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NURSING JOURNAL
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Nursing & Anaesthesia

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Past President's Message

It's hard to imagine my term as President is nearing its end! Looking back at my first message in CORNJ, my enthusiasm and nervous anticipation were clearly evident. I am happy to say the feelings never swayed – every opportunity and challenge presented meant potential for organizational growth. Armed with that knowledge, and with the foundation laid by those before me, it has been an honour and a privilege to contribute to the ongoing development of ORNAC.

I have immense respect and appreciation for the nurses with whom I have worked on the Board. It is their boundless spirit and dedication to the organization, and to perioperative nursing, that has provided direction and a voice for perioperative nursing in Canada. The ORNAC Board works tirelessly on the Standards, the journal, the website, the national conferences, the perioperative program approval process, partnerships with other national and international organizations, and more. They are to be commended for their strength and for their passion. Bravo to all of them!!

My two years as ORNAC President have been an amazing experience both professionally and personally. There have been some milestone achievements along the way, but there is still much work to do. The continued success of perioperative nursing as a specialty nursing profession requires vigilance and the involvement of ORNAC members.

The challenges faced in areas of practice, patient safety, professional growth, and human resources all require our utmost attention. It is not enough to be a spectator if we are to maintain our current profile and expect our profession to flourish. We need to reach out to the students, improve our specialty certification numbers, and lobby for more patient safety initiatives through practice and new technologies. Your involvement and motivation can help move this agenda along! In the coming months and years, ORNAC will continue to introduce new ideas that will assist our members in delivering that high standard of care we all hope to give. It is my hope that many of you will join in and be at the forefront of these developments.

By the time you are reading this I will have finished my term, at the conclusion of the ORNAC National Conference in Newfoundland, so it is my great pleasure to introduce your incoming President, Bonnie McLeod. Bonnie brings a wealth of knowledge, leadership and experience to the table. I know she will represent ORNAC with humour and sound judgement, as well as with a deep commitment to perioperative nursing. Being a good leader takes more than good organizational skills. Leaders are sought after for their abilities to reach out to everyone and to create a climate of acceptance and respect for colleagues. I have no doubt that Bonnie will be an exceptional leader!

Linda M. Sockie

Message from the Incoming President

I am honoured to represent the members of ORNAC as your President. It has been a privilege to be in the company of such superb perioperative nurse leaders who strive for excellence in safe patient care. I am confident that with Linda's guidance and the support of the Executive and Board members I will continue the legacy of ORNAC'S recognition nationally and internationally.

Bonnie W. McLeod

Bonnie W. McLeod, RN, BScN, 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.

Past President's Message

Il est difficile de croire que mon rôle de présidente arrive bientôt à sa fin! En relisant mon premier message dans le CORNJ, je vois clairement l'enthousiasme et la nervosité que je vivais à ce moment-là. Je suis très contente de constater que ces émotions ne m'ont jamais quittée - dans chaque défi affronté s'est présentée la possibilité de faire grandir l'association. Armée de cette certitude et marchant dans les traces de mes prédécesseurs, j'ai eu l'honneur et le privilège de contribuer à l'épanouissement continu de l'AIISOC.

J'éprouve un énorme respect et une grande reconnaissance pour les infirmières avec qui j'ai travaillé au sein du conseil. C'est bien leur esprit indomptable et leur dévouement à l'association, ainsi qu'aux soins périopératoires, qui ont servi de guide et donné une voix aux soins périopératoires au Canada. Le conseil de l'AIISOC travaille assidûment sur les normes, le journal, le site Web, les conférences nationales, la démarche de certification de programmes périopératoires, les partenariats avec des organismes nationaux et internationaux, et bien plus encore. Prenons un moment pour reconnaître l'engagement et la passion de ses membres. Bravo à chacune d'entre vous!

Pour moi, assumer le rôle de présidente pendant les deux dernières années a été une expérience incroyable, autant sur le plan professionnel que personnel. Nous avons connu d'importantes réussites, mais il nous reste encore beaucoup de travail à faire. Le succès continu des soins périopératoires comme spécialité en soins infirmiers exige la vigilance et la participation des membres de l'AIISOC.

Les défis qui se présentent dans les domaines de la pratique, la sécurité des patients, le perfectionnement professionnel et les ressources humaines nécessitent une attention soutenue de notre part.
Pour maintenir notre notoriété actuelle et faire épanouir notre profession, le rôle de spectateur ne suffit pas. Nous devons rejoindre les étudiants, augmenter le nombre de personnes certifiées dans notre spécialité et insister sur encore plus d'initiatives de sécurité des patients basées sur la pratique et les nouvelles technologies. Votre participation et enthousisame peuvent nous aider à rencontrer nos objectifs! Dans les prochains mois comme les prochaines années, l'AIISOC continuera à proposer de nouvelles idées pour aider nos membres à fournir des soins du haut niveau de qualité qui est l'objectif de chacune et chacun de nous. J'espère sincèrement que vous vous joindrez à nous en grand nombre et nous aiderez à façonner l'avenir de notre profession.

Au moment où vous lirez ces mots, à la clôture de la conférence de l'AIISOC à Terre-Neuve, mon mandat sera terminé. Je saisis donc l'occasion et vous présente, avec plaisir, la nouvelle présidente de l'AIISOC, Bonnie McLeod. Bonnie est une mine d'informations et d'expérience, sans oublier ses qualités de leader. En elle, l'AIISOC trouve une représentante pleine d'humour, douée de bon jugement et vouée aux soins périopératoires. De bonnes capacités d'organisation, à elles seules, ne font pas un bon leader. Un leader est choisi pour sa capacité de rejoindre tout le monde et créer un milieu accueillant et respecteux envers ses collègues. Je suis convaincue que Bonnie sera un leader exceptionnel!

Message de la nouvelle president

C'est un grand honneur pour moi de représenter les membres de l'AIISOC en assumant le rôle de présidente. tre en compagnie de leaders extraordinaires en soins infirmiers périopératoires visant toujours l'excellence en soins sécuritaires est un vrai privilège. Je suis certaine que, grâce aux conseils de Linda et à l'appui des membres des conseils exécutif et administratif, je serai en mesure de poursuivre la reconnaissance de l'AIISOC à l'échelle nationale et internationale.

Bonnie W. McLeod, infirmière autorisée, BScN, 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.

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Editorial Contents

6 MENTORING NEW NURSES IN STRESSFUL TIMES
By: Lisa E. Young BScN, RN, CPN(C), MHS

16 NURSING AND ANAESTHESIA: HISTORICAL DEVELOPMENTS IN CANADA
By: Jennifer Dunlop RN, MSN, CPN(C); Geertje Boschma RN, PhD; and Rosella Jefferson RN, MSN

INDUSTRY HAPPENINGS

12 ORNAC STANDARDS 9TH EDITION

24 UPCOMING EVENTS

Nursing & Anaesthesia (cover photo)

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LE MENTORAT DU NOUVEAU PERSONNEL INFIRMIER DANS DES CIRCONSTANCES DIFFICILES

Auteure : *Lisa E. Young, baccalauréat en sciences infirmières, infirmière autorisée, CPN(C), MHS, gestionnaire clinique de la clinique et de la zone d'observation des neurosciences à l'Hôpital d'Ottawa à Ottawa en Ontario. Au moment de la rédaction de cet article, Lisa était facilitatrice des soins du service de Chirurgie thoracique dans les salles opératoires au campus général de l'Hôpital d'Ottawa et terminait le dernier cours pour sa maîtrise en études sur la santé – programme de leadership à la Athabasca University à Athabasca (Alberta).*

RÉSUMÉ

Le respect des directives du programme des temps d'attente en Ontario et le projet d'expansion de l'Hôpital d'Ottawa sont deux motivations critiques poussant le recrutement de personnel périopératoire à Ottawa et dans l'est de l'Ontario. En raison des pressions supplémentaires résultant du vieillissement de la population et de la pénurie nationale d'infirmières et infirmiers, les services périopératoires sont surmenés et sous-équipés. Le préceptorat de nouveau personnel est critique car bon nombre des nouvelles recrues ont très peu ou aucune expérience en salle d'opération. Le modèle d'acquisition de compétences de Dreyfus démontre l'importance du temps et de la patience lors de l'apprentissage dans le but d'améliorer la conservation du personnel, promouvoir le développement professionnel et le dépassement. La création de programmes de mentorat, efficaces grâce au développement de cultures organisationnelles saines, leadership transformationnel et programmes de développement, fournira un meilleur appui pour le personnel infirmier lorsque les temps sont difficiles.

Le stress découlant des efforts pour respecter les exigences de la stratégie de réduction des temps d'attente en Ontario et l'agrandissement des services périopératoires à l'Hôpital d'Ottawa en Ontario constituent les principales circonstances motivant le recrutement de personnel infirmier dans le domaine des soins périopératoires. Le vieillissement de la population canadienne et le manque d'infirmières et d'infirmiers à l'échelle nationale ont comme résultat des services de soins périopératiores surchargés et sous-équipés qui doivent tout de même former le nouveau personnel et s'assurer de répondre aux exigences importantes de la stratégie des temps d'attente. Le présent article traite des tendances actuelles en soins de santé et des changements dans le cheminement de carrière de plusieurs infirmières et infirmiers influencés par la demande en soins spécialisés. Cette discussion est suivie d'un survol du modèle d'acquisition de compétences de Dreyfus. Le mentorat est proposé comme stratégie efficace pour former et encadrer le nouveau personnel. Pour terminer, sont discutés les avantages et quelques propositions pour créer un programme de mentorat apte à appuyer le personnel infirmier lors de circonstances difficiles.

Les normes professionnelles de l'AIISOC relatives à cet article sont citées dans le document suivant édité par l'Association des infirmières et infirmiers de salle d'opération du Canada (2007) : *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires* (8e édition) Module 1, pages 20 à 22. Norme 1.

MENTORING NEW NURSES IN STRESSFUL TIMES

Author: Lisa E. Young BScN, RN, CPN(C), MHS is Clinical Manager of the Neurosciences Observation Area and Neurosciences Clinic at The Ottawa Hospital, Ottawa, Ontario. At the time this article was written, Lisa was the Care Facilitator of Thoracic Surgery in the Surgical Suites at the General Campus of The Ottawa Hospital and completing her final course in the Master of Health Studies - Leadership program at Athabasca University in Athabasca, Alberta.

ABSTRACT

Meeting benchmarks of *Ontario's Wait Time Strategy* and the expansion of The Ottawa Hospital are key issues driving the recruitment of perioperative nurses in Ottawa and Eastern Ontario. Added pressures resulting from Canada's aging population and a nationwide nursing shortage mean perioperative nurses are overworked and understaffed. Preceptoring new members of staff raises valid concerns as many of the new recruits have little or no operating room experience. The *Dreyfus Model of Skill Acquisition* demonstrates the importance of time and patience in supporting the learning process. Mentoring is a valuable strategy in an effort to teach and guide new nurses, to increase nursing retention, and to promote professional growth and recognition. Building successful mentorship programs, through the creation of healthy organizational cultures, transformational leadership and staff development programs, will strengthen support for nurses in stressful times.

The stress of meeting the province-wide benchmarks outlined in *Ontario's Wait Time Strategy* and the expansion of perioperative services at The Ottawa Hospital in Ontario are two key issues driving the need for the recruitment of nurses into the specialty of perioperative nursing. As a result of Canada's aging population and a nationwide nursing shortage, perioperative nurses are over-worked and under-staffed while being faced with the pressure to preceptor new staff members while struggling to meet the daily demands of the wait list strategy. This article discusses current trends in healthcare and the career path changes being made by many nurses in response to the demand for specialty trained nurses. It is followed by a brief explanation of the *Dreyfus Model of Skill Acquisition*. Mentoring is presented as an effective strategy in the guidance and teaching of new nurses with a discussion of the benefits and suggestions on how to build a successful mentorship program to support nurses in these stressful times.

Current Trends in Healthcare: The Pressure Is On!

Canada's Aging Population

Statistics reveal that Canadians are, on average, living longer. The number of senior citizens in the population will accelerate after 2011 when the baby boomers will begin to turn 65. By 2028, the number of people aged 65 and over will have more than doubled from 1.4 million in 1999 to 3.2 million. The number of seniors aged 75 and over will increase from 0.6 million to 1.4 million[1].

As the population ages the requirement for acute health care services rises. In Ontario, cancer continues to be a leading cause of morbidity and mortality, with the risk increasing significantly after age 65[1]. Risk factors such as smoking, obesity, hypertension and diabetes remain problematic for many Ontarians[1].

Ontario's Wait Time Strategy

The aging population's demand for accessible health care spurred the Ministry of Health and Long-Term Care (MOHLTC) to initiate *Ontario's Wait Time Strategy* in November 2004. The strategy's aim is to improve access to health care services by reducing the time adult Ontarians wait for services in five key areas: cancer surgery, cardiac surgery, cataract surgery, hip and knee total joint replacements, and MRI/CT scans[2]. Hospitals are now accountable for their wait lists, reporting their times to the ministry and perhaps more notably, they must make their wait list information available to the general public as they strive to meet the target times set by the MOHLTC. The wait time period is measured from the time the specialist makes a decision to treat the patient until the time the procedure is completed. Ontarians currently have open access to information about province-wide benchmarks in order to determine exactly which hospitals and services have the longest wait times.

Expansion of Critical Care Services at The Ottawa Hospital

In response to the growing population and increased health care demands, The Ottawa Hospital (TOH), a leading academic health sciences center in Canada, has recently expanded critical care services at its General campus. This includes a new state-of-the-art critical care wing housing an expanded intensive care unit (ICU), recovery room, surgical day care unit, and five additional operating rooms (OR) bringing the total of ORs to 17. TOH currently provides service to a population of 1.5 million people in Ottawa and Eastern Ontario. With 71,000

Continued on Page 14

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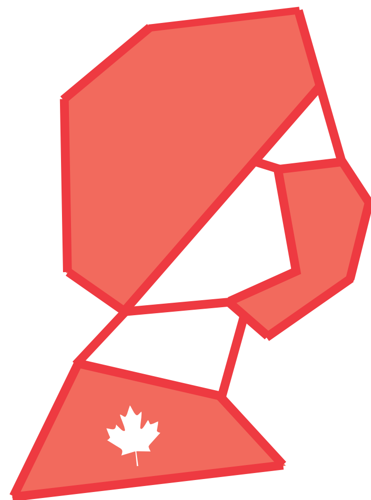

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surgical procedures completed at TOH in 2005[3], and the constant push to meet the demands of the MOHLTC's initiative to reduce wait times for surgery, the recruitment of perioperative nurses is critical to ensuring high quality care is safely and efficiently delivered to this high volume of surgical patients. Where will these nurses come from?

Nursing Today;

Nursing Shortage: General
Canada is currently experiencing a nation-wide shortage of health care providers. Registered Nurses are the largest group of health care professionals with a direct impact on the functioning of our health care system. Although there was a 5.3% increase of nurses from 2000 to 2005, the average age of Canadian nurses also increased from 43.3 in 2000 to 44.7 years in 2005[4], meaning a larger portion of nurses are now moving closer to retirement. Nursing school enrolment has also improved in recent years with new interest in nursing as a profession; however we are far from solving this nationwide nursing shortage.

Recruiting to Specialty Services
Due to the additional training required for specialty services, areas such as ICU, recovery room, emergency room and the OR are even more burdened by the current trends in nursing shortages. The need to recruit and retain specialty nurses is greater than ever. In addition to the generalized training completed in nursing schools, specialized areas are required to invest more time in ensuring nurses obtain the advanced training, skills and experience required to care for patients in these high risk areas. Recruiting nurses from general nursing units to specialty areas creates staffing challenges for the general nursing units which can negatively impact patient care. Overworked nurses will then become more frustrated and stressed. At best, the recruitment of nurses from other units is a band-aid solution for the specialty services and an open wound for the general nursing workforce.

Overworked & Understaffed in the OR
The fast-paced, high energy environment of the OR provides perioperative nurses with a unique opportunity to work closely with the anesthesia and surgical team to anticipate potential problems while ensuring safe, efficient and quality patient care. Highly skilled OR nurses, who are able to confidently manage patient crises, improve the overall quality of patient care provided during the surgical experience. However, today's perioperative nurses are struggling with heavy workloads, high patient acuity, various instrument processing issues, low morale, and staff shortages. As a result, many in the perioperative nursing profession are experiencing burnout, increased sick time, or making the decision to leave the OR for either professional or personal reasons. Bally believes the detrimental effects of these issues are being reflected in poor staff performance and in unsatisfactory patient care outcomes.[6] These issues, if they remain unaddressed, result in an increase in feelings of frustration and cause undue stress on nursing staff. To compound matters, nurses are continually pressured to preceptor and teach new nurses. Most newly hired nurses have little or no OR experience. Preceptors not only orient new nurses to the environment and routines of the unit itself, but teach them how to apply their perioperative nursing education to the practical environment, help build their knowledge base, and work with them to improve their skills. The added responsibility related to preceptoring increases the already heavy workload of the experienced nurse.

Beginners teaching beginners
A major concern, identified by OR nursing staff at TOH's General campus, relates directly to patient safety. Continuously striving to meet province wide benchmarks for key surgeries means surgical cases are rarely cancelled even when the unit is short of nurses. Perioperative nurses are expected to "just manage" which often results in a senior nurse supporting two beginners, senior staff members split between OR suites to cross-cover for break relief, and the newest trend of beginners teaching beginners! "The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) reports, 'inadequate orientation and training of nurses is a factor in 58% of serious errors. …staffing levels have been a factor in 24% of 1609 sentinel events over the past five years".[7] Beginners pushed into high acuity cases before they have acquired the knowledge base necessary

for the job, and with little back-up, increases the beginner's stress level and the overall stress level in the OR. New recruits feel overwhelmed and poorly supported. How is the periperative profession going to retain these new recruits? A positive and supportive environment is necessary for new nurses to practice skills, gain valuable experience and increase self-confidence.

Changing Career Paths – A New Beginning:

In order to understand how to properly support new perioperative nurses, we must first understand where they are coming from. Many who enter the perioperative specialty are experienced nurses who are now starting over in a new specialty service and an unfamiliar environment. Having been experts in their previous area of practice, they are now experiencing a major role reversal and learning how to shift gears and become the student once again.[8] The *Dreyfus Model of Skill Acquisition* outlined by Patricia Benner (1984) shows the stages of movement required by nurses who are new to a practice environment before they become expert in a new specialty (see table 1). This process requires both time and patience. Thomes states, "impatience, more than anything else, can make the new novice doubt his or her decision to change career paths. It can also place too much pressure on the novice to succeed, thereby causing failure".[9] The process of mentoring can aid in the successful transition from novice to expert. Mentors must help novices understand that they will not know all there is to know about their new role and that the learning curve may be steep.[9] Challenges and frustrations are expected and are part of the learning process. Establishing clear goals will provide the novice with a sense of direction and feeling of accomplishment when the goals are achieved.[9]

Mentoring

A Collegial Relationship
Mentoring is a collegial relationship between two nurses "formed on the basis of mutual respect and compatible personalities with the common goal of guiding the nurse towards personal and professional growth".[7] It is a reciprocal relationship where the mentee can develop his/her practice safely and competently, while

Continued on Page 28

Table 1: The Dreyfus Model of Skill Acquisition: From Novice to Expert

Stage	Description
Stage One: Novice	A beginner who has no experience in clinical situations that he/she is expected to perform
Stage Two: Advanced Beginner	Demonstrates marginally accepted performance He/she has begun to understand some of the basic elements of a new clinical setting
Stage Three: Competent	Feeling more comfortable with his/her practice Formulates a conscious, deliberate plan that will help to achieve efficiency & organization
Stage Four: Proficient	Understands the situation as a whole rather than aspects of it, because he/she can perceive it in terms of long-term goals Learns from experience in a situation and how plans need to be modified in response to these events (Benner, 1984)
Stage Five: Expert	He/she has an enormous background of experience and an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions (Benner, 1984)

HISTORIQUE DES SOINS INFIRMIERS ET L'ANESTHÉSIE AU CANADA

Auteures :

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RÉSUMÉ

Il existe peu de détails sur l'histoire du rôle des infirmières dans l'anesthésie au Canada. Selon les quelques sources disponibles, au début du XXe siècle, les infirmières au Canada administraient l'anesthésie. L'historiographie limitée existante révèle que les infirmières travaillant dans les petits hôpitaux ruraux à travers le Canada participaient à l'administration de l'anesthésie en raison d'un manque de médecins spécialisés et de personnel adéquat. Afin d'en apprendre davantage sur le rôle des infirmières dans ce domaine, les auteures ont puisé la collection de sources orales de la British Columbia History of Nursing Society située au College of Registered Nurses à la British Columbia Library. Plusieurs récits indiquent que, entre 1917 et 1953, l'occasion d'administrer l'anesthésie se présentait aux infirmières canadiennes. Les histoires orales identifient le besoin d'administrer l'anesthésie, la capacité des infirmières de fournir ce service, et une flexibilité dans la pratique de la profession leur permettant d'assumer ce rôle. Il existait un besoin grandissant pour l'anesthésie que ne pouvait combler les médecins. Pour explorer plus en profondeur le rôle des infirmières, les auteures ont également examiné les revues contemporaines traitant des soins infirmiers et médicaux.

Le pourquoi de la disparition de ce rôle au Canada tandis qu'il s'établissait fermement aux États-Unis n'est pas clair. Plusieurs causes juridiques de cette période, ainsi que la très grande différence entre les résultats des causes canadiennes et américaines, jetent un peu de lumière sur les raisons possibles pour lesquelles les anesthésistes infirmières ont été exclues de la pratique de l'anesthésie au Canada. Le domaine des soins de santé n'a jamais cessé de changer, et le besoin de services d'anesthésie augmente toujours.

Il s'ensuit donc que de nouvelles questions se posent sur la possibilté de rôles avancés en anesthésie pour le personnel infirmier au Canada. La demande de services d'anesthésie s'agrandit de pair avec le vieillissement de la population canadienne, et le manque de services est le plus prononcé dans les petits hôpitaux ruraux. Cet article offre un contexte historique important sur l'évolution du rôle de l'anesthésiste infirmière au Canada.

Voir l'Association des infirmières et infirmiers de salle d'opération du Canada (2007). *Normes de pratique recommandées, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires de l'AIISOC* (8e édition), Module 1, page 62 pour consulter les compétences professionnelles pour personnel infirmier en pratique avancée (périopératoire).

NURSING AND ANAESTHESIA: HISTORICAL DEVELOPMENTS IN CANADA

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ABSTRACT

There is little historical knowledge available about nurses' role in anaesthesia in Canada. It appears, from the few sources available, that nurses did administer anaesthesia in the early 20th century in Canada. The limited historiography reveals that nurses who worked in small rural hospitals across Canada were, due to the lack of physician specialty and coverage, involved in the administration of anaesthesia. To learn more about nurses' role in this area the authors explored the oral history collection from the British Columbia's History of Nursing group at the College of Registered Nurses of British Columbia Library. Several stories indicated that between 1917 and 1953 there were opportunities for Canadian nurses to administer anaesthesia. The oral histories identified that there was a need for the administration of anaesthesia, that nurses had the skill to provide it, and that flexibility in their nursing practice enabled them to fulfill this role. There was an increasing need for anaesthesia service that was not being filled by physicians. To further explore nurses' role the authors also examined nursing and medical journals from that time period.

There is limited understanding of how this role ceased to exist in Canada while it became well established in the United States. Various legal cases from that time period, and the substantially different results between Canadian and America cases, provide some insight into the reasons why nurse anaesthetists were excluded from anaesthesia practice in Canada. As the Canadian healthcare environment continues to change, and the need for anaesthesia services increases, new questions have begun to arise about the potential for an advanced practice role in anaesthesia for Canadian nurses. The demand for anaesthesia services is increasing in-line with the aging Canadian population and the shortage of available services is most dramatic in small, rural hospitals. This article provides important historical background on the development of the role of nurse anaesthetists in Canada.

Introduction:

Connecting nursing with anaesthesia is not a new concept. Historical documentation shows that nurses began to provide anaesthesia in the late 19th century when anaesthesia first began to be administered on a regular basis during surgical procedures.[1] Nurses practiced anaesthesia during the American Civil War and during both World Wars.[2] Several influences shaped anesthetic practices by nurses. By the late 19th century, nurses began to be skilled in providing many different aspects of patient care. In addition there was an increasing need, which was not being filled by physicians, for anaesthesia to be administered. Nurses were also readily available in both rural and urban hospitals and were flexible in the patient care they were willing and able to provide to many different hospital services. Historical records document several nurses, in Canada, providing anaesthesia at the beginning of the 20th century, although formal education for this role did not evolve in Canada.

> *"By the late nineteenth century, institution's dedication to charitable care was being challenged by dramatic new developments in scientific medicine."*[3]

The combination of the germ theory of disease and the new method of antiseptic

surgery affirmed the need for nursing care in hospitals. In addition to an increase in surgical cases and advances in surgical procedures, there were also advancements in anaesthesia taking place.[4] In the late 19th century "as hospitals became more acceptable places for the middle and upper classes to recover from illness, and in particular to undergo surgery, medical practice became more and more hospital based".[5] Moreover, more hospitals opened training schools for nurses, which enhanced not only the level of care in the hospital, but also its social reputation. In turn, this change influenced the status and training of nurses. Nursing became a respectable, paid occupation, and their skills were in demand.

In the early 20th century, nurses were becoming skilled at working in multiple departments of the newly built and improved hospitals which were spreading throughout Canada. Florence Nightingale's educational model for nurses had transformed how nurses were trained and resulted in their training being intimately linked to the hospital.[6] This resulted in an expansion of nursing specialization within hospitals.

> *"As hospitals employed more graduate nurses to provide direct patient care, nurses began to use certain rituals and behaviors to subtly display their expertise while supporting physicians' traditional place in the hierarchy."*[7]

Nurses began to maintain a permanent presence in the operating room for surgical specialties. Photos of nurses assisting during surgery in the early 1900s are archived in the British Columbia Archives Collection.

This evidence confirms that nurses were skilled in providing surgical care for patients undergoing complex and often painful surgeries. The caring role played by nurses was credited with helping to alleviate patient anxiety before surgery and drew upon the publicly accepted notion of middle-class female compassion that shaped nursing at that time.[8]

Courtesy of Royal BC Museum, BC Archives

Pemberton Memorial Operating Room, Royal Jubilee Hospital, Victoria (1902)

In the beginning of the 20th century there was, due to advances in surgical procedures, an increase in the need for personnel to administer anaesthesia. Hospitals changed from charitable institutions that only looked after the poor, to full medical facilities that served all classes of society.[9,10]

As a result of the establishment of training schools for nurses, during this period, nurses were now available in both large and small hospitals. Multiple resources refer to nurses' presence in both small and large communities.[11,12,13] In contrast there was a shortage of physicians and new advancements in surgery were creating additional demands. Because nurses were always on hand they could fill in when other medical staff were not available.

Nurses showed a greater flexibility around learning new skills to meet the many new demands in the hospitals. Many, for example, became involved with work in the laboratories and some even began providing anaesthesia. Nurses were keen to take on new opportunities within many areas of healthcare. Twohig [14] asserts that the need for a range of work responsibilities in healthcare created ongoing debate, especially in regards to space in hospitals and boundaries between professional groups. This resulted in

competing and contradictory pressures: "The scope and practice of any one occupational group is frequently a matter of negotiation and renegotiation. Workers in health care also have a myriad relationships and roles".[15] The status of women at the time may also have had an influence on nurses and their role in relation to administering anaesthesia in the early 20th century. As Twohig [16] points out, nurses were inexpensive (compared to physician salaries), could also fulfill clerical duties, and could be asked to complete tasks that were more technical or manual. Their lower status as women made them subordinate and allegedly tolerant of the physicians who were predominantly male. This status helped create a perception of their role as medical assistants which would have applied not only to general nursing but to other areas such as anaesthesia.

This article seeks to contribute to the current debate around how to create a more receptive environment for the nurse anaesthetist role in Canada. This debate should also be informed by sound historical knowledge of the early roots of this specialty role in Canada. Reviewing this aspect of nursing history reveals how, in the past, some Canadian nurses negotiated this role and pioneered their own way, facing similar challenges that the proposed new Nurse Practitioner-Anaesthesia role will likely also face. We strongly believe that understanding the past will be a powerful tool in the development

Courtesy of Royal BC Museum, BC Archives

Port Simpson General Hospital (190-)

Courtesy of Royal BC Museum, BC Archives

Nurses in Operating Room, Victoria, BC. (191-)

of a professional identity for Canadian nurse-anaesthetists.

Although there are numerous books available on the history of nursing in Canada,[17,18] there are none that focus specifically on the specialty of anaesthesia. In other histories of healthcare, however, we found evidence that nurses were indeed administering anaesthesia in Canada. These examples provide some starting evidence of the work conducted by some Canadian nurses. In describing the career of two nurses in particular, Greta MacPherson and Margie Fitzpatrick, Twohig[19] mentions examples of nurses practicing anaesthesia. Fitzpatrick was even specifically trained for this purpose.

Greta Macpherson began her nursing career in 1922 performing x-ray and laboratory work.[20] MacPherson was quick to accept a job that others refused, likely because, at the time, there were few hospital jobs available to new nurses. Twohig [21] noted that MacPherson spent "ten years doing lab work, x-rays and she administered anesthesia".

Twhohig's[22] other example, Margie Fitzpatrick, was employed, in 1922, as an anaesthetist at the Chipman Memorial Hospital, NB. She went to Lakeside Hospital in Cleveland, Ohio, to receive her anaesthesia diploma. Twohig[23] states that she "also acquired the responsibility of working in the laboratory as well as providing anesthesia".

These two examples of nurses providing anaesthesia in small, rural hospitals in Canada provides some evidence of how nurses were flexible, available, and skilled to do a job that was not yet being filled by any other medical specialty.

The College of Registered Nurses of British Columbia holds an oral history collection compiled by the members of the British Columbia History of Nursing Group. An in-depth search of this collection revealed some interesting evidence of nurses giving anaesthesia in Canada. Specifically, there were four interviews with nurses who described their involvement with anaesthesia, between 1917 and 1953, during their early nursing careers.

The first reference was from Jo Russell who interviewed Dorothy D'Arcy-Goldrick on July 7, 1987. D'Arcy-Goldrick started her nursing training in 1917 in Vernon, BC. She was only able to complete her first year as the training program was closed due to staff shortages resulting from the First World War. She then moved to Salt Spring Island, BC, to work at Lady Minto Hospital. She worked with one other nurse at this 10 bed hospital that was under the direction of one female physician. She described two separate occasions in which she was involved with anaesthetic during her three-month period of employment. Her first experience involved holding a coal lamp so the physician could administer the ether. It was a memorable experience for her because she was terrified that the ether would be exploded by the lamp she was holding. She described as 'unbearable' the smell of the ether mixed with the coal lamp. Another experience involved a patient who was brought in bleeding profusely from a serious laceration to the leg. She had to administer the ether, before the emergency surgery was performed, as the physician was too busy trying to stop the bleeding. She described it as a terrifying experience. Her account mentions no other training in administering anaesthetics. This example illustrates how nurses were available, flexible and especially needed to provide anaesthesia in a small rural hospital that lacked any other physician support.[24]

Courtesy of Royal BC Museum, BC Archives

Operating Room at Vancouver General Hospital (190-)

In the history of the Lady Minto Gulf Islands Hospital, Charles Kahn and Sue Mouat[25] noted that the physician at the time of D'Arcy-Goldrick's employment was a woman by the name of Sutherland. She worked at the hospital from 1916-1930. It was quite challenging to employ a physician in such a community during this time period as it was difficult for Doctors to make a living in such a small community. "This situation meant that no operations could be performed as one doctor would act as an anaesthetist for the other, and a doctor couldn't perform both anaesthetics and surgery simultaneously".[26] From the accounts described by D'Arcy-Goldrick, however, when there was a life threatening surgical emergency the nurse, as the only available help, was occasionally called on to administer the anaesthetic. This may not have been routine procedure, but there is evidence that it certainly did happen.[27]

In another interview, Gwen Kavanagh spoke with Kathleen Hodgson on April 24, 1987. Hodgson conducted her nursing training between 1926 and 1929 at Royal Inland Hospital in Kamloops, BC. In the interview she described her training in the OR. As a student

Continued on Page 23

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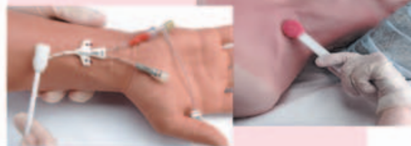

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she completed two and a half months of hands-on training in the operating room and after the completion of her regular training she went back to the OR to further develop her skills in this area. She mentions a woman named Ms. Stone who was the matron in the operating room. Stone was a nurse anaesthetist from the United States who worked at the Royal Inland Hospital during the 1920s. When there were no physician anaesthetists available, Stone occasionally administered chloroform, as an anaesthetic, under the supervision of a nearby physician. This example showed that physicians were not the only individuals meeting the need for anaesthesia services at this small, rural hospital. Nurses were occasionally called on to help meet this surgical need.[28]

Additionally, Audrey Stegen interviewed Marie Logan on February 11, 1988. Logan had received her training at the Toronto General Hospital in Toronto, ON, from 1939-1942. She had always wanted to work in the operating room and because a number of the nurses had left to go overseas for war service she was able to get a job, just six months after graduating, as the head nurse in the operating room. The hospital had three operating rooms – one in each of the three surgical wards. During her time in the operating room she described the anaesthetic room that was adjacent to the operating room. The junior nurse was assigned to work in the anesthetic room and her role was to assist the physician anaesthetist. The anaesthetic room had a machine to provide oxygen and nitrous oxide. For the abdominal surgeries that required greater relaxation, ether was used. The nurse was responsible for preparing and folding the gauze mask that was used but did not administer the ether. Pentathol was often given prior to the ether. She described that there was a definite shortage of physician anaesthetists but, because it was a large training hospital, the interns would administer the anaesthetic on their own under the watchful eye of the head. This example shows that even in large, urban hospitals nurses stepped in to fill a gap, by supervising the interns, when physicians were not available.[29]

In one other example from the 1940s, Marion McLeod interviewed Lillian Loeppky on June 8, 1987. Loeppky received her nursing training, from 1940-1943, at St. Michael's Hospital in Toronto, ON. In 1948 she moved to British Columbia and in 1949 she obtained work at the Cottage Hospital in Abbotsford. During the interview she identified that nurses gave anaesthetics at the Abbotsford hospital when she was employed there between 1949 and 1953. She administered anaesthetics for tonsillectomies and for mothers in labour, and described doing this "many times". "I wasn't afraid of tackling anything, I guess, but when I think of it now, I am very fortunate that I didn't have any problems on my hands". These examples illustrated that nurses skillfully filled a need in providing anaesthesia if no physician was around.[30]

So if nurses were administering anaesthesia in Canada, why did a role of nurse anaesthetists not develop as it did in the United States? From the evidence it appears that the legal aspect of a non-physician providing anaesthetics provided the crucial difference. It is likely that legal cases, and their outcomes, at the time played a key role in the nurse anaesthetist role, and its development, in different countries.

In 1934, in California, a case was brought against nurse Dagmar Nelson, accusing her of prescribing medication without a medical license. The surgeons she worked with fully supported her anaesthesia practice and the court ruled in favour of the nurse, thus paving the way for the development of the current role of the nurse anaesthetists in the United States.[31]

Canadian legal history can, by contrast, provide documentary insight in to the exclusion of nurse anaesthetists in Canada. Of particular importance is the 1939 Canadian court case of McFall versus the Victoria Hospital and Turner. McFall died while undergoing anaesthesia at the Victoria Hospital in Montreal. The court found that the death could not be solely blamed on the anaesthetic that had been administered by a nurse. The court ruled, however, that the

hospital should not have allowed the anaesthetic to be administered by anyone not medically qualified. "The practical effect of the decision has already shown by the fact that those hospitals which were still employing nurse-anaesthetists have given up this practice and now provide qualified medical practitioners in that capacity".[32]

Additionally, the Supreme Court of Canada, in the 1938 case of Sisters of St. Joseph versus Fleming,[33] questioned the limits of liability of hospitals for negligent acts by nurses in their employment. This case, although not specific to anaesthetics, resulted in the hospital being held to be responsible for the negligent acts of nurses.

In the United States, in the early 20th century, surgeons were often hiring their own personal nurse anaesthetists and seemed comfortable with taking on the liability of the nurse. If the nurse was an independent contractor, rather than an employee of the hospital then the liability would have remained with the physician. If, however, the nurse was acting as an agent or a servant of the hospital, within the ordinary scope of her practice, the hospital would be liable. In Canada neither surgeons nor hospitals did seem eager to take on liability for nurses administrating anaesthesia, and the McFall versus Victoria Hospital court case may perhaps explain this to some degree.

Lately, the topic of nurse anaesthetists in Canada is re-emerging in health care literature. Nurses Schreiber and MacDonald[34] were instrumental in revitalizing the debate over bringing the role of nurse anaesthetists to Canada. In 2003 they published an analysis of the advanced practice role of nurse anaesthetists in the United States and pointed out the strong role played by the American professional organization in establishing a large, successful

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anaesthesia nursing practice in most American hospitals. Schreiber and MacDonald suggested linking the role of nurse anaesthetists to the definition of an advanced practice nurse (APN) as described by the Canadian Nurses Association (CNA). The CNA[35] defined advanced practice nursing as an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the needs of clients. Currently, the minimal educational requirement for an advanced practice nurse is a Master's degree. Schreiber and MacDonald noted that linking nurse anesthetists with advanced practice nursing is not a new idea:

> *Our observation of Certified Registered Nurse Anaesthetist (CRNA) practice indicated that CRNAs meet most of all of the competencies and characteristics of* **APN** *as defined by the CNA framework. Their practice is expert and specialized, occurring at the boundaries of nursing's currently defined scope of practice, grounded in nursing theoretical knowledge and based on research findings and evidence.*[36]

In its latest definition statement the CNA[37] recognized four areas of advanced nursing practice: the clinical nurse specialist; the nurse practitioner; the midwife; and the nurse anaesthetist. The first three roles have been implemented in Canada, but the nurse anesthetist role has never become formalized. The implementation of this new advanced nursing practice role faces challenges around the issue of the responsibility of prescribing and diagnosing. In Ontario, regulations have been approved to allow for nurse practitioner (NP) specialty certificates. These four specialties (called extended class) are NP-Primary Health Care, NP-Paediatrics, NP-Adult, and NP-Anaesthesia. It is within this framework that there will likely be further development of a nurse-anaesthetist role in Canada.

In conclusion, historical evidence shows that nurses in the early 20th century were administering anaesthesia in Canada. The findings in the oral histories and cases reported by Twohig [38] support the fact that although the nurses' role in this area was not always "official", and was never fully established, it was definitely present. Nurses provided anaesthesia during this time due to the fact that they were available, flexible, and skilled, and therefore able to provide services to fill the increasing need for this service. This was most significant in small, rural hospitals where it was difficult to maintain full-time physician practice in anaesthesia.

Today, the debate, in Canada, over who should be a part of the "anaesthetic team" continues due to a shortage of physician specialists, in anaesthesia. The current pressures resulting from physician shortages are, in fact, similar to those that influenced the history of this role.

Some argue that the current attempt to formalize the nurse-anaesthetist role in Canada is a situation of re-inventing the health care system.[39] In this process of re-invention nurses may take up the challenge to shape care according to the context of their times, inspired by the work of nurses who did so before them, and encouraged by new opportunities such as the development of the advanced nurse practice role in Canada. The opportunity to use the role of advanced practice nurses to fill the need for anesthetic experts is being encouraged by the acceptance of the nurse practitioner role implementation in other specialties. Due to current physician shortages in the specialty of anaesthesia, the University of Toronto has developed a post-nurse practitioner program in anaesthesia. This program's first class will enroll in 2009. This new role will not be without its challenges, similar to those faced by other advanced practice nurses in the establishment of their practice. Issues such as competition for authority, the enlisting of political support, and the establishment of a clear legal and professional framework for practice, are but a few of the ongoing pressures that this particular practice group will face... not unlike the nurses who walked this path before them.

ANAESTHESIA (cont.)

Refer to the Operating Room Nurses Association of Canada (2007). ORNAC *Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice* (8th edition), Module 1, page 62 to review "Professional Competencies for Advanced Practice Nurses (Perioperative)".

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being supported by an encouraging mentor.[6] The mentor provides the mentee with teaching, counseling, confirmation, acceptance, friendship, protection, coaching, and sponsorship[6]; the benefits of this complex relationship are sharing, growth, learning and empowering.[10]

Butler & Felts describe mentors as "keystoners".[11] A keystone is "the wedge-shaped piece at the crown of an arch that locks the other pieces in place, or something on which associated things depend on for support".[11] The relationship between the keystoner and the new nurse can be mutually beneficial. An effective keystoner engages in self-reflection of traits, attitudes, and behaviours conducive to the role, and the new nurse accepts the responsibility for learning, maintaining an attitude of intellectual curiosity, engaging in self-reflection of traits, attitudes and behaviours, and identifying personal and professional goals.[11]

Benefits of Mentorship

Professional growth & recognition
For the benefit of the profession, experienced nurses must support one another in the quest for professional development, sharing their knowledge and passion with novice nurses. The Canadian Nurses Association (CNA) strongly supports the creation of mentoring programs to aid in this process; to stimulate professional growth, career development, staff morale, and quality within nursing workplaces.[6] Block et al describe the success of the Macmillan Mentorship Training Program in the United Kingdom where mentors reported benefits such as: increased confidence in knowledge, in skills, ability to give feedback, and identification of their own learning and development needs.[7] A descriptive study by Schoessler & Farish found senior nurses, who are moving closer to retirement, eager to share their knowledge with younger nurses before they leave the profession.[12] Mentoring is an excellent method of carrying out this sharing of valuable information. Not only will nurses develop a sense of pride and professional growth from mentoring, they will empower one another, strengthen the nurse to nurse relationship, and more pointedly, increase the long overdue recognition of nursing as a respected profession.[13]

Retention strategy
Perhaps the most powerful outcome of a successful mentorship program is the positive correlation with increased nursing retention.[7] "Mentoring serves as a basis for clinical knowledge and skills, promotes professional development, and increases job satisfaction as vital ingredients to promote retention".[13] Positive work environments and increased employee satisfaction also lead to nurse retention.[7] Increased nursing retention has been associated with adequate staffing, which directly impacts patient safety issues such as medical errors, mortality, and average length of stay.[7]

Building a Mentorship Program

Organizational culture
In order to develop a successful mentorship program it is crucial to first establish an organizational culture that supports mentorship. Bally identifies four factors in a healthy organizational culture: providing opportunities for autonomous clinical practice and participative decision making; being valued as a practicing professional registered nurse throughout the organization; continued learning; and supportive relationships with their peers, physicians, and management.[6] Bally believes transformational leadership in acute care environments can improve nurses' level of confidence, feelings of self-worth, and ultimately promote professional nursing practice through the process of mentoring.[6]

Transformational leadership - Bass' leadership initiatives
Bass proposed four dimensions of transformational leadership to enhance mentoring in an organizational culture: inspirational motivation, individualized consideration, idealized influence, and intellectual stimulation.[14]

Inspirational motivation provides a foundation for mentoring. Nurses inspire one another to understand and utilize mentoring in their practice. Providing a vision of mentoring encourages a sense of purpose, helps attach that purpose to work, and develops collaborative partnerships to implement the vision.[6] Nurses develop a mission

statement incorporating mentoring activities to promote a climate of excellence and create a learning environment that incorporates encouragement, acceptance, and support.[1]

Individualized consideration encompasses the appropriate matching of mentor and mentee, encouraging open and continuous communication, the sharing of experiences, the celebration of milestones and recognition of achievements for positive learning experiences.[6]

Setting mutual goals requires the mentor to understand the learning needs and abilities of the mentee, and to modify their role accordingly.[7] Successful matching in mentoring relationships can lead to increased interest from other staff members, thereby strengthening the depth of the mentorship program within the organization. Unit based recognition programs that reward peers for acting as resources, would provide mentors with a sense of pride and accomplishment[12] and allow mentees to show their appreciation.

Idealized influence in which role modeling is used to establish credibility, trust, interpersonal communication skills and active listening, creates a safe and supportive environment in order to sustain mentoring.[6] Block et al believe that by providing nurses with the means to express their concerns and the opportunity to work alongside positive role models, their role transition will be optimized.[7]

Intellectual stimulation requires collective leadership between nursing management and staff nurses to support professional growth and development of individuals in the organization. Nursing leadership must work to identify and remove barriers to mentoring within the organization[13] and also emphasize the importance of mentoring in their work environments.[6] Mentoring goals, values and ethics must be aligned with values of the organization; an organization whose leadership must be willing to commit both financial and human resources to enable program success.[7]

Staff development programs
Staff development programs are essential to the adequate preparation of mentors for mentorship. It is the responsibility of the organization to ensure that mentors are provided with the knowledge and skills to meet the mentee's needs.[15] Information regarding various learning styles, generational differences and adult learning principles should be provided and be easily accessible, for quick reference, when needed within the unit. Preceptors should gain an understanding of a novice nurse's perspective[7] and how to provide constructive feedback. Introducing mentors to their roles and discussing preceptor expectations is imperative and should occur before a mentoring relationship is entered.[7] A nurse retention plan at the University of Michigan Health System recognized that preceptor preparedness directly affected the orientation of new nurses.[7] They found success in "preceptor action days" which focus on career enhancement, new skill development, and professional collaboration providing the preceptor (mentor) with the tools to be a positive mentor for novice nurses. Mentors and mentees should participate in the planning, education, and evaluation process in order to improve the program for future mentorship participants. Continuous education and training opportunities that are integrated into the work environment will increase staff awareness of the mentoring process and help foster an organizational culture that supports mentoring as a respected professional practice.

Summary

This article has discussed the current trends in health care including Canada's aging population, *Ontario's Wait Time Strategy*, the expansion of critical care services at The Ottawa Hospital, the nursing shortage and how these trends impact perioperative nurses. The *Dreyfus Model of Skill Acquisition* was outlined as demonstrating the challenging transition a nurse must go through to reestablish him/herself in a new role within a new clinical specialty. Mentoring, a collegial relationship based on mutual respect and common goals, was presented as a successful strategy to guide and teach new nurses, to develop professional growth for experienced nurses, to promote recognition of nursing as a profession and most interestingly, to increase nursing retention in these stressful times.

Suggestions to build a mentorship program, including the importance of developing an organizational culture, use of transformational leadership and staff development programs, provided the reader with some background information to promote and sustain a mentoring program within their own organization.

ORNAC professional standards related to this article can be found in the Operating Room Nurses Association of Canada (2007) (ORNAC) *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (8th edition). Module 1, p. 20-22, Standard 1.

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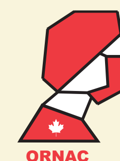

ORNAC WRITING CONTEST

In September 2008 ORNAC encouraged nurses to capture the spirit of the upcoming Perioperative Nurses' Week with the launch of the ORNAC **Writing Contest.** Nurses from across the country were invited to submit essays on the theme 'Why I Choose Perioperative Nursing'. Meaningful essays arrived from across the country and three winners were selected by the ORNAC Awards Committee, according to ORNAC Board and Executive approved guidelines, to receive the following prizes:

1st Place Prize Awarded to **Dawn Affleck** of Brandon, MB – Registration, hotel and travel to the 2009 ORNAC Conference and one copy of the ORNAC Standards.

2nd Place Prize Awarded to **Agata Repec** of Thunder Bay, ON – Registration and hotel for the ORNAC 2009 Conference and one copy of the ORNAC Standards.

3rd Place Prize Awarded to **Jessica Gerrits** of Centreville, NS – Registration for the ORNAC 2009 Conference and one copy of the ORNAC Standards.

CONCOURS DE RÉDACTION DE L'AIISOC

En septembre 2008, l'AIISOC a lancé le concours de rédaction de l'AIISOC dans le but d'encourager les infirmières et infirmiers de célébrer la semaine des soins périopératoires. Les infirmières et infirmiers des quatre coins du pays ont été invités à soumettre un texte expliquant pourquoi ils ont choisi de faire carrière en soins périopératoires. Des textes éloquents sont arrivés de partout au pays, et, selon les critères approuvés par les conseils exécutif et administratif, les trois gagnantes choisies par le comité des prix de l'AIISOC recevront les prix suivants :

Premier prix décerné à **Dawn Affleck** de Brandon (Manitoba) - Inscription, hôtel, transport à la conférence nationale 2009 de l'AIISOC et une copie des normes de pratique de l'AIISOC.

Deuxième prix décerné à **Agata Repec** de Thunder Bay (Ontario) - Inscription, hôtel à la conférence nationale 2009 de l'AIISOC et une copie des normes de pratique de l'AIISOC.

Troisième prix décerné à **Jessica Gerrits** de Centreville (Nouvelle-Écosse) - Inscription à la conférence nationale 2009 de l'AIISOC et une copie des normes de pratique de l'AIISOC.

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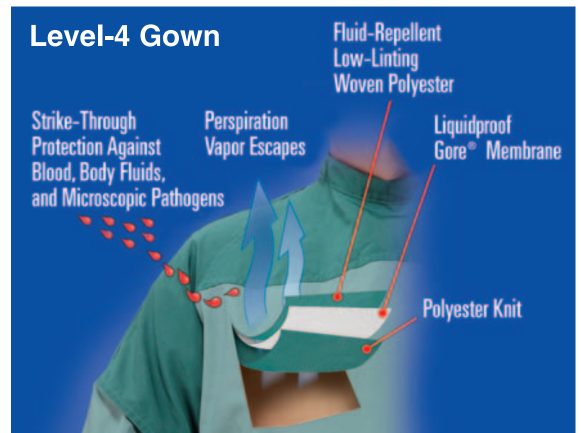

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