



# The Guiding Light

CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES & ASSOCIATES

NOVEMBER 2002 VOL. 12 #47

## REPORT FROM THE EDUCATION DIRECTOR

### Certification!!! It will happen Spring 2004

Included for your information are the development phases and timelines:

	No. of Members	Mandate	Meeting or teleconference	Time
Examination Committee	6	To oversee overall project give direction, make policy decisions, provide final approval	Provide ratings for competencies;	Spring 2003
			Participate in teleconference to finalize	
			Competency ratings	
			Attend five-day session to review items and finalize examination	Late summer 2003
			Attend one day session to set the pass mark	Spring 2004 Immediately after Examination
Competency Development Committee	6-8 members	To develop and finalize the competencies	Attend five-day session to develop draft competencies November 2002	February 2003
			Participate in teleconference to review feedback on competencies and finalize modifications	



## Winners of the Poster Competition

### Winners of the poster competition in St. John's, NFLD:

**First place:** Saskatchewan Chapter "Challenge Yourself"

**Second Place:** Newfoundland Chapter "Hereditary Polyposis"

**Third Place:** Edmonton Chapter "Colorectal Cancer"

*Congratulations to all of you for designing such wonderful, informative posters.*

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	<b>No. of Members</b>	<b>Mandate</b>	<b>Meeting or teleconference</b>	<b>Time</b>
Presidents of local chapters & Quebec representative	5 local chapters presidents & IQC rep.	To hold local meetings with members to gather their feedback	Recruit members to participate in local meetings; organize and chair local meetings with members; return feedback document to consultant	January 2003
Blueprint Committee	5-6 members	To review and approve the blueprint	Attend teleconference to review the blue print	March 2003
Item Writers	10-12	To produce items	Attend five-day item-writing session	April-May 2003
			Participate in online item writing	June-July 2003
Fairness Reviewers	3-4 (not necessarily content experts)	To review the items from the point of view of fairness	Review items according to specific criteria (mail or internet is used)	July 2003
Item Reviewers	5-6 content experts	To review the items	Review items (mail or internet is used)	July 2003
French exam reviewers	5 content experts	To review the French version of the examination	Review and provide comments (via mail or internet)	Fall 2003

So as you can see we will be busy for the next 18 months. Some nurses will be selected to work from their home. If you accept there will be tight deadlines to meet which will need to be respected for the success of this project.

Until we have our own Certification exam we will continue to apply for CEU points at our Annual Conference. This educational Activity can be offered as many times as we wish within the two-year period. This means that any speaker that we had in St. John's can be invited at your local Chapter meetings and offer the same session. Should you wish to do that your participants must receive a certificate of completion. A summary of participant's evaluations must be sent to SGNA headquarters no later than

three weeks after the date of your educational activity. On your report make sure to indicate the identification number on your report which is 02-15 and mail report to SGNA Headquarters 401 North Michigan Ave. Chicago, IL 60611-4267.

The competency group have been chosen. We are going to CNA the week of Nov. 11-15, 2002. The ladies that have accepted the challenge are: Cindy Hamilton, Terry Ledressy, Deb Taggart, Maria Cirrocoo, Kathy Van Veen, Anna Tsang, Cindy James, Nancy Kilfoil and myself.

**Respectfully submitted**  
**Michele Paquette, CGRN**  
**CSGNA Education Director/**  
**Certification Chair**

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**RESEARCH ... POST**  
**INFECTIOUS IRRITABLE BOWEL**  
**SYNDROME**

Dear colleague,

Welcome back from the CSGNA annual conference held in St John's, Newfoundland. By now most of you are aware by word of mouth from other members, Public Health or your own acute experience of gastroenteritis that there had been an outbreak of food poisoning related to the conference.

Many members began having symptoms of gastroenteritis on Sunday, Sept 22 which continued through the following week making return travel back home uncomfortable and difficult.

Previous research has suggested that between 4-30% of patients with acute gastroenteritis may develop

*continued on page 4*



## THE SCOPE OF TORONTO: TOP TO BOTTOM HOLIDAY INN TORONTO AIRPORT SEPT. 18-20, 2003

The CSGNA is hosting its annual conference, in Toronto, September 18th-20th, 2003. Hundreds of gastroenterology nurses and GI associates from across Canada will be exploring the many facets of nursing practice that make a difference to the health outcomes of the patients we care for in our endoscopy and/or GI departments.

Abstracts are invited for but not limited to the following themes:

- § Development of orientation tools for endoscopy departments
- § Creative strategies for evaluating and implementing innovations to nursing practice
- § Occupational Health issues in endoscopy units
- § Creative teaching strategies – for patients and staff
- § Amalgamating units from different hospitals – successful change strategies
- § Developing a care philosophy for gastroenterology units
- § Staffing competencies – how do you develop, implement and evaluate in high tech environments
- § Staffing Mix – the whys of your units
- § Technology and caring – is this a paradox
- § Evaluation process
- § Ethical issues and strategies that result in a win/win scenario
- § Research related to practices, and economic considerations
- § Barriers to staff development
- § Inventory management

Basically, this is an opportunity for you to share with colleagues what you do well and/or what provides challenges in your practice.

### Submission:

Abstracts must include identification of area(s) of focus (background information); a description of the problem; discussion of planning, implementation, evaluation; how your issue promoted health care outcomes or professional development in your area.

### Cover Sheet

Please complete a cover sheet and submit with your abstract. The cover sheet must include title of the abstract, names of all presenters/authors, credentials, and place of employment/academic affiliation. Please indicate main contact's name, telephone number, email address and fax number. Please note: this information will be used in the conference program should your abstract be selected.

### Format

Your typed abstract should not exceed one standard letter size sheet of paper, double-spaced, with one inch margins and standard 12 font.

The title, authors, objective, description, and conclusion should appear on the abstract. This abstract will be included as part of the course syllabus.

Please fax or email your cover sheet and abstract in Microsoft Word or Word Perfect format.

### Other Information

All authors are responsible for any expenses incurred in preparing and presenting their poster (including registration and travel expenses).

### Selection Process

A blind review and selection will be made by the Abstract Review Subcommittee of the Conference Planning Committee. Selection criteria include relevance to conference, clarity, impact on gastroenterology nurses and associates practitioners, or impact on patient outcomes.

Selected abstracts will be developed into poster format by the authors. Posters will be displayed in a prominent location at the conference. A one hour period will be designated for at least one author to discuss the poster and answer questions that delegates may have.

### Notifications

All abstracts will be acknowledged upon receipt. Selection will be completed and acknowledged by Friday, May 2, 2003. Successful authors must indicate their intent to participate by Friday, June 6, 2003 to be included in the conference syllabus.

Submit abstracts to:

**CSGNA**  
**ANNUAL CONFERENCE**  
**The Scope of Toronto:**  
**Top to bottom**  
c/o Maria Cirocco,  
St. Michael's Hospital  
30 Bond Street, 16-132  
Toronto, ON M5B 1W8

Phone: 416-864-6060 ext 2965

Fax: 416-864-5449

Email: [ciroccom@smh.toronto.on.ca](mailto:ciroccom@smh.toronto.on.ca)

**Deadline for submission: March 14, 2003**

*continued from page 2*

symptoms of post infectious IBS (PI-IBS) within 3 months of the acute infection. It is important to gather information on the history of IBS which may follow acute episodes of gastroenteritis. It is unusual to be able to identify a discrete episode of gastroenteritis. This is an invaluable opportunity to follow over time not only your symptoms but the triggers of IBS. By doing this we may gain a better understanding about IBS so that we can help our patients.

Being interested myself as a GI research nurse in the causes and morbidity of Irritable Bowel Syndrome (IBS), I felt that it might be interesting to use this opportunity to study the consequences of this episode among such a captive audience.

We are proposing to follow the participants of the conference by way of questionnaires at 3, 6 and 12 months to determine the incidence of PI-IBS, using uninfected participants as the controls. The participants will be identified only by a number and those of you who do not wish to participate may simply not return your questionnaire. The CSGNA is supportive of this project as their mandate is to provide the membership with education, new ideas and developments in the field of gastroenterology.

I can't stress how important it is for all to participate. It will be tremendously helpful to hear from not only those who had symptoms but also to get baseline information from those of you who were lucky enough not to be infected to act as controls.

Looking forward to hearing from as many participants as can be contacted.

**Yours truly,  
Cindy James, RN, BSN**

Everyone!!! Please remember to return your completed questionnaires as soon as possible **EVEN if you did** not suffer from the gastroenteritis that many of your colleagues suffered. Those who

remained well will be the control group for the study. I hope this clarifies any questions. Otherwise email jamesc@hhsc.ca or phone 905-521-2100 x 75350 for more information. Many thanks for everyone's cooperation on this project.

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#### *PRESIDENT'S REPORT*

When taking over the Presidency of any organization it is said the new leader must have a vision. When first asked what my vision is, I must admit I was at a loss for words and ideas. For the past ten years I have watched the CSGNA expand and illuminate. So much has already been accomplished. The laying of the groundwork for Certification began eight years ago, the concept began earlier. Spawned by dedicated hard working individuals, their vision has become mine. Their hard work, achievements and goals will be illuminated during my term as President. I am privileged to be able to complete what they have begun and I applaud them and thank them for their guidance.

Since the inception of Gastroenterology Nursing, we have played a vital role in safe, accurate and informed GI procedures and research. The CSGNA, realizing the importance of our role, has developed Guidelines, Policies and Procedures to assist us within our scope of practice. We have developed Position Statements to give us direction within our scope of practice. We provide our members with an exceptional Annual Conference filled with an abundance of education and networking tools for the members to take back to their workplace.

What does the future hold for the CSGNA? I wish I knew all the answers, some things are clear. There will be certification. There will be new technology and new procedures. No matter the course our practice may take, it is my hope and desire that the CSGNA will be there to provide guidance, clarity, and education for it's members. You as members are the glue to hold it together and make it work.

In order to make an organization work; a good leader must surround themselves with better people. I have done that; I have surrounded myself with you.

**Sincerely,  
Lorie McGeough  
President CSGNA**

I would like to take this opportunity to thank all of our vendors who contributed to the successful conference in St. John's, Newfoundland. Their support is very much appreciated. I would also like to thank the Newfoundland Planning Committee for all of their hard work, dedication and planning of the educational portion of the conference and the recreational portion of the conference. Thank you again, you did a great job!

**Sincerely,  
Lorie McGeough  
President CSGNA**

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#### *PRESIDENT ELECT REPORT*

I would like to thank the conference planning committee for organizing our National Annual Meeting this year. Having been on two previous planning committees in Ottawa, I fully appreciate the amount of work, sacrifice, and cooperation that it takes to produce such a great product. My congratulations to you for a job well done!

Having survived my inaugural conference as President Elect, I am looking forward to these exciting times in Gastroenterology.

Canadian Certification in 2004 is now a concrete certainty after many years of hard work. I am also pleased to report that quality, affordable education continues to be available at both the national and chapter level. I do hope that you are all taking advantage of these opportunities. It is my privilege to be mentored by a strong, knowledgeable President, Lorie McGeough. I look forward to the challenges that the next four years hold for me.

**Yours in CSGNA  
Nancy Campbell  
President Elect**

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### UPDATE FROM YOUR TREASURER

I would like to congratulate the Newfoundland Chapter on a very successful conference. It was great to see 205 people registered from across Canada and the US. Thanks very much to all of our exhibitors who help make our national conferences possible. The financial aspect of the conference is not finalized, but this usually takes a few months. I would like to thank all chapters who donated a silent auction prize. This has been a very successful fundraiser for our scholarship fund. This year we raised \$739.00.

Sincerely  
Edna Lang

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### SYNOPSIS: BOARD OF DIRECTORS MEETING NEWFOUNDLAND SEPTEMBER 19-22, 2002

#### MINUTES:

A motion to adopt the minutes from June teleconference as circulated was accepted.

#### REGIONAL DIRECTOR REPORTS:

Reports from all Directors Canada East Centre and West were given and will be in this issue of the Guiding Light. Linda gave an update of the conference preparation Sponsorship was decreased, there were no sponsor for some speakers, also some of the meals, therefore CSGNA will cover these expenses. There were 201 registrations at this time, entertainment accommodation had become a problem, we were unable to accommodate vendors.

#### BYLAWS:

575 ballots were sent out for amendments, only 23 returned. We need a new process for voting, and this was discussed. All Bylaws were passed.

#### CHAPTER/BOARD DINNER MEETING:

This was attended by 40 members including three guests, Leslie Ann Patry Certification Coordinator from CNA, Linda Kingsbury from Health Canada,

and SGNA President Elect Jo Wheeler Harbaugh.

#### CERTIFICATION:

Leslie Ann Patry from CNA informed us about the certification process, exam development, competency development, and maintaining certification. Certification fee will be \$400 \$600, CNA or RNAO members less \$175.00. Eligible candidates would have completed 1-2 years full time hours in G.I. nursing. The exam development cycle is divided in 6 phases. CSGNA is now in the process of phase 1 which is competence development. Our goal is to write the exams in the Spring of 2004.

#### OUTGOING BOARD MEMBERS:

Lorraine Miller Hamlyn – President  
Judy Langner

– Director Public Relations

Usha Chauhan

– Director Canada Centre

Linda Feltham – Director Canada East.

#### INCOMING BOARD MEMBERS:

Deb Taggart

– Director Public Relations

Joan Rumsey – Director East

Belinda Tham – Director Centre.

#### NEW CHAPTER EXECUTIVES:

Okanagan Chapter

President Karen Parchomchuk

Secretary Jean Tingstad.

Saskatchewan Chapter

Secretary Linda Benoit

Treasurer Alison MacDonald.

Manitoba Chapter

President Jennette McCalla.

London Area Chapter

President Marilyn Plimmer

Treasurer Mary Campbell.

Saskatchewan Chapter is now called REGINA CHAPTER, a motion was passed to accommodate the name change.

#### EDUCATION:

Guidelines for Training, Reprocessing Endoscopes and Accessories document is now completed. A motion was passed to delete Regional Conference awards, and increase National Conference awards to 12. Michele will review all chapter packages, and forward updated versions to all Chapter Presidents.

#### PRACTICE:

Jean updated all position statements, and reorganized their presentation to be consistent. A lot of interest was shown here during the breakout session, and also at the CSGNA booth.

#### NEWSLETTER:

Deadlines for articles are October 15, February 15, and June 15. All members can submit interesting articles, not necessarily G.I. related. A special edition will have all the updated position statements, and bylaws available in the near future.

#### WEBSITE:

Our website can be used as a resource for contacting all Board/Chapter Executives, Certification Update, and education events are kept as current as the information becomes available. Chapter Executives should forward all their education events for posting as soon as they are aware, this will give our members an opportunity to plan.

#### MEMBERSHIP/TREASURER:

Membership had decreased in general. Where ever the National Conference is held membership increases, then there is a decrease after that. Membership is from June to June. Education funds are kept to be self-sufficient. The Chapters donate 25% of their income to this fund, also silent auction, and donations from sponsors. Operational account is used for paying bills which is ongoing. Outstanding bills from the conference have not been paid as yet. Education Account \$9,498.34 as of September 1, 02, Operation Account \$72,947.82.

#### PUBLIC RELATIONS REPORT:

This is Judy's last CSGNA report. Our exhibitors and sponsors continue to remain our greatest allies. Many hospitals are going to a centralized area for sales staff to come to meet buyers. This will decrease our contact with them, so we will have to work harder at communicating with them, probably at the annual conference and during the middle of the year to let them know of our progress and continued association. Having observed the swing to email for everything, we

should look at our website as a communication tool. She had a very busy four years, most importantly was getting to know so many dedicated co-workers in her field across Canada. She believes we are setting great goals for our co-workers, by working on our own national exam. She looks forward to the changes as we work towards our specialty, and will continue to support us at the chapter level.

#### **FUTURE CONFERENCES:**

2003 Toronto

2004 Calgary

2005 Montreal/World Congress

2006 Regina

Teleconference:

December 3rd, 2002. EST. 19:30

Face to Face: April 11 - 13, 2003

Toronto

**Respectfully Submitted,  
Elaine Binger, Secretary**

#### *CSGNA DIRECTOR CANADA WEST REPORT*

The members from the West who attended the National Conference in St John's Newfoundland in September want thank the Newfoundland and Labrador Chapter of CSGNA and their Planning Committee for a job well done! What a wonderful group of Nurses. The annual conferences are always a memorable experience and what a great opportunity to visit places that you might not have ever been. The camaraderie, the networking and the knowledge each one experiences from these events are truly valuable.

#### **REGINA CHAPTER**

The Saskatchewan Chapter has formally changed their name to the Regina Chapter of the CSGNA.

Congratulations to the Regina Chapter for winning the first prize Blue Ribbon in the poster contest at the National Conference in St. John's. Chapter President Shirley Malach and 3 others from their group attended.

The Regina Chapter is hosting "Gastroenterology Days for Nurses" educational session to be held on Oct.

25<sup>th</sup>. They are looking forward to once again having huge turnout and a day full of education and fun.

#### **CALGARY CHAPTER**

Past President Deb Taggart reports that a dinner meeting was held Oct. 1, 2002, sponsored by Pentax Canada Inc.

Election of officers was held. For the next two year term, positions are being filled as follows: President: Evelyn Matthews, Secretary: Jamie Frew, Treasurer: Doreen Reid, Education: Deb Erickson.

Highlights from the St. John's conference were presented and they discussed Certification 2004.

Deb Erickson and Norma Hunchak will be looking at potential venues for the 2004 CSGNA National Conference being held in Calgary. The next chapter meeting will be held Nov. 14.

#### **OKANAGAN CHAPTER**

Chapter President Karen Parchomchuk reports that their Chapter is planning to have a "little jam session" on the Code of Ethics booklet that has just arrived from the CNA, which every RN in BC and most likely, every Province has received.

#### **VANCOUVER ISLAND CHAPTER**

Chapter Secretary Donna Gramigna reports that their Chapter is anxiously anticipating the Certification Exam. They are thrilled to hear that it is on the horizon.

#### **VANCOUVER REGIONAL CHAPTER**

President Gail Whitley reports that the Chapter will be having a dinner meeting in November. A successor has been found! Adriana Martin will be the new Vancouver Regional Chapter President. Official handing over of duties will take place at that meeting.

Seven members attended the St. Johns conference.

**Respectfully submitted:**

**Nala Murray**

**CSGNA Director Canada West  
October 2002**

#### **REPORT FROM EDUCATION DIRECTOR**

I would like to report the new members on the Education Committee since September 2002. Board members are the following: Jean Macnab and Deb Taggart. Thanks to Usha Chauhan and Judy Langner for their support throughout the year. Evelyn McMullen remains on the committee. The members at large are Monique Travers, Rachel Thibeault Walsh, Nancy Campbell and Sherry Allyn.

We will be working on revising the Chapter packages and these will be mailed to the Chapter Presidents along with the revised by laws. Read them carefully as your Chapter President will facilitate this process.

The teaching guide for Reprocessing of Flexible endoscopes is almost completed and will be ready for our members to purchase before the end of December 2002. We will keep



you posted on our website at [www.csgna.com](http://www.csgna.com).

Lastly and most important: CERTIFICATION. You will all be involved at some point and we will keep you posted. Again consult our website for updates.

**Respectfully submitted:**  
**Michele Paquette CGRN**  
**Education Director**

**CANADA CENTRE REPORT**

I would like this opportunity to introduce myself as the New Canada Centre Director for the CSGNA, and I thank you for affording me this great opportunity. I look forward to working with you, the Chapter Executives and the National Board with Lorie McGeough, with her dedication and vast experience as President.

Those of us who were fortunate to go to St. John's all had a great time, although a great number of our members suffered a type of GI infection. A big thank you to the NF Chapter for a very informative conference. Attending the CSGNA Annual Conferences is an effective way to network and share experiences, education and enthusiasm with other GI nurses across the country. We look forward to having our own Canadian GI Certification in 2004.

Another tool for information is visiting our website: [www.csgna.com](http://www.csgna.com)

**GREATER TORONTO CHAPTER**

Planning Committee is in progress preparing to host the 19<sup>th</sup> CSGNA Annual Conference in Toronto for 2003. Hope to see many of you there.

October 24, 2002 Education Evening at St. Michael's Hosp. Tor.

Topic: "Hepatitis A Nursing Impact" Sponsored by Pentax Precision Canada.

**GOLDEN HORSESHOE CHAPTER**

October 16<sup>th</sup>, 2002 Education Evening at the Royal Botanical Garden, Burlington.

Topic: "Opening the Way - Understanding Stents" Talk given by Dr. J. Urshell and Dr. Ved Tandam.

**CENTRAL ONTARIO CHAPTER**

November 13<sup>th</sup>, 2002 at the Molson House in Barrie is Fall Festival: "ERCP General Overview" by Dr. D. Hemphill and "Cidex - OPA and Communication with SPD". Sponsored by Johnson and Johnson.

**SOUTH WESTERN ONTARIO CHAPTER**

It is to our disappointment that Diane Gray, the President, has to step down for personal reasons. We encourage the Chapter to keep up the good work, but it needs you the members help and support and participation in Chapter activities. The National Executive, of which I am a part of is there to assist you. Please do not hesitate to contact us for any assistance or information.

**OTTAWA CHAPTER**

Canadian GI Certification is keeping some chapter members very busy. At their meeting in October 2002 elections were held. The new President is Monique Travers, Secretary is Jean Macnab (no change), and Treasurer is Michele Paquette.

We will be hosting an evening presentation in February 2003, the date not confirmed. The subject will

be "Endocinch" and our presenter will be Kevin Bentz, sponsored by Bard Canada. We will keep you informed when our program is finalized.

Please check our website for future education sessions and certification update.

**Submitted by,**  
**Belinda Tham**  
**btham@tegh.on.ca**

**DIRECTOR PRACTICE REPORT**

The position statements and guidelines published in this issue have been revised. This year we are working on guidelines for assisting with bronchoscopy, a position statement on the reuse of disposables and a position statement on a nurse performed flexible sigmoidoscopy.

Any questions about practice can be directed to me at: [jmacnab@ottawahospital.on.ca](mailto:jmacnab@ottawahospital.on.ca)

**CALGARY CHAPTER NEWS**

A dinner meeting was held October 3, 2002, sponsored by Pentax Canada Inc. represented by Leighton Friesen. Election of officers was held for the next two year term. Positions are being filled as follows:

- President: Evelyn Matthews
- Secretary: Jamie Frew
- Treasurer: Doreen Reid
- Education: Deb Erickson

Highlights of the St. John's conference were presented by attendees. D. Taggart discussed Certification 2004 and that it will be a reality in April, 2004. Deb Erickson and Norma Hunchak were going to be looking at potential venues for the 2004 national meeting in Calgary.

**CHANGE OF NAME ADDRESS/NAME**

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

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_



**MOVING?  
LET US KNOW!**

Remember to send in your  
change of address!

The next meeting will be held November 14 at which time the main topic of discussion will be this meeting.

**Submitted by,  
Debbie Taggart,  
Past President, Calgary Chapter,  
CSGNA**

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#### SASKATCHEWAN CHAPTER

The Sask. Chapter of the CSGNA has formally changed their name to the Regina Chapter of the CSGNA. The executive members remain the same as currently listed in The Guiding Light.

I was fortunate to be able to attend the annual conference in St. John's, Newfoundland this Sept. with the assistance of a national scholarship. I would like to thank the members of the educational committee for selecting me as a worthy candidate. The organizing committee from St. John's are to be commended for hosting a wonderful educational and social event. Thank you.

Members of the Regina Chapter are pleased to congratulate one of our own on her great accomplishment. To Lorie McGeough, we say congratulations on your assuming the presidency of the CSGNA. We wish you great success in this worthwhile position.

**Sincerely,  
Shirley Malach  
President, Sask. Chapter CSGNA**

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#### GI NURSES DAY MAY 2002

St. Joseph's Health Care, Hamilton, ON.

*"Gee I Wonder What They do in Endoscopy"*

This display included information, statistics of dept. patient education brochures and CSGNA information with registration forms. An open Pentax Teaching Scope with visible channels and a nurse at the booth to answer questions.

**Submitted by,  
Brenda Hillier, RN  
bhillierrn@hotmail.com**

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#### NEWSLETTER REPORT

As you can see we have had some changes to our National Board. Firstly out Past President Lorraine Miller Hamlyn, who was one of the pioneers for Canadian Certification, was a great leader for us and implemented some good changes to the Board with a vision for CSGNA for excellence. Judy Langner our past Public Relations Person, Linda Feltham, Canada East Director, and Usha Chauhan, from Canada Centre, have all been energetic knowledgeable members of our team. On behalf of you the members at large I will thank these ladies for their dedication and commitment to our cause. We wish them all the best and we know they will be supportive of our group even in their retirement from the board.

We welcome our new board members, our President, Lorie McGeough, your vast experience and knowledge with your own vision for our team and members. The President Elect, Nancy Campbell who I might add is no stranger to our group, Debbie Taggart, who has always helped us in many ways, and Joan Rumsey who will represent the East and bring her strength to the group. We look forward to working with you all.

Bravo to the Newfoundland and Labrador Chapter for a great conference. We thank you for being the perfect hosts for our annual conference. A job well done!!! You brought us to the rock and gave us a good informative and great social enjoyment for the few days we spent with you.

To those of you who have interacted with me and shared your articles and ideas with our members I am grateful, and I look forward to your continued support and have more members participate in what we do.

A big thank you to all our vendors who participated, contributed, and helped in whatever way you did to make St. John's a big success. I thank you on our members behalf.

**Yours sincerely  
Kay Rhodes, Newsletter Editor**

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#### REPORT 2002 CSGNA NATIONAL CONFERENCE

On Thursday, Sept. 19, 2002 delegates rekindled old friendships and made acquaintances with new attendees at the wine/cheese reception of the CSGNA national conference in St. John's, Newfoundland. This was followed by a very busy two days of presentations and entertainment. Topics included a representative from Health Canada which stated that a committee is to start on guidelines for endoscopy units which will include a member from the CSGNA, new techniques in treating GI bleeds, treating the pediatric patient, achalasia, bowel surgery, genetics on colorectal cancer and a lively presentation from the motivational speaker. On Saturday there were six breakout sessions which delegates had a choice of attending which included endocapsule, advanced practice, certification, endocinch, safety with glutaraldehydes and position statements/guidelines from the CSGNA.

A representative from the CNA spoke on certification and that 2004 will be the target date.

A thank-you to the companies who participated and sponsored the events that made the conference a success. We have heard only positive feedback from the exhibitors and the conference attendees.

The social events were entertaining even though the "seas" were rough; the bus broke down, evacuation of the hotel and a breakout of gastroenteritis post conference. For those who did get 'screamed' you have made the title of an honorary Newfoundlander.

Last but not least a thank-you to the organizing committee of the Newfoundland Chapter for their hard work and time in making this event a success. Without these groups the conferences would not be an event. There is much work behind the scenes, but that will be a future article for "The Guiding Light."

**Sincerely,  
Linda Feltham**

# CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES AND ASSOCIATES

## BYLAWS

### REVISED 2002

#### CSGNA MISSION STATEMENT

The Canadian Society of Gastroenterology Nurses and Associates is committed to excellence of client care while enhancing the educational and professional growth of the membership within the resources available.

#### CSGNA PURPOSE STATEMENT

The CSGNA carries out its mission by providing opportunities for networking, education, and communication for its members.

#### CSGNA GOALS

##### **Nursing Practice:**

The CSGNA is committed to encouraging members to achieve high standards of care in daily practice by establishing standards of practice.

##### **Networking:**

The CSGNA encourages discussion and exchange of experience between nurses through the formation of Chapters, newsletter publication, and an annual conference.

##### **Education:**

The CSGNA keeps its members abreast of current developments in the field of gastroenterology through seminars and an annual education conference.

##### **Research:**

The CSGNA encourages initiatives and studies in advancement of gastroenterology and endoscopy nursing practice.

##### **Organization:**

The CSGNA is a dynamic, financially stable, well organized association responsive to membership needs.

1.0 NAME  
The name of the organization shall be the "Canadian Society of Gastroenterology Nurses and Associates" (CSGNA). Hereinafter the word "Society" shall refer to "Canadian Society of Gastroenterology Nurses and Associates." The words Officer(s), Board and Executive is used interchangeably.

2.0 PURPOSE  
The purpose shall be to unite into an organization, persons engaged in any capacity in the field of Gastroenterology Nursing in Canada (i.e. in any of the ten provinces and three territories).

3.0 GOALS  
The goals of the society shall be to promote education and quality of patient care by:  
3.1 Setting standards of practice  
3.2 Developing educational programs.  
3.3 Encouraging study, discussion, exchange of information related experience and practice.  
3.4 Promoting continually through the examination of principles and development of protocols.

3.5 Encouraging understanding of the advancements in related technology and sciences

4.0 HEAD OFFICE  
Until changed in accordance with the Act, The Head Office of the corporation shall be in the city of the current Treasurer/Membership chairperson.

4.1 The Corporate Seal of the Society shall be held in safekeeping by the officer designated by the Executive for fiscal year.

5.0 MEMBERS  
There shall be three classes of individual members consisting of active, affiliate, and lifetime.  
5.1 Active – shall be comprised of Registered Nurses or other Health Care Professionals engaged in full or part time Gastroenterology Nursing or Endoscopy Nursing in clinical, supervisory, teaching, research or administrative capacity. They are eligible to vote. Only registered nurses may hold office.

5.2 Affiliate – shall be comprised of Nurses, Health Care Professional/persons engaged in activities relevant to the field of Gastroenterology but not currently engaged in Gastroenterology Nursing or Endoscopy Nursing. They are not eligible to vote or hold office.  
5.3 Lifetime – any member, deemed to have contributed substantial time and effort towards the advancement of the CSGNA may be nominated for a lifetime membership. All past Presidents will be awarded lifetime membership at the end of their term in office. Nominations for other lifetime awards may be submitted by any member of the CSGNA to the National Executive. Lifetime awards are to be voted on by the general membership in attendance at

- the annual business meeting. Lifetime membership will include voting privileges.
- 5.4 Membership is not transferable. All members shall receive all publications from the Association.
- 5.5 The term "Associates", in the title of the Society, refers to CSGNA members who are not qualified as Registered Nurses.
- 5.6 Any member may withdraw from the corporation by delivering to the corporation a written resignation and lodging a copy of same with the secretary of the corporation.
- 6.0 FEES  
A membership fee will be required from the active and affiliate members annually on June 1st and will become delinquent after July 1st of that year.
- 6.1 Membership shall lapse automatically as of July 1st if dues have not been received by the National Treasurer by that time.
- 6.2 The Executive shall determine annual dues payable and shall give appropriate notice to members.
- 6.3 Members will be notified of any change in membership requirements by the regional directors and in "The Guiding Light" publication.
- 6.4 Members of the Executive do not pay any dues while in office.
- 6.5 No membership fee is required from a lifetime member.
- 6.6 All dues are payable in Canadian funds to the "Canadian Society of Gastroenterology Nurses and Associates".
- 7.0 MEETINGS  
The annual business meeting shall be held in conjunction with the annual conference.
- 7.1 At the annual business meeting the results of voting for Executive officers open for election will be announced.
- 7.2 Reports from the Executive officers will be presented as well as bylaw amendments, and any other significant business will be transacted as may be deemed of national concern.
- 7.3 Written notice of the annual business meeting shall be included in the information about the annual conference.
- 7.4 The board of directors shall meet face to face at least twice a year and by teleconference as deemed necessary by the board.
- 8.0 QUORUM  
The quorum shall consist of the majority of members present.
- 9.0 ELECTION OF OFFICE  
All members eligible to vote will be informed of the National Board positions available, and the deadline for nominations via the first "Guiding Light" publication after the annual business meeting. Nominations must reach the Nominations Committee by the date specified.
- 9.1 A slate of candidates for offices open in that fiscal year shall be mailed to the Active membership one hundred and twenty (120) days before the annual meeting.
- 9.2 Ballots are to be returned to the Chair of the Nominating Committee ninety (90) days before the annual meeting.
- 9.3 Each member has one vote per office.
- 9.4 Votes will be tabulated and recorded in the minutes of the annual business meeting.
- 9.5 The successful candidates will be announced to the membership at the annual business meeting.
- 9.6 If there is only one nomination for an office by the deadline for nominations, the officer is elected by acclamation.
- 9.7 Successful candidates will be notified as soon as possible after counting of the ballots in order that they may make the necessary arrangements to attend the annual conference.
- 9.8 If no one is nominated for an office, nominations will be accepted from the floor at the annual business meeting. If more than one nomination, a secret ballot will be held during the Annual Business Meeting.
- 9.9 As the first meeting of the new Executive is extremely important and sets the tone for the whole year, this meeting should be scheduled to take place in conjunction with the annual conference and meeting.
- 9.10 Transfer of duties from retiring Executive to newly elected Executives shall take place at the time of the annual CSGNA conference.
- 9.11 Officers elected must have served the association in some capacity the preceding two years.
- 9.12 Ballots will be kept by the Chair of the Nominations committee.
- 9.13 A motion to destroy the ballots will be made by said chairperson during the annual business meeting.
- 9.14 The ballots will be destroyed only after the motion is carried by a show of hands from the members present.
- 9.15 If a motion for a recount of any office is made and carried tellers will be chosen from the members present prior to the end of the annual conference and the results announced to the membership.

- 10.0 EXECUTIVE  
The executive of the Association shall include President, Past President, President Elect, Secretary, Treasurer, Membership Director, Education Director, Practice Director, Newsletter Editor, Canada West Director, Canada Center Director, and Canada East Director.
- 10.1 The Executive offices are open to all active members of the Association.
- 10.2 The Executive officers shall have the powers and authority as described to perform their expected offices.
- 11.0 TERMS OF OFFICE  
Terms of office will be adjusted by the Board during the transition to the new Board structure.
- 11.1 The President shall serve for one (1) year.
- 11.2 The past President shall serve for one (1) year.
- 11.3 The President-Elect will automatically accede to the presidency when the President's term ends.
- 11.4 He/She shall become acting President and assume the duties of the office in the event of the President's absence.
- 11.5 The President Elect must have served the Association in some capacity prior to being elected to this office.
- 11.6 Persons elected Secretary, Treasurer, Membership director, Education director, and Newsletter editor, shall hold office for two years or until their successor is elected.
- 11.7 No persons can be elected to consecutive terms as President or President-Elect.
- 11.8 No officer of the Executive can hold more than one office at a time.
- 11.9 There shall be no restriction upon the number of terms which other officers may be elected to succeed themselves.
- 11.10 Elections to fill the offices of Secretary, Education Director, Treasurer, Canada East Director, and Canada West Director will be held in odd numbered years.
- 11.11 Elections to fill the offices of Newsletter Editor, Practice Director, Membership Director and Canada Center Director will be held in even numbered years.
- 11.12 An election to fill the office of President Elect will be held yearly.
- 11.13 The President will automatically accede to the Past President when the President's term ends. (One year term).
- 11.14 The President-Elect will automatically accede to the President when the President's term ends. (One year term).
- 11.15 Upon retiring from office, all officers shall deliver all records, correspondence or other property of the Association to their successor within thirty (30) days.
- 12.0 VACANCIES
- 12.1 Whenever the office of President becomes vacant, the President Elect shall succeed to the Presidency for the completion of the unexpired term and continue in office for another full term. If the office of President becomes vacant while there is a vacancy in the office of President Elect, officers shall appoint an acting President from the present Board members who shall serve until the end of that term. A special election shall be held to fill the office of President Elect.
- 12.2 If an elected member resigns or can no longer fulfill his/her duties before the term of office is completed, the Executive shall appoint an interim replacement until the annual meeting, when an election can take place.
- 12.3 The person appointed should be the first runner up from the election, when possible.
- 12.4 If an officer should resign before completion of their term a written resignation shall be sent to the President at least fourteen (14) days prior to the resignation date.
- 13.0 DUTIES OF THE EXECUTIVE  
Duties shall include the following and may be modified as deemed necessary by the Board to meet the needs of the members.
- THE PRESIDENT SHALL:*
- 13.1 Serve as an official representative and spokesperson for the society.
- 13.1.1 Represent CSGNA missions, goals and positions to various publics.
- 13.1.2 Manage daily affairs of the organization.
- 13.1.3 Lead the National Board of Directors.
- 13.1.4 Chair Nominating Committee.
- 13.1.5 Provide mentoring to CSGNA leaders.
- 13.1.6 Submit and present an Annual report to the membership at the Annual Business meeting, and sends it to the member via the National Secretary sixty (60) days prior to the meeting.
- 13.1.7 Submit a report per issue of The Guiding Light.
- 13.1.8 Chair and prepare agenda for the National Board Meetings and Annual Business meeting.
- 13.1.9 Travel commitment as deemed necessary by the Board.
- 13.1.10 Attend the SGNA Conference and the House of Delegates.
- 13.1.11 Encourage vision and growth of the organization by fostering education opportunities and position statement formation.
- 13.1.12 Be an ex officio on all standing committees.
- 13.1.13 Serve a two (2) year term.

### **DUTIES OF THE PRESIDENT ELECT**

#### **THE PRESIDENT-ELECT SHALL:**

- 13.2 Accede to the Presidency when the President's terms ends.
- 13.2.1 Become acting President and assume the duties of the office in the event of the President's absence, disability or resignation.
- 13.2.2 Communicate regularly with the President as deemed necessary.
- 13.2.3 Learn the affairs of the Association.
- 13.2.4 Accompany the President to SGNA Annual Conference and attend the House of Delegates session.
- 13.2.5 Be the CSGNA liaison to SIGNEA.
- 13.2.6 Serve as Advisory member without vote on standing and special committees.
- 13.2.7 Form and chairs the Bylaw Committee.
- 13.2.8 Forwards amendments to these bylaws to the National Secretary in writing ninety (90) days prior to the Annual Meeting.
- 13.2.9 Communicate regularly with provincial nurses organizations and CNA about activities of the Association.
- 13.2.10 Perform such duties as delegated by the President.
- 13.2.11 Serve a one (1) year term with a three (3) year commitment to the Executive.

### **DUTIES OF THE PAST PRESIDENT**

#### **THE PAST PRESIDENT SHALL:**

- 13.3 Serve as an advisory member and mentor to the President.
- 13.3.1 Be responsible for facilitating National GI Nurses Day.
- 13.3.2 Submit an annual report to the membership at the Annual Business meeting.
- 13.3.3 Submit a report per issue of The Guiding Light.
- 13.3.4 Be responsible for maintaining and updating the website.

- 13.3.5 Act as a resource person to the Conference Planning committee.
- 13.3.6 Act as a resource person to vendors.
- 13.3.7 Serve a one year term.
- 13.3.8 Perform such duties as delegated by the President.

### **DUTIES OF THE SECRETARY**

#### **THE SECRETARY SHALL:**

- 13.4 Record the minutes of all meetings of the National Board.
- 13.4.1 Provide a summary of National Board meetings for submission in "The Guiding Light".
- 13.4.2 Forward the minutes of the meetings to all Board members and Chapter Presidents
- 13.4.3 Conduct all correspondence for the Association as directed by the Executive.
- 13.4.4 Compile the Annual Report for distribution to the members ninety (90) days prior to the Annual Meeting.
- 13.4.5 Be a member of the Bylaw Committee.
- 13.4.6 Issue notices of meetings, activities, and conferences to all members.

### **DUTIES OF THE TREASURER**

#### **THE TREASURER SHALL:**

- 13.5 Be responsible for collecting of fees from the members and deposit their fees in a chartered bank or trust company.
- 13.5.1 Maintain a bank account for the Society with a minimum of three signing officers appointed and two signatures required for any transaction.
- 13.5.2 Make such payments as are authorized by the Association.
- 13.5.3 Maintain records of expenditures of the Association.
- 13.5.4 Submit to the Executive, sixty (60) days prior to the annual meeting, a Treasurer's report for publication in the annual report.
- 13.5.5 Maintain financial records of chapter educational sessions and annual reports.

- 13.5.6 Automatically become a member of the Education Committee and Annual Conference Planning Committee.
- 13.5.7 Arrange for an Annual Audit to be conducted by a Chartered Accountant. This is to be an outside firm/person independent of the CSGNA or person therein.
- 13.5.8 Report on the Auditors accounts of the Association to the members in the Annual report.
- 13.5.9 Contribute a report per issue of "The Guiding Light".
- 13.5.10 The Treasurer shall be custodian of the seal of the corporation, which she shall deliver only when authorized by a Resolution of the board of directors to do so and to such person or persons as may be named in the resolution.

### **DUTIES OF THE MEMBERSHIP DIRECTOR**

#### **THE MEMBERSHIP DIRECTOR SHALL:**

- 13.6 Be responsible for collecting and maintaining documentation of all CSGNA members.
- 13.6.1 Issue membership cards and receipts to membership. Collect and maintain records of membership.
- 13.6.2 Forward to the Secretary and President every February a current list of all members of the Association and update as necessary.
- 13.6.3 Prepare a membership list for the publication and distribution to the members upon request.

### **DUTIES OF THE EDUCATION DIRECTOR**

#### **THE EDUCATION DIRECTOR SHALL:**

- 13.7.1 Be responsible for certification.
- 13.7.2 Form and chair the Education Committee.
- 13.7.3 Monitor CSGNA Education Fund in conjunction with the National Treasurer.
- 13.7.4 Establish criteria for use of the fund and review annually.

- 13.7.5 Provide direction to the Conference planning Committee regarding the CSGNA Annual Conference.
- 13.7.6 Review scholarship criteria annually.
- 13.7.7 Maintain records of all CSGNA education events.
- 13.7.8 Ensure that all CSGNA education events remit appropriate reports, financial statements and reimbursements.
- 13.7.9 Review and provides recommendations and approve educational content for CSGNA events.
- 13.7.10 Expand and improve publications, informational products and services that support the field of gastroenterology nursing.
- 13.7.11 Generate ideas for education that best meet the needs of the members.
- 13.7.12 Submit a report of activities of the Committee to the National Secretary ninety (90) days prior to the Annual Meeting for submission in the Annual Report.

**DUTIES OF THE PRACTICE DIRECTOR**  
**THE PRACTICE DIRECTOR**  
**SHALL:**

- 13.8 Monitor, record and update any practice guidelines, position statements and standards of the CSGNA.
- 13.8.1 Initiate new practice guidelines, position statements and standards required by the CSGNA.
- 13.8.2 Maintain a record/library of reference documents reflecting practice guidelines, position statements and standards.
- 13.8.3 Be a resource person for answering questions/concerns on practice guidelines, position statements and standards.

**DUTIES OF THE DIRECTORS**  
**THE REGIONAL DIRECTORS**  
**SHALL:**

- 13.9 Encourage and assist in the formation of chapters in their area.
- 13.9.1 Liaise with the Chapter Presidents and individual members in their Region about the work of the Association.
- 13.9.2 Report to the National Executive at regular intervals as deemed necessary by the Executive.
- 13.9.3 Attend a minimum of two meetings of the Executive in consultation with the National Board.
- 13.9.4 Respond with a written report in sufficient time for those meetings which cannot be attended.
- 13.9.5 Submit a report of activities and future plans for inclusion in the Annual Report, Ninety (90) days prior to the Annual Business Meeting.
- 13.9.6 Submit reports about their region's activities to the Newsletter.
- 13.9.7 There shall be two (2) Directors elected from each of Canada East, Centre, and West. One Regional Director will be elected yearly in each designated region, by the members of that region.
- 13.9.8 Canada East consisting of Prince Edward Island, Newfoundland, Nova Scotia, and New Brunswick.
- 13.9.9 Canada Centre consisting of Ontario and Quebec.
- 13.9.10 Canada West consisting of Manitoba, Saskatchewan, Alberta, British Columbia, Northwest Territories, Yukon and Nunavut.
- 13.9.11 Divisions of regions will be decided by the co-directors. The Director will then inform the National Board and members re their areas of responsibility.

**DUTIES OF NEWSLETTER EDITOR**  
**THE NEWSLETTER EDITOR**  
**SHALL:**

- 13.10 Set guidelines for submissions to "The Guiding Light".
- 13.10.1 Set deadlines for submissions to "The Guiding Light".
- 13.10.2 Pursue appropriate material for the newsletter.
- 13.10.3 Compile and edit submitted material for publication of the newsletter three (3) times annually.
- 13.10.4 Approve the final version of the edited newsletter prior to printing.
- 13.10.5 Provide updated membership list to the newsletter distributor and ensure mail out of newsletter to all membership in good stand.
- 13.10.6 Store copies of all previous newsletters.
- 13.10.7 Submit a report to the National Secretary ninety (90) days prior to the Annual Business Meeting for the Annual Report.
- 14.0 COMPENSATION
- 14.1 All CSGNA financial requests over \$200.00 must be approved by (2) Executives, one of which shall be the treasurer.
- 14.2 Verification of the appropriate receipts and the appropriate use of CSNA funds must be present before reimbursement.
- 14.3 No reimbursement shall be made without appropriate receipts.
- 14.4 The expenses of the outgoing executive will include those incurred at the Annual Conference at which their term of office is complete.
- 14.5 The expenses of the incoming Executive will be paid by CSGNA.

- 15.0 DISCIPLINARY ACTION
- 15.1 Members shall be subject to reprimand, censor, suspension or expulsion by a two thirds vote of the active members for violation of the Constitution and Bylaws or the Charter.
- 15.2 No such action shall be taken against a member until specific charges have been filed.
- 15.3 Members reprimanded, censored, suspended or expelled under the provision as stated may within thirty (30) days after notification of such action, request the Executive of the CSGNA to review any questions of law or procedure involved therein.
- 15.4 Executive members of chapters are subject to the same rules of compensation, discipline and removal as the National Executive.
- 15.5 A "conflict of interest" shall be defined as any situation or potential situation where an individual may gain or is perceived to gain, directly or indirectly from discussion on voting on said matters.
- 15.6 Any CSGNA member on a committee or in an Executive position, finding themselves in a conflict of interest, will remove themselves from voting on said matters.
- 15.7 Any CSGNA member who does not identify a conflict of interest, remains as a part of the discussion and/or voting process, may be asked to resign from the said committee and/or Executive position following a review by the National Executive.
- 16.0 REMOVAL
- 16.1 Officers elected by the membership may be removed by two thirds vote of the active members present at the Annual Meeting.
- 16.2 The successor will be the runner up in the previous election and remains in office until the end of the stated term. When there is no runner up or the runner up is not available to take office, nominations will be taken from the floor. If more than one nomination, a secret ballot will be held during the Annual Business Meeting.
- 17.0 PUBLICATION
- 17.1 The association shall publish three newsletters annually entitled "The Guiding Light".
- 17.2 It shall be sent to all members Winter, Spring, and Fall.
- 17.3 The Editor is responsible for compiling a comprehensive pertinent communique and distributing it free to all members in good standing.
- 18.0 EDUCATIONAL EVENTS
- 18.1 All CSGNA educational programs must complete an "Educational Pre-Program Proposal" form and submit it along with their budget to a regional Director six (6) weeks prior to the event.
- 18.2 The proposal will be approved by a Director and the Education Committee Chair one (1) month prior to the event.
- 18.3 If the program is being presented by a director approval by another Director and the National Treasurer must be obtained.
- 18.4 Chapters will have their educational program and budget approval by the Chapter Treasurer, a Director of their region and the Education Chair one (1) month prior to the event.
- 18.5 If the program and/or budget is not approved by either the Director of the Education Chair, it must be brought to the immediate attention of the President or in his/her absence the President Elect.
- 18.6 The above will result in a discussion with the individual presenting the program and acceptance or rejection of the proposed program and/or budget.
- 18.7 Upon completion of any CSGNA educational program (including chapters), a final report on the "Education Post-Program Report" form must be submitted to the National Treasurer within one (1) month of the event.
- 18.8 The Treasurer will review the report and forward a copy to the Education Chair for the retention in the CSGNA records.
- 18.9 All CSGNA events, sponsored or held by chapters or individual members, shall remit twenty five percent (25%) of all profits generated, to the national Society to support programs for the general membership. (i.e. guidelines for practice, certification process etc.)
- 18.10 Any CSGNA member hosting/conducting an educational or fund raising event utilizing the CSGNA title shall have a bank account requiring two (2) signing officers, both members of the CSGNA.
- 18.11 All CSGNA chapters shall remit twenty five percent (25%) of all profits at year-end December 31, with their financial report for that said year.
- 18.12 An extenuating circumstances needing an extension must be obtained from the National Treasurer and President.
- 18.13 The remainder of profits raised by chapters at CSGNA designated events are to be used for needs as determined by its membership.

- 18.14 The remainder of profits raised by CSGNA members shall be placed in a bank to organize future CSGNA educational meetings, supporting chapter formation costs, and to pay for bank account expenses. (i.e. service charges).
- 18.15 The national CSGNA shall remit ten percent (10%) of the profits from the annual conference meeting to the CSGNA chapter hosting the event. This reimbursement shall be an exception to bylaw 17.3.1 but should be acknowledged in bylaw 17.3.9.
- 18.16 All CSGNA chapters will submit an annual financial report to the National Treasurer at fiscal year end December 31.
- 18.17 All chapters should be available for audits at the request of the National Treasurer.
- 19.0 STANDING COMMITTEES
- 19.1 BYLAWS COMMITTEE
- 19.1.1 Shall consist of the President Elect, President, Secretary, and three regional directors. One director from each region; East, Centre, and West. The committee shall meet at the Spring Board meeting and by teleconference if deemed necessary to complete the bylaws revisions.
- 19.1.2 Shall be chaired by the President Elect.
- 19.1.3 Reviews bylaws and all recommendations for bylaw revisions submitted by members annually and make amendments as necessary.
- 19.1.4 All revisions will be presented to the board of directors at the spring board meeting for approval before submission to the membership for a vote.
- 19.2 NOMINATING COMMITTEE
- 19.2.1 Shall consist of the President and three members as large.
- 19.2.2 It shall be chaired by the President.
- 19.2.3 Duties: recommend candidate(s) for each office. Each nominee must be a member in good standing and must signify his/her consent to stand for office.
- 19.2.4 Mail ballots to the membership.
- 19.2.5 Count the ballots and announce successful candidates to the membership at the annual business meeting.
- 19.2.6 Report tabulations to the Executive for recording in the minutes.
- 19.3 EDUCATION COMMITTEE
- 19.3.1 Shall consist of one regional director from each region, at least four members at large. Effort should be made to include all facets of the specialty. i.e., research, endoscopy, management and general GI wards.
- 19.4 VENDOR RELATIONS COMMITTEE
- 19.4.1 Shall be chaired by Canada Centre Director.
- 19.4.2 Shall consist of Canada Centre Director, Treasurer and one Western Director.
- 19.4.3 Duties: liase with vendors, promote, encourage, maintain relationships, maintains accurate records of vendor recognition, review recommendations of vendor evaluations at the end of each conference, makes recommendations to the executive at the spring meeting, meets annually.
- 19.5 FINANCE COMMITTEE
- 19.5.1 Shall be chaired by the treasurer.
- 19.5.2 Shall consist of Treasurer, one East and one West Director.
- 19.5.3 Duties: reviews and audits financial statements, monitors financial policies, recommends budget, meets as is necessary, reports at each meeting.
- 20.0 SPECIAL COMMITTEES
- 20.1 The Executive, at a general meeting, may appoint a special committee and give it the power as necessary to discharge its duties.
- 20.2 A written report shall be submitted to the Executive upon completion of the special committee's duties.
- 21.0 CHAPTERS
- 21.1 Definition: a chapter is a geographical area (city, region, or town) where ten (10) or more active members reside.
- 21.2 They may apply to the Executive for charter as chapter.
- 21.3 Mandate: a chapter shall, in conjunction with its Regional Directors, coordinate educational activities and functions of the CSGNA within its designated area.
- 21.4 Criteria for formation of chapters: A minimum of ten (10) active members (hereinafter referred to as the local group) must apply to the Executive.
- 21.5 The local group and the Regional Director will determine geographical boundaries for the chapter.
- 21.6 The Executive will supply a list of all active members in the region.
- 21.7 The local group must call for nominations form that list and notify all members of a meeting and election.
- 21.8 The number of officers required for the chapter executive shall initially be determined by the local group and henceforth by the Executive of the chapter
- 21.9 The National Executive of the Society must be notified within thirty (30) days of the election results and of the title of the chapter.
- 21.10 The name CSGNA must appear within the title of the chapter. (e.g. The Edmonton Chapter of the CSGNA)

- 22.0 CHAPTER DUTIES
- 22.1 Promote the Association in its area and encourage membership.
- 22.2 Be sensitive to the concerns and problems of its area and communicate them to its Directors for discussion at the National Executive.
- 22.3 Tabulate the activities of its area and submit details to its Directors for inclusion in the Newsletter and Annual Report.
- 22.4 Elect officers to include president, secretary and treasurer.
- 22.5 Officers shall hold office for two (2) years or until their successors are elected.
- 22.6 There shall be no restrictions upon the number of terms to which an officer may be elected to succeed themselves.
- 22.7 No officer may hold more than one office at a time.
- 22.8 Open and maintain a bank account for the chapter with a minimum of two (2) signing officers.
- 22.9 Membership fees are paid directly to the National office.
- 22.10 A one time one year zero percent (0%) loan may be available to a local group for chapter formation upon application to the National Executive.
- 22.11 Plan a minimum of four (4) education hours per year for the membership in its area. Notification to be sent to the respective members a minimum of 14 days prior to the event.
- 23.0 A CHAPTER MAY BE REVOKED FOR THE FOLLOWING
- 23.1 At the request of the chapter.
- 23.2 Failure to have ten (10) active members. (Until such time that there is one (1) chapter in each province this minimum number may be waived.)
- 23.3 Repetitive failure to respond to communication requests.
- 23.4 Failure to meet the minimum of four (4) education hours per year for the membership in its area.
- 23.5 Failure to assume responsibility for its actions and to comply with CSGNA bylaws.
- 23.6 The chapters President will report to the CSGNA National Executive any Chapter having serious internal problems or failure to meet charter requirements.
- 23.7 Chapter President will report any problems to the Regional Director.
- 23.8 The Regional Director will make arrangements for the chapter and its executive to meet with the CSGNA President or a member of the CSGNA National Executive for the purpose of evaluating the problems.
- 23.9 The results of this meeting will be presented to the National Executive at the next regularly scheduled executive meeting.
- 23.10 The CSGNA National Executive will determine the outcome for the Chapter.
- 23.11 A probationary period of twelve (12) months may be granted to comply with charter requirements.
- 23.12 The chapter may be revoked.
- 23.13 A chapter may also belong to its Provincial Nurses Association provided there is no conflict of interests with the CSGNA.
- 24.0 DISSOLUTION
- 24.1 CHAPTER OR NATIONAL
- 24.2 In the event of dissolution, the chapter executive, after payment of or making provisions for the payment of all liabilities, shall dispose of the assets of the chapter by forwarding the asset to the CSGNA National Executive.
- 24.2 In the event of dissolution of the Society, after payment of or making provisions for payment of all liabilities, shall dispose of the assets to one or more Canadian non-profit Association with similar activities to the CSGNA. (i.e. AORN, ERN, or Geriatric Nurses Association.)
- 25.0 AMENDMENTS
- 25.1 Active Members may submit recommendation for amendments to these bylaws to the Chair of the Bylaws Committee no later than 180 days prior to the Annual Business Meeting. All recommendations will be reviewed. Recommendations inconsistent with or contrary to the current Bylaws or the goals and objectives of the CSGNA will be returned to the member.
- 25.2 Members shall be notified of the proposed amendments in writing, to be included with the information of the annual meeting.
- 25.3 Vote shall be by mail to be received by the committee chair not later than 60 days prior to the Annual Business Meeting. To pass two thirds of the membership must vote in favour of an amendment. All members not voting will be considered a "yes" vote.
- 25.4 Any bylaws of the corporation repealed or amended shall not be enforced or acted upon until the approval of the Ministry of Industry has been obtained.
- 26.0 PARLIAMENTARY AUTHORITY
- 27.0 The rules contained in the current edition of ROBERTS RULES OF ORDER shall govern the Association in all cases to which they are applicable and which are not inconsistent with these bylaws.

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## POSITION STATEMENT

### *Reuse of Single Use Items*

#### **Position**

In the absence of clear regulatory guidelines for the reuse of single use medical devices, based on current scientifically based literature, and taking into consideration concerns for patient safety and ethical practice, The Canadian Society of Gastroenterology Nurses and Associates, support the position that critical medical devices labelled for single use should not be reused.

#### **Definitions**

**Reuse** – refers to cleaning, packaging and sterilization of a single use medical device on a patient for the intended purpose using it on another patient.

**Critical Device** – those which break the mucus membrane, coming into contact with sterile tissue or the vascular system.

#### **Background**

This statement is intended to address the controversy surrounding the issue of reuse of critical devices packaged and labelled for single use. Cost containment concerns have led some Health Care Facilities to consider the reuse of single-use critical medical devices. Manufacturers are required to conduct very stringent testing for reusable products. They must meet FDA criteria to validate that a device may

be cleaned and, if necessary re-sterilized in order for it to be labelled “reusable”. These same stringent tests are not required for items intended for single-use. Based on the result of these required tests, the manufacturers have defined the recommended usage on package labels. The topic of reuse raises concerns about the ability to clean single-use critical devices, how well a device holds up after sterilization, and how many times a device can be used while maintaining patient safety and mechanical effectiveness. Many devices whether labelled as single use or reusable, appear identical on visual inspection. However, manufacturers may for a number of reasons change the material used in the production. Changes in material may not be obvious on visual inspection, but unless the device is labelled reuse, the new materials may not be able to withstand the heat of chemicals required for sterilization.

#### **Disclaimer**

The Canadian Society of Gastroenterology Nurses and Associates assumes no responsibility for the practices or recommendations of any member or other practitioner or for policies and practices of any endoscopy unit.

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## POSITION STATEMENT

### *Use of Reusable Medical Devices Recommended Guidelines in Endoscopy Settings*

#### **Terminology**

**Reuse** – The process by which a reusable device that has come into contact with a patient is cleaned, decontaminated, reconditioned/refurbished, and disinfected or sterilized prior to subsequent use on the same or another patient.

**Reprocessing** – The process by

which a pack, which is opened but unused, is repackaged and sterilized.

**Resterilization** – The further processing of a product (which was sterile and unopened) due to a passing expiry date or for its inclusion into larger pack.

**Non-critical Device** – Any device that comes in contact with intact skin

e.g. blood pressure cuff.

**Semi-critical Device** – Any device which comes in contact with mucus membrane. e.g. endoscopes

**Critical Device** – Any device which comes in contact with sterile areas of the body or the vascular system. e.g. biopsy forceps and sphincter tomes

## Background

Attention must be given to the reuse of medical devices. Contaminated and unsafe medical devices pose a potential source for cross contamination, infection and injury to patients and personnel. Strict guidelines are needed to standardize the process of reusing medical devices. The guidelines are intended to assist institutions and Endoscopy units in the development of their specific needs. Providing the best possible care is the ultimate mission of each healthcare institution and the professionals who staff it. An integral component of delivering quality care is instrumentation. Most Endoscopy procedures are performed on an outpatient basis. The volume of procedures scheduled each day is often high. Whether that schedule can be met and each patient given high quality care is dependent on device reliability and safety.

The reuse of critical and semi critical devices has become a common practice in many institutions.

The reuse of medical devices is a practice undertaken primarily for economic reasons as a means to maximize the effective usage of a particular nondisposable device. It is estimated that 41% of Canadian hospitals reuse medical devices of some kind. Only the devices labeled reusable can be reused.

Due to this concern the CSGNA decided to establish some guidelines and recommendation for reuse of reusable medical devices.

## Recommendations for Reuse

All reusable medical devices must be placed into three categories:

1. Critical
2. Semi-Critical
3. Non-Critical

The process for reuse, reesterilizing and reprocessing is determined by the category in which the medical device is classified.

Reprocessing of reusable endoscopic devices include the following steps:

- Transport to the reprocessing area
- Soaking
- Brush cleaning

- Rinsing
  - Ultrasonic cleaning
  - Inspection
  - Drying
  - Lubrication
  - Packaging
  - Sterilization according to Manufacturer's Recommendation
  - Transport back to the Endoscopy suite
  - Inspection
  - Prepare for use
- {Refer to CSGNA Infection Control: Recommended Guidelines in Endoscopy Setting}

## Reusable Device Reprocessing and Validation of Performance

- Requires thorough policy and procedure program
- Requires assignment of responsibility to highly qualified individuals
- Must ensure integrity of the device

## Issues to Consider to Meet Performance Standards

- Strict adherence to the Manufacturer's Instructions for Reprocessing
- Clinically Proven Device
- Inspect Upon Opening Package
- Necessity to Perform Multi Step Cleaning Process and High Level Disinfection/Sterilization Process
- Ensure Adequate Backup Inventory
- Establish Protocol for Reprocessing
- Establish Protocol for Inspection and Repair
- Establish Training and Retraining Protocols for Staff
- Establish Institutional Policy/Standards to determine maximum number of use for the device

Preventing patient infection means that the device must be free of contamination. Preventing injury means that the device must function according to specifications without degradation of parts that might become dangerous to the patient or staff. Perhaps the most significant risk of injury from product degradation is the fraying of electrical sheaths due to reprocessing plus normal wear and tear during procedures. This is difficult to monitor even with close inspection. The potential of injury to the patient may be significant.

## ISSUES IN REUSE

### 1. Risk of infection

- a) Thorough cleaning: Thorough cleaning is the most integral part of reprocessing. Concern is expressed regarding mechanical parts being difficult to clean, and that porous material, such as plastic, may absorb contaminants and chemicals.
- b) Sterilization: Most manufacturers recommend steam sterilization. Gas is excellent in sterilizing provided the equipment is free from all blood and other organic materials. The item should be dry because the presence of saline or water may form a poisonous chemical in the presence of gas. With the elimination of chlorofluorocarbons (CFCs), which are required for most gas sterilizers, institutions are switching to other technologies. Check manufacturer's label for reprocessing.
- c) High Level Disinfection: High level disinfection may be appropriate for semi-critical devices, but the effect on functionality must be assessed.
- d) Risk to personnel: Personnel performing the reprocessing of the item are at risk if being exposed to body fluids and/or cleaning, disinfection or sterilization products. Personnel must follow the Health and Safety recommendations outlined in the CSGNA Infection Control Guidelines.

### 2. Medical Device Integrity

It is necessary to assess what effect the high level disinfection or sterilization process will have on the integrity and functionality of the device. The number of reuses should be based on manufacturer guidelines.

### 3. Cost-effectiveness

Institutions should consider the following; cost of labour, supplies and machine use, storage, quality assurance programs, overhead, possible additional liability insurance and possible increase in price of an item if fewer are used. There are also protocol development costs and educational costs to consider.

#### 4. Legal Issues

The manufacturer's labelled information on care and usage of reusable products must be adhered to. When infections occur or injuries take place due to an instrument selected and maintained by the institution, there is a potential for significant legal liability. Instruments that are continually reprocessed can increase that risk. Disposal of the instrument after its useful life must be performed according to institutional and governmental regulations. Liability may be avoided or reduced if a reasonable standard of care can be demonstrated, including the adherence to established hospital guidelines on reuse.

#### 5. Ethical Issues

Must the patient be informed that the instruments/devices being used for their procedure is a reusable device? Is this part of an informed consent? Usually, specific consent is not obtained from the patient. The risk of the procedure in general is described to the patient in the same manner whether it is a new or reusable device.

It has been suggested that internal procedures must be developed, approved by the Board of Directors, and that hospital policy must become public policy. The debate revolves around the social responsibility of stakeholders to society and to individuals.

#### SUMMARY

There is a high volume of endoscopic procedures performed in many institutions. For both the patient's safety and the financial health of the institution, it is important that these procedures be performed reliably, safely and efficiently.

Most of the devices used in endoscopic procedures are classified as critical or semi-critical. The threat of potentially life threatening malfunction can lead to patient/staff injury or needless prolongation of the procedure.

Reusable devices provide assured first use performance. After that, a series of steps must be performed to ensure that they are properly reprocessed and provide acceptable performance during subsequent procedures.

It is important that each institution be fully aware of the issues involved in device selection. Institutions that choose to reuse devices needs to validate the sterility and integrity of the reprocessed devices, and have in place detailed protocols to include mechanisms for ongoing evaluation and quality assurance monitoring.

#### DISCLAIMER

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policies and practices of any Endoscopy unit.

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### POSITION STATEMENT

## Recommended Guidelines for Preventing Allergic Reaction's to Natural Rubber Latex

#### Definition

Natural latex is a milky fluid obtained from the hevea braziliensis (rubber) tree found in Africa and South-east Asia. Various chemical agents such as vulcanizers, accelerators, stabilizers and anti-oxidants are added to natural latex.

#### Background

The latex allergy is an enormous public health problem faced by health care workers and patients. Healthcare

workers have become the fastest group to experience latex sensitivity and more often its adverse affects.

Latex is a common component in health care products and consumer products. In 1989 there were 400 reported anaphylactic reactions and 15 deaths due to latex contact. The implementation of universal precautions in 1987, to prevent HIV and other blood borne pathogen infections resulted in an increased demand for gloves. Manufacturing processes may

have temporarily changed to meet this dramatically increased demand for gloves, resulting in latex products with higher allergic and irritant properties being produced and used. Repeated exposure to latex products can cause hypersensitivity reactions locally and systemically. Reducing exposure to latex products will definitely decrease sensitization and symptoms. There is no treatment for latex allergy except complete avoidance of latex.

**Goals in Management:**

The two major goals in the management of latex reactions are successful identifications and treatment of all dermatitis, to prevent future sensitization and identification of latex allergy to prevent serious life threatening sequelae whenever possible.

**Types of reactions to latex:****a) Irritant contact dermatitis**

- most common type of reaction
- not an allergic reaction involving the immune system but rather a skin irritation caused by the chemicals added to the latex during the manufacturing the glove powder itself, repeated irritation from sweating under the gloves or from gloves rubbing against the hands characterized by dry, flaky skin and papules, redness, fissures and thickening of skin.

**b) Allergic contact dermatitis:****Type IV**

- delayed type hypersensitivity
- a cell mediated allergic reaction to the chemicals used during the processing of latex. The more common sensitizers/ allergens are thiurams and carbamates (accelerators).
- results from prolonged contact with these chemicals in gloves
- symptoms usually appears 6-48 hours after exposure
- characterized by localized redness, clustered vesicles, swelling, itching cracking, eczema and fingertips fissures.

**c) Immediate allergic reaction:****Type I**

- an immediate immunoglobulin E mediated allergic response to the latex protein themselves
- reaction usually occurs 5-30 minutes after exposure
- the response is introduced by direct contact with latex on non-intact skin resulting in sensitization before manifesting as a generalized reactions
- Once sensitivity has been initiated, any contact with latex may cause a recurrence of the reaction.

- The protein allergens have been found in water-soluble extracts from latex rubber film. It may also be absorbed by glove powder, which may become airborne.
- The severity of the immediate reaction will depend in the route of exposure; cutaneous, mucosal, inhalation and parenteral, the amount of latex allergen and the degree of individual sensitivity.
- Mild reactions involves skin redness – hives – itchiness
- More severe reactions may imply edema, itching, conjunctivitis around the eyes, rhinitis, nasal itching, sneezing shortness of breath, asthma, airway obstruction due to bronchospasm, anaphylactic shock

**Risk factors for latex sensitivity & allergy**

- persons with spina bifida
- patients and congenital urogenital defects, history of indwelling urinary catheters of repeated catheterizations.
- Patients who have undergone recurrent surgical procedures
- workers with ongoing latex exposure – health care workers, housekeepers, food handlers, tire manufacture workers, workers in industry who use gloves regularly.
- atopic individuals – persons with multiple allergic conditions, eczema, asthma, rhinitis
- individuals allergic to certain food, banana, avocado, chestnut, apricot, kiwi, papaya, passion fruit, pineapple, peach, nectarine, plum, cherry, melon, fig, grape, potato, tomato and celery may cause a cross reactivity with latex protein. No treatments are available to cure latex allergy. The best treatment is to avoid exposure. The treatment for individual allergic to latex is to ensure a safe environment. Medications are available to alleviate the allergy symptoms.

**Recommendations:****Patients**

- All patients are assessed for adverse

reactions or contraindicated substance during their admission assessment. We should provide a latex safe hospital environment for patient allergic and sensitive to latex.

- History for presence of allergies such as hay fever, childhood or adult eczema, asthma and food allergies.
- Multiple surgeries
- Undiagnosed reactions or complications during surgery anesthesia or dental work-angioedema, shortness of breath, rash.
- History of latex exposure: type of latex device, nature and duration of exposure.
- History of latex allergy such as cutaneous symptoms (dermatitis-eczema-urticaria) respiratory symptoms, (rhinitis, wheezing, coughing, sneezing, shortness of breath).
- Any respiratory symptoms experienced when in contact with products containing rubber.
- Other symptoms such as itchy hands, conjunctivitis, localized angioedema, possible systemic anaphylactic symptoms with the use of household latex cleaning gloves, balloons, condoms and diaphragms.

**If a patient has any of the above categories the following measures should be taken**

- Patients with severe documented allergy to latex should be assessed for the need of a private room.
- A cart containing all latex free supplies that are necessary for patient care from admission to discharge. This cart will follow patient to other departments.
- Wear non latex examination and sterile gloves. Vinyl gloves should be changed every 15 minutes to protect the health care worker from blood borne pathogens.
- Identify chart, patient, bed, medication profile, Kardex, physician order sheet with latex allergy stickers.
- Post latex allergy sign on patient's door.
- Wear a cover gown if the possibility that your uniform contains residues of powder from latex gloves.

- Tape over IV tubing ports and do not use.
- Do not inject via T-connectors, buritrol or IV bag, inject and administer medication only through plastic stopcock.
- Remove rubber stoppers from vial then draw up medication. Needle puncturing a rubber stopper can shear off particles of latex, and cause a systemic reaction.
- Glass syringe or latex free syringe must be used, if plastic syringe are used, the solution must be injected immediately after being drawn up.
- If pulse oximetry is used, cover finger with tegaderm then apply probe. The inside surface of most pulse oximeters is covered with latex.
- Avoid skin contact with the bulb and tubing of the blood pressure cuff by placing cloth under the rubber to shield the skin.
- Stethoscope tubing can be covered with a stockinette.
- If catheterization is necessary, use silastic foley catheter.
- Utilize single dose ampules for parenteral medication
- Patient that are highly reactive, may require medications at the bedside.
- Epinephrine should be available if an anaphylactic shock occurs.
- If the patient develops an allergic reaction, remove suspected allergen and provide immediate care.
- All staff interacting with this patient must follow proper hand washing procedures before caring for these patients in order to minimize the exposure to and transfer of latex protein.

#### Health Care worker:

Health care workers should protect themselves from latex exposure and allergy in the workplace:

- Use non-latex gloves for activities that do not involve contact with blood or body fluid
- For activities where contact with infectious materials is expected and latex gloves are used, choose a reduced protein, powder free glove.
- Workers with hand dermatitis, should never wear oil hand cream or lotion with latex gloves. Oil breaks down latex, damages the glove barrier and release additional allergen. Detergents and other chemicals also degrade latex glove.
- After removing gloves, wash hands with soap and dry thoroughly, never reuse glove.
- If you experience any symptoms possibly related to latex allergy, report it to Health and Safety Department, avoid contact with latex gloves until you see your allergiologist.
- Attend latex allergy education session.

#### If allergic to latex:

- 1) Avoid contact with latex gloves, latex containing products and objects such computer keyboards, telephones, that have been in contaminated with latex gloves or glove powder.
- 2) Avoid areas where you might inhale the powder from latex gloves worn by other workers.
- 3) Wear medical alert bracelet
- 4) Attend latex allergy education session.
- 5) Carry an emergency epinephrine auto-injector.
- 6) Avoid cross reacting food such as; kiwi-avocado-chestnut
- 7) Follow your physician's instructions for dealing with allergic reaction to latex

#### Institution

To eliminate or reduce the risk for latex sensitization of asymptomatic staff and minimize the risk of latex exposure to staff already sensitized.

- a) eliminate unnecessary use of latex gloves by providing workers with non latex gloves when there is minimal potential for contact with blood or bodily fluid.
- b) When selecting a latex glove for barrier protection from infectious materials, choose a reduced protein, powder free glove. Glove should be approved by the Canadian General Standard Board.
- c) Provide education to employees about latex allergies hand care and the importance of early care for der-

matitis or other allergy symptoms. Identify and instruct worker in work practices to prevent exposure.

- d) Implement a latex allergy assessment protocol including a screening history questionnaire and protocol of evaluation and treatment of latex reaction symptoms.
- e) Conduct a worksite evaluation, identify areas contaminated with latex dust and make sure cleaning is done more frequently. Ensure that filtration and ventilation systems provide adequately recirculated air in area with high levels of latex aerosols.
- f) Alternative latex free devices must be available.
- g) Identification of medical product containing latex.
- h) Incorporate latex allergy education as part of the annual safety and infection control program, orientation program and also conduct inservices.

Once a diagnosis of latex allergy is confirmed, the employee should accommodate the affected workers. Extremely sensitive individuals may have to be re-assigned to areas where no latex gloves are used.

#### Disclaimer

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## POSITION STATEMENT

# Responsibilities of the Registered Nurse Related to Conscious Sedation

### Position

The Canadian Society of Gastroenterology Nurses and Associates supports the position that registered nurses trained and experienced in Gastroenterology nursing and endoscopy may be given the responsibility of administration and maintenance of conscious sedation in the presence of and on the order of a physician. In addition, the Registered Nurse may be given the responsibility for the administration of reversal agents prescribed by the physician. The Registered Nurse must have education, knowledge of medications used and skills to assess, diagnose and intervene in the event of complications. Whether or not the registered nurse actually administers the sedative/analgesic, the Registered Nurse is responsible for assessing and monitoring the patient throughout the procedure and post procedure phase of the patient's care.

A second Registered Nurse may be required to assist during procedures requiring complex technical requirements or in procedures that are complicated due to the severity of the patient's illness.

Automatic monitoring devices may enhance the ability of the registered nurse to accurately assess the patient, but are no substitute for the watchful, educated assessment by the Registered Nurse.

The Registered Nurse is accountable for the responsibilities he/she accepts. The registered nurse functions within the limitation of the institutional policies and the provincial governing bodies.

### Definition

Conscious sedation provides a minimally reduced level of consciousness in which the patient retains the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

### Background

Conscious sedation is commonly used during diagnostic and therapeutic Endoscopic procedures. The safe administration and maintenance of conscious sedation is one of the most important responsibilities of the Registered Nurse working in an Endoscopy Setting. Care of the patient undergoing a diagnostic or therapeutic

Endoscopic procedure continues to be more critical in nature, more complex in technology and more comprehensive in scope. Nursing care of the patient has changed to include a continuous comprehensive nursing assessment, administration and maintenance of conscious sedation in the presence of a physician, administration of reversal agents, utilization of equipment during the endoscopic procedures, and comprehensive documentation.

### Disclaimer

The CSGNA assumes no responsibility for the practices or recommendations of any member or other practitioner or for the policies and practices of any Endoscopy unit.

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## POSITION STATEMENT

# Role Delineation of the Advanced Practice Nurse in Gastroenterology

### Position

The APN provides service through direct care, consultation, research, education and collaboration with other healthcare professionals. The specific patient population to whom direct care is provided includes Adults, Adolescents, and Children with Gastrointestinal Disorders/Disease or at risk of developing Gastrointestinal Disorders/Disease. The APN may function in a Hospital, Clinic or Community Setting. The care provided may include, but is not limited to advanced assessment, diagnosis, treatment/care planning, implementing, and evaluation and patient education.

### Definition

Role delineation is a description of the responsibilities and functions of a nurse in a specific role, including the current activities common to this role.

### Background

The changing health care environment has led to the development of Advanced Practice Roles in many settings in Canada. Recognizing that the role is still evolving and recognizing the opportunity for Advanced Practice in the field of Gastroenterology, the following is a statement of the CSGNA Position. The purpose of this statement is to broadly describe the responsibilities and functions of the Advanced Practice Nurse specializing in Gastroenterology. The APN may be a Nurse Practitioner, Clinical Nurse Specialist, or a Nurse Endoscopist who through study and clinical practice has met the Provincial Licensing criteria

for advance practice in the field of Gastroenterology. The scope of practice of the APN is distinguished by the level of complexity, responsibility and autonomy of practice. The APN functions within the scope of practice as defined by the Provincial Licensing Body, the CNA Guidelines for Advanced Nursing Practice in Canada and the Employer.

### Role of the APN

The role of the APN includes, but is not limited to the following:

- Performing a comprehensive history and physical assessment.
- Ordering and/or performing diagnostic studies.
- Establishing medical and nursing diagnoses.
- Prescribing, administering and evaluating pharmacological and other therapeutic treatment regimens.
- Managing follow up care.
- Collaborating with other health care Professionals.
- Acting as a consultant for other health care providers regarding the care of patients.
- Serving as a mentor for other Nurses.
- Identifying and providing learning opportunities for other health care providers.
- Documenting patient data to ensure continuity of care.
- Establishing priorities and making ethically sound decisions to ensure safe patient care.
- Identifying groups, families, individuals at risk and developing a plan

to address those risks, including education programs, screening programs and patient education materials.

- Participating in research and use of scientific findings to improve patient outcomes.
- Monitoring performance by developing and participating in Quality Management Activities.
- Being a leader in professional and practice issues.

### Disclaimer

The Canadian Society of Gastroenterology Nurses and Associates does not assume responsibility for the practices or recommendations of any individual, or for the practices and policies of any gastroenterology Unit or Endoscopy Unit

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*POSITION STATEMENT*  
**Guidelines for the  
 Care of the Patient Receiving Conscious Sedation**

**Note:**

This standard should be considered in combination with the procedure specific practical guidelines.

**Definition**

I.V. Conscious Sedation is produced by the administration of pharmacologic agents. A patient under conscious sedation has a depressed level of consciousness but retains the ability to independently and continuously maintain a patent airway and respond appropriately to physical stimulation and or verbal command.

**Pre Procedure**

The RN will ...

1. Complete the nursing history and assessment for, particularly noting prior response to: IV Sedation (Valium, Demerol, Fentanyl, Versed, etc.) Use of narcotics, benzodiazepines or other analgesic sedative or "social" drugs.
2. Inform the patient of restrictions related to driving or using equipment requiring clear judgment or quick physical responses. It is advised not to drive for 24 hours.
3. Advise patients against ingesting alcohol for 24 hours post sedation.
4. Assure the patient has made discharge transportation arrangements according to hospital policy.
5. Document findings and inform physician of significant findings.

**Intra Procedure**

The RN will ...

1. Document medications received by the patient.

2. Provide and document minimal monitoring of all patients including: BP, pulse, respirations, level of consciousness, temperature and dryness of skin and pain tolerance at the initiation, during and at the completion of the procedure. As indicated by the patient response, assessment may be more frequent.
3. Monitor O<sub>2</sub> saturation and heart rate as determined by continuous pulse oximetry.
4. Ensure the immediate availability of Emergency Equipment, e.g. Oxygen, oral airway, ambu. bag, medication to reverse the effects of narcotics and benzodiazepines.

**Post Procedure**

The RN will ...

1. Assess BP, heart rate, respiratory rate depth and effort and level of consciousness on admission to recovery area, after 15 minutes, until stable and at discharge. Post procedure oximetry must be performed until the patient's respiratory status is stable or returned to pre-procedure state.
2. Assess and document unexpected events and post procedure complications as related to sedation and taking interventions as required.
3. Assist and accompany patient to the bathroom, assess presence of orthostatic hypotension.
4. Assess gait prior to discharge.
5. Remove IV access prior to discharge, assess site and document.
6. Reinforce pre procedure teaching regarding driving, equipment operation and making decisions requiring

judgment. The teaching provided should be in written form and a copy given to the patient prior to discharge.

The Registered Nurse functions within the limitations of the provincial licensing body and Institutional policies.

**Disclaimer**

The CSGNA assumes no responsibility for the practices or recommendations of any member or other practitioner or for the policies and practices of any Endoscopy unit

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## ADVERTISING

The CSGNA Newsletter "The Guiding Light" welcomes requests for advertisements pertaining to employment. A nominal fee will be assessed based on size. For more information contact the editor.

**Kay Rhodes**  
 kay.rhodes@swchsc.on.ca

## POSITION STATEMENT

## Recommended Guidelines for Documentation in the Endoscopy Setting

### Terminology

The health record includes documentation of care by all disciplines.

### Background

The information contained in this document pertains to both Inpatient and Outpatient settings. Each Endoscopy setting is different and to provide information that is easily adaptable to each patient care environment these guidelines include documentation for three components: Assessment, Procedure and Post-Procedure. The intent is not to provide a specific documentation form, but to provide information and criteria that can be selected in formulating an individualized document that meets the requirements of the institutional policy and to the Endoscopy setting. Policies for documentation are a minimal expectation.

### Purposes of Documentation

#### 1. Communicating Client Health Information

The health record facilitates communication by making information about the client available in a permanent form to all health care providers. In order for all providers to have access to the record, consideration also needs to be given to where individual pieces and the total record itself are kept.

#### 2. Providing Continuity of Care.

The health record facilitates continuity of care by enabling nursing staff and other health care providers to use current and consistent data, problem statements, diagnosis, goals, and strategies. By reading and using documented information, Nurses are able to be more systematic in providing effective nursing care. The health record facilitates continuity of health care providers to use (One such example of this is health teaching).

#### 3. Demonstrating Accountability.

Documenting in the health record

demonstrates accountability. Nurses are accountable or responsible for the care they give. Since records are considered to demonstrate the nurse's accountability, the record may be used to settle concerns or questions about the care that was given. Nursing documentation is normally readily admissible in legal proceedings. Facts documented at the time an event occurred are generally regarded to be more credible than an oral account of events from memory.

#### 4. Providing Quality Assurance

Documentation is often an integral part of quality assurance mechanisms to evaluate the quality of care. Whenever records are reviewed as part of quality assurance, it is assumed that quality of care is reflected in the documentation. Records as a quality assurance tool however may reflect poor documentation rather than poor care. If so either the system or the documentation requires improvement.

#### 5. Facilitating Research

The health record can be a valuable source of data for health research. From a nursing perspective, the health record can be used to assess nursing intervention, and evaluate patient outcomes, as well as identify care and documentation issues. Accurate recorded information is essential to providing accurate research data.

### Principles of Documentation

1. Documenting Care is an Integral Part of Giving Care. Nursing Documentation should include evidence of the following:

- Assessing the patient's health status including identifying problem/strength statements or nursing diagnosis.
- Developing a plan of care
- Implementing the plan
- Evaluating both the nursing strategies and patient outcomes.

It is important for nurses to document their actions in carrying out both

their independent and interdependent roles – For example documenting social interaction and health teaching is as important as documenting medication administration.

The health record is a vital communication link between health-care providers. For this reason, it is important that relevant information exchanged between professionals is documented. For example when a nurse calls a Dr., he or she documents both what was reported to the physician and the physicians response.

2. Documenting Practices are Consistent. Current and accessible policies are needed to facilitate consistent documentation. Following your establishment's policies is a minimal expectation in documenting care given. Nurses must ensure that they understand any existing policies and advocate improvements in them. Governing Agencies such as the College of Nurses of Ontario suggests that nursing records contain at least:

- The name and address of the client, the location in which care was given, the date and time of the interaction and the time of recording.
- The subjective and objective data obtained on assessment and the nursing diagnosis or clinical judgment made.
- The care plan.
- Outcomes, results, and observations of the care provided

3. The Forms Facilitate the Documentation.

Forms provide a framework to guide documentation.

In Endoscopy one of the most common forms for documenting is the flow sheet. Flow sheets can be helpful in documenting routine and frequently needed information accurately and concisely. When documenting on the flow sheet it is advised that nurses initial rather than tick space to dem-

onstrate accountability for giving that care. Space needs to be available so that each care provider can be identified. Flow sheets are part of the permanent record and are legally recognized, however the use of flow sheets does not eliminate the need for other documentation. The patient's acuity is the leading factor in how much charting is done. Documentation is not to be a rambling narrative but an accurate concise account of events.

4. Records are written by the person who saw the event or performed the action.

The HEALTH DISCIPLINES ACT refers only to the requirement for RN's to document. Agency policy will identify others who may or may not write on the client's record. The policy may require that RN's document observations and actions of other care providers' such as health care aides or techs. In this case, ensure that records are clear so that those reading the record will know saw the occurrence or performed the action, and who did the documenting. In some settings, it is the practice for the documentation to be done by anyone, not necessarily the person who gave the care. This practice is not recommended. Help colleagues, not by documenting for them, but by assisting earlier with the care. Each RN then documents the care that he or she gave.

5. The Closer to the Event the Record is made, the Greater the Credibility.

Nursing standards state that "the nurse documents and updates all information as soon as possible without compromising client safety". The longer the interval between the event and the documentation the less credible the information may be.

6. Entries are in Chronological Order

Entries written chronologically present a clear picture of events. For example: If on occasion entries must be out of chronological order, document both the time of documentation and the time the event occurred. An example of this is charting after the clinic is done or after an unstable patient has been stabilized.

7. Abbreviations are in General Use and Uniform

Abbreviations must be consistent so that they mean the same thing to all persons reading the record. For instance while many of us may assume that a flex may mean a flexible sigmoidoscopy, a law professional could see this as poor documentation "poor notes discredit".

Consistent abbreviations mean consistent care. Abbreviations should be kept to a minimum and a list of acceptable abbreviations be developed.

8. The date, time, signature, and designation are included for every entry.

9. Records are accurate, true, complete, clear, concise, legible and in ink.

10. Documentation is confidential and can be retrieved.

### Documentation

#### Assessment Phase

A patient assessment is performed and documented by the registered nurse. The assessment factors should include physical, psychosocial, current medications, treatment, and previous medical/ surgical, and drug history. Review of the patient's symptoms and history will supply any pertinent information to be documented, i.e. pacemaker, COPD, hepatitis etc. all documentation must include time of performance and name of person performing assessment or intervention. The frequency of assessment is determined by institutional/departmental policy, the physician or the Registered Nurse. Minimal documentation requirements are as follows:

1. Patient's name, birth date age and hospital number.
2. Time of arrival.
3. Time of assessment.
4. Patient stated reason for procedure, procedure and name of physician to perform procedure.
5. Patient/family teaching including discharge criteria.
6. Signed informed consent.
7. Baseline vital signs (Temperature, Pulse, Respiratory status, Blood pressure, and Oxygen saturation prior to procedure)

8. Warmth, dryness and colour of skin.

9. NPO status.

10. Bowel prep compliance (if applicable).

11. Current medications and time of last dose – including ASA, anticoagulants, nonsteroidals, sleeping pills, tranquilizers.

12. Allergies to foods or medications.

13. Presence of prosthetic devices.

14. Physical disabilities.

15. Intravenous line, type, site, inserted by, rate, or presence of saline or heparin lock.

16. Lab results (if applicable).

17. Pre-procedure pain.

18. Patient concerns.

19. Emotional status.

20. Admitting nurses signature.

#### Procedure Phase

1. Minimal monitoring includes, BP, Heart rate and rhythm, respiratory rate and effort, level of consciousness, warmth and dryness of skin, and level of comfort.
2. Procedure performed.
3. Physician, nurse and support staff involved in the procedure.
4. Name, dosage of all drugs agents used including Oxygen (time, route of administration and by whom) and patients response.
5. Type and amount of all fluids administered.
6. Equipment
  - Scope including serial #
  - Dilators, make and size, colour.
  - Ligation bands.
  - Cautery including # of machine setting of cut and coagulation, pad placement, skin condition pre and post procedure.
7. Unusual events, interventions and outcomes.
8. Patient status at end of procedure.
9. Specimens obtained and disposition.
10. Post procedure diagnosis.
11. Signature of procedure nurse.

#### Post-Procedure Phase

1. Time of arrival in post procedure area.
2. Vital signs (TPP, BP, Oxygenation), level of comfort, colour, warmth and dryness of skin.

3. Name dosage of all drugs, agents used including oxygen and patient response (time, route of administration and by whom).
4. IV fluids administered or discontinued including blood and blood products.
5. Unusual events, intervention and outcomes.
6. Abdominal assessment/pulmonary assessment.
7. Mode of transportation for discharge.
8. Person responsible for patient at discharge i.e. (wife, son, significant other).
9. Discharge instructions given to outpatient and/or patients family

and comprehension of instructions – signed by person responsible for patient.

10. Discharge criteria applied.
11. Time of discharge.
12. Signature of discharge nurses and designation.

#### **Disclaimer**

This outline is based on current understanding and practice in the field. Each Gastrointestinal/ Endoscopy Unit is responsible for establishing its own documentation procedures and for creating its own forms, allowing for the differences in operation of each Unit. The CSGNA assumes no responsibility for the practices or recommen-

dations of any member or practitioner, or for the policies and practices of any Endoscopy Unit.

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## *POSITION STATEMENT*

# *Staffing for Therapeutic Endoscopy Procedures on Adults*

#### **Position**

The Canadian Society of Gastroenterology Nurses and Associates support the position that staffing patterns must reflect the responsibilities in the expanded role of the registered nurse in the performance of therapeutic Endoscopy procedures.

The registered nurse in this expanded role must also have skills in delegation and knowledge in the patient monitoring requirements.

The expanded role of the nurse is only to be carried out under the direct supervision of the attending physician. Responsibilities while assisting the physician with the equipment and performing specific actions will be in accordance with the provincial licensing body and the employer. Each nurse is accountable for the responsibilities they accept.

During therapeutic Endoscopy procedures as identified by the Society a minimum of two nurses is recommended to be in attendance. One nurse would be an educated registered nurse experienced in gastroenterology and Endoscopy nursing and a second registered nurse to monitor the patient

pre procedure, during the procedure, and post procedure.

#### **Definition**

Therapeutic endoscopy procedures include but are not limited to: Emergency Endoscopy for control of bleeding (esophageal variceal banding, flindal variceal gluing, variceal sclerotherapy, esophageal gastric tainponade, heater probe/bicap/argon plasma coagulation, endolooping, endocliping), Pneumatic Dilatation, ERCP (diagnostic and therapeutic), Stent placement (esophageal and enteral), Laser therapy, Photodynamic therapy, Endoscopic Mucosal resection, PEG/PEJ insertion, Colonic decompression and Bronchoscopy.

#### **Background**

Gastroenterology nursing has witnessed significant evolutionary changes in the past 15-20 years. Factors such as an aging population, advanced technology and the specialization of gastroenterology medicine have all had an impact on nursing practice. In the specialty of Gastroenterology, the factors that have influenced staffing include the performance of more complex diagnostic and therapeutic

procedures, the changes in the physician practice (where one physician often performs the procedure with a nurse assisting, rather than another physician), and the resultant impact on the expanded role of the nurse.

The primary role of the registered nurse during endoscopy procedures is the maintenance of patient safety through continuous assessment of the patient's condition and intervention as necessary. Therapeutic endoscopy procedures involve advanced knowledge and technical skill in order to safely perform/assist with procedures to achieve desired patient outcomes.

Most patients undergoing therapeutic Endoscopy procedures will require "Conscious Sedation" (see position statement related to conscious sedation).

Accurate documentation is required that reflects that the standards of care have been met.

#### **Disclaimer**

Canadian Society of Gastroenterology Nurses and Associates does not assume any responsibility for the practices or recommendations of any member or other practitioner or for policies and practices of any endoscopy unit.

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## POSITION STATEMENT

# *The Role of the Registered Nurse in Percutaneous Endoscopic Gastrostomy Tube Placement*

### Position

The CSGNA supports the position that a Registered Nurse experienced and educated in Gastroenterology Nursing and Endoscopy may perform the Advanced Role of the Nurse. This role is subject to the approval of the Provincial Licensing Body, the Physician, and the Employer.

The Nurse performing the Advanced Role must have the necessary training as outlined by the Provincial Licensing Body.

The CSGNA supports the inclusion of the following:

- Anatomy
- Physiology
- Pathophysiology
- Procedural Techniques
- Expected Client Outcomes
- Management of Complications
- A Supervised Clinical Practice and
- Demonstrated Competency

The Advanced Role can only be carried out under the direct supervision of a qualified Physician. The

Nurse is accountable for the responsibilities she/he accepts.

When a Nurse is functioning in the Advanced Role, a Second Registered Nurse *must* be present to monitor the patient, administer medication as ordered, maintain a patent airway, and monitor the tolerance of the procedure and documentation.

### Definition

Percutaneous endoscopic gastrostomy tube (PEG) placement is an endoscopic technique for placing a gastrostomy tube or jejunostomy tube for enteral feeding.

### Background

The Primary Role of the Nurse is maintenance of patient safety through continuous assessment of the patient's condition and intervention as necessary.

The Advanced Nursing Practice Role of the Nurse/Delegated Medical Act may include assisting the Physician with manipulation of the endo-

scope, snaring the wire, insufflation of viscera, local infiltration, incision, trocar placement, threading the wire, and positioning of the gastrostomy tube.

### Disclaimer

Canadian Society of Gastroenterology Nurses and Associates CSGNA assumes no responsibility for the practices and recommendations of any member, or other practitioner or for the policies and procedures of any Gastroenterology Unit.

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# *Future National Conferences*

2003 Toronto, Ontario

2004 Calgary, Alberta

## POSITION STATEMENT

*The Role of the Registered Nurse  
in Scope Advancement***Position**

The Canadian Society of Gastroenterology Nurses and Associates CSGNA supports scope advancement in an Advanced Nursing practice/Delegated Medical Act. This is subject to approval of the individual provincial governing bodies and Health care facility.

**Definition**

Advancement refers only to the act of advancing the endoscope under direct supervision of the Endoscopist.

**Background**

The primary role of the registered nurse during endoscopy procedures is maintenance of patient safety. Ad-

vancement should only be carried out under direct visualization. The registered nurse must have the knowledge, skill and judgment to assist with the procedure and independently know when to stop advancing. An education program including Anatomy and Physiology, principles underlying the procedure, nursing implications and expected outcomes are integral components. This can only be carried out under the direct supervision of a qualified Physician.

**Disclaimer**

The Canadian Society of Gastroenterology Nurses and Associates (CSGNA) assumes no responsibility for the practices and recommendations

of any member or other practitioner or for policies and procedures of any Endoscopy unit.

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## POSITION STATEMENT

*Role of the Registered  
Practical Nurse/Licensed Practical Nurse in Endoscopy***Position**

The Registered Nurse (RN) may delegate appropriate activities to the RPN. The RN's decision to delegate care is based on both the assessment of patient needs and the educational preparation and clinical experience of the RPN. The RN maintains responsibility for the guidance or supervision of the RPN in carrying out activities, which contribute to the identification of patient needs, and the planning, provision and evaluation of nursing care. When the RN delegates nursing care activities to the RPN the RN should be satisfied regarding the RPN's competence to perform those activities. The RN must be aware of the scope of practice of the RPN and the policies of the employing agency. RN's are accountable for the total nursing care of patients and for the delegation of nursing care activities to RPN's. RPN's are responsible and accountable

for the performance of nursing care activities delegated to them by RN's.

The role of the RPN/LPN includes, but is not limited to:

- Observing, reporting and recording significant changes, which require intervention, or changes in the patient's care plan.
- Implementing interventions within the limitations of licensure and institutional policy.
- Establishing priorities and making ethically sound decisions to ensure safe patient care.
- Responding to emergency situations to promote optimal patient outcomes by recognizing changes in the patient's health status.
- Documenting patient data to ensure continuity in the provision and coordination of patient care.
- Assisting with the follow up care i.e. discharge.
- Collaborating with other health care professionals.

- Participating in continuing Education.
- Should demonstrate knowledge of equipment and how to clean and decontaminate it.

**Definition**

Role is a description of the responsibilities and functions of a health care worker in a specific role, including the current activities common to this role.

**Background**

Registered Practical Nurses (RPN's), Licensed Practical Nurses (LPN's) or Registered Nursing Assistants (RNA's) are provincially trained through an approved program and are nationally tested by the Canadian Nursing Association Testing services (CNATS) and regulated under provincial or territorial legislation. The LPN/RPN are trained to provide the optimum level of care to individuals in all developmental stages. They provide services under the direction of a quali-

fied medical practitioner or registered nurse. The Provincial licensing body in conjunction with the nursing administration in any agency determines both the standards for nursing practice and the appropriate scope of practice for employees providing nursing care.

### Disclaimer

The CSGNA assumes no responsibility for the practices or recommendations of any member or other practitioner; or for the policies or practices of any Endoscopy unit.

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## POSITION STATEMENT

### Infection Control:

## Recommended Guidelines in the Endoscopy Setting

### Terminology

**Clean** – Visibly free from debris

**Endoscope-Flexible** – Flexible fiberoptic or video endoscope used in the examination of the hollow viscera (i.e. colonoscope, gastroscope, duodenoscope, sigmoidoscope, branchoscope).

**High-Level Disinfectant** – A liquid chemical germicide which is capable of destroying all microbial life including high numbers of bacterial endospores but is used under conditions where it achieves the destruction of all vegetative bacteria, viruses and fungi but not necessarily all bacterial endospores.

**Patient-Ready Endoscope** – An endoscope rendered clean after being subjected to a validated cleaning procedure subjected minimally to a high level disinfection process and rinsed so that it does not contain residual chemicals in amounts that can be harmful to humans.

**Alcohol** – 70% isopropyl or ethyl alcohol.

**Air** – Airflow provided by a pump or compressor.

**Detergent** – Low-sudsing enzymatic formulations recommended by the manufacturer of the endoscope.

**Water** – Clean potable water or potable water has been filtered by passage through a .2um filter of otherwise treated by a method documented to improve the microbiological quality of the water.

### Background

Attention must be given to the implementation of infection control standards. Contaminated endoscopes and accessories are potential sources of infection for both patients and personnel. Strict guidelines are needed to standardize the cleaning/disinfecting/sterilization process. These guidelines are intended to assist institutions and Endoscopy units in the development of policies for their specific needs.

### Recommendations for Safety of Personnel

Safety is of the utmost importance and should be in the fore front of each employee's mind. Consistent practice must be maintained to prevent the spread of disease and to protect from the dangers of the chemicals used in the cleaning and high level disinfection of endoscopes. Universal precautions must be practiced at all times.

- All personnel should be immunized against Hepatitis B.
- Health care workers who have respiratory problems (i.e. asthma) should be assessed by Occupational Health prior to working with chemical germicides.
- Eye protection and moisture resistant masks or face shields should be worn to prevent contact with splashes during the cleaning procedure and disinfection/sterilization process.
- Moisture resistant gowns should be

worn to prevent contamination of personnel due to splashes of blood or other body fluids or injury due to chemical disinfectant/sterilant contact. The changing of gowns is recommended between procedures.

- Protective apparel (gown and mask) should be removed when leaving the procedure room and cleaning room.
- Gloves should be worn for handling and cleaning of dirty equipment as well as for any potential contact with blood or body fluids. Chemical resistant gloves (nitrile) are recommended when handling disinfectant solutions.
- All needles and sharps are to be appropriately disposed of in puncture resistant containers at their point of use. Do not recap needles.
- Fingernails should be kept short to prevent the puncturing of gloves. Jewellery should not be worn on the hands because it harbours microorganisms and may puncture gloves.
- Meticulous hand washing should be done between patient contact, after glove removal and when entering or leaving the Endoscopy area. If hands and other skin surfaces are contaminated with blood or body fluids, wash immediately.
- Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling pa-

tient care equipment until the condition resolves.

### Recommendations for Endoscopes

Refer to the manufacturer's instructions for cleaning and disinfecting each particular endoscope: Scrupulous cleaning and disinfection after each patient use must be completed to prevent the spread of infection. Only trained personnel will perform this procedure.

### Inspection

At all stages of handling there should be inspection of the endoscope for damage.

Leakage testing of the endoscope should be done each time before the cleaning process starts.

Ensure immersion cap is placed on all videoscopes.

If damage is detected or bubbling occurs, ensure the pressure is maintained through the leakage tester and proceed to carry out a thorough external cleaning and cleaning of the internal channels. Follow your service provider's instructions concerning disinfection of a damaged fiberscope. However, with proper maintenance of internal pressure, manual disinfection of the scope in many cases can be achieved. Send to the repair service immediately. If the scope cannot be cleaned prior to transport, ensure that it is clearly labeled 'contaminated'.

### Cleaning

Meticulous manual cleaning is the most important step in the cleaning process. It is imperative that all channels, removable parts and all immersible parts of the endoscope be cleaned.

Wipe the outer surface with enzymatic soaked gauze immediately after removal of the endoscope from the patient. Using the air/water channel valve, flush the air/water channel with water from the water bottle. Transport the scope to the cleaning area.

- If unable to initiate the manual cleaning process immediately, the endoscope may be flushed and then soaked with enzymatic solution.
- Leakage test the scope following

the manufacturer's instructions.

- Fully immerse the scope in a solution with an enzymatic cleaner to prevent the drying of secretions. Brush all channels to remove the organic material and decrease the number of organisms present. Ensure that access to the air/water/CO<sub>2</sub> channel is attained, as these channels are very difficult to clean.
- Ensure the outer surface of the scope is thoroughly cleaned. Use of a soft bristle toothbrush to clean the lens end is acceptable.
- All channels must be brushed and irrigated to remove particulate matter. A channel irrigator should be used to facilitate complete cleaning of all channels.
- Rinse all the channels and the endoscope thoroughly with water following the cleaning process to remove the residual of the enzymatic agent.
- Remove all excess water from the channels by injecting air via the all channel irrigator to decrease the possibility of dilution of the disinfectant solution.
- Clean all non immersible parts with a hospital recommended surface disinfectant.
- Non immersible endoscopes should be replaced because they are very difficult to clean and disinfect.

### Sterilization and Disinfection

When deciding whether to sterilize or disinfect the endoscope, it is important to refer to the following classifications;

1. Critical devices are those that enter sterile tissue: the vascular system or body space, (i.e. biopsy forceps, polyp snares and surgical instruments).
2. Semi-critical devices (i.e. laryngoscopes, endoscopes) come into contact with mucous membranes or non-intact skin during use and should at least receive high-level disinfection (defined as the inactivation of all micro organisms with the exception of bacterial endospores).
3. Non-critical devices (i.e. blood

pressure cuffs, bedpans) come into contact with intact skin.

Endoscopes that come into contact with mucous membranes are classified as semi-critical items. Endoscopes that enter sterile body cavities are classified as critical items.

- High level disinfection of the endoscope internally and externally must be performed after scrupulous mechanical cleaning has been completed. All processes will be rendered ineffective if any organic material or moisture is present on or in the endoscope.
- Chemical agents registered with Canada Health and Welfare, as sterilant/disinfectants are appropriate for high level disinfections. To ensure efficacy, the manufacturer's instructions regarding use of disinfectant must be adhered to.
- All internal and external surfaces and channels must be in contact with the disinfecting agent for not less than 20 minutes.
- Disinfectant agents must be chosen carefully and must be used according to the manufacturer's instructions including monitoring chemical concentrations. Disinfectant life is more dependent on frequency of use rather than on a predetermined time or duration of use.
- Ethylene Oxide (ETO) gas sterilization requires an extended time to complete the sterilizing and aeration process. This may not always be practical.
- The Peracetic Acid based automated system sterilizes immersible instruments and rinses them with sterile water. Contact of all external and internal surfaces with the sterilant must occur. Check with the manufacturer's instructions regarding the cleaning of the elevator channel of the duodenoscope.
- Hydrogen Peroxide (H<sub>2</sub>O<sub>2</sub>) is acceptable for endoscopic reprocessing although it can damage the external surfaces of the insertion tube and corrodes copper, zinc and brass.

**Rinsing**

To remove all traces of the disinfectant, adequate rinsing must follow the disinfection process. Any residual chemical can cause toxic effects in a patient if it is transmitted during the next endoscopic procedure.

The use of sterile water for rinsing is recommended. If tap water is used, follow with 70% alcohol rinse and dry with compressed air.

**Drying**

Air drying by the use of forced air should be done after disinfection and before storage.

Prior to storage, facilitate drying of the endoscope by flushing all channels with a 70% isopropyl alcohol followed by forced air. Dry the insertion tube completely. Moist environments are conducive to bacterial growth.

Channel valves should remain out of scopes at the time of storage to facilitate the drying of channels.

**Storage**

Endoscopes should be stored hanging vertically in a well ventilated area in a manner that prevents recontamination or damage. They should not be coiled and stored in their cases.

Wipe down the storage cupboard with disinfectant solution weekly.

**Documentation**

Results of disinfectant solution testing should be documented. Institutional policy may require documentation of disinfection cycles.

**Culturing**

Culturing requires very precise techniques done in close consultation with an infection control department. Institutional policy may dictate when and how culturing of scopes should be carried out.

**Special Considerations**

Sterilization or high level disinfection should be used as directed by institutional policy. Diagnosed or suspected infection, including Hepatitis B, VRE, MRSA or HIV is not a contraindication for endoscopy. It is not recommended to have instruments

dedicated for use with infected patients.

**Recommendations for Accessories**

Non-disposable accessories require meticulous manual cleaning and disinfection or sterilization after each use according to manufacturers guidelines and as directed by institutional policy. Cleaning Brushes should be disposable or thoroughly cleaned and receive high level disinfections after each use.

**Biopsy Forceps**

Meticulous manual cleaning with a brush and an enzymatic agent is required as soon as possible after the procedure.

Ultrasonic cleaning is recommended to remove debris that hand cleaning cannot.

Biopsy forceps break the mucosal barrier. Therefore they are classified as critical instruments and require sterilization.

The only method that will effectively penetrate the metal coils of the spring like structure and any residual organic material is steam under pressure. Chemical sterilization does not completely penetrate the coils and therefore is not effective.

**Cleaning Brushes**

The cleaning brushes should be disposable or thoroughly cleaned and high level disinfected after each use.

**Water Bottle**

According to manufacturer's instructions, sterilize or high level disinfect the water bottle and its connecting tubing at least daily.

For endoscopic irrigation, fill the bottle with sterile water.

Each ERCP procedure requires a fresh sterile bottle with sterile water. Pseudomonas aeruginosa colonization of equipment has been associated with patient infection following ERCP.

**Other Accessories**

Clean all non-disposable accessories (i.e. polyp snares, tripods and foreign body forceps) meticulously with an enzymatic agent followed by rinsing thoroughly with water. Use the ultrasonic cleaner prior to steam autoclave.

Consult the manufacturer if steam sterilization is not applicable.

Critical accessories (i.e. sclerotherapy needles, electrocautery probes and hot biopsy forceps) should be sterilized or discarded after each use.

**Medical Equipment**

Keep all non-critical equipment (i.e. teaching heads, light sources, cameras) visibly clean with soap and water or recommended institutional disinfectant.

If significantly soiled, use an intermediate disinfectant after cleaning.

**Recommendations for Environment General Cleaning**

For general wipe down of equipment such as procedure carts, stretchers, sinks, etc. after each use, an EPA registered housekeeping product is recommended.

**Spills**

In keeping with Universal Precautions:

- Use gloves; blot spills of blood or body fluid with disposable towels.
- Wipe the area with clean, disposable towels soaked in a freshly prepared household bleach (1:10) dilution or an EPA registered tuberculocidal 'hospital disinfectant' and allow to dry.

Disinfectant spills should be handled by consulting the solution MSDS (Material Safety Data Sheet) WHMIS Guidelines.

**Waste**

Minimal handling of all medical waste should be encouraged.

The storage and disposal of waste should be handled according to institutional policy and provincial and federal guidelines.

**Processing Area**

Patient care areas should be separate from cleaning/disinfection areas.

Clean and dirty areas should be separate with proper plumbing and drains. Adequate storage space should be provided.

The use of covered containers and proper ventilation to remove toxic vapours is essential.

Periodic air quality monitoring of glutaraldehyde levels should be performed.

**Automated Washers/ Disinfectants**

Endoscopy unit cleaning/ disinfecting process may be standardized by the use of scope washer/ disinfectants. This equipment may be useful in circulating germicides, containing vapours and decreasing exposure of personnel to contaminated equipment and disinfectants.

Meticulous manual cleaning must precede the use of any automated system as previously described.

Clean all non-immersible parts of the endoscope with hospital recommended surface disinfectant.

The following capabilities must be present in any washer/disinfectant;

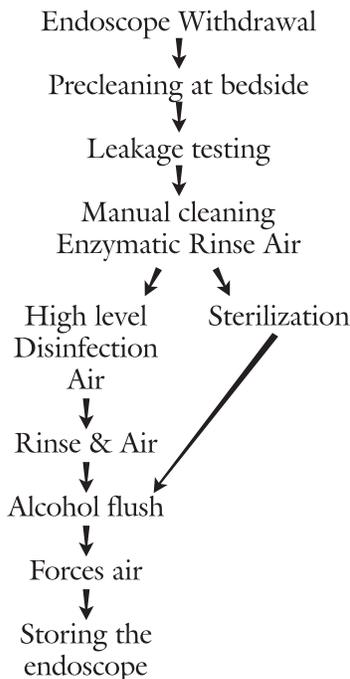
- Enzymatic and/or disinfectant should be circulated through all channels at equal pressure without trapping air.
- Washing and disinfecting cycles should be followed by thorough rinsing cycles followed by forced air to remove the used solution.
- Disinfectant should not be diluted with wash or rinse water.
- Routine disinfection of the washer/ disinfectant according to the manufacturer's recommendations and institutional policy must be done.

**Other considerations;**

- A channel irrigator may miss a blockage of one channel.
- When used to disinfect duodenoscopes, ensure that the channel for the elevator is cleaned and disinfected as part of the processing cycle or it may require manual processing.
- A forced air drying cycle or air drying should be completed by hand after the final rinse.
- If unsterile water is used in the final rinse following the disinfection cycle all endoscope channels must be flushed with 70% alcohol and dried with air.
- Colonization of bacteria may be caused by residual water remaining in the water hoses and reservoirs.

This could lead to contamination during subsequent instrument processing.

**Cleaning Disinfection and Sterilization Procedures**



**Disclaimer**

The Canadian Society of Gastroenterology Nurses and Associates assumes no responsibility for the practices or recommendations of any member or other practitioner or for the policies and practices of any Endoscopy Unit.

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To order:

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Some of our old favorites have been re released.  
The following songs are on a new album called  
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Marvin Gaye "I Heard It Through the Grape Nuts"

The Who "Talkin' Bout My Medication"

The Troggs "Bald Thing"

## LIPSTICK/PERSONALITY CHART



1. *Slant keeps close to original slant and tip shape.*

- Abides by the rules
- Great follower
- Does not like too much attention
- A little self-conscious
- Somewhat reserved
- Likes a schedule
- May occasionally color hair to attract attention



2. *Rounded, smooth tip.*

- Easy-going
- Peacemaker
- Even-tempered
- Steady
- Likeable
- Generous



3. *Sharp-angles tip.*

- Opinionated
- High-spirited
- Dislikes schedules
- Selective of friends
- Outgoing
- Likes attention
- Argumentative



4. *Sharp-angled, but curved tip.*

- Creative
- Enthusiastic
- Energetic
- Talkative
- Loves attention
- Falls in love easily
- Helpful
- Needs schedule, but dislikes one



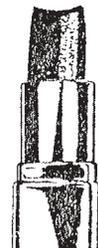
5. *Rounded tip to a point.*

- Lovable
- Family-oriented
- A "doer"
- Can give orders easily
- Domestic
- Exaggerates sometimes
- Stubborn over little things
- Needs people around



6. *Flat top.*

- To the point
- High morals
- Needs approval
- Careful about appearance
- Very dependable
- Conservative
- Quick mind
- Loves challenges



7. *Flat top concave.*

- Makes a great detective
- Makes friends easily
- Inquisitive
- Adventurous
- A prober
- Complex
- Exciting



8. *Sharp angles both sides.*

- Spiritual
- Curious
- Seeks attention
- Mysterious
- Big ego
- Faithful
- Looks for easy way
- Loves life

## GUIDELINES FOR SUBMISSION to "THE GUIDING LIGHT"

- white paper with dimensions of 8 1/2 x 11 inches
- double space
- typewritten
- margin of 1 inch
- submission must be in the possession of the newsletter editor 6 weeks prior to the next issue
- keep a copy of submission for your record
- All submissions to the newsletter "The Guiding Light" will not be returned.

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## CSGNA EDUCATION COMMITTEE POINT SCORING SYSTEM FOR AWARDING SCHOLARSHIPS

Each year as a member (cumulative points)	1 Point
Each year served on National Executive (cumulative points)	3 Points
Each year served on Annual Conference Planning Committee (cumulative points)	3 Points
Each year served on Chapter Executive (cumulative points)	2 Points
Each time submitted an article for publication in “The Guiding Light” not reports (cumulative points)	2 Points
Can demonstrate actively recruited members	1 Point
Each time has acted as speaker at a CSGNA conference or seminar (cumulative points)	2 Points
Each time served on an ad hoc committee of the CSGNA (e.g.) Bylaws (cumulative points)	2 Points
Outlines geographical location and travel expenses	1 Point
Actively participates in Chapter events (E.G.) fundraising	1 Point
Each year as a member on the planning committee for a regional conference (cumulative points)	1 Point
CSGNA certification	1 Point
Types format	1 Point

REVISED September 2002

M. Paquette, Education Director

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# Canadian Society of Gastroenterology Nurses & Associates

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C/O EDUCATION CHAIR: MICHELE PAQUETTE, 501 SMYTH ROAD, OTTAWA, ON. K1H 8L6

## APPLICATION FORM FOR CSGNA ANNUAL SCHOLARSHIP AWARD

The Annual National Conference award of \$700.00 is to be used for travel and accommodation to the Annual National Conference in Canada.

### EXCEPTIONS:

1. Applicant cannot have received **THIS** award in the previous two years.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarships are available only to active members.

### PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A written summary of how this scholarship and attendance at the proposed meeting would benefit you in your work.
2. A current Curriculum Vitae.
3. Please specify your past involvement in the CSGNA: e.g., acted as speaker at a meeting, actively recruited new members for CSGNA, aided in the formation of a local Chapter, served on an Ad Hoc Committee, and any Newsletter articles submitted. Describe your current involvement with your Chapter: e.g., fundraising or planning Chapter conferences.
4. Outline projected financial needs to attend this meeting.
5. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.
6. Copy of CSGNA Membership Card.

**APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY MAY 1 OF THE CURRENT YEAR.**

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SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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Ouvert aux infirmières et autres membres de la santé engagés à plein ou demi-temps en gastroentérologie ou procédure endoscopique en temps que superviseurs, enseignants, recherches application clinique ou administrative.

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40,00\$

Ouvert aux médecins, actifs en gastroentérologie endoscopique ou personnes engagés en activités en gastroentérologie/endoscopiques incluant représentants de compagnies sur une base individuelle.

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