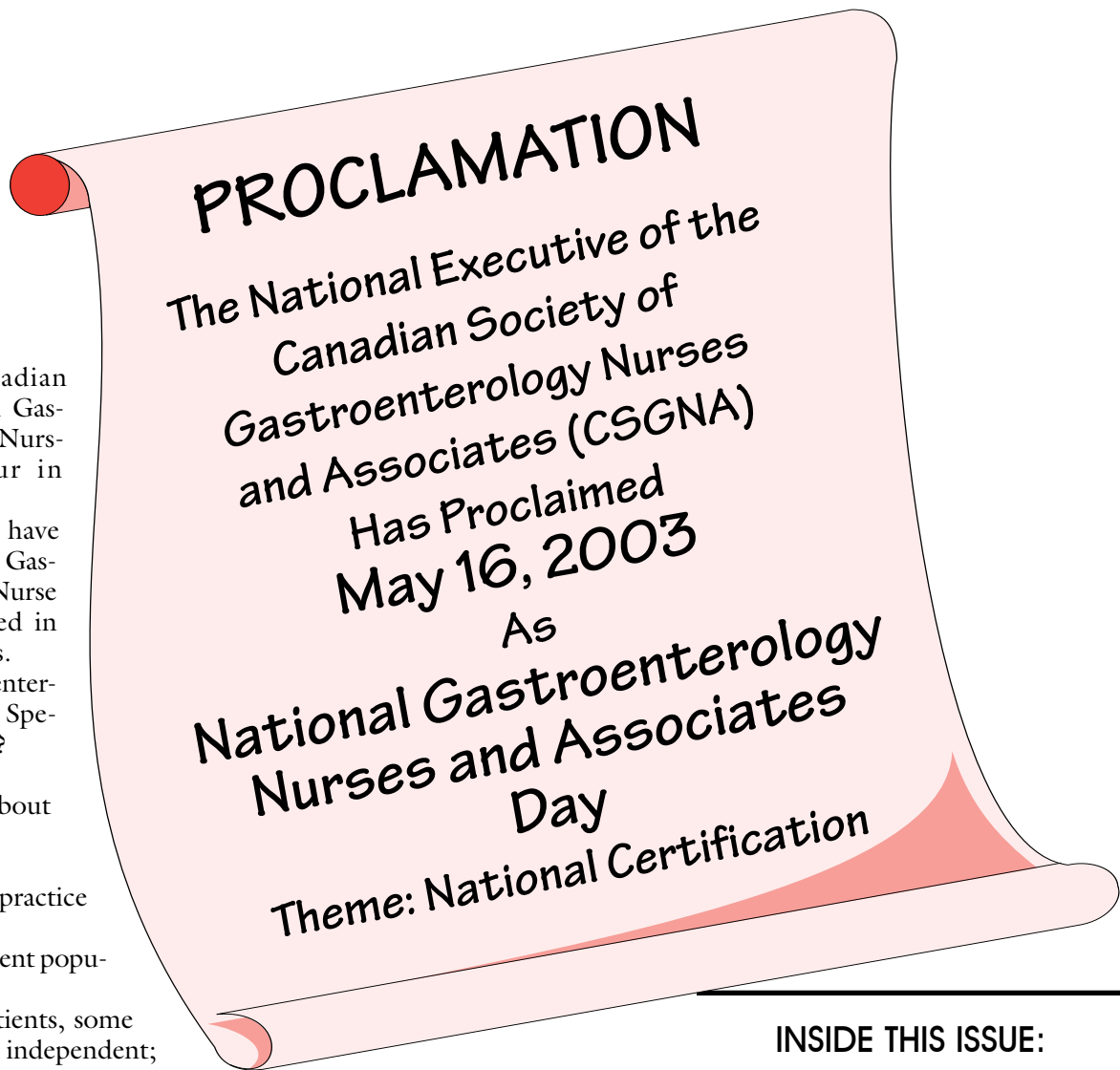




# The Guiding Light

CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES & ASSOCIATES

MARCH 2003 VOL. 13 #48



## PROCLAMATION

The National Executive of the  
Canadian Society of  
Gastroenterology Nurses  
and Associates (CSGNA)  
Has Proclaimed  
May 16, 2003

As  
National Gastroenterology  
Nurses and Associates  
Day  
Theme: National Certification

- The first Canadian Certification in Gastroenterology Nursing will occur in Spring 2004.
- Our goal is to have every Canadian Gastroenterology Nurse become certified in the next 5 years.
- Why is Gastroenterology Nursing Specialty so special?

What is so special about Gastroenterology Nursing?

- The advanced practice setting.
- The diverse patient population.
- The type of patients, some very stable and independent; others critically ill and dependent on the Gastroenterology Nurse's expertise and skill.
- Patient teaching about disease processes, lifestyle management, medications.
- Assisting physicians with procedures, some very invasive, therapeutic and quite technical.
- Fascinating technology always evolving.
- The nursing colleagues committed to high standards.

- Physicians value expertise of the Gastroenterology Nurses and work alongside with them.
- Professional growth is provided through our association by means of educational opportunities to keep abreast.

In conclusion remind yourselves how fortunate you are to have love and passion for your special Nursing Specialty.

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# ENDOSCOPIC ULTRASOUND

By Sandy Saioud RN

## WHAT IS ENDOSCOPIC ULTRASOUND?

Endoscopic Ultrasound (EUS) is a procedure that combines the versatility and resolution of high frequency ultrasound imaging with the access of endoscopy to obtain images and information about the gastrointestinal tract and the surrounding tissue and organs. Endoscopy refers to the procedure of inserting a long flexible tube via the mouth or the rectum to visualize the gastrointestinal tract whereas ultrasound uses high-frequency acoustic waves within the GI lumen to produce detailed ultrasound images of the gut wall, and the ability to examine deep structures behind superficial tissues that once would have been impossible to see. This not only makes diagnoses more accurate and reliable, it makes possible diagnoses that once might have been missed altogether. By visualizing from within the tubular organs, endoscopic ultrasound systems can penetrate deeper areas with higher frequency ultrasonic waves than is possible with extra corporeal ultrasonography.

Endoscopic ultrasound was first introduced in 1984. This technology is widely used in Europe and in the United States for numerous applications. EUS utilizes an endoscope with an ultrasound transducer or probe at its tip. This scope is referred to as an echoendoscope. By inserting the echoendoscope into the upper or the lower digestive tract, one can obtain high quality ultrasound images of the organs inside the body. It is like sitting in a room and being able to see what is behind the wall of that room. Because of the proximity of the ultrasound transducer to the organ(s) of interest, the images obtained are frequently more accurate and more detailed than the ones obtained in traditional ultrasound.

When imaging the gastrointestinal wall with endosonography, it presents in a typical five echo-layer structure which is differentiated by an echo-rich or an echo-poor layer. Echo-rich may also be referred to as hyperechoic, likewise echo-poor may also be referred to as hypoechoic. The first layer closest to the transducer is an echo-rich layer, which refers to the border echo. The second layer is an echo-poor layer, which corresponds to the Mucosa. The third layer is echo-rich and corresponds to the Submucosa. The fourth layer is echo-poor and corresponds to the Muscularis Propria. The fifth layer is echo-rich and corresponds to the Serosa and Subserosa, or it is a border echo with surrounding fat in the esophagus and rectum. EUS uses two basic instrument designs, both of which use an ultrasound probe/transducer at the end of an endoscope. The Radial imaging echoendoscope produces a cross-sectional image, which is used for diagnostic purposes to assess the anatomy of the GI tract wall and surrounding structures. This application is widely used in tumor staging. The Curvilinear Array (CLA) echoendoscope uses Doppler and pulse Doppler ultrasound and produces a longitudinal image, which is used for therapeutic applications, namely ultrasound guided fine-needle aspiration, or biopsy of lymph nodes and masses.

Until the mid 80's, most diagnostic ultrasound devices were of the extracorporeal type, which literally means outside the body. Typically, these probes contact the skin directly, after an acoustically conductive gel has been applied. Unfortunately, ultrasound cannot be transmitted through the gases and bones inside the body, and the ultrasound frequency required to penetrate to the deeper organs is too low with extracorporeal ultrasound to enable accurate visualization.

In the past 18 years, endoscopic ultrasound (EUS) endoluminal, blind rectal, esophageal and mini probes have found their way into the market. These devices differ in that they are introduced into the body rather than being placed on it. Today, EUS is well established as the single best technique for the local staging of esophageal, gastric, rectal and pancreatic disease. Yet only two decades ago, accurate detection of pancreatic tumors at an early stage was impossible. EUS is now regarded as a critical diagnostic tool and essential in deciding which patients would benefit from surgical versus non-surgical treatments.

Ultrasound probes were developed to observe and diagnose extremely deep areas beyond the range of an ordinary endoscope. Designed to pass through the instrument channel of a conventional endoscope, ultrasonic probes feature an insertion tube with a very narrow diameter. With the development of ultrasonic mini-probes, EUS is becoming more popular, more efficient and more economical than ever. Mini-probes are becoming more common in that it offers the user the ability to perform a EUS procedure at the time of endoscopy. A mini-probe can be passed down the instrument channel of any regular endoscope and the user can get high quality ultrasound images of the GI tract. Mini-probes are used widely in intraductal ultrasonography for pancreaticobiliary lesions and also for endobronchial ultrasound applications.

## ADVANTAGES OF ENDOSCOPIC ULTRASOUND:

- Most sensitive and accurate method in staging GI cancers.
- Gives user minimally invasive access to perform therapy within the GI tract.

- Least expensive modality to assess both malignant and benign disease.
- Few complications

### **CLINICAL APPLICATIONS/ INDICATIONS FOR ENDOSCOPIC ULTRASONOGRAPHY:**

#### **\*Current:**

- Detection and Staging of esophageal, gastric, pancreatic, and colorectal cancer
- Detection of bile duct stones
- Mediastinal lymph node assessment for lung cancer
- Evaluation of benign, potentially pre-cancerous, GI disease e.g. Barrett's esophagus, chronic pancreatitis, and sub-mucosal tumors.
- Confirm diagnosis via EUS guided Fine Needle Aspiration (FNA)
- EUS-Guided Celiac Plexus Block (for chronic pancreatitis)
- EUS-Guided Celiac Plexus Neurolysis (for Pancreatic CA)

#### **\*Future:**

- EUS-Guided Pseudocyst Drainage
- EUS-Guided therapy
- Fine Needle Injection (FNI for directed Anti-Tumor therapy)

### **SCANNING TECHNIQUES:**

For EUS and ultrasound studies, a special condition is required; that is, a sonolucent material must be between the scanner and the target lesion, and usually de-aerated water is employed.

Three kinds of scanning techniques are used in EUS and ultrasound probe studies. One is the balloon-contact method, which is performed by filling a small balloon which is applied at the tip of the echoendoscope with de-aerated water and contacting the balloon against the gastrointestinal wall to examine the esophagus, pancreaticobiliary system or the gastric pylorus. This method can be used even when some air bubbles still remain.

The inflated balloon is usually less than 3 cm in diameter.

Another technique used for gastrointestinal lesions is the water filling method in which de-aerated water is infused into the gastrointestinal tract through the instrumental channel of the echoendoscope until the wall is extended and the scanner and target lesions are covered by water. This method enables evaluation of surface layer of the gastrointestinal tract including the stomach. This technique is also used for ultrasound mini-probe studies, for example, of the papilla of Vater, because most ultrasound probes do not have a balloon attached except for a special type of balloon mini-probe. When this method is used for examining esophageal lesions, it is necessary to remove all the air in the stomach before infusing the water into the esophagus to avoid air reflux.

The third method is a combination for the balloon-contact and water-filling methods and is the recommended technique for all lesions and organs.

### **PREPARATION FOR EUS PROCEDURE:**

- Nothing to eat or drink for 6 hours prior to procedure except for medications
- If a rectal EUS is to be performed, bowel preparation with laxatives and/or enemas will be required
- Complete instructions should be provided to the patient
- Complete medical history obtained
- If taking any type of blood thinner, such as Coumadin, patient should stop taking this medication several days before the procedure.
- Sedation will be administered for the procedure, so a driver is required to take the patient home

### **EQUIPMENT:**

Endoscope and all other items used in an endoscopy procedure along with the following additional items:  
Radial Scanning Echoendoscope  
Curvilinear Array Echoendoscope  
Radial and Linear balloons  
Aspiration Needle Kit: Reusable or disposable, 22-gauge and larger 19 gauge  
Cytology supplies

### **PRE-PROCEDURE:**

- Good assessment should be obtained
- Baseline data should be obtained- Blood Pressure, heart-rate, oxygenation, Respiration, pain status and anxiety level
- Intravenous access
- Patient teaching related to the procedure
- Upper EUS: Similar to upper GI endoscopy, except the patient should be aware that multiple scopes might be passed.
- Lower EUS: patient may not be sedated, full feeling due to balloon and water
- Medication: Same medications as used in endoscopy procedures but maybe a higher dosage or top-up due to the length of the EUS procedure.
- Explanation of Fine Needle Aspiration (method used to obtain tissue of tumors, cysts, and lymph nodes)
- Obtain informed consent

### **INTRA-PROCEDURE:**

- Prepare equipment for use and ensure proper functioning
- Apply balloon to echoendoscope and fill with de-aerated water until all air bubbles are removed from the balloon
- Talk to the patient- introduce yourself, find out if they have any questions, explain what you're going to do before you do it
- Apply monitoring devices
- Spray the patient's throat with local freezing
- Position in left lateral position
- Give sedation
- Assist physician as required
- Requires 1 RN for monitoring the patient and 1 to assist the physician
- Assistant should **only** assist the physician  
Physician almost always perform a Radial EUS first to look for abnormalities.

If the user detects abnormal anatomy during Radial scanning EUS, then Curvilinear Array EUS is performed.

Always be prepared during a CLA EUS procedure to do a Fine Needle Aspiration (FNA).

Monitoring nurse may be asked to hold the scope in place during an (FNA) procedure.

**FNA Procedure:** A small lumen catheter with an aspiration needle is placed through the instrument channel of the ultrasound scope and suction is applied by using syringe or wall suction. Using the ultrasound guidance of the echoendoscope to visualize the cyst or tumor, the needle is inserted into the tumor or cyst and advanced back and forth by the physician to get a good tissue or fluid sample. The aspiration needle is then withdrawn from

the scope with suction still present and then the fluid or tissue sample is aspirated onto the slides, prepared according to instructions and sent to the lab for analysis. FNA needle sets are available in disposable and reusable. With the disposable needle set, everything is discarded after use. With the reusable needle set, the coil sheathing and handle is reusable (following manufacturer's guidelines on reprocessing) but the needle inserts are single use and comes in a package of 5.

#### **POST-PROCEDURE:**

- Monitor vital signs and oxygen saturation
- Assess level of consciousness
- Observe for possible signs of complications - bleeding, pancreatitis, aspiration, perforation

- Report any abnormal findings to physician

#### **DISCHARGE INSTRUCTIONS:**

- Patient should not drive or operate any machinery for the rest of the day if sedation was given
- Ensure the patient understands that he/she should notify the physician if they experience any bleeding, fever/chills, persistent abdominal pain, or nausea/vomiting.
- Provide written discharge instructions with phone number to call if complications occur.

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**REMINDER: YOUR CSGNA MEMBERSHIP NEEDS RENEWAL BEFORE JUNE 1st, 2003. THE MEMBERSHIP YEAR IS JUNE TO JUNE.**

# The disappearance of India Ink

Commercially available India Ink has been used by endoscopists to mark or "tattoo" lesions for subsequent surgery or endoscopy. The ink has to be diluted and sterilized by autoclave in order to reduce the possibility of inflammation and microabscess formation within the gut wall.

A new purified and sterilized preparation of carbon black has been developed. It is sterile and pre-diluted and has no clinical side effects. It should replace commercial India Ink which contains shellac-phenol and ammonia.

The new product is called SPOT and can be obtained from Instrumented Surgical. It costs \$320.00 for 10 syringes. It comes in a suspension containing highly purified very fine carbon particles. The composition of SPOT is water, glycerol, polysorbate, Benzyl, Alcohol, simethicone, high purity carbon black. For more information on this product call 1-800-667-5653

#### **DIRECTIONS FOR USE:**

- A 25 gauge sclerotherapy needle with a needle length of 4mm or less is recommended.
- The SPOT syringe should be shaken vigorously for 15-20 seconds prior to loading the injection catheter.
- With the needle retracted insert the catheter through the biopsy channel of the endoscope.
- Insert the needle tangentially into the submucosal space of the colon.
- Inject 0.5-0.75 ml into each injection site.
- A minimum of four marker injections is recommended one in each of the four quadrants of the colon around the area of the lesion.
- Maximum recommended dose is 8ml per patient.

#### **STORAGE:**

Store the product at room temperature.

Product has a shelf life of two years.

Store syringes in the canister provided with the syringe tips pointed upwards.

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The Disappearance of India Ink. Fiedler LM, Wayne JD, Harpaz N. Henry D, Janowitz Division of Gastroenterology and Division of Pathology, Mount Sinai Medical Center, New York, NY  
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**Submitted by:**

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Education Chair Director**

# Home Parenteral Nutrition Patients: Their life is on the “line”!

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St. Michael's Hospital

## INTRODUCTION

It is a fact: we all need to eat to live. Nutrition is the process of consuming, absorbing and using nutrients needed by the body for growth, development and maintenance of life. Nutrients are the chemical substances in food that nourish the body. Macronutrients are the proteins, fats, carbohydrates and some minerals that we need daily in large quantities. Micronutrients, vitamins and trace elements are required in smaller quantities but they help to catalyze the utilization of macronutrients.<sup>1</sup>

It is generally accepted that a functional gastrointestinal tract should be used as the route for nutritional support wherever possible.<sup>2</sup> If required, nutritional supplements are offered to patients orally as the first approach, however, if there is an impediment, that is, swallowing difficulty or the nutritional requirement far exceeds that which can be managed by mouth then consideration must be given to enteral feeding methods.

If indeed the gut is not able to be used or there is not sufficient bowel length to allow for adequate absorption then parenteral nutrition (PN) may be the only option for some patients. The word “parenteral” is derived from the Greek words “para” meaning – opposite and “enteron” meaning – the intestine. In this case, nutrition is given not via the intestine but via the venous system. Technological advances and refinement of delivery systems has certainly made PN an almost routine aspect of patient care in hospitals and home settings nowadays. Yet the idea of a treatment modality becoming “routine” does not mean that we as nurses should let down our guard.

Parenteral nutrition is not completely devoid of risks. One area where the nurse can excel is in the care and maintenance of vascular access devices (VAD) through which the PN is given. It is all well and good for the medical team to determine that a patient is in need of PN but the question is what kind of vascular access device is needed. This article will address some of the issues in and around the longterm parenteral nutrition client and vascular access.

## WHO NEEDS PN?

Patients may require PN temporarily or indefinitely for a host of different reasons. Some patients have an intact gut but suffer malabsorption problems. Some individuals have a condition known as short gut meaning they have less than three feet of small bowel. A trauma or an ischemic event can mean significant segments of bowel be removed. Certain motility disorders, pseudo-obstruction can leave the gut paralyzed either temporarily or permanently. Tumours can cause intestinal obstructions and interfere with a persons ability to maintain their nutritional intake. A patient may present malnourished preoperatively which may force a postponement in surgery until such time as the client is deemed able to withstand the intervention. Intractable diarrhea, pancreatitis, cystic fibrosis, enterocutaneous fistula are also situations in which PN may also be offered.

## THE VASCULAR ACCESS CHALLENGE

Patients are often admitted to hospital with complicated medical histories suffering from multiple diseases (e.g. Peripheral vascular disease, diabetes,

congestive heart failure, emphysema, chronic obstructive pulmonary disease and use of steroid drugs) which contribute to a compromised venous access.<sup>3</sup> It is essential then that clinicians have an understanding of the principles and practice associated with the use of vascular access devices.<sup>4</sup> Once it is established that a patient requires PN it is most often initiated in the acute care facility. When a patient is ready for discharge to home and the only issue is the continuation of PN in the home setting, arrangements can then be made with the community nursing agencies.

There are a variety of vascular access devices that can be used for longterm PN. Successful venous access begins with choosing the appropriate device. Most PN solutions are hyperosmolar and must be administered into the central vascular system.<sup>5</sup> Central venous access is defined by the location of the catheter tip rather than the site of insertion.<sup>6</sup> Central line tip termination within the distal superior vena cava/proximal right atrium offers increased hemodilution of the infusate and less trauma to the vessel wall thereby reducing the incidence of catheter related complication.<sup>7</sup>

The manufacture of vascular access devices is an industry unto itself. Research and development into biomaterials has focused on less thrombogenic products which may prove less likely to serve as a nidus for microbial colonization.<sup>8</sup> Each vascular access device has its own pros and cons. In the acute care setting percutaneous triple lumen central lines are often used to accommodate for multiple intravenous needs. Incompatible drugs can be safely administered via the separate and

distinct lumens. But this type of line is not suitable for the home setting.

One of the recommended central lines for discharge to home is the tunneled catheter (e.g. Hickman). Upon insertion a portion of the catheter is tunneled into the subcutaneous tissue allowing a "cuff", several centimeters from the exit site to grow into the surrounding tissue. The cuff prevents both microbial migration and catheter dislodgement. The peripherally inserted central catheter (PICC) is placed in an arm vein and threaded into the central venous system. It is more difficult for a patient to care for this type of line themselves since one really needs both hands to be able to reach the hub for accessing and deaccessing. A subcutaneous port (e.g. Port-a-cath) could be considered an option, however, it is really intended for intermittent delivery of intravenous therapy and not very practical for everyday usage. All the longterm central lines come with the option of single or double lumen. Certainly if a patient has a need for additional medications to be delivered intravenously or blood needs to be obtained via this route on a regular basis then a dual lumen central line may be selected.

Increasingly central lines are inserted by interventional radiologists, but some hospitals now have specially trained nurses who are able to insert PICCs at the patients bedside.

No matter which type of catheter is used the complication of long term venous access remains the same and is always a challenge. Catheter sepsis is a constant threat to a clients well

being. Strict adherence to handwashing and aseptic technique remains the cornerstone of prevention of catheter related infection.<sup>9</sup> Intravascular device related bloodstream infection is largely preventable.<sup>10</sup> Dennis Maki, one of the foremost authorities on central venous access devices and infection, says that "vascular access devices must be thought of in fundamental terms as a direct conduit between the external world with its myriad of microorganisms and the bloodstream of the patient". Therefore, treat these devices with respect and make them last. It is problematic for the home PN patient to have central lines removed and reinserted and puts them at risk of losing available access in the future. Patients are encouraged to be very protective of their "life lines".

Catheter occlusion is another complication that can occur at any time. If resistance is felt when trying to flush the line it is better not to be too forceful for fear of blowing a hole or fracturing the line itself. It is very often the case that a blood clot forms just inside the tip of the catheter. If blood is the suspected culprit, preventing adequate flow, then a thrombolytic agent (e.g. Alteplase Tpa) may be instilled and allowed to dwell in order to dissolve the clot. If successful, patency is restored and use of the line may be resumed. Regular maintenance of the central line involves flushing the line with normal saline and/or heparin upon completion of an infusion or for daily maintenance and if performed correctly helps to prevent blood clots at the tip of the line.

Air embolism is always a risk to patients with central lines and special care must be taken to ensure all tubing connections/caps are secured with a luerlock device. An air embolism is potentially deadly. Air can create an "air lock" if allowed to float to the pulmonary outflow tract, blocking blood flow to the heart resulting in death. If air is thought to have entered the heart via a disconnected or broken central line, the nurse or the patient should clamp the line immediately, position the patient lying on their left side which will allow the air bubble to float to the apex of the right ventricle where it will do no harm and slowly be absorbed.<sup>11</sup>

Infection can occur at the exit site of the catheter and even creep up the outside of the line creating what is called a tunnel infection for a Hickman or a pocket infection for a Port-a-cath. Such infections are difficult to treat and more often than not result in the removal of the line. A bloodstream infection can be caused by carelessness at the hub by contaminating the end of a tubing or syringe cannula. However, some patients even though they are well trained and appreciate the seriousness of proper technique are still susceptible to infection just by the very nature of their medical condition. Recurring catheter related bloodstream infection is an ongoing therapeutic challenge in the home PN patient population. Recently, a novel antimicrobial agent called Taurolidine (Rx) has been found to be effective as a lock technique in the prevention of infection.<sup>12</sup>

### 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.

### C.S.G.N.A. DISCLAIMER

The Canadian Society of Gastroenterology Nurses and Associates is proud to present The Guiding Light newsletter as an educational tool for use in developing/promoting your own policies and procedures and protocols.

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

If a central line is ever under suspicion as the source of infection, the recommendation is to stop the PN for at least forty eight hours, obtain blood cultures both peripherally and (retrograde) via the central line. Treat with broad spectrum antibiotics via the suspected line. Once culture results are obtained fine tune the antibiotics according to the sensitivities. So long as the antibiotic treatment is administered through the offending line there is the possibility of salvaging it which is meaningful to the patient and avoids unnecessary line removals and reinsertions. An antibiotic lock or dwell is also a good idea to maximize the interaction of the drug on the inner surface of the central line making it more likely that it will be saved.

Thrombosis is another serious concern for the patient dependent of PN since it can render a vein in essence unusable. The hallmarks of acute thrombosis are the onset of pain and swelling usually in the arm or base of the neck on the side the central line is placed. Less rapid occlusion is associated with noticeable collateral vessel formation on the chest wall.<sup>13</sup> One option for treatment consists of admitting the patient to an ICU bed for close monitoring following the administration of Alteplase Tpa via a new catheter placed right at the thrombus formation site. Dribbling Alteplase Tpa directly on the clot may only prevent the further growth of a clot but may not be able to reduce to any great extent what has already become a well established thrombus. In this case, angioplasty may be attempted or even the placement of

an expandable stent.<sup>14</sup> If there comes a time when the approach to the central veins is not feasible due to occlusion and the superior vena cava is also affected then the only other option is to place what is called a translumbar line with its tip in the inferior vena cava.

**CONCLUSION**

As you can see vascular access is a very grave matter for the patient receiving PN. The interventional radiologists when placing the line need to know that the appropriate vascular access device has been chosen by the clinician who orders it. The number of lumens is usually minimized, the exit site is placed where the patient can readily care for the catheter. Consideration should also be given to the clients preference with relation to the side of the body, making allowances for clothes for example where a bra might interfere with the exit site.

The objective of PN for the patient on longterm therapy is to achieve and maintain a desirable body composition and a capacity for physical and mental work. Many Home PN patients are participating in life fully and appreciate the advances in medicine that have afforded them the opportunity to resume their activities with their families and friends. The nurse can play a great role in ensuring the safe delivery of this treatment without interruption due to mechanical or septic problems. The nurse by being a patient advocate, communicator, teacher and caregiver can make a real difference in the successful treatment for this special patient population.

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**MOVING?  
LET US KNOW!**

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# GI Certification and Competency: What it means to You!

Submitted by Kathy Van Veen RN, MN

During a week in November 2002, nine gastroenterology nurses from across the country gathered together at CNA House in Ottawa to define and develop competencies for gastroenterology nursing. These competencies will be the guidelines for developing exam questions for the GI Certification program. The individuals involved included Cindy Hamilton, Maria Cirocco, Terry LeDressay, Debbie Taggart, Anna Tsang, Cindy James, Nancy Kilfoil, Michele Paquette and myself. Why we were there, what we needed to accomplish and how this will affect you and your nursing practice is the basis of this article.

**Certification** is the validation of knowledge and skills. It is a periodic, voluntary process through which individuals can meet established national standards. The purpose of the Canadian Nurses Association Certification Program is to promote excellence in nursing care through the establishment of such standards. Specifically, the advent of this program allows the opportunity for gastroenterology nurses to identify and confirm their competence within their specialty. Currently, there are 11 specialty certification programs in Canada with gastroenterology nursing as one of the latest additions! Through the dedication and hard work of the CSGNA Executive, the recognition of GI Nursing in Canada as a specialty area has been accomplished.

**Competency** in the dictionary is defined as "capable, sufficient, and adequate to do the job" (Oxford, 2003). In nursing, competency can be defined as job-related knowledge and skills that are required for performance at the level defined by members of that specialty. A specifically defined list of competencies in a specialty area, provide the foundation for exam development. The exam should focus

on common clinical situations, a core knowledge of the specialty, observable behaviours and specific actions performed. What a good list of competencies does is provide clear statements of what is considered to be important to the performance in that specialty (Alien & Nagy, 1995).

The task of the group in Ottawa was to identify those competencies specific to gastroenterology nursing, once they are defined these competencies will then be used as a basis for exam development. It was clear from the onset, we would need to expand beyond diagnostic procedures and encompass everything from nutritional support to liver disease. This group came with a variety of experiences and extensive expertise from many different clinical areas and settings. Consequently, this provided us with lively discussion and challenged the group to come to a consensus on what should be included in the gastroenterology (GI) competencies. The work included developing a framework for GI nursing, and outlining categories within that framework. Across Canada, six CSGNA chapters, approximately 40 people, are currently reviewing this initial draft. Our group will be convening again in a few months via teleconference to finalize these competencies. Once this is complete, another group of GI Nurses will meet in Ottawa to formulate and finalize the exam questions.

What does all this mean to you? Historically, graduation from a nursing program and the successful passing of licensure exams presumed competency of nurses through their careers. Nursing professions have recently acknowledged that this is no longer realistic in today's practice settings, particularly, with the rapid ongoing changes in health care technology and the explosion of nursing knowledge worldwide (Cook, 1999). Continued competence,

are the current buzzwords within nursing professional associations across the country. There is an expectation that nurses demonstrate how they maintain their knowledge and skill levels within their area of practice.

The exciting news is that the advent of GI Certification allows gastroenterology nurses the opportunity to effectively demonstrate continued competence. Successful completion of the exam validates your qualifications on a nationally recognized level, and demonstrates a commitment to ongoing nursing excellence. Furthermore, it is a great opportunity for personal growth and satisfaction, and may be recognized within local Collective Agreements with a monetary increase in hourly wage. If you are interested in a baccalaureate degree in nursing, certification can provide credit towards your degree, as well as, provide you with greater career advancement and opportunities.

Certification, along with participation in your local CSGNA chapter and attendance at national conferences all contribute to maintaining continued competence in your profession! I strongly encourage each of you to consider certification and to get the word out to your colleagues regarding the current work being done on certification. It is an exciting time for CSGNA as we continue to move Gastroenterology Nursing into the future!

## REFERENCES

- Allan, P. & Nagy E. (1995). Competencies Defined [Online]. Bowling Green, Ohio: Career Services Bowling Green State University. <http://www.bgsu.edu/offices/sa/career/students/competencies.html>
- Cook, C. (1999). Initial and continuing competence in education and practice: Overview and summary. *Online Journal of Issues in Nursing* (September 1999). <http://www.nursingworld.org/ojin> Accessed February 2003.





## THE SCOPE OF TORONTO: TOP TO BOTTOM HOLIDAY INN SELECT – TORONTO AIRPORT TORONTO – SEPT. 18-20, 2003 LAST CALL FOR ABSTRACTS 2003

The CSGNA is hosting its annual conference, in Toronto, September 19th AND 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
- New Procedures

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 31, 2003**

# We Have So Much to Give

Have you ever considered how valuable a learning centre GI Units can be?

In Saskatchewan the Nursing Programs are encountering tremendous challenges in providing practical experiences for their students. Finding Medical/Surgical areas that are not under crisis management (high patient acuity, low staffing levels, low morale) is difficult. The massive transition from inpatient to outpatient clinics has increased dramatically leaving what is perceived by the Schools of Nursing fewer places for students to gain practical experience.

The GI setting is rich in culture and expertise. In a GI setting a student is able to practice technical skills such as intravenous placement and therapy, medication administration, enema administration, tube placement, and vital sign monitoring. More experience includes the nursing processes, such as, admission assessment, preprocedure teaching, intraprocedure participation and post procedure monitoring and discharging. Students will gain first hand knowledge and practice of infection control, being able to practice universal precautions in a day to day real life scenario. One of the greatest

attributes a GI setting can offer our future nurses is the beauty of teamwork. The culture of GI Units is one very rich in teamwork showing the benefits of people working together. Nurses, physicians, LPN's, technical aides, service aides, and housekeepers work together on a daily basis making these Units function like a fine tuned automobile (which requires a great team of mechanics). By working side-by-side with the nurse, students are able to benefit from the collaborative methods and contributions of other members of the team.

In our Unit in Regina we have become one of the popular spots for nursing students. It did not come easy. We have advertised ourselves at great lengths to prove we have much to offer. Mentoring students has become part of our everyday lives in our Unit. We view this as a win-win situation. Not only do the students benefit from their experience, so do the staff. Nurses in particular are given a chance to make a positive impact on our future nurses. They are able to show them how rewarding clinical practice can be under a hectic and challenging pace. Students are helpful, in our units we function most

often at a very hectic pace, students can help in relieving some of that pressure, by monitoring vital signs, IV therapy and portering. Mentoring students can bring enrichment to nurses, allowing them to showboat their expertise and maintain high standards of care. There is also the beauty of being surrounded by the energy and exuberance of youth, it becomes contagious.

We are fortunate to have students come through our area on a regular basis. We accept students at all levels of their training. To date the feedback has only been positive. That feedback has identified us as a hot spot for nursing students.

We have so much to give and it is our responsibility to help retain our students. The GI setting provides a new and unique environment, allowing students to experience all facets of the nursing process. If your area is student-less, perhaps you should be contacting the nursing faculty and show them what you have to offer. Students will have delightful, memorable experiences, as will you.

**Lorie McGeough**  
President CSGNA

**QUESTION: "CJD SCREENING" AN INFECTIOUS CONTROL DEPARTMENT WOULD LIKE TO KNOW IF ANYONE IS DOING ANY KIND OF SCREENING FOR CJD IN THEIR DEPARTMENTS?**

Could you kindly return your answers to our Practice Director Jean MacNab in Ottawa.

## *Future National Conferences*

2003 Toronto, Ontario

2004 Calgary, Alberta

# Hospital Merger – an Ottawa perspective

In 1999 talks began to merge two teaching Hospitals and a community Hospital in Ottawa. A fourth hospital, which was a Community Hospital, was slated to close. The General Hospital was the bilingual teaching hospital, the Civic the English teaching Hospital, and the Riverside was the community Hospital to be merged. The Salvation Army Grace Hospital was slated to close.

The Riverside closed as an Inpatient hospital and reopened in 2000 with only Outpatient facilities. The change in care delivery had a big impact on the Riverside Hospital staff. The staff at the Grace were also affected as their hospital closed and the nurses and clerks were bumped into new positions and work areas. Bumping, although common practice in today's work environment has long lasting effects. Friendships and working relationships that have lasted for years are suddenly gone leaving the nurse with a deep sense of loss and insecurity about the future.

The Riverside now has an efficiently run Endoscopy unit with two rooms running most days. The Therapeutic procedures have moved to the teaching Hospitals. Although the working environment is new for this staff, they work very well together as a team. The next big challenge for this team is the movement of the unit from their present location to a new location in the hospital and the addition of one more room. This transition should occur in the Fall of 2003.

The General and the Civic Endoscopy units remain much the same since the merger in terms of the types of cases done. The acuity has definitely increased over the last two years. The age and the overall health status of our

patient's have changed. We are also doing more challenging techniques on these outpatients. Five years ago we would never have done a PEG or inserted a stent on an Outpatient. This now happens on a frequent basis.

With the merger now into its third year and accreditation around the corner we are looking at a Standard approach to care. On the surface, this sounds quite straightforward. In terms of procedures we are all doing similar tests. However, from admission to discharge the approach is quite different but the outcome the same. Culturally these 3 Units are very different. The culture does not have to change in order to standardize.

I think it best to start off small and build a sense of accomplishment among the players. To date we have done the following:

Our first major project we worked on was a flow sheet for the Physicians to use. The Physicians had three different charts to work with and wanted one sheet with pictures on it that they could work from. We combined standing orders from one unit with a history form from another unit. This has taken 10 months to complete but it is now done.

The second project the nurses did was to compare and revise the Patient Handouts we have in all three units. We now have a simplified version. Once it is translated and available in a bilingual format that project will also be completed.

The Policies and Procedures are next. To date we have 2 Corporate policies completed. The first policy is about giving conscious sedation if the patient does not have a ride, and the second is how to deal with rooms running late.

Purchases and supplies are a very costly part of running an Endoscopy unit. We are presently reviewing all the supplies we use with the intent to standardize all available supplies with the best product at the best price. We are currently doing a trial with a new forcep at all three sites simultaneously. The advantage to this is the feedback can all be evaluated in the same time frame, which makes the decision making easier.

The biggest challenge we will face this year is the implementation of the New Model of Nursing Care. This new model will be the basis from which care is administered at the Ottawa Hospital. The model combines the many types of Care Delivery we had. Some of these models are primary nursing, case management, team nursing and the Friesian approach.

Our 3 units are in the unique position to grow in this changing environment. Since the merger the nurses have become better acquainted not only through our local CSGNA evening sessions but also with working together on projects, floating between units and giving each other inservices. We can learn so much from each other.

As we move into 2003 we must keep reminding ourselves of our accomplishments instead of being overwhelmed with what we still have to do. Mergers are not easy and we are constantly being reminded that something else has changed. At the end of the day we need only to keep our focus on what we do best and that is to look after our patients in the best possible way. There is no absolute right way to do this.

**Jean Macnab – Manager Corporate Endoscopy Ottawa Hospital.**

# Quebec City Conference

I attended a nursing conference in Quebec City Nov. 22-24th, 2002. They had a great response with 103 registrants out of 110 membership. I spoke to them about Certification and gave out surveys on the same. I have received 37 responses to date. The results are as follows:

- 22 wish to write the exam in 2004.
- 3 will write in 2005, and 12 at other times.

About joining CSGNA:

- 27 said yes.
- 10 said no.

Examination in French:

- 27 said yes.
- 3 said either French or English.
- 7 did not respond.

About assisting with exam development:

- 24 people said yes.
- 13 said no.
- 7 people said they were not interested in Certification. 5 of the 7 listed their reason as being their impending retirement.

I felt that I was well received and I was invited to sit with Judy Ann Boyer for lunch and she is quite receptive to Certification. She encourages her membership to support our quest for Certification. The group is having problems finding executive positions as 6 people on the executive expressed a desire not to run again, and of those 6 people 3 of them have been in their current positions for 10 to 12 years. They have offered to do an extra preceptor year to coach new recruits. They

also suggested that if no one offers to run for the positions, there is a good chance that the association will fold.

There was nomination from the floor for a vice president after these statements. He had never served on the executive.

Francine Paradis, a representative from Boston Scientific, said that her company would be interested in supplying translation at our Toronto conference. We asked for a show of hands for those who would be interested with this idea, a show of 30 hands responded. I was approached by a current executive member who has served for 10 years, he is considering running for our executive!!! Interesting n'est-ce pas??

**Submitted by Vice President,  
Nancy Campbell**



## MESSAGE FROM THE PRESIDENT

I would like to extend my sincere gratitude to all that participated in the competency development. This is so exciting. We are so close to achieving our goal of certification. All the years of hard work is coming to harvest. Next step is the item writing, ladies and gentlemen, get your computers ready.

This year our celebration for National GI Days will highlight Certification. It will be very important for us to advertise our specialty. By promoting our specialty we will hopefully gain recognition within our Health Regions and sites. Job security can be discussed and challenged. Perhaps monetary benefits can be discussed with each individual employer. There are benefits to be had; certification is the first step towards them.

The CSGNA will be meeting in April for our face to face meeting. If anyone has any issues or ideas please submit them to your Director for presentation in April. We welcome all feedback and ideas.

Take care and have a great year.

Lorie McGeough

## PRESIDENT ELECT REPORT

The Bylaw committee have been busy revising bylaws and writing new ones.

These will be reviewed by the Board at our Face to Face meeting in April.

They will then be submitted to you the membership for your vote at our national conference in Sept. 2003.

I will be attending the SGNA conference in Atlanta, Georgia in May.

I am looking forward to our national conference in September in Toronto.

Yours in CSGNA,  
Nancy Campbell.

## REPORT FROM EDUCATION DIRECTOR

Time is just going too fast and we are already two months in the year

2003. The Education Committee has been busy responding to the needs of our members. We have sold 8 orientation manuals and responded to many requests from the members seeking for Standards of care; teaching pamphlets, Position Statements and guidelines. The manual for Cleaning and Dinsinfecting of scopes is finalized and will be ready for distribution in April. You will be able to find the information on our website to order the manual and in our Guiding Light.

The Chapter revision packages will be mailed to the Chapter Presidents in April. We hope this will be helpful to you and if there is anything you wish to be included in the package to make your life easier please do not hesitate to let us know.

Just a reminder that there are scholarships available for the annual conference and the deadline is May 1.

## Certification update

As you are aware the year 2004 will see the administration of the first Certification examination in Gastroenterology Nursing in Canada.

The development of the Certification Examination is funded by the Canadian Nurses Association and CSGNA, and the whole project is managed by Assessment Strategies Inc.

We have completed the initial step in the development of a certification exam and that is the preparation of a set of competencies i.e. skills, abilities and knowledge required to practice gastroenterology Nursing in Canada. This process brought together nurses from different provinces in Canada for a period of 5 intense days. This document is now being reviewed by gastroenterology nurses across Canada, working in different clinical settings, that are regarding the appropriateness and relevance of the draft competencies. The Presidents of different local Chapters were approached by C N A and were asked to recruit 5-6 nurses who were willing to provide their written feedback and attend in the near future a 2-3 hour meeting in their local area.

## What is left to do?

Next month the competency group will review the feedback from your colleagues and a final document will be issued.

In April the blue print committee will be formed and will develop the recipe for the exam.

In May-June and June-July another group of nurses will attend a five day session at CNA for item writing as well as on line session. So we will be recruiting more nurses to help us with the process.

In September the exam committee will spend 5 day session at C N A to finalize the exam.

In the Fall the exam will be translated and reviewed by a committee.

In Spring 2004 the exam should be ready for distribution.

Respectfully Submitted,  
Michele Paquette CGRN

**CSGNA Education Corner**

Announcements from the Education Committee

- CAG/CSGNA Scholarship applications in this and every issue.
- Criteria for scholarships in this issue.
- Orientation package for GI units being developed.
- Check out the HepNet website [www.hepnet.com](http://www.hepnet.com).

Education Committee Members:  
 Deb Taggart – Calgary  
 Evelyn McMullen – Halifax  
 Jean Macnab – Ottawa  
 4 members at large  
 Education Chair, Michele Paquette  
 Phone: 613-737-8384

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## REPORT DIRECTOR OF PRACTICE

During the past year I have answered many queries about Infection Control Practices and Staffing levels in Endoscopy. These questions are very welcome questions as they cause us to reflect on our practices. The most recent question I received was on NPO status. The question was "should NPO status be a requirement if the patient is requiring conscious sedation". In my own experience the patients are always fasting at least 6 hours prior to a Gastroscopy or Bronchoscopy. The patients in our Unit having a Colonoscopy can drink fluids up to 2 hours before the procedure. When we ask the NPO status we are checking if it is 2 hours before the test. In our experience we have not experienced any vomiting with this practice. I would welcome any ideas you have on this subject.

Jean Macnab

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## SYNOPSIS OF CSGNA NATIONAL EXECUTIVE E-MAIL MEETING

December 9-12, 2002.

1. REVIEW AND ADOPTION OF AGENDA:  
A motion was passed to adopt the agenda after being reviewed. Michele/Edna.
2. REPORTS:  
Directors gave their reports and these are in the Guiding Light.
3. TREASURER REPORT:  
First payment to CNA for our exam has been sent. Conference expenses were not completely paid, as we are still waiting for money promised. Cost to set up visa payments on our website is \$50.00 - \$100.00, and a 4% for each transaction.
4. BYLAWS:  
#6 Board Financial Reimbursement Policy. Add # 7. New Board members will have their attendance at the Annual Conference paid by CSGNA. Members will vote on new Bylaws prior to September

Conference in Toronto. In future members will be using one ballot for both Nomination and Bylaw. This will be finalized at the April conference.

5. NOMINATIONS:  
Positions opened for 2003 are, Secretary, Education, Treasurer, Practice, Director East, and Director West.
6. NEWSLETTER:  
Abstract from Maria Cirocco regarding poster presentation are in the Guiding Light. Articles are still needed, approach all chapter and units for articles. Scholarship criteria is also included in each issue of the Guiding Light.
7. CERTIFICATION UPDATE:  
Competencies have been developed, and Michele will give her report on this. Chapter packages have been completed. Teaching guide for Reprocessing Flexible Scopes are ready for distribution, at a cost yet to be determined.
8. PUBLIC RELATIONS:  
Deb Taggart has proposed the CSGNA, website be updated, and allow Webray.com to redesign the webpage. A motion for this proposal was passed Nala/Nancy.
9. PRACTICE:  
Jean is working on Position statements on Nurse Performed Sigmoidoscopy, and Guidelines for Assisting with Bronchoscopy.
10. TORONTO UPDATE:  
All Board members will be part of the prep course. The Chapter/Executive meeting will continue on Thursday night @ 1730, with a light snack, as the Toronto group has an event planned for that night which includes a meal.
11. THE QUEBEC CONNECTION:  
Nancy attended the G.I. conference in Quebec November 22-24, spoke on certification, and felt it was well received.
12. EDMONTON CHAPTER:  
This Chapter will be collecting the National fees, and forward them

to the National Treasurer. Regina Chapter has been doing this for years, and it works well.

### 13. WORLD CONGRESS:

This is SIGNEA'S only conference. Cindy Hamilton is the Canadian representative. Both Lorie and Cindy will be attending this conference.

### 14. FACE TO FACE

CONFERENCE:  
April 11-13, 2003. Toronto

Respectfully Submitted,  
Elaine Binger, CSGNA Secretary.

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## REPORT FROM THE DIRECTOR, PUBLIC RELATIONS

Since assuming this role in Sept. 1, I have been focusing on the Website. Working with Mary Carbonneau at WebRay, we have been looking at improvements to meet our members' needs and to better promote Gastroenterology Nursing Practice. Members have put many suggestions forth and all have been seriously considered. From the national executive email conference in Dec., the decision was made to update the look of the site promptly but to assess the value/cost of additions. Some of your suggestions have included: online membership renewal, online Guiding Light, contact list of nursing experts for specific areas of practice (especially therapeutic endoscopy), online membership list, potential certification exam questions, and case study examples with images to name only a few. All of these additions come at a price but need critical review if we are to assist our members in keeping current by the most efficient means possible. I welcome your suggestions and will present at our face to face meeting in April.

I believe we need to implement many of these changes, acknowledging that we hope to have an expanding membership with Certification. We need to recognize our Certification is for all nurses in gastroenterology practice whether medical, surgical, pediatric, parenteral therapy or research

nurses. Some of us need to broaden our vision that GI nursing is only endoscopy. Our patient care will only improve if we take a more holistic view of our practice. "On the Road to Certification" we hope to attract more members who will enhance and expand our thinking in how best to care for our GI patients.

Sincerely,  
Debbie Taggart

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### UPDATE FROM YOUR TREASURER

The financial aspect of the Newfoundland conference is finally completed, and all of the hard work of the chapter has paid off. Last years profit was approximately \$14000.00. Great work ladies. The national conference is the main fundraiser for the National component of the CSGNA with 10% going to the hosting chapter. I would like to remind all chapters that the year end reports are due. If you do not have a copy of this form please let me know & I will e-mail or send it to you. The financial statements have once again been submitted to our accountant at PricewaterhouseCoopers LLP for our annual review. This will be presented in our annual report. Any questions or concerns please contact myself or any member of the Executive.

Sincerely,  
Edna Lang

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### NEWS FROM YOUR MEMBERSHIP DIRECTOR

I would like to welcome all of our new members that have joined in the last few months. Our membership is 534 as of Feb 28 / 03. As everyone should be aware our membership runs from June to June of each year, and renewals will be sent out in April. Please fill out the application completely and please print so we can keep accurate records.

Sincerely,  
Evelyn McMullen  
Membership Director

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### CANADA CENTRE REPORT

The Greater Toronto Chapter: they hosted an education evening on ENDOSCOPIC ULTRASOUND on Feb 19th, given by Dr. Paul Kortan, a gastroenterologist with the St. Mikes's group. The evening was sponsored by Carsen Group, we would like to thank Carsen for their continued support to our educational cause. The evening was attended by 70 members and was a great success.

Some members from the chapter are busy planning the upcoming national conference in Toronto.

The Ottawa Chapter: they hosted an evening on ENDOCINCH – Endoscopic Suturing Device in February. The evening was sponsored by BARD Canada. The session was followed by a dinner at Capone Restaurant.

The London Chapter: they will be hosting an education evening on March 3rd, 2003 at the London Health Sciences Centre, University Campus. The topic is "COLON SCREENING" by Dr. J McDonald. Their sponsor will be PENTAX Precision.

The Golden Horseshoe Chapter: is planning an Educational Day Event at the Inn on the Twenty in Jordan for June 6th, 2003, from 0815 to 1545. Registration Fee: \$65.00 for member, and \$75.00 for non-members. Applications must be received by May 10th, 2003. The topic is "TIPS" and "ENDOCAPSULE" given by Dr. John Rawlinson and Dr. John Marshall respectively. Dr. Seaton will be sharing his experience in the Cayman Islands. Other topics will include, "SINGLE USE". Several sponsors are involved with this event.

Good job everyone, keep up with the good work and all the best.

Submitted by,  
Belinda Tham,  
Canada Centre Director

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### CANADA EAST REPORT

I am not sure if it is the mountains of snow or the bitterly cold temperatures that are keeping us indoors but things have been very quiet on the eastern front.

The NFLD chapter have not met since the fall for a regular meeting. The conference planning committee did go out to dinner and reminisce about the "FUN" we had planning the 2002 conference in St. John's.

Plans are in the works for an upcoming inservice to be given by one of our ENT physicians on "ESOPHAGITIS & TREATMENT".

A small group from our chapter is involved with revision of the competencies from CNA for the upcoming Certification exams. A meeting was planned for February to discuss feedback on our initial assessment.

I would like to say congratulations to Paulette Bassett and Bonnie Greydonas on their recent election as president and vice president to the NB/PEI chapter.

Looking forward to the face to face Board meeting in April.

Submitted by,  
Joan Rumsey,  
Canada East Director

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### CSGNA DIRECTOR CANADA WEST REPORT

The Specialty of Gastroenterology Nursing is fast becoming a reality as we move towards C.N.A. Certification. How exciting to anticipate National recognition for the work that we do. Many CSGNA members are, have and will be actively involved in this complex process. The CSGNA has had this vision for about 10 years and much ground breaking was done to get to this exciting point in our evolution. As Director Canada West, I am happy to report that three Chapters from the West have been assigned to critique the Competencies. They are Edmonton, Regina and Vancouver Regional. Meetings including several members from each of these Chapters are currently

taking place. Deadlines are being met! Most G.I. Nurses that I speak with view writing the exam with a sense of doom and dread! I would project that each of us knows far more than we ever realized! With some study, review, networking and support, I feel this will be an attainable reality.

**Nala Murray**

## **CHAPTER REPORTS:**

### **Manitoba Chapter**

Secretary Janet Shymanski, reports that a Chapter Meeting held in October was sponsored by AMT. With a presentation called "New Possibilities in Electrosurgery". That meeting welcomed the New Chapter Executive and President; Jennette McCalla paid tribute to Sylvia Dolynchuk in recognition for her years of service with the Manitoba Chapter of CSGNA. Roberta Thompson was also recognized for her past service as Secretary and was presented with a gift. At a meeting held at Seven Oaks General Hospital on January 9, 2003, 20 members attended. Excellent turnout! They had an Educational session entitled "Medications for Procedural Sedation" (Actions and Interactions).

The Chapter is busy planning their local Spring Conference to be held May 3, 2003 at the Norwood Hotel in Winnipeg.

### **Edmonton Chapter**

On Saturday, May 03, the Edmonton Chapter will be hosting a Spring Conference called "Spring Into Endo." Topics to include a comparison between Pediatric and Adult GERD, Updated versions of Colonic Stents, and a GI Research Nurse will be giving an update on What's New. The Chapter would like to recognize the members from their Chapter, who are involved with the GI Competency Review, they are Helga McCallum, Jan McNeil, Marla Wilson, Tammy Grund and Shelley Bible. They wish to pass on CSGNA wide condolences to Cherry Weatherman, a long time member whose spouse recently passed away.

### **Regina Chapter**

President Shirley Malach reports that a dinner meeting was held in January to set the Chapters' goals and objectives for the upcoming year, as well as to review the events of the past year. The meeting was well attended in spite of the very cold weather and we accomplished a great deal. Chairpersons and volunteers were chosen to co-ordinate upcoming events such as National G.I. Nurses Day, and our local Fall Conference. We also discussed scholarships for the CSGNA National Conference and ways to increase our membership. The next meeting is scheduled for sometime in June where we will start to work on the program for our local fall conference.

### **Calgary Chapter**

President, Evelyn Matthews reports that a dinner meeting held on November 14, 2002 and was sponsored by AMT. Discussion centered around the 2004 National Conference which they are hosting. A venue was chosen for the National Event.

On January 7, 2003, a business meeting was held. Deb Taggart, a member of the Competency Development Committee, spoke about the Certification process and Examination development. Topics and dates for future education sessions were decided upon. The next education session will be on February 20, 2003 with Jenefer Pardy from Southmedic presenting "Capsule Endoscopy".

### **Okanagan Chapter**

Secretary, Jean Tingstad reports that they attended a workshop on "Nursing Care of Patients receiving Conscious Sedation". Emphasis was on the Nurses' role, responsibilities and Practice Standards. Endoscopy Services are expanding in Kelowna. The Chapter members have been very involved in the workplace, sharing their knowledge and skills to formally orientate nurses new to Endoscopy. They are looking forward to the Canadian, Gastroenterology Certification. Two nurses will soon be ready to re-certify and 2-3 nurses are anticipating their first Certification Exam.

### **Vancouver Island Chapter**

Irene Ohly has recruited a new Chapter Secretary, Shirley McGee. Welcome aboard, Shirley.

The Chapter members have attended sessions on the Use of Endo-loop and Endoclip by Dan London of Olympus, and an ERBE Inservice. They had a four hour introduction to PDT as this service will soon be available.

The Endoscopy Clinic at Royal Jubilee Hospital in Victoria has been amalgamated with Respiratory, Ophthalmology, and Colposcopy clinics at a new Out Patient Clinic.

### **Vancouver Regional Chapter**

Official handing over of duties to the new Chapter President; Adriana Martin has been delayed due to the Chapters' involvement with the C.N.A. Certification process. The Chapter plans for a dinner meeting at the end of February sponsored by Carsen Group. Adriana is keen and enthusiastic and has plans for the spring Education Day. She works at Lion's Gate Hospital in North Vancouver, the place where the Whistler patients go!

**Respectfully submitted,**

**Nala Murray**

**CSGNA Director Canada West**

## **NEWSLETTER EDITOR REPORT**

As you can see the buzz word is, "Certification". This is only the beginning, so if you have not been infected as yet, it will not be long before the bug comes your way. I do not think we can be beaten so I suggest you join the certification wagon. Study groups are the order of the day. This winter being as harsh as it is, a Gastroenterology Book is not a bad read curled in front of a nice warm fire, with a mug of hot chocolate and your pet, (if you have such critters), at your side. Get in the GI Cert Groove and pass it on...

**Submitted,**

**Kay Rhodes**



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**THE SCOPE OF TORONTO:  
TOP TO BOTTOM**

**HOLIDAY INN TORONTO AIRPORT  
SEPT. 18 - 2, 2003**

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## **CONTEMPLATING MERGERS AND ACQUISITIONS. HERE ARE A FEW TO KEEP AN EYE ON:**

1. XEROX and WURLITZER  
(They're going to make reproductive organs)
2. FAIRCHILD ELECTRONICS and HONEYWELL COMPUTERS.  
(The new company will be called Fairwell Honeychild)
3. POLYGRAM RECORDS, WARNER BROTHERS and KEEBLER.  
(The new company will be called Poly-Warner-Cracker)
4. W.R. GRACE CO., FULLER BRUSH CO., MARY KAY COSMETICS, and HALE BUSINESS SYSTEMS.  
(The new company will be called Hale, Mary, Fuller, Grace)
5. 3M and GOODYEAR  
(The new company will be called MMM Good)
6. JOHN DEERE and ABITIBI-PRICE  
(The new company will be called Honey Deere Abi)
7. HONEYWELL, IMASCO and HOME OIL.  
(The new company will be called Honey Im Home)
8. DENISON MINES, ALLIANCE and METAL MINING.  
(The new company will be called Mine All Mine)
9. GREY POUPON and DOCKERS PANTS.  
(The new company will be called Poupon Pants)
10. KNOTT'S BERRY FARM and THE NATIONAL ORGANIZATION FOR WOMEN.  
(The new company will be called Knott NOW)
11. ZIPPO MANUFACTURING, AUDI, DOFASCO and DAKOTA MINING.  
(The new company will be called Zip Audi Do-Da)
12. MOTOROLA and ENRON.  
(The new company will be called MORON)

### **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



## **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
CBGNA certification	1 Point
Types format	1 Point

REVISED September 2002

M. Paquette, Education Director

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# Canadian Society of Gastroenterology Nurses & Associates

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.**

NAME: \_\_\_\_\_

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ PROV: \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_ HOME TELEPHONE: ( ) \_\_\_\_\_

FAX: ( ) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

HOSPITAL/EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ PROV: \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_ JOINED THE CSGNA IN \_\_\_\_\_ (year).

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

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# Canadian Society of Gastroenterology Nurses & Associates

CSGNA Membership runs from June to June of each year.

27 Nicholson Dr., Lakeside, Nova Scotia B3T 1B3

## MEMBERSHIP APPLICATION

(CHECK ONE)

ACTIVE  
\$40.00

Open to nurses or other health care professionals engaged in full- or part-time gastroenterology and endoscopy procedure in supervisory, teaching, research, clinical or administrative capacities.

AFFILIATE  
\$40.00

Open to physicians active in gastroenterology/endoscopy, or persons engaged in any activities relevant to gastroenterology/endoscopy (includes commercial representatives on an **individual** basis).

LIFETIME  
MEMBERSHIP

Appointed by CSGNA Executive.

## FORMULE D'APPLICATION

(COCHEZ UN)

ACTIVE  
40,00\$

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.

AFFILIÉE  
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.

MEMBRE  
À VIE

Appointed by CSGNA Executive.

## APPLICANT INFORMATION / INFORMATION DU MEMBRE

Please print or type the following information / S.V.P. imprimer ou dactylographier l'information

SURNAME / NOM DE FAMILLE \_\_\_\_\_ PRÉNOM / FIRST NAME \_\_\_\_\_  
 MR / M    MRS / MME    MISS / MLLE    MS / MS

HOME ADDRESS / ADRESSE MAISON \_\_\_\_\_

CITY / VILLE \_\_\_\_\_ PROV. / PROV. \_\_\_\_\_ POSTAL CODE / CODE POSTAL \_\_\_\_\_ HOME PHONE / TÉLÉPHONE (   ) \_\_\_\_\_

HOSPITAL/OFFICE/COMPANY NAME / NOM DE HÔPITAL/BUREAU/COMPAGNIE \_\_\_\_\_

TITLE / POSITION \_\_\_\_\_ E-MAIL: \_\_\_\_\_

BUSINESS ADDRESS / ADRESSE TRAVAIL \_\_\_\_\_  
CITY / VILLE \_\_\_\_\_ PROV. / PROV. \_\_\_\_\_ POSTAL CODE / CODE POSTAL \_\_\_\_\_

BUSINESS PHONE / TÉLÉPHONE TRAVAIL (   ) \_\_\_\_\_ EXT. LOCAL \_\_\_\_\_ FAX / TÉLÉCOP. (   ) \_\_\_\_\_

CHAPTER NAME / NOM DU CHAPITRE \_\_\_\_\_ TITLE / POSITION \_\_\_\_\_

SEND MAIL TO (CHECK ONE)    HOME    BUSINESS   ENVOYEZ COURRIER À (COCHEZ UNE)    MAISON    TRAVAIL

EDUCATION (CHECK ONE)    RN    RNA    TECH    OTHER (EXPLAIN)  
ÉDUCATION (COCHEZ UN)    IN    I AUX    TECH   AUTRE (SPÉCIFIEZ) \_\_\_\_\_

MEMBERSHIP (CHECK ONE)    RENEWAL    NEW   ABONNEMENT (COCHEZ UN)    RÉNOUVELLEMENT    NOUVEAU

WOULD YOU BE INTERESTED IN HELPING ON ANY OF THE FOLLOWING COMMITTEES?

- BY-LAW
- STANDARDS OF PRACTICE
- EDUCATION
- MEMBERSHIP
- CONFERENCE PLANNING
- NEWSLETTER

I have enclosed my cheque payable to CSGNA. (Mail with this completed application to the above address.)

SERIEZ-VOUS INTÉRESSÉS À AIDER EN FAISANT PARTIE DE CERTAINS COMITÉS?

- BY-LAWS
- STANDARD DE PRATIQUE
- ÉDUCATION
- ABONNEMENT
- PLANIFICATION CONFÉRENCE
- JOURNAL

J'ai inclus mon chèque payable à CSGNA. (Envoyez avec cette formule d'application dûment remplie à l'adresse ci-haut mentionnée.)

# CSGNA 2002-2003 Executive

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