extend an invitation to you to attend "Elevating the Field of Perioperative Nursing". Mark your calendars and make plans to attend. Visit www.ORNAC.ca for

By/Par: S. Styles

Past, present, and future ORNAC presidents. L to R: Linda Socha (Past), Bonnie McLeod (Present), Karen Frenette (Future)

delegate and exhibitor on-line conference registration and accommodation bookings.

The ORNAC national conference is held every two years. The 2013 ORNAC National Conference will be held in Edmonton AB.

For those interested, 2009 National Conference photos have been posted www.ornac.ca.

- The 2009 ORNAC Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice (English) is available in both hard copy and in .PDF electronic format. The French 2009 ORNAC Standards edition printing has been delayed but remains a priority. Visit www.shopcsa.ca or www.ORNAC.ca to purchase the 2009 ORNAC Standards.

- The peer-reviewed Canadian Operating Nursing Journal (CORNJ) is published four times annually. The ORNAC/CORNJ editorial advisory committee encourages perioperative nurses to write for the CORNJ. There is an ongoing need, in the various knowledge and 'hot' topics of interest, for shared perioperative nursing knowledge related to patient safety, workplace environment, education, leadership, teamwork/scope of practice and technological advances impacting perioperative nursing practice. The process

of writing for CORNJ is easily navigated and guidance/assistance from the ORNAC Editorial Advisor and Editor is available as needed. Visit www.ORNAC.ca and click on Journal, to begin your writing.

- ORNAC, in partnership with 3M, is excited to launch the 3M Canadian Infection Prevention Champion Award. Criteria and nomination/application deadlines for this, and all ORNAC awards, is available at www.ORNAC.ca. Every member is encouraged to submit nominations/applications for ORNAC awards and bursaries.

  In addition, the perioperative nursing Creative Writing Contest is once again taking place and prizes are all related to the 2011 National Conference. Visit page 18 in the Journal or www.ORNAC.ca for further details.

- ORNAC Executive and Board members continue extensive collaboration with many Canadian health related professional groups on a variety of initiatives relevant to safe perioperative patient care including: the Canadian Patient Safety Institute (CPSI) Safer Healthcare Now, Accreditation Canada, Canadian Blood Services/Organ and Tissue Donation and Transplantation, Canadian Standards Association (CSA), Canadian Nurses Association (CNA), Institute for Safe Medication Practices (ISMP), and Canadian Anaesthetic Society (CAS).

- ORNAC continues to represent Canadian perioperative nursing practice in the global arena. President Bonnie McLeod was a delegate and speaker at the Association for Perioperative Practice Conference (AfPP) in Harrogate, UK; Association for Perioperative Registered Nurses (AORN) in Denver, CO; and Australian College of Operating Room Nurses Conference (ACORN) in Perth, AUS. While at these conferences Bonnie also attended the International Federation of Perioperative Nurses (IFPN) meetings.
  The ORNAC Spring 2010 Executive

By/Par: S. Styles

CORNJ Committee. L to R: Tracie Scott, Barb Mushayandebvu, Ronn Ginther, Mireille Belanger, Line Michaud, Aline Gagnon

Meeting was held in conjunction with the International Summit taking place during the 2010 AORN Conference. ORNAC Past-President, Linda Socha, has been appointed the IFPN website and publicity ambassador (2009-2010) and sits as the Canadian member on the International Relations Committee.

- The ORNAC Board approved a motion to house the ORNAC archive collection in the museum and archives of the College and Association of Registered Nurses of Alberta. The ORNAC archival items will be sorted, catalogued, and stored to preserve ORNAC history. The ORNAC archival collection database will be available at www.nurses.ab.ca .

- The ORNAC Policy and Procedures revision process, to reflect currency and recent ORNAC Incorporation, is expected to be complete by the Fall 2010 ORNAC Board Meeting.

- An ORNAC copyright permission form can be found on the ORNAC website www.ornac.ca and must be completed for utilization of ORNAC trademarked items (i.e. the ORNAC Red Lady logo).

- The ORNAC Board continued discussions relating to ORNAC strategic planning and the selection of an Executive Director. The magnitude of change inherent in the strategic planning process and the realities of securing an ORNAC executive director are immense.

By/Par: S. Styles

ORNAC standards committee. L to R: Cathy Timmons, Rupinder Khotar, Corenia Price, Anne Smith, Cathy Ferguson, Chris Downey, Kathy Radcliffe, Leah Restall.

- ORNAC board members approved the 2010-2011 ORNAC budget.
- The ORNAC board approved a one year extension of the ORNAC treasurer and secretary term to accommodate significant ORNAC national conference planning transition.
- As is usual at ORNAC spring meetings (due to provincial executive turnover), this was the last ORNAC meeting for Marlene Weeks (BC), Kelly Kuz (AB), Donna Fallis (MB) and Corenia Price (NL). On behalf of the ORNAC board and executive, in bidding farewell, Bonnie expressed gratitude for the contributions of these board members.

ORNAC welcomes your comments, feedback, announcements, and questions on matters relating to perioperative nursing practice via **www.ORNAC.ca**.

AIISOC EN BREF – PRINTEMPS 2010

Soumis par : *Sue Styles, secrétaire de l'AIISOC*

La réunion du conseil d'administration de l'AIISOC et l'assemblée générale semestrielle des membres de l'AIISOC se sont tenues à Toronto le 8 et le 9 mai 2010.

- Le conseil d'administration de l'AIISOC se compose actuellement de cinq membres exécutifs, de deux représentants de chaque province et d'un représentant de chaque groupe affilié à l'AIISOC (CORL, RNFANC et ESPC). L'AIISOC est à la fois reconnaissant et encourage la collaboration entre les membres que certaines provinces entretiennent avec le Yukon, les Territoires du Nord-Ouest et le Nunavut tout en étant fortement intéressée à développer encore plus ces liens ainsi que ceux entre toutes les infirmières autorisées en soins périopératoires au Canada.
- La présidente de l'AIISOC, Bonnie McLeod, a chaleureusement souhaité la bienvenue à tous les membres exécutifs et membres du conseil d'administration, et a présenté les nouveaux membres du conseil, à savoir : Anita Esson (représentante de l'Ont.) et Tracie Scott (présidente des ESPC) ainsi que l'observatrice du Québec, Line Michaud. Bonnie a rapidement donné le ton à la réunion qui s'est concentrée sur un résumé en 8 étapes pour « Améliorer votre milieu de travail » (www.nurseone.ca).
- Le processus de planification de la conférence nationale de l'AIISOC est en pleine métamorphose. L'AIISOC estime que les changements apportés à la planification de la conférence sont nécessaires pour réduire les risques liés à la responsabilité, assurer une vaste représentation du statut de la pratique en soins périopératoires et garantir un rapport coût-efficacité tout en conservant le caractère unique de chaque conférence nationale locale.
- La conférence nationale de l'AIISOC 2011 à Regina, en Saskatchewan qui se tiendra du 8 au 11 mai est dans moins d'un an! Le comité de planification nationale 2011 de l'AIISOC, la province de la Saskatchewan dans les Prairies et la ville de Regina vous invitent à participer à la conférence intitulée « Améliorer le domaine des soins périopératoires ». Encerclez ces dates sur

Continued on Page 33

BEFORE OR NURSING JOURNALS (cont.)

Reports from meetings and other items of potential interest to nurses were also published in the Journal. One item that stood out was in regard to an O.R. Safety Code.[80] The CNA secretary attended a 1960 meeting of the Canadian Standards Association Committee, on Hospital Hazards and reported on the proceedings. Various aspects of a proposed safety code for the OR were presented at this meeting. It addressed issues such as electrical concerns, static sparks, and the safe storage of anaesthetic gases and oxidizing agents.

Very little correspondence was published in the early years of the Journal and the correspondence that was published was rarely related to the OR. Correspondence was usually placed randomly throughout the Journal until, in 1951, a specific section was created – initially titled "In Our Mail" and then re-named "Random Comments". In 1947, a letter was published, from an unknown source, thanking the Journal for its assistance in the recruitment of an operating room nurse. [81]

The correspondence progressed with the changes in nursing. This is reflected by a 1960 letter, from a nurse in New Brunswick, requesting more information about a new nursing unit:

> "*Would you please feature 'Intensive Care Unit'. It is an apparently very new way of providing specialized care to very ill patients. It is separate and apart from the postoperative recovery room.*"[82]

The editor acknowledged this request and forwarded it to a nurse who was knowledgeable about this type of unit and who could write an article about the subject. It is interesting to see the Intensive Care Unit (ICU) being identified as a new unit separate from the PACU. The correspondence column in the Journal now provided another forum in which specific educational needs could be identified and addressed.

OR Nursing and The Canadian Nurse journal:

The CNA believes that learning from history is critical to the advancement of the nursing profession. In a position statement issued by the CNA in 2007, it is noted that:

> "*An understanding of the history of nurses and nursing practice contributes to the development of a professional identity among nurses. Knowledge of past events and people and of how they have shaped nursing has the potential to promote professional self-understanding, group cohesiveness, and a certain amount of pride. The idea of who is a nurse and what constitutes nursing practice has changed over time….The study of history can challenge conventional wisdom by suggesting alternative explanations for current nursing issues.*"[83]

An exploration of *The Canadian Nurse* during the period of 1940-1960 demonstrates how past events helped to shape the development of surgical nursing and OR nursing. This development helped to create the field of perioperative nursing as we know it today and, as a result, is crucial to our understanding of our current position. The growth of OR nursing as a specialized profession, requiring specific knowledge and competencies was portrayed through the various issues of the Journal.

The Journal takes readers on a fascinating journey from general nursing in to today's defined nursing specialty. It travels through the emergence of post-graduate OR courses, the formation of OR nursing associations, the numerous articles outlining the work of surgical nurses (before their role become the exclusive responsibility of OR nurses), the evolution of two distinct roles (surgical nurse and OR nurse) and the evolution of product advertising and the publication of OR research that reflects the changing developments, needs and areas of interest for nurses.

This brief historical review of *The Canadian Nurse* offers an illustration of the complexity and diversity within surgical and OR nursing during 1940-1960. This glimpse into the past offers a historical accounting of OR nursing as an emerging specialty and the role played by journals such as *The Canadian Nurse*.

The author gratefully acknowledges Dr. Pauline Paul.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009). Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (9th edition), in Section 1, Page 47, Standard 8.

References

1. "AORN Journal: Official journal of the Association of periOperative Registered Nurses" AORN Inc. (1963).

2. "Canadian Operating Room Nursing Journal" ORNAC (1983).

3. "4-month course for Graduate Nurses in Operating Room Technique and Management, limited to Registered Nurses who have already had operating room experience, Royal Victoria Hospital, Montreal" The Canadian Nurse. 37 (1941) : 423.

4. "16-week supplementary course in Operative Aseptic Technique offered to qualified registered nurses, The Johns Hopkins School of Nursing, Maryland, USA" The Canadian Nurse. 51 (1955) : 12.

5. " …meals in cafeteria, laundry for uniforms, $75 for first 2 months, $100 second 2 months, $150 for last 2 months, Vancouver General Hospital" The Canadian Nurse. 50 (1954)

6. "6-month post-graduate OR Technique and Supervision course; limited to 6 qualified graduate nurses. Course offerings include major and minor surgery, doctor and nurse lectures, demonstrations, field trips, and post anesthetic room experience, Winnipeg General Hospital" The Canadian Nurse. 49 (1953) : 146.

7. "Post-Scolaires offerts: Salles d'opération, Hôpital Notre-Dame, Montréal" The Canadian Nurse. 51.8 (1955) : 599.

8. "The largest eye hospital in the US offers a six-month course in nursing care of the eye, OR training included; applicants required to be graduates of accredited nursing schools, Wills Eye Hospital, Philadelphia" The Canadian Nurse. 56 (1960) : 302.

9. "Between Ourselves: A few Canadian hospitals have organized courses for the training of a new category of worker – the Operating Room Technician" The Canadian Nurse. 56 (1960) : 676.

10. Operating Room Nurses Association of Canada. "Position statement: staffing the surgical suite" Ottawa. (Revised 2005).

11. Wagner, D, Kee, C, Gray, P. "A historical decline" AORN. 62 (1995) : 771-782.

12. "Funding for post-graduate study; 2 bursaries of $250.00 available from the AARN" The Canadian Nurse. 37 (1941) : 502.

13. Canadian Nurses Association. "About CNA: History" [1 screen]. [document on the Internet]. Ottawa: The Association [cited 2010 Mar 20].

14. "Edmonton nurses announce formation of Association of Operating Room Nurses, submitted by Joan Cragg, Royal Alexandra Hospital, Edmonton" The Canadian Nurse. 50 (1954) : 402.

15. "A meeting to organize the operating room nurses was held at the Hôtel-Dieu-Hôpital, Montreal, in November" The Canadian Nurse. 52 (1956) : 198.

16. "Wanted a graduate nurse experienced in and holding a certificate for post graduate course work in surgery, Penticton Hospital Board" The Canadian Nurse. 36 (1940) : 232.

17. "Surgical nurse for the Manitoba School for Mentally Defective Persons, Portage La Prairie" The Canadian Nurse. 46 (1950) : 320.

18. Chisholm, A. "A married nurse returns to duty" The Canadian Nurse. 40 (1944) : 491-492.

19. "Experienced OR nurses, post-graduate work or training preferred, Pembroke Hospital, Ontario" The Canadian Nurse. 37 (1941) : 424.

20. "New units, all new suites, 5 day week, Massachusetts" The Canadian Nurse. 49 (1953) : 227.

21. "$15 bonus paid for each night call, New York" The Canadian Nurse. 56 (1960) : 1133.

22. "The Montreal General Hospital would welcome applications for Operating Room Technicians" The Canadian Nurse. 56 (1960) : 757.

23. "Male or female Registered Nurses considered for all positions, Kingston General Hospital" The Canadian Nurse. 56 (1960) : 477.

24. "Nurses are also required for Operating

Room…Railway fare to Edmonton refunded after six months service, University Hospital, Edmonton" The Canadian Nurse. 41 (1945) : 578.

25. "The Vancouver General Hospital…Salary: Operating Room Nurses, $286.25 - $343.25. A clinical differential of $10 a month in addition for approved postgraduate course" The Canadian Nurse 56 (1960) : 89.

26. "Theatre sisters with good previous experience wanted, Guys-Mauddsley Neurosurgical Unit, London, England" The Canadian Nurse. 56 (1960) : 279.

27. "RCAMC Nursing Service. Official announcement has been made of the safe arrival in Britain of 85 members of the R.C.A.M.C. Nursing Service" The Canadian Nurse 39 (1943) : 112.

28. "Making nursing an adventure…as a nursing sister with officer's pay, RCAMCorps" The Canadian Nurse 56 (1960) : 151.

29. "Front line surgery: The Canadian army overseas now has mobile surgical units which follow the fighting men into battle…On a recent large maneuver…these new surgical units were tested in the field. Canadian nursing sisters donned battle dress to accompany the doctors of these well-equipped units…" The Canadian Nurse 39 (1943) : 130.

30. Odier, L. "Geneva convention" The Canadian Nurse 47 (1951) : 331-333.

31. Fisher, J. "From Crimea to Korea" The Canadian Nurse 47 (1951) " 334-337.

32. Canadian Nurses Association. "77 years of remembrance" [1 screen]. [document on the Internet]. Ottawa: The Association [cited 2010 Apr 17].

33. "New Products: d-Tubocurarine Chloride Solution, Brent Laboratories Ltd, Toronto" The Canadian Nurse. 46 (1950) : 519.

34. "Surgical belts for fallen organs and floating kidneys, Clarice Corset Shoppe" The Canadian Nurse. 36 (1940) : 176.

35. "Anti-fog, a chemical solution that has been developed by scientists that prevents fog from forming on goggles and spectacles…useful for the surgeon's spectacles too" The Canadian Nurse. 45 (1949) : 179.

36. " J cap for OR nurses…professional correct OR cap that can be autoclaved…no pins or curlers needed, Johnson & Johnson" The Canadian Nurse. 55 (1959) : 429.

37. "Announcing TIS-U-SOL, a new physiologic irrigating solution specifically formulated for use in surgical procedures to maintain cell viability, Baxter Laboratories of Canada Ltd." The Canadian Nurse. 56 (1960) : 728.

38. "Elastoplast, the synonym for quality and reliability in the surgical field, Smith & Nephew Limited" The Canadian Nurse. 56 (1960) : 907.

39. "New blue Line Ray-Tec X-Ray Detectable Sponges, the important line between safety and a lost sponge, Johnson & Johnson" The Canadian Nurse. 56 (1960) : 925.

40. "Pour bottles fill immediate needs for sterile uniform solutions, Ingram & Bell" The Canadian Nurse. 56 (1960) : 1019.

41. "Lite-Rite Shoe Tester to test the static-charge conductivity of footwear to determine the suitability of selected footwear in the operating room" The Canadian Nurse. 56 (1960) : 44.

42. Hull, Sister R. "Recovery" The Canadian Nurse. 41 (1945) : 700-702.

43.Honey, E. "Post Anesthetic Recovery Room: The Canadian Nurse. 46 (1950) : 465-470.

44. Griffith, H "Recovery Room" The Canadian Nurse. 46 (1950) : 791-792.

45. Wainwright, G. "Pentothal – the nursing approach" The Canadian Nurse. 44 (1948) : 350-354.

46. Cochrane, J. "A noiseless tonsillectomy morning" The Canadian Nurse. 42 (1946) : 219-221.

47. Adams, C. "Planned operating room experience for the student nurse" The Canadian Nurse. 43 (1947) : 370-371.

48. Ellison, B. "The value of operating room experience to the student nurse" The Canadian Nurse. 51 (1955) : 881.

49. Burwash, N. "Student nurse and the patient in the O.R." The Canadian Nurse. 56 (1960) : 709.

50. Martin, B. "Ligatures and sutures" The Canadian Nurse. 48 (1952) : 833-835.

Before OR Nursing Journals (cont.)

51. Batson, M. “Rotation in relation to clinical experience” The Canadian Nurse. 40 (1944) : 399.

52. Eichel, M. “Clinical instruction in the operating room” The Canadian Nurse. 41 (1945) : 203.

53. MacKay, H. “Practice for a blitz” The Canadian Nurse. 39 (1943) : 115-117.

54. Dearden, A. “ An operating room set-up for plastic surgery” The Canadian Nurse. 39 (1943) : 109-110.

55. Coleman, W. “The care, maintenance and conservation of hospital equipment” The Canadian Nurse. 41 (1945) : 949-953.

56. Fairweather, M. “Nursing care in surgical goitre” The Canadian Nurse. 36 (1940) : 141-143.

57. Fraser, R. “Lumbar anaesthesia in obstetrics” The Canadian Nurse. 36 (1940) : 404-409.

58. Sister Helen Marie, Bryant, C. “Advantages of a central dressing room” The Canadian Nurse. 39 (1943) : 341-343.

59. Mackie, L. “A central tray room” The Canadian Nurse. 37 (1941) : 554-556.

60. Smith, M. “The problem of staphylococci in the operating room and central supply room” The Canadian Nurse. 55 (1959) : 801-804.

61. MacNeil, H. “Prevention of staphylococcal infections in the operating room” The Canadian Nurse. 55 (1959) : 799-800.

62. Iwamoto, S. “Operating room technicians” The Canadian Nurse. 56 (1960) : 710.

63. Placide, Sister Marie “Fire and explosion in the operating room” The Canadian Nurse. 56 (1960) : 702-704.

64. Effler, D. “The era of open-heart surgery” The Canadian Nurse. 56 (1960) : 695-697.

65. Rowland, B. “Neurosurgery and hypothermia” The Canadian Nurse. 56 (1960) : 697-701

66. “A new teaching technique – television” The Canadian Nurse. 45 (1949) : 677-679.

67. Griffin, A. “Evaluation of experience in the Operating Room” The Canadian Nurse. 56 (1960) : 705-708.

68. “Between Ourselves” The Canadian Nurse. 47 (1951) : 850.

69. “Book Reviews: Anesthesia Principles and Practice – A presentation for the nursing profession” The Canadian Nurse. 45 (1949) : 932.

70. “Book Reviews: Surgery for Nurses” The Canadian Nurse. 47 (1951) : 294.

71. “Book Reviews: Surgical Nursing” The Canadian Nurse. 47 (1951) :598.

72. “Book Reviews: Surgical Nursing and After” The Canadian Nurse. 48 (1952) : 570.

73. “Book Reviews: The Operating Room Supervisor at Work” The Canadian Nurse. 54 (1957) : 320.

74. “Book Reviews: Operating Room Technique” The Canadian Nurse. 46 (1950) : 62.

75. “Book Reviews: Introduction to Operating Room Technique” The Canadian Nurse. 53 (1957) : 65.

76. “Book Reviews: The Care of Patient in Surgery Including Techniques” The Canadian Nurse. 56 (1960) : 75.

77. “News Notes: Vancouver General Hospital” The Canadian Nurse. 42 (1946) : 985.

78. “News Notes, Winnipeg General Hospital: Doris Wellar, supervisor of the operating room is taking a post-graduate course in operating room technique at the Toronto General Hospital” The Canadian Nurse. 41 (1945) : 741.

79. “Yorkton Chapter: Alice Gwilliam, of the Yorkton General Hospital operating room staff, has completed a post-graduate course in surgery at Vancouver General Hospital and has returned to the position of supervisor of the operating room” The Canadian Nurse. 41 (1945) : 660.

80. “Nursing Across the Nation” The Canadian Nurse. 56 (1960) : 638.

81. “Getting Results” The Canadian Nurse. 43 (1947) : 575.

82. “Random Comments” The Canadian Nurse. 56 (1960) : 594.

83. Canadian Nurses Association “Position statement: The value of nursing history today” CNA (2007).

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votre calendrier et organisez-vous pour y assister. Visitez www.ORNAC.ca pour l’inscription en ligne des délégués et des exposants à la conférence ainsi que pour les réservations quant à l’hébergement.

La conférence nationale de l’AIISOC se tient tous les deux ans. La conférence nationale de l’AIISOC de 2013 aura lieu à Edmonton, en Alberta.

Des photos de la conférence nationale de 2009 ont été affichées sur le site www.ornac.ca.

By/Par: S. Styles

le Comité de prix de l'AIISOC G à D: Charlotte Roach, Katherine Wood, Anita Esson

- La version anglophone de la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés 2009 de l’AIISOC est disponible en format imprimé et en format PDF en ligne. L’impression de la version francophone a, par contre, été retardée, mais demeure une priorité. Visitez les sites www.shopcsa.ca ou www.AIISOC.ca pour vous procurer une copie des normes de l’AIISOC de 2009.

- La Revue de l’Association des infirmières et infirmiers de salle d’opération du Canada (RAIISOC) est évaluée par les pairs et publiée quatre fois par année. Le comité de rédaction de l’AIISOC/RAIISOC encourage les infirmières et les infirmiers en soins périopératoires à rédiger des articles pour la RAIISOC. Nous avons constamment besoin, tant dans le domaine des sujets d’intérêt général que dans celui des sujets de l’heure, de personnes désireuses de faire part de leurs connaissances en soins périopératoires liées à la sécurité des patients, au milieu de travail, à l’éducation, au leadership, au travail d’équipe/à la portée de la pratique et aux progrès technologiques ayant des répercussions sur la pratique des soins périopératoires. Le processus pour rédiger un article pour la RAIISOC est facile à suivre et le conseiller de la rédaction ainsi que le rédacteur en chef de l’AIISOC sont disponibles pour vous donner des conseils/de l’aide, au besoin. Visitez www.ORNAC.ca et cliquez sur Revue (Journal) pour débuter votre article.

- L’AIISOC, en partenariat avec 3M, est impatiente d’instituer le Prix-étoile 3M pour la prévention de l’infection au Canada. Vous pouvez consulter les critères d’admissibilité et les dates limites pour poser une mise en candidature/une demande pour ce prix, ainsi que tous les prix de l’AIISOC, sur le site www.AIISOC.ca. Nous encourageons tous les membres à soumettre leur mise en candidature/demande aux prix/bourses de l’AIISOC.

  De plus, le concours de création littéraire en soins périopératoires se tiendra encore cette année et les prix seront tous liés à la conférence nationale de 2011. Rendez-vous à la page 19 de la revue ou visitez www.AIISOC.ca pour plus de détails.

- Les membres exécutifs et les membres du conseil d’administration de l’AIISOC continuent de collaborer de façon intense avec de nombreux groupes de professionnels dans le domaine de la santé en ce qui a trait à toute une série d’initiatives pertinentes aux soins périopératoires sécuritaires offerts aux patients, y compris avec : l’Institut canadien pour la sécurité des patients (ICSP), l’organisme Des soins de santé plus sécuritaires maintenant!, Agrément Canada, la Société canadienne du sang/don

AIISOC EN BREF (cont.)

et transplantation d'organes et de tissus, l'Association canadienne de normalisation (CSA), l'Association des infirmières et des infirmiers du Canada (AIIC), l'Institut pour l'utilisation sécuritaire des médicaments du Canada (ISMP) et la Société canadienne des anesthésiologistes (SCA).

❖ AIISOC continue de représenter la pratique des soins périopératoires au Canada au plan mondial. La présidente Bonnie McLeod a été déléguée et conférencière lors des conférences de l'Association for Perioperative Practice (AfPP) à Harrogate, UK; de l'Association for Perioperative Registered Nurses (AORN) à Denver, CO; et de l'Australian College of Operating Room Nurses (ACORN) à Perth, AUS. Lorsqu'elle a assisté à ces conférences, Bonnie a également participé aux réunions de l'International Federation of Perioperative Nurses (IFPN).

La réunion des membres exécutifs de l'AIISOC du printemps 2010 a eu lieu en même temps que le sommet international qui se tenait lors de la conférence de l'AIIASP 2010. L'ancienne présidente de l'AIISOC, Linda Socha, a été nommée ambassadrice du site Web de l'IFPN et de l'information publicitaire (2009-2010) et elle siège à titre de membre canadien au International Relations Committee.

❖ Le conseil de l'AIISOC a approuvé une requête pour héberger la collection d'archives de l'AIISOC au musée et aux archives du Collège et de l'Association des infirmières et des infirmiers autorisé(e)s de l'Alberta. Les articles à archiver de l'AIISOC seront classés, catalogués et entreposés afin de préserver l'histoire de l'AIISOC. La base de données de la collection d'archives de l'AIISOC sera disponible à www.nurses.ab.ca .

❖ On s'attend à ce que le processus de révision des Politiques et procédures de l'AIISOC afin que ces dernières reflètent la récente constitution en société de l'AIISOC soit terminé à la réunion du conseil d'administration de l'AIISOC de l'automne 2010.

❖ Vous trouverez le formulaire d'autorisation pour les droits d'auteur de l'AIISOC sur le site Web de l'AIISOC à www.ornac.ca. Ce dernier doit être rempli pour avoir le droit d'utiliser les éléments ayant une marque déposée de l'AIISOC (p. ex. : le logo de la femme en rouge de l'AIISOC).

❖ Le conseil de l'AIISOC a continué ses discussions concernant la planification stratégique de l'AIISOC ainsi que la sélection d'un directeur général ou d'une directrice générale. La portée des changements relatifs au processus de planification stratégique ainsi que les réalités auxquelles nous faisons face pour dénicher un directeur général/une directrice générale pour l'AIISOC sont considérables.

❖ Les membres du conseil de l'AIISOC ont approuvé le budget de l'AIISOC pour 2010-2011.

❖ Le conseil de l'AIISOC a approuvé la prolongation du mandat du trésorier et de la secrétaire de l'AIISOC pour une année additionnelle afin d'accommoder la transition quant à l'importante planification nécessaire pour de la conférence nationale de l'AIISOC.

❖ Comme nous y sommes habitués lors des réunions du printemps de l'AIISOC (en raison de la rotation de l'organe exécutif provincial), cette réunion était la dernière réunion de l'AIISOC pour Marlene Weeks (C.-B.), Kelly Kuz (Alb.), Donna Fallis (Man.) et Corenia Price (T.-N.). Au nom du conseil et des membres exécutifs de l'AIISOC, Bonnie leur a fait ses adieux et leur a exprimé sa reconnaissance pour leurs contributions.

À l'AIISOC, il nous fait plaisir de recevoir vos commentaires, votre rétroaction, vos annonces et vos questions concernant la pratique des soins périopératoires que vous pouvez faire parvenir à **www.AIISOC.ca**.

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References
1 The Joint Commission. The Statistics page. Available at: http://www.jointcommission.org/NR/rdonlyres/D7836542-A372-4F93-8BD7-DDD11D43E484/0/SE_Stats_12_07.pdf. Accessed March 13, 2008.

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