



The Guiding Light

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Interest and Participation in Support Group Programs Among Patients With Colorectal Cancer

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Previous studies have demonstrated that support intervention improved quality of life and survival for patients with breast, melanoma, prostate, and gastrointestinal cancer. A standardized approach to encourage participation in support group programs among patients with colorectal cancer (CRC) had been initiated at this study site. The purpose of this study was to examine the characteristics of patients with CRC interested in this type of intervention and to identify barriers to attendance at an established patient support program.

Consecutive patients with CRC were informed and encouraged to attend Wellspring, a nonprofit patient support program that offers a wide range of services. A patient survey was conducted and correlated with data on the clinical, social, and demographic characteristics of patients. Factors predictive of interest in the Wellspring support program and barriers to attendance were examined.

Fifty eight patients were eligible for this study. A total of 44 (76%) surveys were completed. Predictors of interest in patient support were age less than 65 years, encouragement from medical staff to attend, level of education, comfort in spiritual beliefs, religious affiliation, and complementary/alternative medicine use. Disease stage, gender, ethnicity, and level of social supports were not significant in this population. Although patients were routinely informed about the program in a standardized fashion, a significant proportion (36.4%) of patients did not recall receiving encouragement. Multiple logistic regression showed that level of education and recollection of encouragement from medical staff were independent predictors of interest. Although 14 patients were interested in attending (32%), only 4 ultimately attended Wellspring programs (9.1%). The most frequently cited barrier to attendance was a perception of adequate support at home, followed by living too far away, no perceived need of supports, and not feeling well.

A significant proportion of patients with CRC are interested in structured support programs, but only a minority of patients ultimately participate in such programs. Further participation may be achieved by recognizing com-

mon barriers to participation and optimizing strategies to enhance attendance. Optimizing use of support services such as Wellspring has the potential to improve the effectiveness of the multidisciplinary cancer care of patients with CRC.

INTRODUCTION

Patient demand for a holistic approach to management, encompassing all aspects of well being, has been increasing recently, especially as consumerism in healthcare increases. Support interventions, distinct from mainstream diagnostic and treatment pathways, have become progressively more popular. Increasingly, self help and professionally led support groups are available to patients suffering from a variety of ailments, including cancer.¹ Much of the early data focused on breast and prostate cancer.²⁻⁴ The increasing popularity of support interventions in the cancer patient population is underscored by studies showing improved quality of life, compliance with therapy, and even early data supporting prolonged survival.^{1,5-7}

Although colorectal cancer (CRC) is the second leading cause of cancer death in North America, the importance of patient support group programs in the context of patients with CRC has not been well studied. Early data are provoking, and a recent modernized clinical trial showed that professionally led support in the pre-operative and postoperative periods in patients with gastrointestinal malignancy significantly prolonged survival.⁸ A secondary

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analysis in the same study confirmed this finding in the specific group of patients with CRC.⁸ Improving recruitment into support programs could be optimized by identifying which patients with CRC would be inclined to participate and what barriers exist to preventing participation. This has not been specifically studied. In fact, support intervention has been traditionally underpromoted by clinicians⁹ and under used by patients.³ We believe that surgically treated patients with CRC will be positively affected if measures are taken to develop a seamless continuum of care from the cancer clinic to the support intervention.¹ The purpose of this study was to characterize the features of patients with CRC who expressed interest in attending a support program and to identify barriers to participation.

■ METHODS

PATIENTS AND STUDY SETTING

Patients were accrued from the practice of a single surgical oncologist (AJS). Data collection was carried out prospectively between July 1999 and May 2000. Eligible patients were those who had surgical treatment for either primary or recurrent colorectal adenocarcinoma. Importantly, all patients had been treated with curative intent and had no evidence of disease at the time of survey.

Patients in this study were seen and treated at the Toronto Sunnybrook Regional Cancer Centre (TSRCC) and the Sunnybrook Campus of the Sunnybrook and Women's College Health Sciences Centre, Toronto, Ontario. This site is an academic institution affiliated with the University of Toronto. Multidisciplinary care is emphasized at the cancer center, with on-site provisions for surgery, chemotherapy, radiation therapy, social support services, palliative care, and the Wellspring support-group program. Importantly, the concept of the "colorectal cancer team" is visibly emphasized in the cancer center, and patients in the study had a single primary nurse (BAM) who worked closely with the surgeon and who was an integral part of the team.

PROMOTION OF THE WELLSPRING PROGRAM

Encouragement was provided with a verbal overview of the Wellspring program by the surgeon-nurse team and an enthusiastic endorsement of the potential benefits of the program. Interviews were always held with the surgeon, primary nurse, and patient, although, in some cases, the primary nurse stayed behind at the end of the interview to expand upon initial questions the patients had about the program. A strong distinction between the standard clinical aspects of the follow up visit and the endorsement of Wellspring was made to reinforce the importance of the support intervention and to distinguish it as a form of additional therapy. Two weeks after the visit, patients received a brochure and cover letter through the mail from the surgeon and primary nurse. The brochure outlined further details of the Wellspring program and contained telephone numbers for those patients who wanted more information.

SUPPORT INTERVENTION

The support intervention in this study was on the on-site Wellspring program and support center. Wellspring is a patient-founded professionally led nonprofit support program that is housed in a separate building located on the hospital campus. The aim of the program is to meet the social, emotional, and other nonmedical aspects of cancer care. Wellspring offers a wide range of support and coping skills programs, including structured patient, peer, and caregiver support. Other activities include Yoga, Qui gong, Meditation, Reiki, and therapeutic or healing-touch programs. The wide breadth of activities available at Wellspring differentiates it from traditional "support groups."¹ Importantly, previous Wellspring participant questionnaires have shown that a great deal of effective support function comes coincidentally in the context of interactions occurring in and around the atypical support activities. The variety of programs available is considered a strength of Wellspring, because previous research has shown that various interventions may be appropriate for different people.¹ Programs are weakly sessions, ranging from 4 to 6 weeks. Patients were not financially charged for joining the Wellspring program.

INSTRUMENT

The instrument used to measure patient interest and barriers to participation in the support program was a structured 15 question survey (Figure 1). The questions were designed to determine programs of interest, patient participation in programs, reasons for nonattendance, ability to recall receiving encouragement from medical staff to attend Wellspring, and social quality-of-life variables. Items in the survey were selected based on previous research that identified factors associated with participation in cancer support¹⁰ and variables that affect quality of life.¹¹ Social variables measured included level of education achieved, religious affiliations, spirituality, and availability of social supports. By differentiating between religious affiliation and spirituality, the investigators sought to discriminate between people who had formal religious affiliation (eg, regularly attended church) and those who may not have formal affiliation but still maintained a sense of a "higher power." Quality-of-life variables measured included mental health, ability to cope with disease, and general experience with the medical community. Thirteen of the questions were multiple choice, and 2 questions (those addressing why people didn't *call* or *attend* Wellspring) had an open-ended component.

All patients in this study received a mailed survey within 3 months after their surgery. Telephone interviews, conducted by a medical student, were used to survey patients who did not respond to the mailed survey.

ANALYSIS

The results of this survey were combined with clinical variables obtained from the TSRCC prospective CRC database. Univariate analyses using the Mann-Whitney U test,

binomial test, and t test were performed to identify factors associated with interested in Wellspring programs. Multiple logistic regression was performed on the data to determine independent predictors of interested. A forward conditional stepwise modeling was used, and a factor was added only when its addition to the model demonstrated significance of <0.05 according to the Chi-square test. A P value $<.05$ was considered significant.

■ RESULTS

There were a total of 58 eligible patients with CRC who were seen during the study period. All 58 patients received a standardized delivery of information and encouragement to participate followed by a mailed brochure. Of the 58 patients, 44 (76%) completed the survey. Numerous telephone calls were made to the 14 patients who did not complete the survey. Of the 14, 12 could not be reached and 2 were not interested in participating. The patients in this study were divided into 2 groups: those who expressed interest in the Wellspring program ($n = 14$) and those who expressed that they did not have a specific interest ($n = 30$). The clinical and sociodemographic characteristics of each group are outlined in Tables 1 and 2. Most patients had early stage disease. Of note, 30 of the 44 patients (75%) were at stage II or less and only 7 patients had surgery for metastases (15.9%). Other than age, there were no significant differences in patient clinical characteristics (Table 1).

Table 2 presents a univariate analysis demonstrating that patient recollection of encouragement from staff, complementary/alternative medicine use, comfort in spirituality, reliance on religious affiliation for support, and level of education were significant factors associated with interest in the Wellspring programs.

The factors listed in Tables 1 and 2 were then included in a multiple logistic regression analysis to identify independent predictors of interest in Wellspring programs. Level of education and recollection of encouragement from medical staff to attend were the only independent predictors. The Hosmer and Lemeshow test for goodness of fit was significant at $P = .001$, and the model had a predictive probability of interest in support of 86.1%. Patients with a college or university education had odds of 22:1 of being interested in support program participation compared with those who did not.

Of the 14 patients who were interested in attending Wellspring, 8 were interested in meditation (57.1%) (Figure 2). This was followed by peer support, patient support, yoga, and Reiki, therapeutic, or healing touch, each with 35.7% interest (5 patients). Meditation was the most popular program at Wellspring in this sample.

Although 14 patients were interested in Wellspring programs, only 4 patients attended, including 3 women and 1 man. All patients who attended reported a positive experience. The barriers to attendance in the remaining 40 patients were analyzed.

Among the 40 patients who did not attend Wellspring the reasons offered for not attending included (1) have enough support already (17, 42.5%), (2) live too far away (14, 35.0%), (3) have no need (13, 32.5%), and (4) not feeling well (11, 25%) (Figure 3). A total of 16 (36.4%) patients reported not attending because they did not understand, were uncomfortable, and/or did not speak English (16, 36.4%). Of the 2 patients who did not attend for other reasons, 1 stated that she was unaware that the programs at Wellspring were running and the other believed that the programs offered at Wellspring were "too feminine" for him.

■ DISCUSSION

Nearly 1 out of 3 surgically treated patients in this study expressed interest in 1 or more of the Wellspring support programs. This significant rate of interest was generated by an intervention process that involved a straightforward brief discussion with the surgical oncologist and primary nurse and an information brochure. Nonetheless, it is clear that further improvements beyond generating interest must be made. Identifying and avoiding potential barriers to patient participation, especially in those who are interested, is paramount to achieving this goal.

Patients' lack of awareness of supports, in part from the failure of physicians to promote support programs, likely represents the single most changeable barrier to participation.^{3,9,12} This is emphasized by our finding that "encouragement from medical staff" was an independent predictor of interest in support-group participation. We, like Berglund et al,¹³ found that encouragement from professional healthcare staff (ie, nurse, surgeon) positively affects patients' interest in support-group participation. Additionally, we found that only in the group of patients who later recalled being encouraged was there a positive association between encouragement and interest. This finding emphasizes the importance of delivering effective and comprehensible encouragement on the part of the clinician. The reason patients do not recall being encouraged may be a function of information overload at the time of the clinic visit and underscores the need to repeatedly make patients aware of the services available to them.¹⁴ More than 60% of the patients in this series recalled learning about Wellspring from the mailed brochure and not from the clinic visit.

The level of education was also an independent predictor of interest in support-group participation. Other studies have also found that level of education was positively associated with support group participation.^{15,16} In this study, the association among patients with CRC is further quantified as odds of 22:1 for patients with a college or university education to express interest in support program participation.

This study found that gender did not relate to level of interest in the support programs for the patients with CRC. However, actual attendance may be gender related. Previ-

ous studies have found that men participated less than women in support groups.^{10,17} This study did not contradict this finding. Krizek et al³ found that although men participated less than women in cancer support groups, the men who attended were as likely as their women counterparts to continue attending. Comments from men in this study included one who expressed “that the programs were too female oriented.” It is possible that presenting gender-sensitive support groups may increase men’s participation in CRC support programs. Krizek et al³ have suggested that the description of “information session” be used as an alternative to “support group” as a potential strategy to increase men’s participation.

It is likely that support programs will only appeal to a subset of patients. Like others, we have also found that interest in support programs is limited to certain patients with cancer.^{10,14} In this study population, patients who were interested in support group participation were more likely to be younger, users of complementary/alternative medicine, spiritually inclined, and reliant on a religious affiliation for support. An awareness of individual coping styles on the part of the clinician will also assist in identifying patients who would or would not be interested in support programs. In those patients who were not interested in the Wellspring programs, we have found, like others³, that adequate supports in the home and no perception of a need for support were common reasons for nonparticipation. Perhaps different strategies and supports would be more useful in those groups.

In our study, unlike Bauman et al,¹¹ distance from the facility was a limiting factor in attendance. Patients’ physical well-being proved to be a limiting factor for some. It is not surprising that issues such as pain control or wound and stoma management might limit attendance for some patients. This underscores the importance of revisiting the idea of support activities as people progress in their postoperative recovery. When acute postoperative issues have been

resolved, patients may be increasingly inclined to embrace additional supports.

LIMITATIONS

This study’s size and scope are limiting. We did not exclude any patient with surgically treated CRC to maintain generalizability. However, by including only those patients who had surgery, these results are only generalizable to groups that have a relatively higher performance status. On the other hand, this study found that physical well-being was a limiting factor to participation, and thus, it is possible that groups with lower performance status would not have high interest or participation rates. The instrument we used was based on previously identified factors, but it needs to be further validated in subsequent studies. It was also applied at one point in time and based on an intervention that occurred during the patients’ primary recovery time from surgery. Further study will be required to address

Table 2 ■ Univariate Analysis of Sociodemographic Factors in Postoperative Colorectal Patients

	Not Interested in Attending Wellspring,* No. (%)	Interested in Attending Wellspring,† No. (%)	<i>P</i>
Ethnicity			.150
Caucasian	22 (73.3)	8 (57.1)	
Other	8 (26.7)	6 (42.9)	
Level of education			.01
High school or less	20 (66.7)	1 (7.1)	
College or university	10 (33.3)	13 (92.9)	
Method patient recalled as introduction to Wellspring			.840
Mail	18 (60.0)	9 (64.3)	
Clinic doctor	7 (23.3)	2 (14.3)	
Other	5 (16.7)	3 (21.4)	
General positive experience with medical staff	29 (96.7)	12 (85.7)	.694
Encouragement from staff	16 (53.3)	14 (100)	.001
Perception of adequate social supports	26 (86.7)	13 (92.9)	.525
Complementary/alternative medicine use	4 (13.2)	6 (42.9)	.001
Reliance or comfort in			
Spirituality	18 (60.0)	14 (100)	.02
Religion	11 (36.7)	9 (64.3)	.03
Predominate emotional state in the past 6 months			
Depression	1 (3.3)	0 (0.0)	.924
Anxiety	4 (13.3)	2 (14.3)	.278
Hopelessness	1 (3.3)	0 (0.0)	.947
Perception of how they are coping			
Poorly or getting by	12 (40.0)	11 (78.6)	
Very well	18 (60.0)	3 (21.4)	

*n = 30

†n = 14

Table 1 ■ Clinical Characteristics of Study Patients

	Not Interested in Attending Wellspring (n = 30)	Interested in Attending Wellspring (n = 14)	<i>P</i>
Median ag, y	71	57	.018
Sex (M/F)	14/16	7/7	.855
Stage, no. (%)			.251
Not available	5 (16.7)	0 (0)	
I	5 (16.7)	4 (28.6)	
II	5 (16.7)	4 (28.6)	
III	4 (13.3)	3 (21.4)	
IV	4 (13.3)	3 (21.4)	
Surgery for, no. (%)			.285
New primary	25 (83.3)	13 (92.9)	
Metastasis	3 (10.0)	1 (7.1)	
Recurrence	2 (6.7)	0 (0)	

Patient Support Survey

ID# _____

- 1) Who provided you with the information regarding Wellspring?
 MD in Clinic
 By Mail
 By other means (please specify): _____

- Don't recall
- 2) When did you receive this information? (Approx.): _____
 _____ Month/Year

- 3) Did you call Wellspring
 Yes When? (approx. date of first contact): _____
 _____ Month/Year
- No Why?
 Please check all that apply:
 Not feeling well enough
 Didn't understand program
 No time
 Live too far away
 I have enough support from family and friends
 I use another support network
 Didn't feel comfortable calling
 I feel there is a cultural or language barrier
 I feel I don't have a need to
 Other reason: _____

- 4) Did you attend any of the Weelspring programs?
 Yes When? (approx. date of first contact): _____
 _____ Month/Year
- No Why?
 Please check all that apply:
 Not feeling well enough
 Didn't understand program
 No time
 Live too far away
 I have enough support from family and friends
 I use another support network
 Didn't feel comfortable calling
 I feel there is a cultural or language barrier
 I feel I don't have a need to
 Other reason: _____

- 6) Have you sought help/treatment from complementary medical sources (eg, chiropractic, herbal, massage)?
 No Yes
 Please specify which ones: _____

- 7) Do you have a religious affiliation that you draw support from (eg, church, temple, mosque)?
 No Yes

- 8) Do you find comfort in your faith or spiritual beliefs?
 No Yes

- 9) Do you feel that you have
 Adequate or Inadequate social supports?

- 10) How do you feel you are coping now compared with when you first received your diagnosis?
 Very well Getting by Not very well at all

- 11) Your experience with the medical community has been generally:
 Negative Negative & Positive Positive

- 12) Did you receive encouragement from medical staff to attend Wellsprings?
 No Yes

- 13) What is the highest level of education that you have attained?
 Less than high school High school
 College University

- 14) How have you felt in the past 6 months?
- | | | | |
|-----------|--------------------------|--------------------------|--------------------------|
| | Never | Occasionally | Often |
| Depressed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxious | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Are there any additional comments you wish to make?

Thank you for your time.

5) Please complete the following table by checking the appropriate boxes (Please check all that apply):

Program Name	Not Interested/ Did Not Attend	Registered- Hope to Attend in Future	Attended but Withdrew Before Completion	Currently Attending	Have Completed	Would Recommend to Others
Peer Support						
Yoga						
Body/Mind Meditation						
Qi Gong						
Patients' Support Group						
Caregivers' Support Group						
Breast Cancer Support Group						
Reiki, Therapeutic or Healing Touch						

the effectiveness of intervention at repeated or later dates. Quite possibly, interest and participation rates may change during a longer follow-up period, but this cannot be determined by the current study design.

Nonetheless, we were able to include 76% of all eligible patients with the broad criteria of surgically treated CRC. This was important for us in addressing the primary goal of identifying the characteristics of patients who were interested in attending a support group program. It is possible that further barriers may have been lost in those who did not respond to the follow-up survey, but it is less likely that this significantly affected our ability to identify characteristics predicting interest. In addition, despite this study's size, our findings are generally consistent with previous studies. However, unlike previous studies, this study is specific to the population with CRC.

CLINICAL IMPLICATIONS

It is clear that as the population ages, a greater number of patients will be diagnosed with CRC. With evidence to support that intervention enhances quality of life and potentially prolongs survival, clinical professionals should encourage all patients with cancer to attend support programs. This study furthers our understanding of the characteristics of surgically treated patients with CRC who are more likely to be interested in support programs and who would respond to a simple reproducible standardized approach of staff encouragement and in information brochure. The study also helps identify those who are not likely to respond to this standardized approach due to either barriers to participation or lack of interest. In these nonresponders, removal of these barriers or modifications to the presentation of support groups will be needed to promote participation. On the other hand, we do remain sensitive to the likelihood that support groups are not necessary and/or not helpful for some patients. Hopefully, this study will help clinicians better identify which patients with CRC would be good candidates for a support-group program. We are already using these results as a basis for further research into improving support-program promotion techniques and for designing alternate methods of support in those groups of patients with CRC who are less likely to join a structured support-group program.

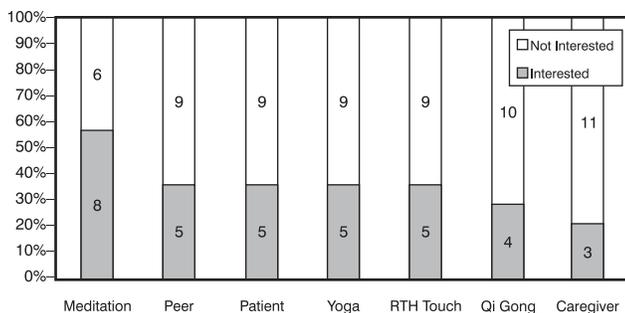


Figure 2 ■ Interest in Wellspring programs among surgically treated patients with colorectal cancer.

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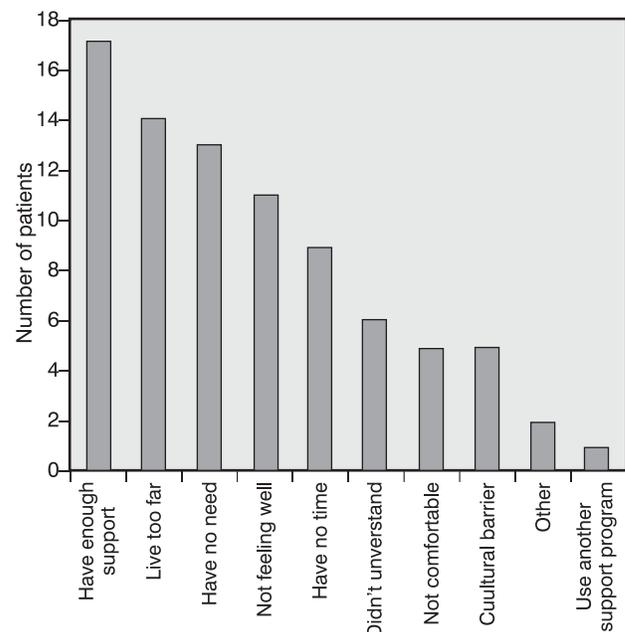


Figure 3 ■ Barriers to Wellspring attendance in postoperative patients with colorectal cancer.

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**CELEBRATE! GI NURSING
NATIONAL NURSING WEEK
MAY 10-14, 2004**

Submitted by Debbie Taggart
Public Relations Director

*Lorie McGeough, President CSGNA,
proclaims
May 14, 2004
as National GI Nursing Day
with the theme
Celebrate! GI Nursing.*

This year is definitely one to celebrate our achievements. 2004 marks the 20th anniversary of CSGNA and our first Certified Gastroenterology Nurses (CGN) in Canada. Choose to celebrate on your unit in a number of ways. Acknowledge those RNs who have gone the extra mile to write the certification exam. Highlight new technology and share with others in your workplace. Recognize changes in practice and/or delivery of care which have impacted our patients. Share with colleagues something new you've learned. Promote GI nursing practice in a way that makes new nurses want to become involved. You get the idea. Celebrate!

WHAT'S IN A NAME?

While studying for the upcoming CNA Gastroenterology exam, I am sure many of you have struggled with the names of the parts of the GI system as I have. Where do they get those names?

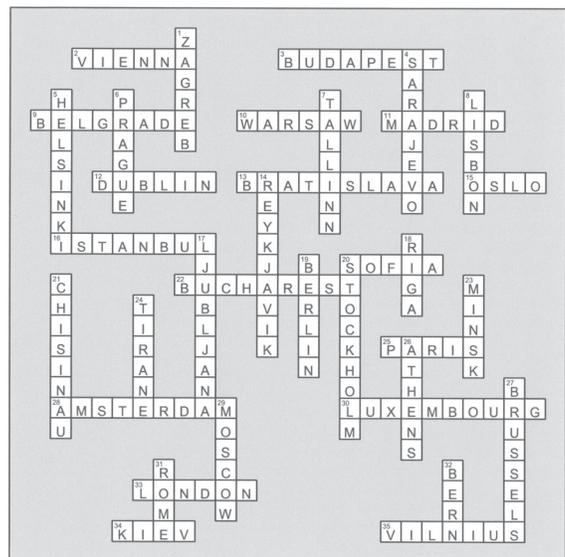
Well, the main pancreatic duct, duct of Wirsung, was named after Johann Wirsung, Professor of Anatomy in Padua, Italy, in 1642. Unfortunately, according to an article by Sanjay A. Pai in CMAJ, Dec 2002, a Belgian student, probably as a result of a quarrel over who first discovered the duct, murdered him in 1643. Apparently Wirsung never knew what the function of the duct was or that the duct was named after him.

In 1720, Abraham Vater of Germany described the nipple-like papilla that now bears his name. It was Giovanni Santorini, an Italian anatomist, who, in 1724, described the accessory pancreatic duct, the duct of Santorini. It wasn't until 1869 that Rugerio Oddi of Italy, you guessed it, discovered the sphincter of Oddi.

I wonder where Bilioth came from ...

Submitted by Elaine Burgis

Answer to Crossword on Page 28



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!

Surgical procedures and nursing care of patients undergoing surgical management for colorectal cancer

Barbara Anne Maier, BScN, RN, CONGO, GI site resource nurse
Toronto Sunnybrook Regional Cancer Centre

Colorectal cancer is the second most common cause of cancer-related death in Canada. (Canadian Cancer Statistics 2001). Colorectal cancer is a malignant tumour that arises from the inner lining of the bowel wall or mucosa and follows a fairly predictable pattern of growth. These tumours can spread through the mucosa to deeper layers of the bowel and to adjacent lymph nodes in the abdomen. As in other malignancies colorectal cancer can metastasize to other organs of the body, primarily the liver and lung.

The primary therapy for colorectal cancer is surgery. In many cases, colorectal cancer is curable when it is surgically removed at an early stage. Chemotherapy and/or radiation therapy frequently plays an adjuvant or supplementary role in the treatment of colorectal cancer patients. Nursing plays a significant role in the care of the surgically managed colorectal patient throughout their care continuum. This continuum starts with the initial diagnosis and follows through the early post-operative period and into the follow-up period.

When the goal of surgery is curative, the aim is the removal of the tu-

mour and obtaining negative or disease free margins of tissue. For the surgical management of colon cancer, the section of the bowel that contains the cancer is surgically removed along with the lymph nodes that drain the area. The remaining sections of colon are joined together (**anastomosis**). This procedure is called a **partial or hemi-colectomy**. For rectal cancer, surgical management is dependent on a number of factors including the size, specific location, stage of tumour (depth of invasion into the layers of the mucosa), whether it is attached to any surrounding tissues, and whether the anal sphincter can be preserved while still achieving negative/disease free margins. As a result of the small bony structure of the pelvis, surgical management for rectal cancer can be challenging. Care must be taken by the surgeon to remove all of the cancer and the surrounding tissues (including lymph nodes) to ensure that all of the cancer is resected. Occasionally, the optimal treatment of rectal cancer is multimodal, with patients receiving pre-operative and post-operative chemotherapy and radiation therapy, as well as the surgical resection of their disease. Rectal tumours

are removed using the **TME or Total Mesorectal Excision** technique, which is applied to both the **abdominal-perineal resection** and the **low anterior resection**. This technique describes the wide excision of the rectum and the associated lymph nodes. This technique has been shown to decrease the rates of local disease recurrence and to increase the chance for anal sphincter preserving surgery thus decreasing the need for permanent colostomies. (Note: a colostomy is a surgically created opening in the abdominal wall through which the colon is brought up and the patient passes feces into a pouch or appliance). The **low-anterior resection (LAR) or proctectomy** is a surgical procedure, which is completed to remove the malignant rectal tumour and preserve the anal sphincter thus resulting in the patient not requiring a permanent colostomy. Reconnection of the colon to the low rectum is made possible by a high tech "circular stapler". The **abdominal-perineal resection or APR** is also a type of resection for rectal carcinoma. An APR is completed if the patient presents with a tumour lower down in the rectum, and a distal negative margin cannot be ob-

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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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.

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tained without compromising the function of the anal sphincter. Patients who undergo an APR receive a permanent colostomy.

The nurse caring for the patient receiving surgical management of their colorectal cancer has a variety of roles along the cancer care continuum. It may start with the support and information exchange in dealing with the new diagnosis of cancer, the preparation for surgery, the preparation and teaching for neoadjuvant (before surgery) treatment, through the post-operative care in the hospital and through follow up and surveillance.

During the new patient visit, patients may need both information and emotional support in dealing with their diagnosis of cancer. The nurse is available to answer questions about the treatment, diagnostic work-up, and offer other required information and links to supportive resources. For patients undergoing neoadjuvant therapy, nurses play a vital role in patient education, including providing information about side effects, assessment and symptom management. In the pre-operative period, patients frequently undergo diagnostic testing to evaluate them for surgery. Nurses teach patients and their families the rationale for the diagnostic testing and help to reduce anxiety while waiting for results. In addition, nurses' involvement in pre-operative teaching is essential. Information about pain management, physical activity and deep breathing and coughing are reviewed. Depend-

ing on the type of surgery that is planned, nursing may need to introduce the concept of a colostomy and be available to answer a multitude of questions related to body image, life style changes, colostomy management and nutrition.

Patients are instructed to expect a post operative hospitalization of about 5-10 days if there are no complications from the surgery. Post-operatively, nurses are involved in the care of the mid line incision, perineal incision (in the APR), Jackson-Pratt (JP) drain (usually placed in the abdominal cavity), intravenous infusions including pain medication with a patient-controlled anesthesia (PCA) pump, monitoring vital signs and signs of infection. The nurse plays a significant role in facilitating recovery by encouraging the patient to ambulate and increase activity. Assessments of pain control, bowel activity and the advancement of diet assists in determining when the patient is ready for discharge. The nurse has a vital role in assessing for follow up community care nursing and/or assistance with personal care at home. In addition, surgical oncology nurses may assist the patient and their family in coping with the diagnosis of cancer or waiting for pathology results.

After discharge, nursing continues to play an important role in the post operative period. The nurse may be consulted about wound care, post-operative pain management, diet, alteration in bowel function, exercise

tolerance and sexual activity. After the initial post-operative period (usually 4-6 weeks), other therapy (adjuvant) may be recommended, depending on the pathology results. Chemotherapy with/ or without radiation therapy may be added to the treatment plan. If these are added to the treatment, nursing will be involved in the patient teaching related to side effects, their assessment and symptom management.

At the completion of active treatment, a patient participates with their health care providers in a period of surveillance for recurrence of their disease. This surveillance may last up to five years and the intensity of follow-up may vary depending on institution routine or the patient's medical history. Follow up colorectal cancer surveillance may include regular physician visits with radiology examinations, blood tests and colonoscopies.

Colorectal cancer is one of the most common cancers. Appropriate and timely surgery can offer the chance of cure in a large proportion of patients. As illustrated above, nursing care is a central component of the care of the patient before and after undergoing surgical management of their colorectal cancer.

Reviewed by:

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Quick Tip:

Here's something to laugh at ... Laughter increases the production of disease-killing antibodies and endorphins (natural painkillers) in your body. In addition, researchers are discovering that laughter and humour may also play a significant role in increasing the human lifespan.

Source: Spectrum Education

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@sw.ca

Reuse of Single-Use Devices: An Ethical Framework for Decision-Making

INTRODUCTION

In the absence of federal, provincial and professional guidelines, ethics can provide a decision making framework to assist nurses in the reuse of single-use items. This article will highlight the ethical debate surrounding reuse of single-use items and the duty of care owed to the patient by the nurse.

BACKGROUND

The move to single use devices occurred in the late 1980s as a result of advances in medical technology. Plastic and other synthetics allowed the development of instruments with smaller lumens and intricate, delicate working mechanisms. While less invasive these devices were more difficult to disassemble and clean than instruments made of glass, metal and rubber. Add the fear of contracting hepatitis or transmitting HIV, plus the implementation of universal precautions, and disposable medical devices made good sense.¹ Further, the move to disposable medical devices informed administrative decision-making and was a strategy used in organizational downsizing that reduced one time staffing costs. Today, supporting arguments tend to focus on cost savings and the lack of documented adverse patient reactions. Some experts argue that many single use items are identical to the reusable version and the single use designation is a marketing choice.² Opposing arguments focus on the difficulty of cleaning and sterilizing sin-

gle use medical devices and the lack of quality control that would ensure sterility and functionality.³

BALANCING THE NEED TO SAVE MONEY AND THE NEED TO ENSURE SAFE PRACTICE

It has been estimated that the US health care industry could save a billion dollars every year by reprocessing just 1% or 2% of all medical devices.⁴ There have been no Canadian estimates of how much money could be saved system wide. Nonetheless, a survey of Canadian acute care facilities in 2001 found widespread reuse of single use devices and that reuse increased per institution since the last Canadian survey in 1986⁵ Presumably, this increase can be attributed to continuing fiscal constraints placed on administrators to reduce costs. Against this need to save money is the growing public concern around safety. There have been numerous large studies in several countries showing that health care systems are prone to error⁶ and that the risk of adverse events is significant.⁷ Further, a report from the Change Foundation⁸ points out that the ethics of health care imply that patients have a right to know if there are any significant deviations from the norm during medical treatment. In recent years, hospitals and health authorities, reflecting increased respect for patients' rights, have been more pro-active in warning patients about potential harm and reporting error. It is against this backdrop that

the ethics of reprocessing single use items is considered.

REGULATIONS GOVERNING REPROCESSING OF SINGLE-USE DEVICES.

The Health Protection Branch regulates the sale of medical devices under the Food and Drug Act and maintains that the use of devices is not covered under the Act, only their sale. So, by implication, neither is their reuse. It also holds that hospitals that reprocess single use devices are not "manufacturers".⁹ Therefore, a third party must carry out the reprocessing of single use items.¹⁰

Health Canada has not banned the reprocessing of single use devices but rather recommended institutional oversight via the creation of a Reuse Committee. The membership should include persons with expertise in biomechanics, infection control, materials management, and sterilization to assess the safety of reprocessing single use medical devices on a case-by-case basis.¹¹ Not every hospital has the necessary expertise to establish and monitor a Reuse Committee nor is there third party reprocessing facilities close at hand. In the absence of clear regulation and/or an official committee, the decision to reprocess a single use device may be left to one person, for example the manager and accountability may rest with the provider of the service.

¹ Dunn, D., Reprocessing Single-use Devices-The Ethical Dilemma, AORN Journal, May 2002, Vol. 75, No 5.

² American Society for Healthcare Central Service Professionals. *Comments to FDA's two guidance documents*. URL: <http://www.ashcsp.org/public/articles/details.cfm?id=9#603> Date of access: February, 2004

³ Health Canada: Reuse of Single-use Medical Device in Canadian Acute-Care Health Care Facilities, 2001. Volume 27-23, December 1, 2001

⁴ Selvey, "Medical device reprocessing: Is it good for your organization? Infection Control Today 5 (Jan. 2001) 22

⁵ Health Canada: Reuse of Single-use Medical Device in Canadian Acute-Care Health Care Facilities, 2001. Volume 27-23, December 1, 2001

⁶ The Canadian Nurses Association: Position Paper: Patient Safety, 2003

⁷ Ibid

⁸ Wong, J., Beglaryan, H., Strategies for Hospitals to improve Patient Safety: A review of the Research, The Change Foundation, February, 2004

⁹ Health Canada: Reuse of Single-use Medical Device in Canadian Acute-Care Health Care Facilities, 2001. Volume 27-23, December 1, 2001

¹⁰ Health Canada: Reuse of Single-use Medical Device in Canadian Acute-Care Health Care Facilities, 2001. Volume 27-23, December 1, 2001

¹¹ Ibid

THE CANADIAN NURSES ASSOCIATION POSITION RELATED TO REUSE OF SINGLE-USE DEVICES

The Canadian Nurses Association (CNA) is silent on the reprocessing of single use devices. However, in a position paper about patient safety, the CNA reiterates the nurse's commitment to providing "safe, competent and ethical care."¹² Continuing, the CNA states "patient safety is fundamental to nursing care and health care across all settings and sectors. It is not merely a mandate; it is a moral and ethical imperative in caring for others."¹³ Though the CNA recommends that institutions have an obligation to provide safe practice environments for nurses, in everyday practice nurses at the bedside make decisions about reuse of single use devices and are expected to uphold the values and norms of the nursing profession.

AN ETHICAL FRAMEWORK FOR DECISION-MAKING

Lack of federal or provincial regulations and specific professional guidelines for reprocessing of single use medical devices, requires the nurse to explore her own ethical standards. As with most ethical debates, there is no one right answer; each situation requires consideration of the available information, including the technical, legal, safety and cost considerations. Any determination of what constitutes ethical practice in the reprocessing of single use medical devices requires the understanding and articulation of a set of moral principles. These principles serve as an analytical framework that expresses the general values underlying rules in common morality.¹⁴ There are four clusters of moral principles commonly used in medical ethics. The first is that of respect for autonomy, which is the norm of respecting the decision-making capabilities of autonomous

persons. The second called non-maleficence refers to the norm of avoiding the causation of harm. The third principle of beneficence is really a group of norms that provides benefits and balances benefits against risks and costs. The final principle is justice and in health care settings refers to a group of norms for distributing benefits, risks and costs fairly.

PATIENT AUTONOMY

Patient autonomy is based on the ethical principle of respect for person. The autonomous person is an individual capable of deliberation about personal goals and acting in accordance with those goals. Consent is important because it recognizes persons right to self-determination. The doctrine of informed consent is a legal requirement that has been legislated through the formulation of the Health Care Consent Act (1996). While consent implies acceptance of treatment, a patient has the right to accept or refuse treatment. Reprocessing a product that was specifically designated for single use without informing the patient can be construed as deceiving the patient. Professional ethics requires that nurses and doctors inform patients of all material risks associated with any treatment. In the context of reuse of single use items, this means that the patient must be aware of the risks and benefits of the proposed treatment and any alternative to the recommended treatment. In this case that would mean the differences, if known, between the reprocessed device and the new device. Unfortunately, in the case of reuse of single use items, institutions have not conducted clinical trials, or more specifically published research findings that show reprocessed single use items to be as safe as the new single use item. As reported by Durin¹⁵, "unless an institution can demonstrate and document that patient safety and device effectiveness are not compromised by reprocessing medical devices,

reprocessing is not recommended." A Center for Patient Advocacy survey showed 82% of nurses and 71% of surgeons surveyed would be uncomfortable if a reprocessed single-use device were used on themselves or a family member.¹⁶ The nurse, as patient advocate, not only needs to be aware of risks, but also has an obligation to inform administration and lobby for changes to practice that would respect patient autonomy, such as seeking informed consent when a single use item is being reused as part of the patient's care.

BENEFICENCE AND NONMALEFICENCE

Persons are treated in an ethical manner, not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Some have argued that health care professionals have a moral obligation to act in order to benefit others. That is, to put the patient's interests above self-interest. Generally, two rules have been formulated as complementary expressions of beneficent action. These are do no harm (nonmaleficence) and maximize possible benefits and minimize possible harms. In the context of reuse of single use devices this means the nurse considers the benefits and risks to the patient. Reuse should not impose on the patient a burden or more harm than would occur if the patient had received an original single use item. It is the duty of the user of the device (hospital/nurse/doctor) to gather scientific and technical information that would lead to a reasonable conclusion that reuse of a single use item presents minimal risk. Considerations must include the nature of the device, for example reuse of invasive single use items have been shown to increase risk of infection sevenfold.¹⁷ For optimal patient care, even a small risk of infection is considered unacceptable. While supporters cite

¹² Canadian Nurses Association, Code of Ethics, 2001

¹³ Canadian Nurses Association, Position Paper: Patient Safety, 2003

¹⁴ Beauchamp, T., Childress, J., Principle of Biomedical Ethics, 5th Ed. Oxford University Press, New York, 2001

¹⁵ Dunn, D., Reprocessing Single-use Devices-The Ethical Dilemma, AORN Journal, May 2002, Vol. 75, No 5.

¹⁶ Payne, Doug, Medical Post 2003

¹⁷ Castille, To reuse or not to reuse that is the question, 48-52

lack of evidence of adverse reactions as rationale for the practice, Fox et al cite current methods of patient surveillance as inadequate or lacking as the reason for the low number of adverse events associated with the reuse of single use items.¹⁸ Further, there are insufficient scientific studies in the safety and efficacy of reusing individual supplies and certainly published data continuing whether the risk of cross infection exists in reuse is lacking. In light of this uncertainty doing no harm for the nurse means advising the supervisor of unsafe practices pertaining to reuse and advocating for clear policies and procedures, which incorporate validation studies of each and every device to be reused in order to increase patient safety and minimize harm.

JUSTICE

Distributive justice asks who ought to receive the benefit from reprocessing single use devices and who should bear the burden? This is a question of justice, in the sense of "fairness in distribution" or what is deserved. An injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is unduly imposed. In other words, distributive justice attempts to guide how one ought to act in the allocation of goods in limited supply. Supporters of reuse have argued that discarding single-use devices as intended creates problems if care is denied to any group because of the cost of using single use devices only once. In the case of reuse, if denying the reuse of single use items meant that some patients would be deprived of health care service, then one might argue that it is unjustified to waste resources, particularly when reuse does not increase the patient's risk or result in significant loss of the devices effectiveness.¹⁹ Focusing on the benefit side of distributive justice, should benefits from cost savings be equally distributed in soci-

ety? Some have argued that using the cost savings to buy needed hospital equipment benefits society, hence meets the condition of distributive justice. In addition, distributive justice asks that risks be distributed equitable among members of society. This is not as easy as it sounds. What criteria should be used to determine which patient will receive the original single use item and which one will receive the reprocessed item. Further, is there a difference if the item has been reprocessed once, twice, three times and do we need criteria for every reuse? Are there some patients who are compromised, for example, immuno suppressed patients where even a chance of imposing minimal risk is unacceptable? Where careful investigation has been undertaken, there may be an acceptable risk in reuse. If this is the case, the risk of reuse needs to be shared equally by all those for whom the risk is acceptable. For example, if the standard of care in your institution is to reuse single use devices, then they should be completely interchangeable with the new device. Decisions about who should receive a used device as opposed to a new device should be made based on objective clinical data of superior outcomes for a particular clinical situation and not according to a willingness to pay for example or a personal relationship with the health care provider. The heightened awareness of the public regarding safety and the potential for adverse events requires that nurses understand and appreciate the consequences for patients and advocate that their institutions follow recommended federal guidelines pertaining to decision-making about the reprocessing of single use devices.

WHAT SHOULD THE NURSE DO IN PRACTICE?

Professional standards and the CNA Codes of Ethics make explicit the nurse's duty of care towards the patient. This duty obligates the nurse to "re-

spect and promote the autonomy of persons and help them to express their health needs and values, and also to obtain desired information and services so they can make informed decisions."²⁰ The nurse should know the hospital policy concerning the reuse of single use items and provide the patient with the information to make an informed decision. This information might include the institution's policy or lack thereof, the harms and benefits of reprocessing the single use item of concern to the patient and whether the patient will receive a reused or new single use device. Ethics requires that the nurse be truthful and disclose any material risks associated with reuse. Where no policy exist, the nurse should lobby in her capacity as patient advocate for the development of an institutional policy that considers the legal, ethical, technical and safety issues of reuse versus one use of single use devices.

In conclusion, in the absence of an institutional policy and comprehensive procedures about the reuse of single use devices, including a process for obtaining consent, reuse activity should be considered research and subject to ethical review. In this way, a sufficient level of evidence might be generated about the safety, efficacy and cost effectiveness of reuse strategies in containing health care cost.²¹ Last, manufacturers will provide requested services, lobbying for safe, cost effective reusable medical devices that can be properly cleaned and sterilized is in the best interest of patients, nurses and the health care system.

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Competing Interests: Non Declared

¹⁸ Fox, R., et al, Reusing single-use items, *New Zealand Medical Journal* 109 (Aug 9, 1996) 302-303

¹⁹ Solomon, Ronni, Ethical ways to reuse single-use devices, *Materials Management*, Feb 1997

²⁰ Canadian Nurses Association, *Code of Ethics for Registered Nurses 2002*

²¹ Dunn, D., Reprocessing Single-use Devices-The Ethical Dilemma, *AORN Journal*, May 2002, Vol. 75, No 5.

Clarification of CSGNA Role in Infection Control Program

Beginning in April 2004, Carsen will be offering a three day education session on proper procedural endoscopy cleaning. The target audience will be staff educators, managers, unit coordinators, infection control practitioners, and risk management staff. It will not be geared toward the everyday cleaning staff. As part of their education session, they have asked the CSGNA to provide an introductory portion to the education session. Carsen recognizes the CSGNA as a national organization with national standards and believes managers, risk management, and infection control people need to become better acquainted with their role.

CSGNA would provide an approximate 3-hour morning presentation on the first day of the education session. This is no different than any other education day in which CSGNA may play a role in across the globe. The highlights and purposes of the CSGNA presentation would include: role of the CSGNA, Guidelines, Position Statements, Infection Control issues and microbiology of infection control (a portion of our program).

After the CSGNA presentation, Carsen will then continue on with their own planned education program specific to their own needs. This is also no different than any other education day.

Other points include:

- Carsen will not dictate or 'own' any portion of the presentation, CSGNA is simply a guest presenter
- Carsen would provide a honourarium to the CSGNA for presenting, as they would any guest speaker. Travel expenses and honourarium to be discussed.

- The CSGNA is free to offer this kind of presentation to any facility, company or organization that desires it.
- There will be no endorsement of the CSGNA/Carsen Group associated with any products or equipment.
- In the event that the CSGNA is asked to present to a facility, the CSGNA will ask the facility which products/equipment they use and include the appropriate clinical application specialist from that company. For example, if the CSGNA is asked to present in the Regina Health District (which uses Olympus), Carsen will then be informed that this is happening and may choose to follow up the presentation with more specifics to the appropriate instruments/products. It is important that the appropriate companies do their own specific training. This leaves the responsibility on the manufacturer/distributor to inform their clients of equipment specifications. This is not the role of the CSGNA.
- The CSGNA will allow Carsen to advertise in their Program brochure the CSGNA participation as a guest presenter as outlined in the statement in the second paragraph.

This has been discussed and agreed upon by:

Lorie McGeough, President, CSGNA
Sandy Saioud, Clinical Application Coordinator, Carsen Group
Date: January 20, 2004

NURSE

*Nurse are we
as if a tree
planted firm ... strong,
Branches reach out with diversity to
capture cardinal winds,
Trunk so solid with seeded foundation,
Leaves so tender and reaching to caress
the passing breeze
with kisses from heaven.*

*Beneath the sweltering sun or rains
we render shade ... shelter
and weather natures' storms.
Borrowing its tales for the next
generation.*

*There stands a forest
firm ... strong
united in purpose.
Breaking the torrent of harsh wind that
tries to break us, revitalizing the earth
with essential breath
and nurture comfort, hope and life.*

Heidi Furman (1994)

**CSGNA Annual
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Calgary, AB
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***Call for Abstracts:
Deadline April 30, 2004***

The CSGNA is soliciting poster presentations for the 2004 meeting in Calgary. The theme of this conference is Celebration 2004, GI Nursing: Peaks and Valleys. We welcome proposals that have innovative and practical application in the practice of gastroenterology nursing. If you're hesitant, we encourage you to step out of the box and share what you know with us all. Send your ideas, questions, or comments to dctaggart@shaw.ca

Please contact myself about any comments you may have about this newsletter or any ideas for the future.

Email: kay.rhodes@sw.ca

A Volunteer's Perspective on the Nurse-Patient Relationship

By Mom Yeon
University of Toronto 3rd Year Student

Through the volunteer services at the Toronto East General Hospital, I have been a fortunate university student to be able to work with the nurses and doctors in the endoscopy unit. It is within this hospital quad that I have been able to observe the relationships built and maintained between the nurses and their patients. These relationships are a vital part of the health care profession and system.

As a volunteer, my duties are to prepare the patients in their gowns and blue, paper boots before their procedures take place, to maintain the cleanliness of the recovery rooms, and to respond to the needs of the nurses in accordance with qualifications. These duties have provided me an opportunity to observe the nurse and patient relationship up close.

While it is undisputed that doctors are central to maintaining care for patients during endoscopy procedures, it is my observation that, in addition to engaging in activities relating to health procedures, nurses play a crucial role not only in and maintaining the health of patients before and after the procedure has been completed but also in providing comfort to the patients.

Many patients enter the doors of this unit with their eyes glazed in fear, tired from a sleepless night. In many cases, understanding that they will be given a mild sedative before their procedures seems only to heighten their level of fear.

I am continually impressed by how these nurses are able to alleviate many of the patient's emotional stresses and the stresses of their concerned loved ones. Time and time again I have observed patient's high levels of anxiety just by being in the waiting room; the

annoyance felt by a tired sick body lacking the morning's food filled with nutritive value; the fear of the unknown procedures and results that lie ahead; and the resulting repetitive questions asked by patients. Nonetheless, the nurses of this ward have been outstanding in addressing patient needs both before and after their procedures through a variety of gestures. Nurses are extremely knowledgeable and answer questions professionally and in plain language. But they do more than just answer questions. They provide reassurance with a calm voice and a smile, helping to replace anxiety and fear with the tranquillity and composure the patient requires to go through with the procedure at hand. This dedication to patients needs and care begin in the waiting room and end in the recovery room.

This relationship between nurses and patients is important – to me it represents a perspective on the health care profession that appears to me to be largely underrated. In the medical scheme of things, nurses are the ones who interact most with patients,

Therefore, along with providing medical care, nurses have a heavy responsibility to their patients in helping to maintain a positive attitude and in alleviating stress.

I have seen many patients, awake from their procedures, thanking the wonderful nurses for their care, support, assurance and help. This important recognition by patients during their time of sickness and need demonstrates the important role of nurses – in my quad, in the hospital, in the system. As a student volunteer I feel privileged to be able to play a small part in this.



WALKING SAFETY TIPS

1. **Warm-up** before you start – stretch your back and legs.
2. **Layering** is the key to comfort in hot or cold conditions. Avoid cotton. Choose microfiber or synthetics which breathe and keep sweat away from the skin, allowing it to evaporate quickly. Sunscreen is a must.
3. **Carry identification** and a small amount of cash, including coins for a payphone if you do not carry a cellular.
4. **At night**, carry a flashlight and wear a reflective vest with reflective strips.
5. Carry – and drink – **enough water**.
6. Select **proper-fitting shoes** with a tread that suits the terrain and weather.
7. **Breathe deep and fully**. You should be able to carry on a conversation.
8. **A walking stick or pole helps with stability** and also minimizes hand swelling.
9. Don't overdo it. **Pace yourself**, take breaks as you need them.
10. **Choose your route** carefully. Avoid traffic and dangerous terrain.
11. **Use the buddy system**. If you must walk alone, let someone know or leave a note with your intended route.

“I look to the future because that's where I'm going to spend the rest of my life.:

George Burns

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 Treasurer: June Peckham

A NEW YEAR, GREAT BEGINNINGS. FRESH STARTS!!!

2004, I wish all of you members out there in CSGNA land all great things for this leap year.

Our newsletter has a NEW sponsor, "PENTAX". We welcome Don Montgomery and Michael Small and the team at PENTAX MEDICAL for their commitment, continued support and their knowledge helping us with our worklife, (providing endoscopic equipment), and our educational growth, and now helping CSGNA by sponsoring one of our communication tools, this, our newsletter for the years 2004/2005. On behalf of our members I take this opportunity to say a "BIG THANK YOU" and welcome to our friends at PENTAX.

Certification is upon us, so those of us who procrastinate can stop and put the study thing in high gear as April 3rd is fast approaching. Good luck to those who are writing this year.

A new Chapter was formed in Montreal making that our 17th!!! We all welcome your group, and we hope to get to meet you all at the World Congress in Montreal, September 2005.

Submitted by newsletter editor
Kay Rhodes

IT'S A NEW YEAR

Well wishes and greetings from the National Executive to each member of the CSGNA.

The past year has certainly left a mark on all Canadians. The devastation, morally, fiscally and most importantly, personally, SARS has left on our nation. The 'heads up' Canada must pay attention to with Mad Cow Disease. The search for a vaccine for West Nile Virus. We certainly have our work cut out for us. However, it has not all been bad.

The year 2004 will prove to be one of the most exciting years for the CSGNA. As a group of dedicated nurses we have bonded together even stronger. Our Ontario colleagues will

set a new precedent in infection control and teamwork; their endeavours will not go unnoticed. The CSGNA will be celebrating 20 years of excellence. And, we will be celebrating it in style! Our commitment to excellence in GI Nursing will be rewarded with our first writing of a national certification exam in April. We've come a long way.

Most importantly, 2004 marks the start of a new year for each and every one of us. Resolutions are made, updated, remade and sometimes broken. But being a nurse is one of the most resilient professions one can be. We need to look at our environment and assess it as we would a patient. What do we need to do next, and how do we make a difference. In the course of one day, how many times do we stop, look and listen. Do we appreciate the expertise of our colleagues and ourselves? Do we appreciate our working environment, the technology that diagnoses and cures? Do we appreciate the patient who has something to share and in whose lives we make a difference? Do we appreciate the students who look to us for guidance and reassurance? Do we appreciate our managers who try their best to make ends meet? Often we can get lost in what was done yesterday and what we will do tomorrow. Perhaps, we would be wise to spend a little time with today. Enjoy each day for what it is and what it will bring to us and those around us.

It is what we do today, that will make a difference in tomorrow.

Lori McGeough, President, CSGNA

We have been busy handling requests from all over Canada to buy our CSGNA Reprocessing Manual on Flexible Endoscopes and Accessories and we are very pleased as we hope to standardize the Reprocessing across Canada. Anyone interested in purchasing the manual should contact me at mpaquette@ottawahospital.on.ca and I will forward you an order form. The manual costs \$75.00. It contains information on infection control, scope

mechanics, selection guidelines of high-level disinfectant, cleaning and reprocessing of endoscopes and accessories, QA material with documentation forms, CSGNA position statement and also diskettes for teaching purposes.

Certification update:

There are 94 nurses registered to write the first Gastroenterology exam in Spring 2004. Congratulations to you all for showing your commitment to nursing excellence. On February 9-10, 3 bilingual reviewers will spend 2 days at Assessment Strategies to review the French version of the examination. This will be the last mandate to fulfil before April 2004.

The prep guide is a useful tool to ready yourself for the certification exam. You must however review all areas of your specialty before the exam especially those in which you have not been practicing recently. You might prefer individual study or study with others and form study group. Should you wish to receive more study mate-

CSGNA Education Corner

SCHOLARSHIPS
FOUNDATIONS
SPEAKERS BUREAU
POSITION STATEMENTS
CHAPTERS
TOPICS
POSTERS
GUIDELINES
CEU'S
EVALUATIONS

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.

Education Committee Members:
Deb Taggart – Calgary
Elaine Burgis – Toronto
Branka Stefanac – Kitchner
4 members at large
Education Chair, Michele Paquette
Phone: 613-737-8384

rial contact me and I will e-mail you the information. Good luck in your preparation.

Michele Paquette CGRN

CANADA WEST DIRECTOR REPORT

When we, "Celebrate – Gastroenterology Nursing" across Canada, in May 2004, at Nursing Week; 94 GI Nurses will have taken the plunge to write the C.N.A. Gastroenterology Certification Exam. Pass or fail, these nurses will have made a commitment to their personal and professional growth and development. We recognize, appreciate and salute the CSGNA for the more than 11 years of work that it took to achieve this goal. In the big picture, countless numbers of Canadians, whose health and well being is affected by gastrointestinal complaints, now have access to some of the most advanced Science, Technology, Research and Care available in Health Care today. We all should be so proud to be a part of it. Without our dedication and pride in the work that we do, this just would not be happening! Good Luck and Bon Chance to all who have committed to April 3.

MANITOBA CHAPTER

The Chapter had 12 members out to a meeting on a cold -50C January evening! The Hawaiian theme "Aloha Endoscopy," was a Huge success. Costumes, food, G.I. Jeopardy, great door prizes and 'Hawaiian Dance' lessons from President Jennette McCalla! made for a great evening.

They are planning an Education Day that they hope to take to Brandon or Kenora, by van or bus.

Treasurer, Donna Dunford, presented highlights of her three-week trip with "International Hope of Canada," to the Ukraine. She was part of a group who went into Hospitals, assessed the needs of each site and distributed much needed medical supplies that they collected here at home.

EDMONTON CHAPTER

President Shelley Bible, reports that the Edmonton Chapter has had some difficulty getting members out to Chapter meetings due to the extreme weather conditions. Edmontonians were hit hard by the winter freeze. They send a message to all Chapter members across Canada. "We hope all endured the tremendous weather conditions and that everyone remained safe and that no one suffered any horrendous incidents." The next Chapter meeting is planned with Dr. Switzer, from the Grey Nuns Hospital GI. Unit, speaking on "Celiac Disease." The talk will include updates and recent changes to treatment. The presentation will include an actual patient's perspective, with regards to living with the disease.

REGINA CHAPTER

Due to scheduling conflicts and extremely bad weather the Chapter had to cancel several meetings in 2004. They rescheduled the first meeting of the year on Feb. 16th. Topics addressed were National G.I. Nurses Day celebrations; local scholarships to the National Conference in Calgary; electing a planning committee for our Provincial Education Day in the fall, and brain storming will begin in earnest for the planning of the CSGNA National Conference to be held in Regina in 2006. They are very pleased that 6 of their members will be writing the Certification exam. "To all the members across Canada writing the certification exam, we wish you well and congratulate you for your efforts."

"To all the Chapters across Canada we wish you increasing memberships and a productive year of growth within the CSGNA."

CALGARY CHAPTER

President, Evelyn Mathews reports that the Planning of the 2004 Conference is the focus of their monthly meetings! In October, the Chapter meeting was followed by a Thai dinner sponsored by Boston Scientific. The November Chapter/planning meeting was

followed by an educational session by Dr. R Hilsden, who practices at the Peter Lougheed Hospital. He presented "Endoscopy Use in Alberta." Pentax sponsored the evening.

A study group has been formed and they meet weekly for those chapter members writing the Certification exam.

OKANAGAN CHAPTER

Three nurses, including secretary Jean Tingstad are studying up a storm for the certification exam. They are happy that they will be able to write in Kelowna.

In January, the Chapter held a dinner meeting with Dr. Remo Pancioni from Calgary speaking on Inflammatory Bowel Disease. They also attended an educational session on Obstructive Sleep Apnea. The GI nurses were invited to a dinner meeting of the Kelowna Gut Club, where one of their surgeons gave a very informative talk on the diagnosis and treatment of Perianal Disease. Happy Studying!

VANCOUVER ISLAND CHAPTER

Irene Ohly reports "There are five of us in Victoria who are studying to write the exam with one in Naniamo, that I know of". Next month they will be orientated to assisting with Endoscopic Ultrasound.

The next Chapter meeting will be held in April, after the exam. Fundraising is being organized, in hopes of getting more of their group to the CSGNA National Conference in Calgary this September.

VANCOUVER REGIONAL CHAPTER

President, Adriana Martin reports that the Chapter Education Day held on Nov. 29 was a great success! The topics included, Endoscopic Management of Pulmonary Bleeding; Ergonomics in the Endoscopy Setting, Peg Tube Management and Care, Remicade, Management of Upper GI Bleeds. They successfully recruited 27 CSGNA members on that day. Hoo-

ray!! (12 of those had been members before). They will be actively promoting their members to attend the Calgary Conference ... watch for the BC Tour Bus "on the road to Calgary!"

Respectfully submitted by
Nala Murray RN
CSGNA Canada West Director

MEMBERSHIP DIRECTOR REPORT

I am pleased to report that our membership has increased to 614 members. We have had huge growth in the Vancouver Chapter area.

This year, our annual membership fee has increased to \$50. This is the first increase in a number of years. Chapter presidents should have received a package containing information and new membership forms. If any president did not receive their package, please contact me.

All members will be mailed their membership forms in May for the June renewal date. This year the form asks if you are a member of CNA. When filling out your form, please print clearly, include e-mail if possible, and indicate which chapter you are affiliated with. Local chapter activities enrich our practice, foster idea sharing with colleagues and provide great social interaction. I encourage you to become active in your chapter! If you have questions on which chapter you could belong to, contact me and I can help you out.

Since our first CNA exam in Gastroenterology is fast approaching, I'd like to take this opportunity to wish all exam participants good luck.

Please feel free to contact me regarding membership questions and any suggestions you may have to promote our association.

Respectively submitted by
Elaine Burgis
burgis@rogers.com

**CSGNA MEMBERSHIP
YEAR RUNS FROM
JUNE TO JUNE.**

UPDATE FROM YOUR TREASURER

Once again our financial information has been sent to our accountant at PricewaterhouseCoopers Assurance and Business Advisory Services for our annual review. This information will be published in our annual report. I would like to congratulate the Greater Toronto Chapter on the financial success of the 2003 National conference; they have surpassed the profit made at any previous conference. 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 also like to thank Cindy Hamilton and Janet Mann for their donations to our education fund. 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.

Submitted by Edna Lang

CANADA CENTRE REPORT

Another year has come to a beginning. Over the holiday season, I am sure many of us have taken the time to reflect on 2003 – its challenges and its successes. For CSGNA, it proved to be another exciting year from the introduction of Certification, to new visions and strategic plan, to the addition of New Directors.

Gung Hay Fat Choy, or Happy Chinese New Year, the year of the Monkey. It is definitely a Monkey Celebration year for CSGNA. The Monkey spirit leads everyone in CSGNA nutty energy and charm to burn. There will be lots of parties, good times, celebrations and monkeying around not forgetting to carry the funky Monkey over to the other areas of our lives.

Now, its time to look ahead and see what 2004 will bring. Take the opportunity to upgrade yourself by certification and perhaps encourage one another in preparation for certification by an organized study group. Along with this exciting event, CSGNA will also celebrate the addition of a new

Chapter in Montreal, Quebec. Looking ahead, we are also preparing for the celebration of CSGNA 20th Annual Conference, Calgary in September. Once again, I hope that all members and non members GI enthusiasts will join us in Calgary to support CSGNA as we strive to achieve the best of the best in education, while still continuing to provide all the trimmings!

THE NEWEST CHAPTER – THE MONTREAL CHAPTER

Congratulations!

The President, Georgina Walters. Thank you Nancy Campbell and Michele Paquette for assisting in setting up the chapter in Montreal. I had the privilege to speak with Georgina, and she is delighted and very thankful for such an opportunity to lead the chapter and will be looking forward to holding more meetings and education sessions in Montreal. They are now in the deep freeze, will be getting to some activities once they thaw a little!!!

CENTRAL ONTARIO CHAPTER

Many thanks to the immediate past President Daniela Abbruzzese and Secretary Janet Young Laurin for remarkable contributions and dedicated effort. Welcome to New President Jane Leigh and Secretary Linda Denis and thank you for stepping forward to share your expertise and commitment. We appreciate Heidi Furman continuing her position as Treasurer. Great job!

Next educational session:

Monday, April 26th at 5.30 pm
At The Town and Country Restaurant
Subject

- 1) Dr. R. Petroniene –
Crohn's/Ulcerative Colitis
- 2) Sheri McQueen (AMT)
Argon Plasma Coagulator

THE OTTAWA CHAPTER

Education Evening – February 5th 2004 "Stop GI Bleed: Medical and Radiological Approach" Sponsored by Cook Canada.

Future Seminar in May on Issues of infection control e.g. MRSA, VRE,

and West Nile Virus. Date and time to be confirmed.

Submitted by Belinda Tham

QUEBEC CITY

December 5th-6th, 2003 Michele Paquette and myself attended the 13th annual Quebec GI conference held at the Chateau Frontenac in Quebec City. There were over 100 delegates present. We attended the business meeting held Friday evening where I spoke about the World Congress 2005 being held in Montreal. I extended an invitation to all and informed them that we had been successful in obtaining permission to have simultaneous translation. We asked for their collaboration to pledge numbers for attendance as well as their help to fundraise to support this project as it is primarily Quebec participants who will benefit from this offer. On Saturday we attended an excellent conference where topics such as Endocapsule, Pancreatitis, Irritable Bowel (to name a few) were presented. Michele spoke on Certification and was very well received. Several people approached Michele regarding study material and there appears to be a definite interest in writing the exam. Michele suggested a few study books but will be looking for further study material to provide for the group. I spoke again about the World Congress and my suggestion to ask their physicians to close their units to enable more nurses to attend was followed by a few chuckles. I am hopeful that a seed was planted.

In summary it was an enriching weekend of learning and sharing of knowledge.

Submitted by Nancy Campbell
Vice President CSGNA

I was fortunate to have been able to speak in December at the Quebec GI nurses conference and again in January to a group of Montreal nurses regarding CSGNA's activities. As co-chair of the World Congress in Montreal in 2005, I am pleased to say that work has begun on the nursing program. This will be an event that any GI nurse in Canada should absolutely plan to attend. CSGNA is very happy to welcome a Montreal chapter on board just in time for the World Congress. Quebec was the only province in Canada without a chapter. CSGNA can now truly state that we are a national organization embracing every Canadian province. Congratulations Montreal! I would like to wish "Good Luck" to everyone writing the first GI Certification exam in April.

Yours in CSGNA.
Nancy Campbell
Vice President CSGNA

MONTREAL

At our National conference last September in Toronto, Lorie McGeough and myself were approached by several Montreal nurses who expressed an interest in forming a chapter. They asked for an education session which was to include advice on how to form a chapter. This, I am happy to state occurred on January 10th, 2004 at the Royal Victoria Hospital McGill Campus in Montreal, Quebec. There were 22 attendees on

what transpired to be a bitterly cold Saturday morning. The opening speaker was a Montreal Gastroenterologist, Serge Mayrand, who spoke on "Newer Trends In The Management Of Gerd." This was an excellent presentation which both refreshed our memories and also brought new ideas to us. I spoke on chapter formation and the benefits of being a member of CSGNA. Michele Paquette, CSGNA Education Chair, shared news regarding GI Certification which was of great interest to all. The session was wrapped up by a tour of the Royal Vic GI Unit and lunch. This bilingual day was a huge success and CSGNA welcomes and looks forward to a Quebec chapter on board. A special thank you to Georgiana Walter, Lidia Ferguson and Salima Yip Hoi, three nurses from the Royal Vic, for taking the initiative to organize this day and also for recognizing the need for this venture. I would also like to welcome two new members who signed up that day. They are Sandra Kambites and Helene Bacha both from the Montreal Children's Hospital.

Submitted By Nancy Campbell
Vice President CSGNA

PRACTICE DIRECTOR

In the area of infection control.

New guidelines are in progress for the procedures of bronchoscopy including the use of the N95 respirator masks. If you are doing bronchoscopy procedures at your hospital, it is necessary to go through proper fitting for the N95.

FUTURE NATIONAL CONFERENCES

2004 CALGARY, ALBERTA

2005 MONTREAL, QUEBEC

WORLD CONGRESS

2006 REGINA, SASKATCHEWAN

For now the latest news on SARS: the time is now to be cautious and protect both yourself, your patients and family.

Wash your hands after patient contact – 45 seconds!

Use alcohol gel when you can't use soap and water 8–9x then soap and water to remove residue.

Keep your hands away from your face.

Get a flu shot and keep other vaccines up to date.

Do not work if you are ill: Fever >38 with respiratory symptoms, and vomiting and/or diarrhoea.

Adhere to isolation guidelines. Contact me with your questions, concerns or suggestions. Good luck to all writing the exam in April!

gibranka@rogers.com
Branka Stefanac RN BScN

CANADA EAST DIRECTOR REPORT

Time is certainly passing quickly, especially for those of us set to write the Certification exam. I hear that there are 94 people writing and I wish all the best of success.

NEWFOUNDLAND CHAPTER

A meeting held in November was attended by a couple of new staff members who came to see what we were about. Hope to have them joining in the near future. Discussion at the meeting centered around the upcoming GI meeting being held here in St. John's, June 17-19, 2004. A preliminary letter has been sent to the eastern members with info on dates, location and hotel. More info to follow on speakers and topics.

NOVA SCOTIA CHAPTER

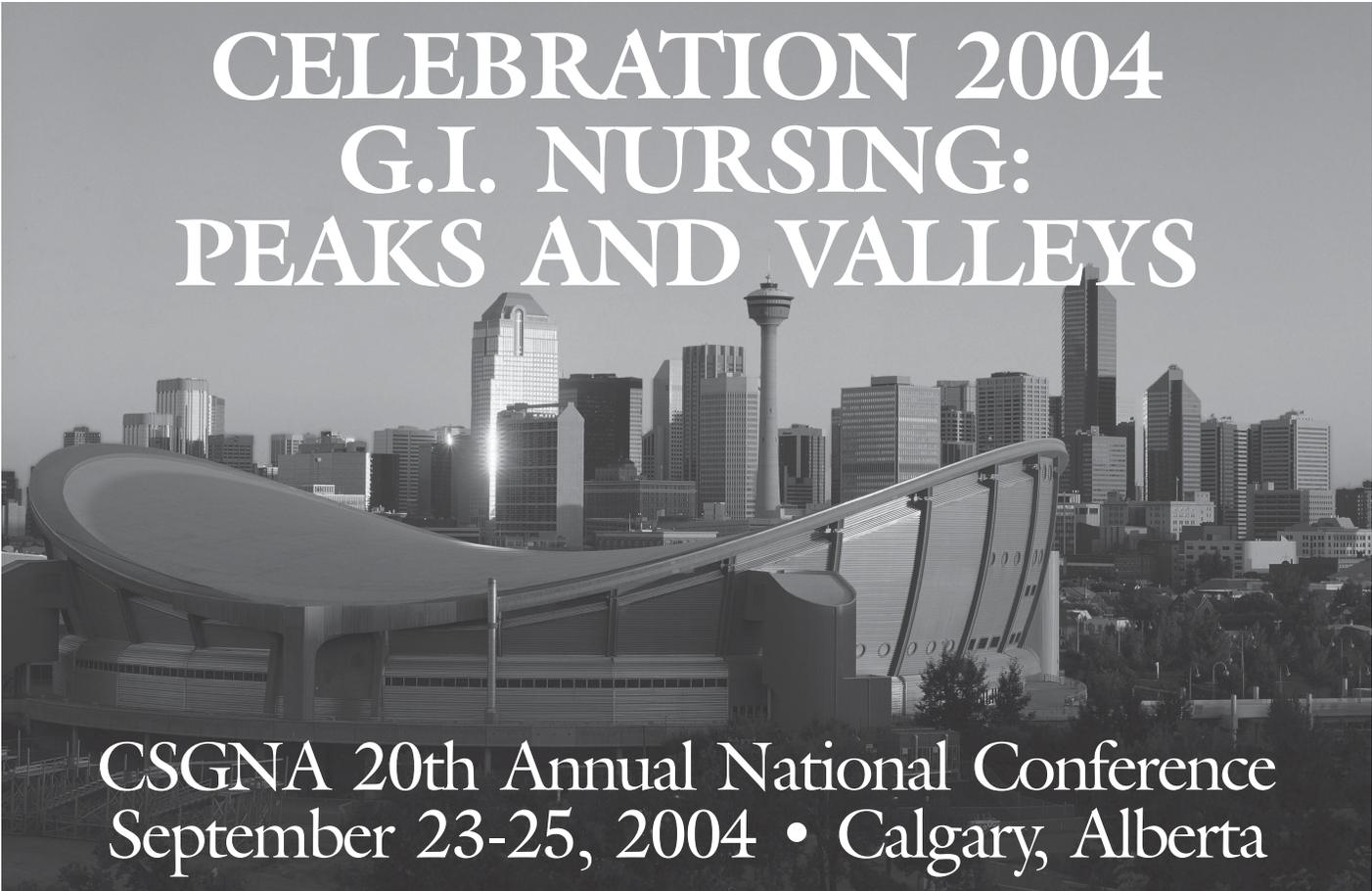
The NS Chapter held an education day in November. The day was well attended with good topics presented. An election of new executive took place. The new executive include: Evelyn McMullen as president, Suzanne Winter as secretary and Lisa McGee as treasurer. Congratulations to the new executive and a special thank-you to the outgoing executive on a job well done.

P.E.I./ NEW BRUNSWICK CHAPTER

The chapter held an education day in November with approximately 30 people in attendance. All found the day interesting and informative. The next chapter meeting is slated for May 29, 2004. A session on scope cleaning and disinfecting will be provided.

Submitted by Joan Rumsey
Canada East Director

**CSGNA MEMBERSHIP FEES ARE
NOW \$50.00 PAYABLE BY JUNE.**



CELEBRATION 2004 G.I. NURSING: PEAKS AND VALLEYS

CSGNA 20th Annual National Conference
September 23-25, 2004 • Calgary, Alberta

Synopsis of CSGNA Email Meeting November 24-28, 2003

1. **REVIEW AND ADOPTION OF AGENDA:**
A motion was passed to adopt the agenda after being reviewed. Michele / Usha
2. **REPORTS:**
Canada EAST NFLD, NS, PEI/ NB chapter,
3. **TREASURER:** Edna reported that the Toronto conference expenses are not finalized, but it looks like we will have approximately \$50,000.00 profit.
4. **BYLAWS:** We have been approached in writing by one member at large and by several others through verbal contact that they don't feel going back to a Past president and one year term is productive. Reasons: 1) one year term is not long enough to carry out plans successfully. 2) Adding another person to the executive is not needed as we are thinking about hiring a part time business manager, which would in fact delete some positions on the executive, also the money spent on those people can be spent on a contract for a part time person. The bylaws committee discussed this and their recommendation is that we return to the two year terms and explore the possibility of a business manager and at that time restructure the executive accordingly.
Comments: The consensus was that one year term was too short and that each position should be a two year position therefore the commitment will be six years from president elect to president to past president. If the executive is in agreement with the bylaws committee recommendation, we will require a motion and a vote. A motion was not passed.
6. **NEWSLETTER:** This publication is in the mail now. Also we have the abstracts from the annual meeting were also included in November edition of the Guiding Light. Kay also received a lovely Pentax digital camera from Pentax Medical. The camera is for CSGNA use, to be kept by the editor.
7. **CERTIFICATION UPDATE:**
94 Nurses have shown commitment to write the examination in April 2004
8. **PUBLIC RELATIONS:** Deb and Mary Carbonneau are working towards changing the website. One of the changes is to get a password protected website which would contain information for special interest groups.
9. **PRACTICE:** The standards of practice are on a disc and can now be distributed to the members easily.
10. **CALGARY UPDATE:** Evelyn sent The Calgary Conference agenda for review by the board members. The planning committee felt that Lucille Aufferey or Janet Mann would be a great speaker to have at the opening ceremony on Friday. Letters for the Vendor and Exhibitor registration form were sent to Calgary Conference planning committee.
10. **WORLD CONGRESS 2005:** The registration fee for the conference will cost \$300 (US). We are invites to the opening ceremonies and Canada Night. There will be a charge of \$50 per person for Canada Night.
11. **FACE TO FACE CONFERENCE:**
Winnipeg April 16-18,2004

Submitted by Usha Chauhan

WHY DO WE MESS UP EXAMS?

A year has 365 days for you to study.

After taking away 52 Sundays, there are only 313 days left.

There are 50 days in the summer that is way too hot to work so there are only 263 days left.

We sleep 8 hours a day in a year, that counts up to 122 days so now we're left with 141 days.

If we fooled around for only 1 hour a day, 15 days are gone, so we are left with 126 days.

We spend 2 hours eating each day, 30 days are used in this way in the year and we are left with 96 days in our year.

We spend 1 hour a day speaking to friends and family, that takes away 15 days more and we are left with 81 days.

Exams and tests take up at least 35 days in your year, hence you are only left with 46 days.

Taking off approximately 40 days of holidays, you are only left with 6 days,

Say you are sick for a minimum of 3 days, you're left with 3 days in the year to study!

Let's say you only go out for 2 days! You are left with 1 day!

But that 1 day is your birthday...so...

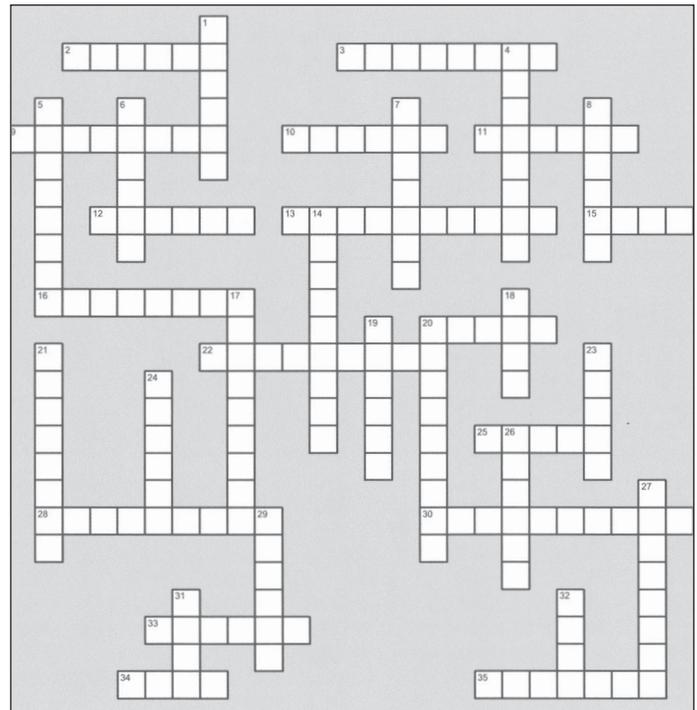
Good luck to everyone on your exams.

WORD SEARCH



- | | |
|---------------|------------|
| ADULTS | PANCREAS |
| ANATOMY | PASS |
| CARE | PATIENTS |
| CERTIFICATION | PENCIL |
| DISEASE | PHYSIOLOGY |
| DOCTOR | QUESTIONS |
| DRUGS | RELAX |
| EDUCATION | RESEARCH |
| ERASURE | SAD |
| EXAM | SMILE |
| FAIL | STRESS |
| GROUP | STUDY |
| LIVER | TIME |
| MUCOSA | TIPS |
| NURSING | WAIT |
| NUTRITION | WRITING |
| PAEDIATRICS | |

CROSSWORD



Across

2. Capital of Austria
3. Capital of Hungary
9. Capital of Serbia
10. Capital of Poland
11. Capital of Spain
12. Capital of Ireland
13. Capital of Slovakia
15. Capital of Norway
16. Capital of Turkey
20. Capital of Bulgaria
22. Capital of Romania
25. Capital of France
28. Capital of Netherlands
30. Capital of Luxembourg
33. Capital of the United Kingdom
34. Capital of Ukraine
35. Capital of Lithuania

Down

1. Capital of Croatia
4. Capital of Bosnia
5. Capital of Finland
6. Capital of Czech Republic
7. Capital of Estonia
8. Capital of Portugal
14. Capital of Iceland
17. Capital of Slovenia
18. Capital of Latvia
19. Capital of Germany
20. Capital of Sweden
21. Capital of Moldova
23. Capital of Belarus
24. Capital of Albania
26. Capital of Greece
27. Capital of Belgium
29. Capital of Russia
31. Capital of Italy
32. Capital of Switzerland

See answer on page 7

**NOMINATIONS FOR CSGNA
EXECUTIVE POSITIONS ARE
ACCEPTED ALL YEAR ROUND.**

February 2004

This is a letter we have drafted to alleviate possible fears our clients might have regarding contracting a disease while undergoing an endoscopic procedure, because we are using a reprocessed endoscope. I hope this will be a useful tool for you to use.

**Patient Information Sheet
Cleaning and Disinfecting Processes in
The Ottawa Hospital Endoscopy Units
M.Paquette CGRN; J.Macnab RN.BN.Med
C.Martell**

The following information is being provided to you, in response to questions that have arisen from recent publicity associated with disinfection practices in several hospitals in Ontario.

The Endoscopy Units at The Ottawa Hospital use a variety of flexible scopes to examine the lung, the stomach and the bowels. Maintaining high standards in infection control is a critical part of the care and treatment we provide.

The Ottawa Hospital requires that all staff responsible for cleaning the scopes be certified through the successful completion of a training course and maintain certification through an annual Scope Cleaning Exam. The staff is trained in all new equipment and their cleaning techniques are assessed regularly.

The cleaning processes that we follow adhere to the infection control standards of the Canadian Society of Gastroenterology Nurses and the Association for Practitioners in Infection Control, as well as the manufacturers' instructions.

Our staff in Sterilization and Disinfection, Infection Control and in Gastroenterology have reviewed the processes.

All scopes are cleaned in the following manner:

- § Each scope is cleaned first by a nurse immediately following the procedure.
- § The scope is then given to the attendant who performs all steps in the thorough cleaning and disinfection process.
- § Each step of the cleaning process is documented clearly and these records are kept on the Unit.

All of the equipment we use for biopsies, snaring and injecting is disposable. We use it once, and then it is discarded.

If you have any questions, please ask any of the nursing staff. We are there to help you.

5 January 2004

Février 2004

Voici une lettre que nous avons composée pour réassurer nos clients qui seraient inquiets d'attraper une infection à la suite d'une endoscopie parce que nous utilisons un endoscope réutilisable. Nous espérons que cet outil vous sera utile.

**Fiche de renseignements à l'intention des patients
Processus de nettoyage et désinfection dans les Unités
d'endoscopie de l'Hôpital d'Ottawa**

Vous trouverez ci-après des informations en réponse aux questions soulevées à la suite de récentes déclarations sur les pratiques de désinfection en vigueur dans plusieurs Hôpitaux ontariens. An sein des Unités d'endoscopie de l'Hôpital d'Ottawa, on a recours à une variété d'endoscopes flexibles pour examiner les poumons, l'estomac et les intestins. Le respect de normes rigoureuses en matière de prévention des infections est une composante critique des soins et des traitements que nous offrons.

L'Hôpital d'Ottawa exige que tous les employés responsables du nettoyage des endoscopes soient accrédités après avoir réussi un cours de formation et qu'ils se soumettent chaque année à un examen portant sur le nettoyage des endoscopes afin de renouveler cette accréditation. Les employés ont été formés pour utiliser le nouvel équipement et leurs techniques de nettoyage sont évaluées régulièrement.

Les processus de nettoyage en vigueur à l'HO sont conformes aux normes de prévention des infections de la Canadian Society of Gastroenterology Nurses et de l'Association for Practitioners in Infection Control, ainsi que des directives du fabricant. L'ensemble de ces processus a été revu par le personnel de la Stérilisation et de la désinfection, du Contrôle des infections et de la Gastroentérologie. Tous les endoscopes sont nettoyés de la façon suivante :

- § Chaque endoscope est d'abord nettoyé par une infirmière immédiatement après l'acte médical.
- § L'endoscope est ensuite remis au préposé qui effectue toutes les étapes d'un processus approfondi de nettoyage et de désinfection.
- § Chacune des étapes du processus de nettoyage est clairement documentée et ces renseignements sont gardés en dossier à l'Unité.

Tout l'équipement utilisé pour les biopsies ainsi que les anses et les seringues sont jetables. Les instruments sont utilisés une fois, puis jetés.

Pour toute question, n'hésitez pas à vous adresser au personnel infirmier. Nous sommes là pour vous aider.

5 janvier 2004

**SCHOLARSHIP REQUESTS SHOULD BE SENT TO THE EDUCATION
CHAIR BEFORE THE DEADLINE ON APPLICATION FORMS.**



Left to right: Beth Weir, Nancy Campbell, Shelly Landry, Valley Regional Hospital GI Unit, Kentville, Nova Scotia, October 2003.



Michele Paquette speaking re: Certification Quebec City, December 2003.



Left to Right: Lidia Ferguson, Georgiana Walter, Nancy Campbell (CSGNA Vice President), Salina Vip Hoi, Royal Vic Hospital GI Unit, McGill Campus, Montreal, Quebec, January 2004.



Executive Members AGIAG President Judy Boyer, Michele Paquette, CSGNA Education Chair (back left) and Nancy Campbell CSGNA Vice President (right front), Quebec City, December 2003.

Green Bean Casserole

Ingredients

- 1½ tablespoons butter
- 3 tablespoons all-purpose flour
- 1½ cups milk
- 3 to 4 teaspoons dry ranch-style salad dressing mix
- ¼ to ½ teaspoon white pepper
- 1 cup chopped onion
- 2 cloves garlic, minced
- 1½ cups sliced fresh mushrooms
- 1¼ pounds fresh green beans, cooked until crisp-tender
- 1 cup fresh bread crumbs, toasted

- 1 To make white sauce, melt butter in small saucepan over low heat. Stir in flour; cook 1 to 2 minutes, stirring constantly. Using wire whisk, stir in milk; bring to a boil. Cook, whisking constantly, 1 to 2 minutes or until thickened. Stir in dressing mix and white pepper; set aside.
- 2 Preheat oven to 350°F. Spray medium skillet with nonstick cooking spray; heat over medium-high heat. Add onion and garlic; cook and stir 2 to 3 minutes or until tender. Remove half of onion mixture; set aside.
- 3 Add mushrooms to onion mixture remaining in skillet and cook about 5 minutes or until mushrooms are tender. Combine mushroom mixture, green beans and white sauce in 1½-quart casserole. Combine bread crumbs with reserved onion mixture; sprinkle over casserole. Bake, uncovered, until heated through, about 20 to 30 minutes.



Canadian Society of Gastroenterology Nurses & Associates

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

APPLICATION FORM FOR CSGNA REGIONAL SCHOLARSHIPS AWARD

The Regional Conference award of \$400.00 is to be used for travel and accommodation to a Regional Conference in Canada. Six scholarships will be awarded yearly.

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.

APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS AT LEAST 8 WEEKS PRIOR TO THE EVENT.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ PROV: _____

POSTAL CODE: _____ HOME TELEPHONE: () _____

FAX: () _____

NAME OF THE MEETING YOU WISH TO ATTEND: _____

DATE OF THE MEETING: _____

CITY WHERE PROPOSED MEETING WILL BE HELD: _____

JOINED THE CSGNA IN ____ (year).

SIGNATURE _____ DATE _____



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 _____



Canadian Society of Gastroenterology Nurses & Associates

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

APPLICATION FORM FOR CAG NURSE SCHOLARSHIP PRIZES

The Canadian Association of Gastroenterologists (CAG) scholarship prizes are available to one research nurse and one endoscopy nurse in the amount of \$500.00 each, to be used for travel to an appropriate endoscopic gastroenterology or research meeting. The CAG nurse scholarship prize is sponsored by an Educational Grant from the Canadian Association of Gastroenterology.

ELIGIBILITY:

1. You are and have been for two years or more, an active member of the CSGNA.
2. You actively support CSGNA goals and objectives.

PRIZE APPLYING FOR: (please circle one) RESEARCH NURSE ENDOSCOPY NURSE

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A two page summary of how this scholarship and attendance at the proposed meeting would benefit you in your research / endo - clinical role in gastroenterology, and what self initiated research projects you are involved in.
2. A current Curriculum Vitae.
3. A letter of reference from your Unit Director.
4. Two letters of reference from CAG members.
5. Copy of CSGNA Membership Card.

APPLICATION FORMS AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY FEBRUARY 15 OF THE CURRENT YEAR. THEY WILL BE FORWARDED TO THE SECRETARY OF THE CAG FOR SELECTION.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

HOME TELEPHONE: () _____ FAX: () _____

HOSPITAL / EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

NAME OF DIRECTOR OF UNIT: _____

NAME OF THE MEETING YOU WISH TO ATTEND: _____

DATE OF THE MEETING: _____ CITY WHERE MEETING WILL BE HELD: _____

JOINED THE CSGNA IN _____ (year). E-MAIL: _____

SIGNATURE _____ DATE _____



Canadian Society of Gastroenterology Nurses & Associates

G.I. Unit, Pasqua Hospital, 4101 Dewdney Avenue, Regina, SK S4T 1A5

NOMINATION FORM

Please complete this form and submit to the Chair of the Nominations Committee (currently the President of the CSGNA) 150 days before the Annual Meeting for national office. Ballots will be sent to the active members 120 days before the Annual meeting and must be returned within 90 days.

Candidates must be active CSGNA members in good standing.

Name of nominee: _____

Address: _____

_____ Postal Code _____

Phone (home) _____ (work) _____

Employer: _____

Title: _____

Education: _____

CSGNA member since: _____

Offices held: _____

Committees: _____

Other related activities: _____

Explain what has led you to chose to run for national office? _____

I hereby accept this nomination for the position of _____

dated this _____ day of _____ 20____. Signed _____

Nominated by _____ & _____



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



Canadian Society of Gastroenterology Nurses & Associates

CSGNA Membership runs from June to June of each year.

Elaine Burgis, 102 Tilman Circle, Markham, Ontario L3P 5V3

MEMBERSHIP APPLICATION

(CHECK ONE)

ACTIVE
\$50.00

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
\$50.00

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
50,00\$

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
50,00\$

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

CNA Member YES / NO
(Canadian Nurses Association)

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 2003-2004 Executive

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