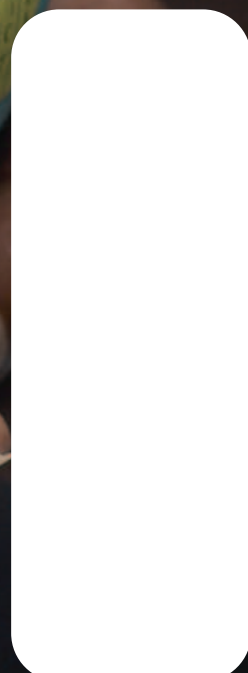


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President's Message

I am writing this message in my hotel room in Ottawa where I am attending the Canadian Nurses Association (CNA) Biennium. ORNAC, as an associate specialty group, attends a networking meeting for the associate/affiliate/emerging groups (AAE) at these biennial conferences. With individuals representing 40 groups you can imagine the energy and the passion!

The individuals representing these groups seem, to me, to share certain common characteristics — vision; passion & self-sacrifice; confidence, determination & persistence; and they are role-models and mentors.

I have met too many amazing nursing leaders to name them all but I would like to take this opportunity to recognize a few of these special people who I, personally, consider to be mentors in perioperative practice.

Margaret Farley is one such leader and mentor. Many of you know her personally or know of her as the Past-President of ORNAC. Margaret is my inspiration — she is the person who encouraged me to get involved in ORNAC and has helped support me over my years of involvement. At this year's CNA Conference she was the inaugural recipient of the *Order of Merit for Clinical Nursing Practice* and both ORNAC and myself could not be more proud! To put this honour into perspective, just over 20 years ago perioperative nursing was not recognized as a body of knowledge nor was it recognized as a specialty group within nursing. The dedication of several nurses challenged the status quo and today our leaders are being acknowledged in our clinical practice. Thanks to those motivated nurses, perioperative nursing is flourishing as a dynamic specialty group and ORNAC is recognized by its peer-groups around the world! Congratulations to Margaret on this well deserved achievement!

In addition to the countless other inspiring perioperative nurse leaders I've met in Canada, I have had the privilege of meeting many from all around the world. Despite our different locations and languages, we share a common thread with our commitment to providing safe patient care across the surgical continuum.

Paul Ward was a Senior Lecturer & Deputy Director, Operating Department Practice at the School of Healthcare Studies at Cardiff University who had worked tirelessly and unselfishly to enhance perioperative nursing practice. The first time I met Paul, we literally bumped into each other at a conference in Dublin. We crossed paths again in Harrogate and at the ORNAC Conference in Victoria. Anyone who met him will remember his passion and

commitment to mentoring and teaching. Paul passed away, tragically, after a routine operation that took place shortly after taking the trip to Victoria with his beautiful family. In memory of Paul, we have the great honour of including one of his articles in this edition. His spirit and gentle soul will always be remembered and I will remain grateful for having had the opportunity to meet such an amazing person and mentor.



Dr. Lois Hamlin is another such international dynamo who I consider a leader and mentor. Dr. Hamlin was the most recent recipient of the Judith Cornell Oration at the Australian College of Operating Room Nurses (ACORN) 2008 Congress. She is a perioperative nurse and a senior lecturer in Sydney, has completed doctoral studies in perioperative practice, has written and presented several papers, and is currently the writer and lead editor of the first Australian perioperative textbook. Her final words to the group at this congress will forever reverberate in my mind as I carry on in my nursing career:

"You are the giants on whose shoulders I (and others) stand. If we can see further than you, or things at a greater distance, it is not by virtue of any sharpness of sight on our part, but because we stand on your shoulders." (ACORN: Standing on the Shoulders of Giants, Dr. Lois Hamlin, 2008)

We can all be inspired by and learn from those around us, but the greatest challenge lies in what we do in our everyday work lives and how we inspire others! *

Linda M. Socha

Linda M. Socha, RN, BSN, RNFA, CPN(C), CEPT, CTBS, is President of the Operating Room Nurses Association of Canada. She is Clinical Nurse Educator for the OR at Saskatoon City Hospital and Casual Tissue Donor Coordinator for the Saskatchewan Transplant Program. She is also the past Chair of the ORNAC Editorial Committee. Linda M. Socha, infirmière autorisée, baccalauréat en sciences infirmières, RNFA, CPN(C), CEPT, CTBS, est la présidente de l'Association des infirmières et infirmiers de salle d'opération du Canada. Elle est infirmière clinicienne enseignante de salle d'opération au Saskatoon City Hospital et coordonnatrice occasionnelle des dons de tissus pour le Saskatchewan Transplant Program. Elle est également la présidente sortante du comité de rédaction de l'AIISOC.

President's Message

J'écris ce texte dans une chambre d'hôtel à Ottawa où je participe à la réunion biennale de l'AIIC. Lors de ces conférences, l'AIISOC, en tant que groupe spécialisé associé, assiste à une réunion facilitant le réseautage entre les groupes associés, affiliés et naissants. Avec plus de 40 groupes représentés, je vous assure qu'il ne manque ni d'énergie ni de passion dans cette salle de chefs de file dans le domaine des soins infirmiers!

Les représentants de ces groupes semblent, selon moi, partager les caractéristiques suivantes :

Ils ont une vision;

Ils sont passionnés et n'ont pas peur de faire des sacrifices;

Ils ont de la confiance en soi, font preuve de détermination et de persévérance;

Ils servent de modèles de rôle et de mentors.

J'ai rencontré trop de leaders en soins infirmiers extraordinaires pour les nommer tous, mais j'aimerais tout de même saisir cette occasion pour reconnaître quelques-unes de ces personnes fantastiques que, personnellement, je considère comme mentors en pratique périopératoire. Chacune de ces personnes est une amie en qui j'ai confiance et qui a partagé avec moi sa passion et ses connaissances.

Margaret Farley est une de ces personnes. Plusieurs d'entre vous la connaissent ou la connaissent de réputation en tant qu'ancienne présidente de l'AIISOC. Margaret est mon inspiration; elle m'a encouragée à m'impliquer dans l'AIISOC et m'a offert son appui dans mes travaux au sein de l'association. Pendant la conférence de l'AIIC cette année, elle était la première récipiendaire de l'Ordre du mérite en pratique infirmière en clinique (*Order of Merit for Clinical Nursing Practice*). Moi et toute l'AIISOC en sont très, très fières! Permettez-moi de fournir un peu de perspective. Il y a à peine 20 ans que les soins infirmiers périopératoires n'étaient pas reconnus comme ensemble de connaissances ni comme domaine spécialisé au sein des soins infirmiers. L'engagement de certaines personnes a pu changer les idées et aujourd'hui nos chefs de file sont reconnus en pratique clinique. Grâce à ces individus motivés, les soins périopératoires prennent de l'envergure comme spécialité pleine de dynamisme et l'AIISOC est reconnue par ses homologues partout au monde! Félicitations à Margaret pour cette grande réussite bien méritée!

En plus du très grand nombre de leaders en soins périopératoires que j'ai rencontrés au Canada, j'ai aussi eu le privilège d'en rencontrer d'un peu partout au monde. Malgré de diverses origines et de différentes langues, nous partageons l'engagement aux soins sécuritaires des patients du début à la fin de toute procédure chirurgicale.

Paul Ward était chargé d'enseignement et directeur adjoint de la pratique au service chirurgical à la School of Healthcare Studies de Cardiff University. Il a travaillé, patiemment et sans cesse, pour améliorer la pratique en soins périopératoires. La première fois que je l'ai rencontré, on a presque eu une collision à une conférence à Dublin. Nous nous sommes croisés encore une fois à Harrogate et lors de la conférence de l'AIISOC à Victoria. Personne qui le rencontre ne peut oublier sa passion et son dévouement au mentorat et à l'enseignement.

Paul est décédé, tragiquement, suivant une procédure chirurgicale habituelle peu après son voyage à Victoria avec sa famille. En mémoire de Paul, nous avons l'honneur d'inclure un de ses articles dans ce numéro. Nous n'oublierons jamais son esprit et son âme tendre et je suis très contente d'avoir eu la chance de connaître ce mentor et cette personne inoubliable.

La docteure Lois Hamlin est une autre autorité internationale que je vois comme leader et mentor. Dr Hamlin est la plus récente récipiendaire de la Judith Cornell Oration du congrès 2008 de l'Australian College of Operating Room Nurses (ACORN). Elle est infirmière périopératoire et chargée de cours à Sydney, a terminé ses études de troisième cycle en pratique périopératoire, a rédigé et présenté plusieurs articles et est actuellement rédactrice en chef du premier manuel pédagogique traitant des soins périopératoires. En poursuivant ma carrière d'infirmière, je n'oublierai jamais ses derniers mots de son discours à ce congrès :

« Vous êtes les géants les épaules sur lesquels je suis (et d'autres sont) debout. Si nous pouvons voir plus loin que vous, ce n'est pas grâce à une meilleure acuité visuelle de notre part, mais parce que nous sommes debout sur vos épaules. »

(ACORN: *Standing on the Shoulders of Giants* (Debout sur les épaules de géants), Dr Lois Hamlin, 2008)

Notre profession et nos patients méritent tous nos efforts pour que nous soyons les meilleurs leaders et mentors qu'il nous est possible. Nous pouvons tous être inspirés par et apprendre de nos collègues, mais le plus grand défi, c'est se concentrer sur notre travail de tous les jours et sur comment inspirer les autres! 🍀

Linda M. Locke



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FORMATION PERIOPERATOIRE INTERPROFESSIONNELLE MONDIALE : UNE DISCUSSION REALISTE

Auteur : Paul R. Ward a suivi sa formation comme praticien de service chirurgical à Londres pendant les années 80, a travaillé en Australie, est retourné à Londres en 1989 et a déménagé au pays de Galles en 1990 pour travailler au sein du Service nationale de la santé du Royaume-Uni.

En 1996, Paul a assumé le rôle de directeur adjoint du service de pratique chirurgicale à la University of Wales College of Medicine, maintenant Cardiff University, où il a fourni une contribution extraordinaire au développement du service et au portfolio de compétences offertes. Ce faisant, il a aussi contribué grandement à la profession du praticien de service chirurgical et au développement de la formation périopératoire en général.

À la grande tristesse de tous, Paul est décédé le 22 juillet 2007, à l'âge de 39, en raison de complications suivant une procédure chirurgicale habituelle.

Cet article est basé sur une portion d'un discours présenté lors de la Conférence nationale de l'AIISOC en 2007.

RESUME

Dans bon nombre de pays, plusieurs rôles distincts en salle d'opération ont été bien définis, et les responsabilités assumées par des personnes pratiquant une variété de professions. Chacune de ces professions a tendance à former ses praticiens dans un milieu presque complètement isolé des autres professions périopératoires et de ses homologues dans d'autres pays.

Imaginez, car il s'agit d'une réalité actuellement imaginaire, les bienfaits éventuels pour le personnel et pour les patients du partage d'expériences cliniques et de formation entre pays ainsi qu'entre personnel infirmier et non infirmier au sein d'équipes périopératoires. Si un

tel niveau de partage existait, la communauté périopératoire globale entière en profiterait.

Le transfert de pratiques cliniques et de formation entre pays, toutefois, exige une stratégie bien pensée. Plusieurs disciplines pédagogiques et professionnelles ont mené des recherches sur comment transférer et partager de meilleures pratiques entre des systèmes établis et ceux qui ne font que commencer à instaurer des pratiques semblables. La pratique périopératoire nécessite un effectif de chercheurs ayant analysé les difficultés intrinsèques du transfert et du partage entre pays. Il est essentiel de déterminer quelles informations devraient être partagées pour le bien des patients, lesquelles seraient abordables et quelle méthode de partage conviendrait le mieux à une stratégie globale mondiale de pratique périopératoire.

L'objectif du présent article est de se servir du récent exemple d'une méthode de formation périopératoire multi-professionnelle adoptée par des infirmières et infirmiers périopératoires dans le but de brosser le portrait d'une possibilité de pratique future. Le point de mire de cette discussion est de stimuler plus de discussion et de recherches efficaces qui, si elles sont bien menées, pourraient encourager la coopération entre professions et entre pays dans le domaine périopératoire, et ce, dans le monde entier.

Nota : Dans le contexte de cet article, le rôle périopératoire comprend plusieurs rôles réglementés de soins directs du patient, à part celui du médecin, dans un milieu périopératoire.

GLOBAL INTERPROFESSIONAL PERIOPERATIVE EDUCATION: DISCUSSING THE REALITY

Author: Paul R. Ward trained as an Operating Department Practitioner in London during the 1980s, worked in Australia for a time, before returning to London in 1989 and moving to Wales, to work in the UK National Health Service (NHS), in 1990.

GLOBAL EDUCATION(cont.)

In 1996, Paul became Deputy Director of the Department of Operating Department Practice, University of Wales College of Medicine – now Cardiff University - where he made an outstanding contribution to the development of the department and the portfolio of qualifications offered. In doing so he also made a significant contribution to the Operating Department Practitioner profession and to the development of perioperative education more broadly.

Sadly, and at the tragically young age of 39, Paul died on 22nd July 2007 as a result of complications following routine surgery. He is sorely missed by all who knew him.

This article is based on a portion of a presentation given at the 2007 ORNAC National Conference.

ABSTRACT

Many countries of the world have outlined clearly defined and distinct roles, for the perioperative environment, that are played by various individuals from a range of professions. Each of these professions tends to educate its practitioners in an environment that is almost completely isolated from the other perioperative professions and from its peers in other countries.

One can only, currently, imagine the potential benefits to be gained from the sharing of educational and clinical experience between countries and between nursing and non-nursing perioperative team members, for both patient and the entire perioperative team. If such a level of sharing existed then the entire global perioperative community would benefit.

The transfer of education and clinical practice, however, between countries needs careful thought. Many educational and professional disciplines have conducted research into ways of transferring/borrowing good practice between established systems and those just commencing similar practices. Perioperative practice needs a similar research base that has explored the dilemmas of transfer and borrowing between countries. It is important to determine what

information should be shared, in the best interest of the patients, what sharing is affordable, and what method of sharing will fit in to an overall, global, strategy for perioperative practice.

This paper seeks to use a recent example of multi-professional perioperative learning undertaken by Advanced Scrub Practitioners to provide a possible first glance in to the “crystal ball” of future practice. The aim of the discussion is to stimulate further discussion and effective research that, if carried out correctly, will seek to encourage interprofessional and international co-operation between perioperative professionals worldwide.

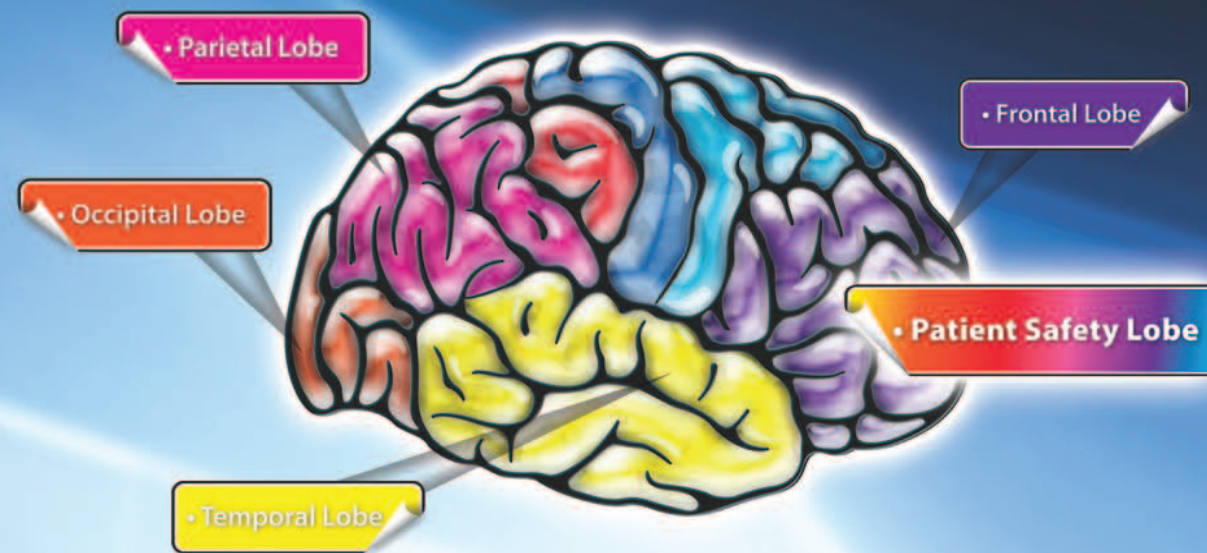
NB: For the purpose of this article the Perioperative Role comprises many of the regulated direct patient care, non-physician roles in the perioperative environment

Introduction

Students of perioperative education attend education institutions, or operating theatre seminars, on a daily basis throughout the world. Scrub skills are taught, observed and practiced by students in a variety of settings the world over.

The improvement of existing practices, using an evidence-based and reflective process, is ongoing in UK operating theatres, Canadian operating rooms and US clinics. Imagine for a moment that new developments in ‘good practice’ were being discussed by, and demonstrated to, students of perioperative practice in Victoria, Canada, Cardiff, Wales, Denver, USA, and Jerusalem, Israel, simultaneously through the use of modern technology. What if the training picture was expanded to envision theatre nursing students learning instrumentation alongside medical students and Operating Department Practitioners. Or perhaps midwives and oral surgeons learning, together, about the principles of infection control. Is such a vision just ideological dreaming or is it a future reality?

Continued on Page 10



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This paper will seek to open up the discussion of the very real possibility of future global perioperative education that may someday be available not only to students in Toronto but also those in Tonga, Trinidad and Tanzania.

Background to Perioperative Education in the UK and Beyond

Surgical practice, as seen in the perioperative setting of the UK, is provided by teams of highly specialised and trained professionals. The perioperative role is carried out by both Operating Department Practitioners and Theatre Nurses. Both groups are required to hold professional registration and are regulated in order to ensure public protection. The adherence to regulations and standards is clearly a responsibility associated with both roles.

The Operating Department Practitioner is trained to undertake all perioperative roles, including assisting the anaesthetist and surgeon, helping patients recover from anaesthesia, and fulfilling teaching and management roles.

The Theatre Nurse, who is initially equipped with general nursing training, usually steps into a surgical, anaesthetic or post-anaesthesia care role and thereby gains experience and/or qualifications in that specific area of practice.

Often Operating Department Practitioners and Theatre Nurses will have the same job description, be on the same pay scale and be eligible for promotion into similar perioperative posts. In recent years clinical roles such as Advanced Scrub Practitioner, Surgical Care Practitioner and Anaesthesia Practitioner have provided an extension to skills development and delivery.^{1,2,3} This has resulted in some theatre nurses or operating department practitioners now acting as First Assistant, working as a part of the wider surgical team, undertaking surgical intervention under the supervision of the operating surgeon, and delivering anaesthesia as a part of the anaesthetic team.⁴

The workplace picture described above is not, however, repeated throughout the world. Whilst the distinct professions of Operating Department Practitioners and Theatre Nurses are now working far more collaboratively than ever before in the UK, the professional boundaries are still very clearly defined in other so-called western nations.

Furthermore, in many developing countries surgeons still work alone or aided only by unskilled support workers. Many countries of the world have poor or inadequate standards of practice and regulation of perioperative practitioners. However, in our current environment of increasing globalisation, other countries are able to learn about the model of collaboration and those in countries with inadequate practices and resources are still able to learn about the need to, and how to, improve their standards.

Sharing Practice

Recognizing that information about best practices needs to be shared worldwide is just a first step. Simply transferring a practice from one country to another may not be the answer. Certainly evidence from other disciplines has shown that ‘context’, among a host of other cultural considerations, matters.⁵

Research needs to be conducted and published on the subject of the international transfer of perioperative practice and the effectiveness of various models. Individuals in established and long-standing roles have only started to consider what elements constitute the essential experiences and practical skills necessary for safe and competent perioperative practice. In order to encourage this shift toward worldwide practice, some perioperative nursing groups have joined together to form the International Federation of Perioperative Nursing (IFPN). IFPN uses its resources to provide basic training, access to instructional materials and assessment of need through visits to developing countries.⁶ Yet even IFPN has not yet ‘crossed the divide’ to begin working collaboratively with perioperative professionals who are not nurses.

Despite a growing interest in extending perioperative nursing practice support to nations in need, the profession is still holding back from sharing of practice with other professions that work in their own operating rooms! Surely it would be to the benefit of patients, education providers, tax payers, and so forth, if the body of knowledge and the skills and experience of all perioperative professionals was used for the common good.

Advanced Scrub Practitioner Example

In February 2007 the Perioperative Care Collaborative published guidelines (available at www.proprius.org.uk) for the role of the Advanced Scrub Practitioner, with many aspects of the role formerly falling under the title of ‘First Assistant’. In addition, the National Association of Assistants in Surgical Practice developed, in 2006, a ‘toolkit’ resource pack for potential applicants to use, in-house, to develop the role. It includes information on education, legal aspects, role development, job descriptions, and more. Following these developments, Cardiff University established formal university programs to support the role.⁷

The UK Government views the development of existing practitioners and the diversification of scope of practice as beneficial. The government’s ‘lifelong learning’ and ‘continuing professional development’ initiatives are just a couple of the many drivers for change.^{8,9}

Increasingly practitioners undertaking advanced roles, that have evolved or extended naturally over time, only have in-house experience to provide competence. However, employers prefer experience to be based on an initial formal qualification, that has been kept up-to-date, rather than experience alone.

The need to recognize and value the learning process that the students had already been involved in is essential. As Leathwood and O’Connell¹⁰ suggest, under “the new Labour government there has been an elision from ‘student’ to ‘learner’, with learners constructed

as active consumers of educational services, taking responsibility for their own learning as independent, autonomous and self directed individuals.” As a result of national initiatives, such as the development foundation of the Surgical Care Practitioner role, the Welsh Assembly Government followed the Department of Health’s lead and undertook, in 2003, ‘The Review of Health and Social Care in Wales’. The result was the commissioning, in 2004, of the Operating Department Practice, Cardiff University, in order to establish a programme for Surgical Care Practitioners.^{2,11,12,13} One of the specific recommendations of the review in Wales was that:

“Specifically, Wales needs to be more innovative in developing some of the new professional roles being planned elsewhere in the UK and beyond... Piloting new ways of working will be important.”¹² (p. 74).

Whilst Wanless is right in the need for flexibility of modern staff within the UK National Health Service, it is also important to support the changing educational models, required to deliver redirection and re-training, while they are being developed. The university programme, developed to provide the theory and practice required for competent practice, was welcomed when developed at Cardiff University. The programme was advertised to perioperative practitioners, regardless of professional background, as an opportunity to improve current practice and achieve academic recognition through completion of the certified programme.

All available places were filled for the first running of the programme in 2006. The first group comprised Operating Department Practitioners, Theatre Nurses and Midwives (in the UK many midwives have opportunity to scrub in for caesarean sections and related obstetric cases). The mixture of backgrounds brought a richness of experience to the programme that enhanced debate and group discussion. It also brought with it challenges in terms of teaching to varying levels of experience. Such challenges should not, however, detract from interprofessional

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GLOBAL EDUCATION(cont.)

education, but rather should encourage new developments by curriculum designers.

Designing a curriculum to meet such student needs, and to be in line with the Wanless Report, can be challenging. There is an ever present, subtle, market force pressure upon providers of higher education to remain competitive in terms of programmes offered, the quality of the teaching and learning, the ease of international transfer, and the financial viability of the provision. Naidoo suggests that:

“the ability to compete successfully in the world context has come to be seen to rely on the production of higher value-added products and services, which are in turn dependant on knowledge, especially scientific and technological knowledge, and on continual innovation. In this context, higher education has been positioned as a crucial site for the production, dissemination and transfer of economically productive knowledge, innovation and technology...”¹⁴ (p.249)

In describing the changing influences, on curriculum development, in higher education, Knight et al note that, in the case being considered:

“Working to promote professional learning both in higher education and in the health care professions, she (Tait) has championed action learning approaches and advocated ‘appreciative enquiry’.”¹⁵ (p. 320)

In the areas of healthcare teaching and management it is extremely difficult to provide collaborative learning while balancing the needs of students, quality assurance reviews, curriculum requirements, learning styles, and the maintenance of professional competence. Adding in the dimension of international sharing is the next challenge to be faced.

Conclusion and Next Steps

The transfer of practice from between countries and within professions needs careful thought.

Careful consideration must be given to the international transfer of practice and research into an effective model of perioperative practice that encompasses the experiences associated with that practice. If practice is to be shared worldwide, it requires a strong understanding of exactly what needs to be shared for the benefit of the patient, what is affordable, and what fits with the overall strategy of perioperative practice. The next stage is a cultural understanding so that everyone is prepared for the effects of transferring practice from one country to another and so that the ‘good practice’ is effectively adopted. Finally, the take-up of the practice must be driven locally and not imposed by an external group or country.

Global comparisons and sharing of information are currently happening. The internet has allowed for the access to a country's perioperative standards by people from around the world. As a result, there exists the risk that wrong practices can also be adopted via the internet.

There is a professional responsibility on every discipline and profession to develop a body of knowledge. Once such a body of knowledge has been developed, then should it not be available for the entire world to share? The International Federation of Perioperative Nurses⁶ (p. 1) has the aim of “actively promoting perioperative nursing globally...” and expanding upon the need “to work towards globally improving patient care...” To do this responsibly and ethically requires a correct approach.

Shah considers the general increase in research across cultures stresses the need to “communicate meaningfully across these divides”¹⁶(p. 549). This “... demands an understanding of the indigenous culture, its values, beliefs, customs and way of life, all of which interact.”¹⁷ (p. 30.) If carried out correctly it will encourage interprofessional and international co-operation between perioperative professionals worldwide.

Continued on Page 29

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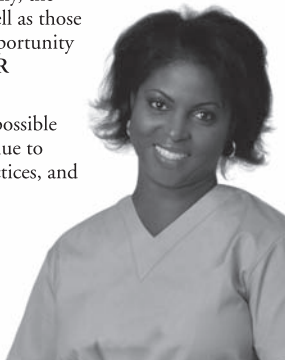
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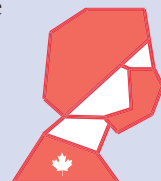
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LES GAGNANTS, TELS QUE CHOISIS PAR LE COMITE DE PRIX DE L'AIISOC, SERONT CONTACTES LE 15 FEVRIER 2009 AU PLUS TARD.

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Contest entries should be comprised of 500 to 1500 words on "Why I Choose Perioperative Nursing". As the winning essay may be published in CORNJ, all entries must be submitted according to the CORNJ Editorial Guidelines found at www.ORNAC.ca (excluding the length of essay and submission details).

Entries must be received by **January 15, 2009** and should be submitted to awards@ornac.ca or to Marlene Weeks, **ORNAC** awards chair, 3562 Promenade Crescent, Victoria, BC, V9C 4L1.

AUTHOR ELIGIBILITY FOR THIS CONTEST IS AS FOLLOWS:

- ❖ Must be a perioperative registered nurse and active member of Provincial Perioperative Group/Association as of January 15, 2009 as identified on the **ORNAC** National Database.
- ❖ **ORNAC** Board of Executive/Directors are not eligible
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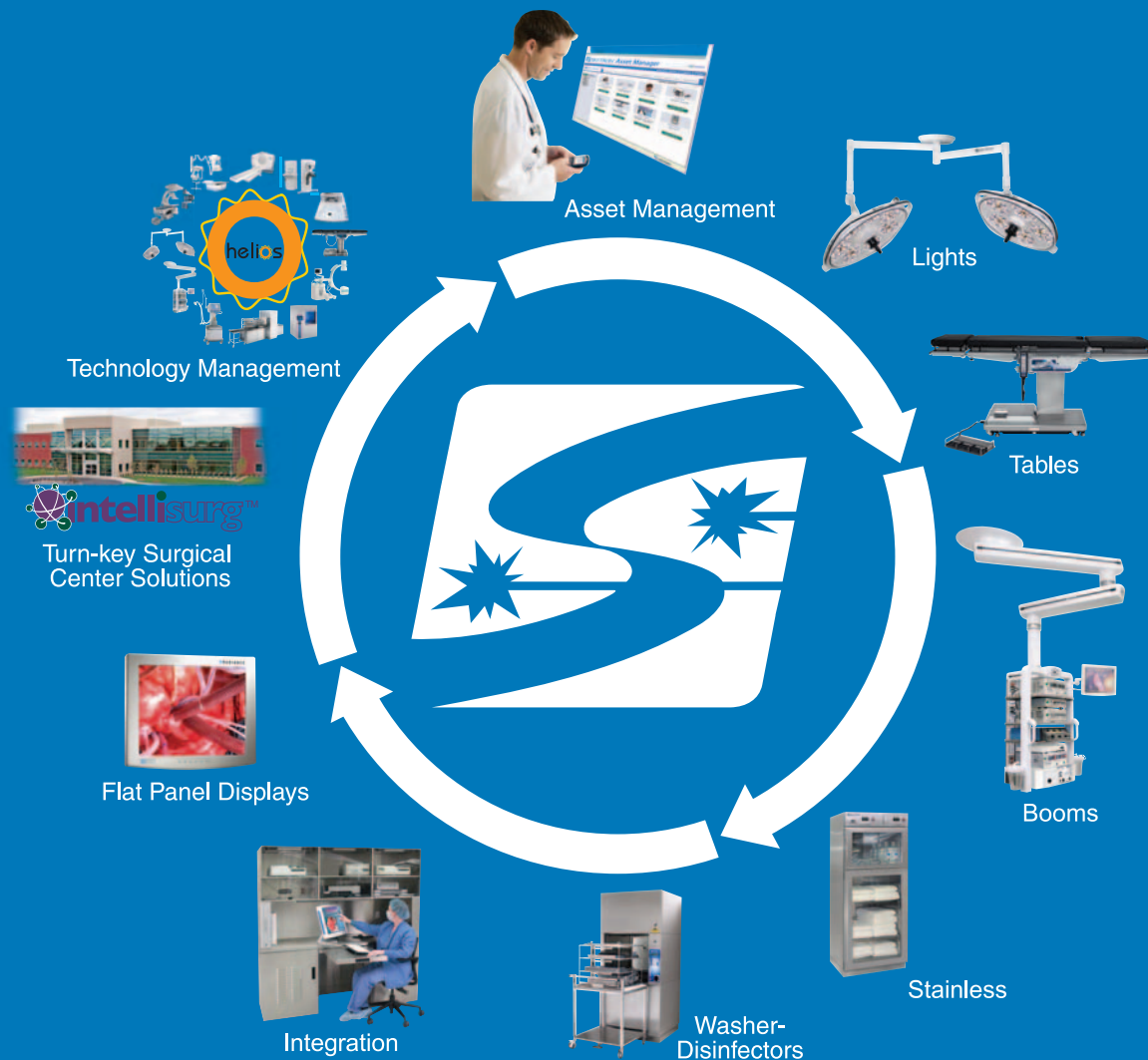
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NE BRISEZ PAS LA CHAÎNE : L'IMPORTANCE DE LA GESTION DE LA CHAÎNE D'APPROVISIONNEMENT DANS LA SALLE D'OPERATION

Auteure : Candis Bilyk, maîtrise en sciences infirmières, baccalauréat en sciences infirmières, est coordonnatrice de chaîne d'approvisionnement au bureau des contrats institutionnels et au service de chaîne d'approvisionnement. Elle gère les processus de chaîne d'approvisionnement de salle d'opération de deux hôpitaux, Grey Nuns Community Hospital et Misericordia Community Hospital à Edmonton en Alberta.

RESUME :

La gestion des fournitures dans une salle d'opération joue un rôle important dans la baisse du coût des soins de santé tout en maintenant un haut niveau de qualité des soins. Ce domaine des soins de santé exige donc un suivi assidu de la part des utilisateurs finaux, c'est-à-dire les gestionnaires, les médecins et le personnel infirmier de salle d'opération.

Cet article vise la compréhension de la gestion de chaîne d'approvisionnement dans le contexte de la salle d'opération. Les renseignements présentés dans l'article peuvent s'appliquer aux centres de santé de petite ou de grande taille. La gestion de chaîne d'approvisionnement est définie, un bref aperçu des processus de chaîne d'approvisionnement est présenté et les bienfaits de suivre ces processus sont expliqués. L'article offre également des recommandations pour améliorer la chaîne d'approvisionnement de salle d'opération.

Les responsabilités du personnel infirmier périopératoire en matière de gestion des ressources sont articulées au sein des compétences en pratique des soins périopératoires présentées dans le module 1 (2007) de l'Association des infirmières et infirmiers en salle d'opération du Canada (AIISOC). *ORNAC Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice*. (8^e édition).

DON'T BREAK THE CHAIN: IMPORTANCE OF SUPPLY CHAIN MANAGEMENT IN THE OPERATING ROOM SETTING

Author: Candis Bilyk MN, BSCN, is a Supply Chain Coordinator, Corporate Contracting Office and Department of Supply Chain Operations. She coordinates the operating room supply chain processes for two hospital sites, Grey Nuns Community Hospital and Misericordia Community Hospital, Edmonton, AB.

ABSTRACT:

Management of supplies within the operating room (OR) has considerable implications for decreasing healthcare costs while maintaining high-quality patient care. This area of healthcare therefore requires more monitoring by end-users including OR management, physicians, and nursing staff.

This article is based on understanding supply chain management in the OR setting. Information provided throughout the article can be applied to small or large health care centers. It defines supply chain management and contains a brief overview of supply chain processes. It reviews the benefits of following these processes. The article also includes recommendations for improving the supply chain in the OR.

INTRODUCTION:

It is estimated that Canada's healthcare system spends approximately 21% of its annual budget on medical/surgical supplies.¹ In hospitals, costs of medical/surgical supplies are second only to labor expenditures. Within the OR, equipment and supplies account for 50% of operational costs.¹ There is no question that OR supply management is an area that requires attention. The literature states, "the supply chain is one of the largest determinants of where cash flow will be derived and where capital will be consumed."² Management, physicians, and OR nurses have a responsibility to acknowledge the importance of managing OR supplies.

DON'T BREAK THE CHAIN (cont.)

One of the major hospitals in Edmonton, Alberta, follows supply chain best practices. As a result this hospital experienced, in one fiscal year, a 34% reduction in direct buy spending on OR supplies.³ In just over three years, this hospital decreased its overall OR medical/surgical supply costs (excluding consignment inventory) by 42% and increased its on-contract spending by 52% (as highlighted in Figure 12).^{3,4} What does this mean? It means that managers, physicians, and nurses need to take a close look at the supplies they are using and stocking on their shelves and ask themselves important questions like: Why do we stock this product? How much does it cost? How often do we use this product? Does this product provide the best care to my patients?

Effectively managing this area of healthcare requires preliminary groundwork that includes understanding the term 'supply chain management'; the benefits of supply chain management; and the steps required to improve the supply chain in the OR.

WHAT IS A SUPPLY CHAIN?

There are numerous definitions of supply chain management. Some definitions refer to the elements of a supply chain while others focus on the management perspective. In an effort to provide an operational definition, supply chain management will be defined as coordinating the "production, inventory, location, and transportation among the participants in a supply chain to achieve the best mix of responsiveness and efficiency for the market being served."⁵ Supply chain management integrates supply and demand within and across companies. For the purposes of this discussion, supplies will refer to consumables, typically single use medical/surgical items that are used, in the OR, during surgical cases.

SUPPLY CHAIN PROCESSES:

The five most important aspects of the supply chain that are driven by responsiveness and efficiency include:

- Production;
- Inventory;
- Location;
- Transportation; and
- Information⁵

An efficient supply chain will streamline inventory and the distribution of supplies in order to minimize the transportation costs of moving supplies from the manufacturer to the point of use.⁶ Inventory in the OR should include items that are used on a regular basis by most surgeons. Each item is labeled, is assigned a location, ordered using a set schedule (bi-weekly), and has a minimum and maximum (par level) quantity. This information is stored using Information Technology (IT) databases related to inventory management.

It is important to establish specified procedures for purchasing OR supplies.⁶ One way to achieve this is to develop a regional product request form. Standard information is provided through the utilization of this form. The request for new product purchases or evaluations are driven by end users (managers, physicians, and nursing staff) and are based on clinical and functional preferences that are supported by evidenced-based justification.⁷ Standard elements of the product request form are outlined in Figure 2. Once the form is completed, the supply chain coordinator works with management, the vendor(s), and corporate head office to outline financial implications of the new product so that management can make an informed decision regarding the product that is being requested for purchase or evaluation.

BENEFITS OF SUPPLY CHAIN MANAGEMENT:

One of the benefits of managing supplies in the OR is the ability to make informed decisions about the purchase and evaluation of supplies. It is important to involve end users in these processes so that all decisions reflect OR and patient care needs. "Supply chain products and services literally touch every part of the patient's experience throughout the integrated delivery system."⁶ An ideal supply chain will provide supplies at the right place, right time, right price, and when they are needed.^{6,8} This is achieved by analyzing supplies for cost, utilization, and the ability to support quality patient care.⁶

In the absence of supply chain processes the selection of supplies is often driven only by

Continued on Page 30



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Author: Dorothy Dewar, ORNAC Secretary 2007-2009

The ORNAC Executive & Board met for its biannual meeting in Toronto May 3rd and 4th, 2008.

- ❖ The ORNAC Standards Committee met for two extra days, prior to the meeting, on May 1st and 2nd. This committee is hard at work on further revisions to our Standards document. They deserve our thanks and praise for their dedication to ORNAC.
- ❖ ORNAC President Linda Socha welcomed observer Barbara Mushayandebvu from Alberta and extended a thank you to Laura Ellsworth, for standing in as proxy for the NL during this meeting and to Alicia Oucharek Mattheis for stepping back in as a board member for SK.
- ❖ ORNAC bids farewell, and a huge thanks, to Sue Pardy, NL, Sue Styles, AB, and Donna Gramigna, BC, for all their hard work over the years on the ORNAC Board. Past Board member pins were presented to Sue Styles and Donna Gramigna by President Linda Socha on Sunday afternoon. Sue Pardy will receive hers at a later date as she was unable to attend this Board meeting.
- ❖ The St. John's National Conference Committee is working diligently to organize the ORNAC National Conference on June 7th – 12th, 2009. Put this date in your diaries – we hope to see you there! Perioperative Nurses will be able to register on-line for this Conference so keep an eye on the ORNAC website, and in this Journal, for details.
- ❖ ORNAC's web site will be getting a face lift in July of this year. Check out the newer, more user friendly, web site at www.ORNAC.ca.

- ❖ In June, Margaret Farley from SK (Past President of ORNAC) received the Order of Merit Award for Clinical Practice from Canadian Nurses Association (CNA). Congratulations to Marg, from the ORNAC Board, on receiving this well deserved honour.

- ❖ Two new awards are being presented at the National Conference in St. John's, NL. They are the *Gloria Stephens Award for Excellence as an Educator in the field of Perioperative Education* and the *RMAC Patient Safety Award* which is sponsored by RMAC Surgical Inc. Please check out details about all ORNAC awards on the ORNAC web site or in this Journal.
- ❖ ORNAC Board members continue to be involved with several groups on a variety of initiatives: Canadian Nurses Association (CNA) and their Environmental Health Workshop; CPSI (Canadian Patient Safety Institute); and Canadian Standards Association (CSA) and the design and construction of Canadian Health Care Facilities.
- ❖ ORNAC has endorsed the World Health Organisation's (WHO) "Surgical Safety Checklist". This initiative will introduce a check list in every OR around the world in an effort to improve patient safety.
- ❖ European Operating Room Nurses Association (EORNA) joined International Federation of Perioperative Nurses (IFPN) at the Association of periOperative Registered Nurses (AORN) Conference in Anaheim, CA. IFPN now has a membership of 80,000 perioperative nurses worldwide.
- ❖ ORNAC members who are moving should visit the ORNAC web site at www.ORNAC.ca to change their address and ensure they continue to receive their copy of the Journal. Members who do not have on-line access can contact a member of their provincial executive in order to update their address. ✱

L'AIISSOC en bref – Printemps 2008

Auteure : Dorothy Dewar, secrétaire de l'AIISSOC, 2007 à 2009

Les conseils exécutif et administratif de l'AIISSOC se sont réunis à Toronto le 3 et 4 mai 2008 pour leurs réunions biennuelles.

- ❖ Le comité des normes de L'AIISSOC s'est réuni le 1^{er} et 2 mai, les deux jours précédant la réunion principale. Ce comité continue à travailler assidûment pour réviser notre document de normalisation. Nous voulons remercier et reconnaître ce comité pour tout son travail et son engagement envers l'AIISSOC.
- ❖ La présidente de l'AIISSOC, Linda Socha, a accueilli l'observatrice Barbara Mushayandebvu de l'Alberta. Elle a également remercié Laura Ellsworth pour avoir assumé le rôle de représentante par procuration de Terre-Neuve pour la réunion et Alicia Oucharek Mattheis pour être revenue comme représentante de la Saskatchewan.
- ❖ L'AIISSOC dit au revoir et merci beaucoup à Sue Pardy (Terre-Neuve), Sue Styles (Alberta) et Donna Gramigna (Colombie-Britannique) pour tout leur travail pendant plusieurs années comme membres du conseil de l'association. Dimanche après-midi, Sue Styles et Donna Gramigna ont reçu des épingles reconnaissant leur engagement de la présidente Linda Socha. Sue Pardy recevra la sienne plus tard car elle n'a pas pu assister à la réunion.
- ❖ Le comité de la conférence nationale à St. John's travaille diligemment pour préparer la conférence nationale qui aura lieu du 7 au 12 juin 2009. Notez ces dates dans vos agendas car nous voulons vous y voir! Les infirmières et infirmiers autorisé(e)s pourront s'inscrire en ligne pour cette conférence, alors consultez régulièrement le site Web de l'AIISSOC, ainsi que cette revue, pour plus de détails.
- ❖ En juillet de cette année, le site Web de l'AIISSOC changera d'allure. Visitez notre nouveau site Web plus convivial à www.ORNAC.ca.
- ❖ En juin, Margaret Farley de la Saskatchewan (ancienne présidente de l'AIISSOC) a reçu de l'AIIC l'Ordre du mérite pour la pratique clinique (*Order of Merit Award for Clinical Practice*). Le conseil de l'AIISSOC vous offre ses félicitations à l'occasion de ce prix si bien mérité.
- ❖ Deux nouveaux prix seront présentés lors de la conférence nationale à St. John's à Terre-Neuve. Il s'agit du Prix d'excellence Gloria Stephens pour la formation en soins périopératoires (*Gloria Stephens Award for Excellence as an Educator in the field of Perioperative Education*) et le Prix de sécurité des patients RMAC (*RMAC Patient Safety Award*) commandité par RMAC Surgical Inc. Pour plus de détails sur les prix de l'AIISSOC, veuillez consulter le Web ou cette revue.
- ❖ Les membres du conseil de l'AIISSOC participent toujours à plusieurs groupes visant une variété d'objectifs : la formation sur la santé environnementale de l'AIIC, l'Institut canadien pour la sécurité des patients (ICSP) et la conception et construction d'installations médicales avec l'Association canadienne de normalisation (CSA).
- ❖ L'AIISSOC appuie la liste de contrôle pour réduire les risques chirurgicaux proposée par l'Association Mondiale de la Santé (OMS). Cette initiative introduira une liste de contrôle dans toute salle d'opération partout au monde afin d'améliorer la sécurité des patients.
- ❖ La European Operating Room Nurses Association (EORNA) s'est jointe à la International Federation of Perioperative Nurses (IFPN) pendant la conférence de l'Association of periOperative Registered Nurses (AORN) à Anaheim en Californie. L'IFPN compte maintenant une adhésion de 80 000 infirmières et infirmiers autorisé(e)s à l'échelle mondiale.
- ❖ L'AIISSOC utilise maintenant une ressource électronique nommée *Eliminate* permettant à de petits groupes de communiquer en ligne dans un contexte de salle de classe.
- ❖ Tout membre de l'AIISSOC changeant d'adresse postale est encouragé à visiter le site Web www.ORNAC.ca pour changer d'adresse et assurer la livraison future de la revue de l'association. Les membres sans accès à Internet peuvent contacter un membre de leur conseil exécutif provincial pour mettre à jour leur adresse. ✱

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GLOBAL EDUCATION(cont.)

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surgeon preference.⁸ By following supply chain processes, supplies are driven by the need to provide quality care to patients and to minimize healthcare costs. Supplies are chosen based on the product's ability to meet the needs of the patient, not solely on the preference of one or more surgeons. An example of this may occur if there are two similar supplies that can be ordered. Supply "A" costs \$250.00 each and has been used by the surgeon (who is requesting this product) at another hospital site. Supply "B" costs \$150.00 each, is used by all other surgeons in the specialty service on site, and will not compromise the quality of care provided to patients. Supply chain management processes would support the purchase of Supply "B" in this example. This information would be communicated to the requesting surgeon and the rationale for the decision would be provided. Supply chain management decisions should be made considering best patient outcomes and wisest utilization of resources.

Another major benefit of supply chain management in the OR is the impact it has on saving healthcare dollars. It is estimated that, by implementing supply chain processes, ORs could save, in one fiscal year, between 15 and 30% on supply costs.⁹

Managing the supply chain also includes the use of IT inventory systems that track and monitor supply use in the OR. Supply-related costs are substantially reduced, through the utilization of IT, since all supply chain processes are supported and coordinated using an inventory management system.⁶ The most common IT applications used in supply management include the use of database supply management systems; inter-operative charting applications that identify supply usage and case costing; and regional index catalogues which list all of the products available from a regional warehouse.

All inventories are counted annually to manage supplies effectively. This includes 'ward' stock (regional warehouse supplies ordered by OR); direct buy purchase items; and specialty items such as implants (pacemakers, stents, etc.). Consignment inventory (mostly comprising orthopaedic implants) are high cost items that

are monitored closely and counted on a monthly basis for variances. It is important to note that, regardless of the IT application that is chosen, the focus is on building a reporting system that collects and presents data that is strategic, tactical, and operational.⁵ When considering automation of supply chain processes, a system should be chosen that meets the needs of the department, is adaptable, and is well researched for its options.¹⁰ It is also important to involve the end users in all stages of the process. "If the technology is implemented in the right way, it is basically free, because it is subsidized with lower expenses and better results."⁶

The use of bar code technology provides one example of how IT is being used in supply chain management. Supplies with bar codes monitor physician use and can, for reporting purposes, link the specific patient to the supplies. By identifying OR supplies, through the use of bar code technology, the technology enables staff to accurately capture case costs, reorder supplies as they are used, and closely monitor on hand inventory of high cost supplies (such as implants). In 2005/06, one of the major hospitals in Edmonton tracked 4,230 supplies using bar code technology.⁴ Bar code technology applications are now expanding to include tracking the usage of instruments consigned and purchased from vendors as well as the location of purchased equipment being used in all clinical settings.

Implementing supply chain processes in the OR also encompasses the management of vendors. Streamlining supplies in the OR promotes the use of fewer vendors and the commitment to purchase large quantities of products from select vendors.⁶ This leads to the possibility of larger volume discounts. Many hospitals across Canada and the United States have adopted Corporate Administrative Directives that pertain exclusively to vendors. Some of the highlights include: vendors are required to sign in every time they enter the OR; vendors must ensure they have made an appointment, or have been invited, to be in the OR; and vendors are present to provide education and assistance to OR staff (no selling or promotional activity is allowed). Enforcement of this directive depends on the cooperation and collaboration between management, physicians, and nursing staff

on site. The literature indicates "savings can be realized through sustainable improvements in contract compliance and product selection."⁶

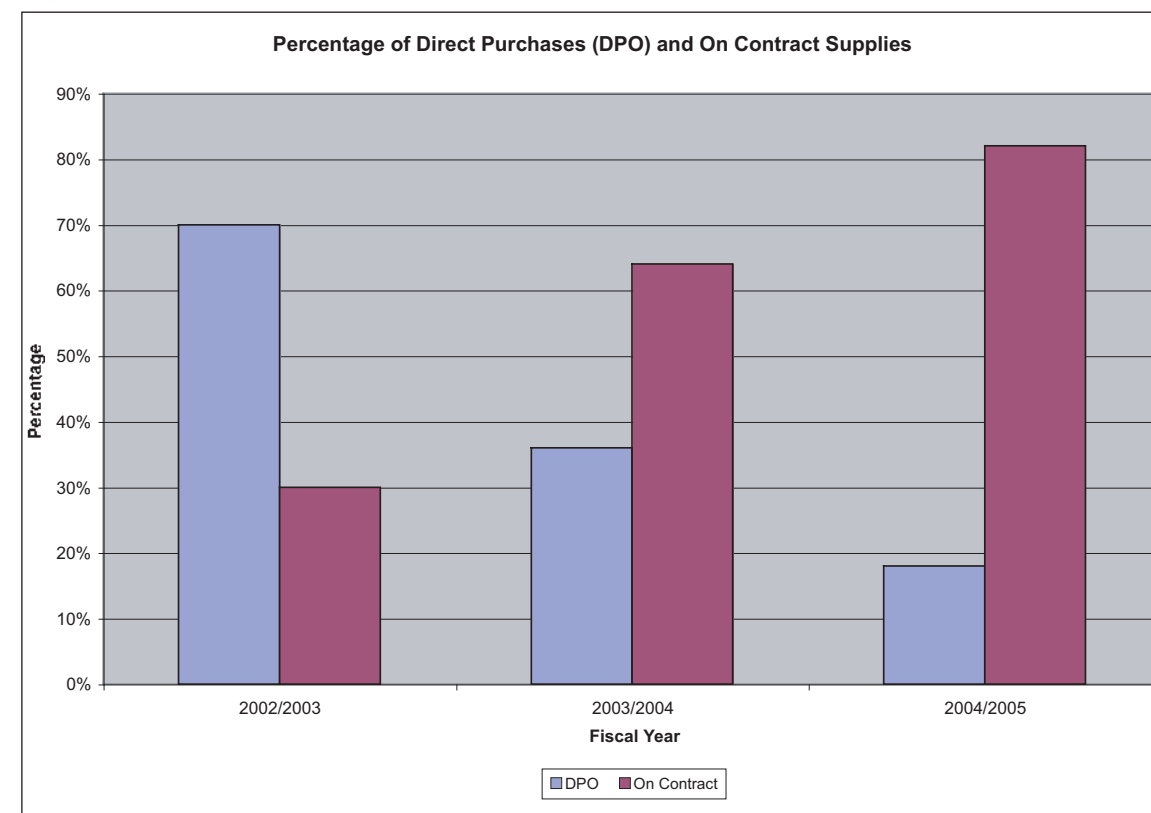
Another benefit of managing supplies in the OR is that vendors are contracted to provide their products. Essentially this means that a pricing agreement will be in place for a set term (usually two years with the possibility of extension for an additional year). Contracts are set regionally so that all hospital sites within the health region are able to purchase the vendor's products for the same price.

KEY STEPS TO IMPROVING SUPPLY CHAIN MANAGEMENT IN THE OR:

Collaboration between management, physicians, and nursing staff is essential for the successful improvement of supply management in the OR. Questions arise such as: How can supply chain management be improved in my OR setting? What can I do to improve supply management in the OR? These issues can be addressed using the following strategies as a guide.

It is important to educate end users about the relevance of supply chain management. Key Stakeholders are likely to embrace new initiatives when empirical evidence is provided to support the use of supply chain management processes, a reduction in supply costs, and the provision of high quality patient care. Education on the subject should include outlining the processes to be followed; explaining the timelines and rollout of processes; and enabling end users to provide their input. Focus group meetings, for example, could be set up and include representation from OR management, physicians, and nursing staff. To improve supply chain processes (as listed in Figure 3) a multi-disciplinary team should be created to involve stakeholders both early in the process and often throughout all six steps.¹¹ "The most effective way for most hospitals to reduce supply costs is to work with physicians to reduce costs for physician-preference items."⁹

Figure 1^{3,4}



DON'T BREAK THE CHAIN (cont.)

Assessing the status of the supply chain in an OR will provide a starting point. Questions that should be reviewed during this step are: How much variability exists between supplies for each surgical specialty and for each surgeon? Do we have redundant inventory that can be eliminated? How many vendors do we have supplying similar products? Can vendor selection be streamlined? Are there supplies currently bought directly from vendors that are available through the regional warehouse? Can high price inventory items (such as implants) be minimized? What products do we need to stock in order to maintain high quality patient care?

It is important to next evaluate how a process change would impact OR costs. Representatives of site and/or regional finance can offer support during this step. Reports outlining current spending on supplies (including ward stock, direct buy purchases and consignment inventory) will provide a baseline of supply cost information. Creating a teamwork atmosphere, and being committed to providing safe, effective patient care, will translate into a reduction in supply costs and an improvement in clinical efficiency.⁹

Design supply chain processes based on benchmarks from other health regions, research findings, input from key stakeholders, and resources available at the hospital site. Supply chain improvement goals should be strategically driven based on organizational goals, take a flexible approach, and create innovative relationships in, and across, organizations.⁶

IMPLEMENTING SUPPLY CHAIN PROCESSES:

Some immediate actions, that can reduce costs within the OR, include: reducing variations in supplies; eliminating unused items in case carts; changing from disposable to re-usable products wherever possible; standardizing and reducing custom procedure packs; and whenever a new product is requested ensuring someone asks why it is needed.^{7,12}

Quick wins need to be identified during this step. Involvement and support from end users is also a pivotal marker of success during implementation. The literature indicates that

physician involvement in rationalizing supply choices and reducing variation of supplies is essential elements to successfully improving the supply chain within the OR setting.⁷

Track progress by highlighting the outcomes, the changes over time, the cost containment successes, and the quality of care provided. This can be achieved by communicating the changes occurring in the OR supply chain. The use of a staff newsletter, placing a report in the staff lounge or on bulletin boards, sending out a distribution email to all OR staff, and conducting staff meetings and in-services, are all effective ways to communicate both progress and change to OR staff members. "If companies and people in a supply chain have real-time access to the data they need then they will steer toward their targets [and] if they are rewarded when they achieve their targets then they will learn to hit these targets more often than not."⁵

Other strategies for successfully improving supply chain management in the OR include:

- Building a compelling case (using statistics and benchmarking to guide decision-making regarding the use of high cost supplies);
- Engaging physicians throughout the process by enabling them to have a voice in supply contracts and negotiations;
- Sticking to supply chain processes as outlined; and
- Sharing rewards with all staff (for example: money saved on supplies can be used to purchase other much-needed equipment)^{3,6,9,12}

CONCLUSION:

Within Edmonton alone there are four centres (of varying size) working on decreasing OR supply costs by implementing supply chain processes. Supplies in the OR environment are a commodity that can be managed efficiently and effectively. The implementation of supply chain processes can have a significant impact on healthcare dollars and quality of care provided to patients. Implementation of these processes depends on the availability of information systems and may need to be modified accordingly. End user involvement and the establishment of clear processes are, however, essential to the successful integration of the supply chain in the OR.

Figure 2
Standard elements of product request form

PRODUCT REQUEST FORM
To be completed by end-users (*whomever is requesting the product*)

- Requestor name (typically a physician)
- Product name/description, code, vendor, rationale for request
- Identify current product(s) being used for this purpose (name/description, code, vendor)
- Identify if new product will decrease need for or eliminate use of current product
- Identify estimated annual usage of new product
- If evaluation, identify how long the evaluation will be (# of cases) and the quantity of product required
- Signature of requestor
- Signature of surgical specialty chief
- Signature of manager (either approving or denying request)

Figure 3
Six steps to improve supply chain processes.

KEY STEPS TO IMPROVING SUPPLY CHAIN¹¹

1. Create a multidisciplinary assessment team with representation from OR management, physicians, and nursing staff
2. Conduct an assessment of your current supply chain/supply management processes
3. Evaluate how a process change would impact OR costs
4. Design supply chain processes (based on benchmarks from other health regions, research findings, input from key stakeholders, and resources available at your hospital site)
5. Implement supply chain processes (identification of quick wins and buy-in from end-users)
6. Track progress (track outcomes and change over time, cost containment successes, quality of care provided)

The perioperative registered nurses responsibility related to resource management is further articulated within the competencies of the perioperative registered nursing practice found in Module 1 (2007) of the Operating Room Nurses Association of Canada (ORNAC) (2007). *ORNAC Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice* (8th edition).

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GLORIA STEPHENS AWARD FOR EXCELLENCE AS AN EDUCATOR OF PERIOPERATIVE NURSING

A new award will be presented at the 2009 ORNAC National Conference. The "Gloria Stephens Award for Excellence as an Educator of Perioperative Nursing" was established at the suggestion of and in collaboration with Ms. Gloria Stephens, herself a passionate perioperative nurse and educator for many years. The award, which will be presented during National Conference years, will celebrate a nurse recognized by his/her students, peers, and managers as an outstanding educator and role model in the field of perioperative nursing. The winner of this award will receive a cheque for \$1000 donated by Ms. Stephens, a plaque, and a pin. Nomination forms will be available for downloading from the ORNAC Website.

Completed nomination forms must be submitted to the ORNAC Awards Chair no later than **January 15th** of a National Conference year. Incomplete forms will not be considered. For more information and to download nomination forms, visit www.ornac.ca and click on *Education*, then *Awards*.



PRIX D'EXCELLENCE GLORIA STEPHENS POUR LA FORMATION EN SOINS PERIOPERATOIRES

Un nouveau prix sera présenté lors de la conférence nationale de l'AII SOC en 2009. Le **Prix d'excellence Gloria Stephens pour la formation en soins périopératoires** a été établi suivant la recommandation et à l'aide de Mme Gloria Stephens, elle-même infirmière périopératoire et formatrice passionnée. Ce prix, qui sera présenté lors de chaque conférence nationale, reconnaît un(e) infirmier(ère) autorisé(e) identifié(e) par ses étudiants, collègues et superviseurs comme formateur(trice) exceptionnel(le) et modèle de rôle dans le domaine des soins périopératoires. Le gagnant ou la gagnante de ce prix recevra un chèque de 1 000 \$ offert par Mme Stephens, une plaque et une épingle. Les formulaires de nomination seront disponibles sur le site Web de l'AII SOC.

Tout formulaire dûment rempli doit être soumis à la présidente du comité des prix au plus tard le **15 janvier** de l'année d'une conférence nationale. Aucun formulaire incomplet ne sera accepté. Pour plus de détails sur le téléchargement du formulaire de nomination, veuillez visiter www.ornac.ca, cliquez sur *Education*, et ensuite sur *Awards*.

UPCOMING EVENTS / EVENEMENTS SUIVANTS

PROVINCIAL & REGIONAL CONFERENCES

Alberta	Red Deer	October 22-25, 2008
British Columbia	Penticton	April 28 - May 1, 2010
Saskatchewan	Saskatoon	September 2008
Manitoba	Winnipeg	March 2009
Quebec	Quebec City	October 28 - 31, 2008
Newfoundland & Labrador	Saint Anthony's	September 18-21, 2008

ORNAC CONFERENCES www.ornac.ca

21st National	St. John's, NL	June 7-12, 2009
22nd National	Regina, SK	May 8-13, 2011
23rd National	Edmonton, AB	May 5-10, 2013

INTERNATIONAL CONFERENCES

ACORN (www.acorn.org.au)	Adelaide, AUS	September 22-25, 2009
AORN (www.afpp.org.uk)	Chicago, USA	March 15-19, 2009
AFPP (www.afpp.org.uk)	Harrogate, UK	October 6-9, 2008
EORNA (www.afpp.org.uk)	Copenhagen, Denmark	April 17-19, 2009

RELATED PROFESSIONS

CAS (www.CAS.ca)	Vancouver, BC	June 26-30, 2009
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For details visit www.ornac.ca

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