The CSGNA invites all its members to celebrate
GI Nurses Day, May 12th, 2006!
Share your day with the rest of the membership.
Send in your pictures and let us know how you celebrated!

President’s Message

As Deb Taggart and myself prepare to attend the Canadian Digestive Disease Week Conference February 24th-28th 2006 with our fellow GI colleagues we mark another CSGNA milestone. It is the first time that two CSGNA executive board members have attended this meeting as members. To us it is a natural evolution in pursuing similar goals to enhance patient care.

Unfortunately our Public relations Director, Jennifer Belbeck was forced to resign due to study commitments and we all thank her very much for her contribution to CSGNA and wish her well in her studies. Perhaps we will see her back with us in the future as a board member! In the interim the fantastic remaining board members will share the Public Relations Director duties so that all will run smoothly until September when we will have a new public Relations Director.

CSGNA executive have our Face to Face meetings March 3rd-5th 2005 in Ottawa. We have a full 2 day agenda ahead of us. Of course the Regina conference planning is well under way and the “GI Loves Regina” Conference is going to be one not to miss!

I would urge you to look among your ranks and submit a candidate for the GI Professional Nursing Award. The deadline for submissions is May 31st 2006. What an honour to be voted and recognized by your peers as having been an exceptional Canadian GI nurse!

Respectfully submitted,
Nancy Campbell RN CGN®
President CSGNA

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Nancy Campbell and Debbie Taggart had the privilege of representing CSGNA at the annual Canadian Association of Gastroenterology meeting, CDDW, in Banff, AB. from Feb. 24-27, 2006. National and international experts in gastroenterology presented timely issues in GI. These included not only procedural and practice guidelines but also wait times, patient access to services with a comparison of Canadian statistics with those in England and the United States. Different models of care in providing endoscopic procedures to GI patients were explored with pertinent questions raised by the audience. The Canadian perspective also presented a breakdown of gastroenterologists per 100,000 populations in each Canadian province with the anticipated attrition rate over the next 5 years.

Session formats included lectures by individuals, panel discussions, small groups such as “Breakfast with the Experts”, medical student presentations and posters. The exhibit hall housed the latest in endoscopic equipment and accessories, pharmaceutical representatives, nutrition providers plus not for profit voluntary medical research organizations such as the Crohn’s and Colitis Foundation of Canada. Various awards were presented including the Canadian Association of Gastroenterology Nurse Scholarship Award for 2006 to Nancy Campbell, National President of CSGNA.

RN attendees were from clinical, research, hepatology, and educational backgrounds. We are very appreciative of the opportunity to attend an event of such high calibre. Any CSGNA member who is presented with the chance of attending this annual event should seriously consider it as a valuable learning and continuing competence opportunity for our nursing practice. The physician perspective enhances our knowledge to provide excellent, evidence based care to our gastroenterology patients.

Respectfully submitted,
Debbie Taggart RN, BN, CGRN, CGN(C)
CSGNA, President-elect

This award was presented to Nancy Campbell in Banff, AB. on February 26, 2006 at CDDW, the annual meeting of the Canadian Association of Gastroenterology (CAG). The award was presented by Dr. Rob Enns of Vancouver who acknowledged Nancy as a leader in GI nursing in Canada. Dr. Enns recognized the significant role nurses play in allowing physicians to fulfill their roles and in providing excellence in patient care to our gastroenterology patients. As President of CSGNA, Dr. Enns identified Nancy as a role model for GI nurses across the country.

Nancy’s tenure on the CSGNA board began with a term as Canada Centre Director. After a brief hiatus, Nancy returned as President-elect prior to her current Presidency. Patient care of our GI patients has always been a top priority. Under her leadership the first exam in GI Certification was written. She has promoted the significant role the CGN(C) can play in GI nursing care in Canada. She has advocated for our GI patients by dialoguing with CAG, CNA, and other nursing professional organizations from around the world. Nancy has suggested innovative ways in which we can provide patient education and promote access to procedures and she has a particular interest in colon cancer screening. Nancy has encouraged board members to think in creative ways to better utilize our resources, talents and knowledge. Fiscal responsibility of our organizational finances has been paramount under Nancy’s leadership.

We applaud her commitment to our patients and practice. Nancy’s colleagues are proud to honour her as the deserving recipient of this award in 2006.

Respectfully submitted by,
Debbie Taggart RN, BN, CGRN, CGN(C)
CSGNA, President-elect
Education Seminar
Current GI Trends

The Ottawa Chapter of the CSGNA is holding a day seminar
On Saturday May 13th from 8:00 am to 4:00 pm.
Titled; Current GI Trends. The seminar is being held at the
Ottawa Health Centre Amphitheater B.
For more information contact M. Paquette at
mpaquette@ottawahospital.on.ca.
**REPORT FROM EDUCATION DIRECTOR**

April 1st is just around the corner. This is the certification exam date. How is the studying going? Do you need any help? We are there to support you. As well do not forget the CNA website at www.cna-aic.ca. They have a wonderful resource manual free of charge to help you prepare for this exam.

In January I represented The CSGNA at the Canadian Standards Association meeting in Quebec City. I am part of a technical subcommittee who is reviewing the document on Decontamination of Reusable Medical Devices. On that committee we have a very diversified group of very knowledgeable people such as Michelle Alfa, representation from infection control, Health Canada, Logistic Services, Central Processing, Nurse Clinician and sales people for Automated Pre-processors. The meetings are very interesting and the document is still under development. It will eventually be released for public viewing for your feedback. I will keep you posted. We conducted some of the business by teleconference which is an efficient way to save costs.

Did you remember to send nominations for the GI Professional Nursing Award? This award promotes and enhances the image of a GI nurse in his/her hospital or community. You may obtain the form in the Guiding Light. Please note that nominations will be accepted up to May 31 (Previous date was March 15). So hurry up and look amongst your peers for a candidate and send the name to the Education Director as soon as possible.

The annual conference this year will be held in beautiful Regina on September 15-16.

We would like to encourage you to present abstracts. This is an opportunity for you to share with colleagues what you do well and/or what provides challenges in your practice. **Respectfully submitted**

Michele Paquette
CSGNA Education Director

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**REMEMBER**

As per Bylaw 18.10, all CSGNA Chapters shall submit an annual educational summary to the Education Director by June 30th annually.

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**CALL FOR ABSTRACTS**

Abstracts are invited for but not limited to the following themes:
- Development of orientation tools for endoscopy departments
- Innovations to GI nursing practice-strategies for development, implementation evaluation.
- Occupational Health issues in endoscopy units
- Creative teaching strategies for patients and staff
- Successful change strategies in GI departments
- Developing a care philosophy for gastroenterology units
- Staffing competencies – how do you develop, implement and evaluate in high tech environments
- Staffing mix – the why’s of your units
- Technology and caring – is this a paradox?
- Financial management
- Evaluation process
- Ethical issues and strategies that result in a win/win scenario
- Research related to practices and economic considerations
- Barriers to staff development
- Inventory management

**Deadline for submission:**
April 30, 2006

Submit abstracts to:
Michele Paquette
CSGNA Education Director
Email: mpaquette@ottawahospital.on.ca

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

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**COVER SHEET:**

Please complete a cover sheet and submit with your abstract. The cover sheet must include title of the abstract, names of all presenters/authors, credentials, and place of employment/academic affiliation. Please indicate main contact’s name, telephone number, e-mail address and fax number.

**FORMAT:**

Your typed abstract should not exceed one standard letter size sheet of paper, double-spaced, with one-inch margins and standard 12 fonts. The title, authors, objectives, description, and conclusion should appear on the abstract.

**OTHER INFORMATION:**

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

**SELECTION PROCESS:**

A blind review and selection will be made by the Abstract Review Sub-committee of the Conference Planning Committee.

Selection criteria include relevance to the conference, clarity, impact on gastroenterology nurses and associates, or impact on patient outcomes.

Selected abstracts will be developed into presentation format by the authors. Posters will be displayed in a prominent location at the conference. A 30 minute time period will be designated for the authors to discuss the poster and answer questions that delegates may have.

**NOTIFICATIONS:**

All abstracts will be acknowledged upon receipt. Selection will be completed and acknowledged by May 31, 2006.

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**FROM THE EDUCATION CORNER**

**Frequently asked question:**

**Question:** How long can an endoscope be left for extended period before being Reprocessed?

**Answer:** An endoscope shall not be left for extended periods, (e.g. overnight). Conditions that promote
the formation of biofilms (soaking in enzymatic product). The best practice is to reprocess a flexible endoscope immediately after the procedure, and completed in a timely manner. In addition, an endoscope for gastrointestinal procedure should be reprocessed if storage exceeds 7 days. New repaired or loaned endoscopes shall be reprocessed prior to use.


**ENDOSCOPIC SHUFFLING FOOD FOR THOUGHT**

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

I would like to share with you the highlights of an article published in the Q-Net monthly educational newsletter by Dr. Muscarella. If you are interested in reading the whole article is available with the references on the website at www.myendosite.com. I encourage you to visit the site.

Endoscopic shuffling is defined as the use of a lower GI endoscope to perform an upper GI procedure (or vice versa). Manufacturers selling endoscopes label them for their intended uses. For instance, the labelling of a colonoscope states that its intended use is “to provide optical visualization of, and therapeutic access to, the lower gastrointestinal tract”. Therefore the use of a colonoscope to perform upper GI endoscopic procedure contraindicates endoscopic shuffling. Colonoscopes are manufactured in accordance with a specific set of design parameters for their safe and effective passage through the colon; these parameters include the insertion tube’s working length, diameter, stiffness and angle of view.

Another example of endoscopic shuffling is the use of a colonoscope to perform push enteroscopy. Such practice may limit access to, and visualization of, the proximal small bowel, reducing the endoscope’s advancement and possibly, the diagnostic yield, compared to a push enteroscope.

A reduction in diagnostic yield is problematic, because it can jeopardize patient health by increasing the risk of misdiagnosis and “false negative” results (i.e. failure to detect and identify diseased tissues).

In addition to having potential legal and ethical implications, endoscopic shuffling can raise infection control and hygienic concerns. For instance, using a colonoscope via the oral cavity that has been used previously on patient per rectal route would seem to be, at the very least, a violation of hygienic standards. Moreover Olestra, a fat-based dietary substitute that has been reported to coat the colon’s lining and, in turn, the endoscope’s insertion tube during colonoscopy is very difficult to remove during reprocessing. There is a concern that colonoscope contaminated and coated with Olestra not removed during cleaning and used to perform both upper and lower GI procedures could transmit embedded and shielded bacteria and other types of microorganisms and viruses from one patient’s colon to another patient’s oral cavity resulting in nosocomial infection.

**FOOD FOR THOUGHT:**

Does endoscopic shuffling require patient disclosure?

One should clarify patient’s presumptions, understandings and expectations. In general patients undergoing GI endoscopy presume and trust that their GI endoscopist will provide optimal health care and will not compromise diagnostic yield. Patients would not expect a colonoscope, used previously to perform colonoscopy, to be introduced into their oral cavity to perform push enteroscopy. It seems fair to ask whether two patients, both being evaluated for potential cancer of the proximal small bowel, receive the same standard of care. If one undergoes push enteroscopy using a push enteroscope as opposed to the second patient undergoing push enteroscopy using a (shorter) instrument, a colonoscope. No doubt this scenario appears to present a double standard of patient care, because reports suggest that for the second patient the potential exists for a reduced diagnostic yield, a compromised clinical outcome and misdiagnosis.

**CONCLUSION:**

The use of an upper, or lower GI endoscope to perform a lower, or upper GI procedure respectively, violates the endoscope’s labelling and intended use and may reduce diagnostic yield, increasing risk of misdiagnosis and patient injury.

Moreover the interchangeable use of a GI endoscope to perform upper and lower GI procedures violates at the very least hygienic standards, if not the principles of infection control, posing a potential risk of fecal-oral disease transmission via an improperly reprocessed endoscope.

Finally, the use of a GI endoscope to perform both upper and lower GI procedure in sequence and on the same patient without reprocessing endoscope between the two procedures is inconsistent with endoscope reprocessing guidelines and manufacturer’s instructions which recommend reprocessing the endoscope after each procedure or use.

**Michèle Paquette RN, CGRN, CGN[c]**

**CSGNA Education Director**

**MEMBERSHIP DIRECTOR REPORT**

Our membership remains strong with 662 members at present. This is 40 members more than last year at this time. Our membership numbers are steady and this year we can see some growth in new areas. This is great! Already in 2006, we have welcomed 5 new members.

This year a new level of membership is available to those members who have retired from gastroenterology nursing. An increasing number of our members are retiring from nursing, and this new level will afford them an op-
portunity to continue their association with CSGNA, at a reduced rate.

Membership renewal forms will be sent out in April for membership renewal due June 1st. Membership renewals not received by this date will result in forfeiting your continuous membership years, by which qualification for scholarships and awards are measured. As always, I ask that you print all your information clearly to avoid address errors. A pre-printed address label applied to your form is great!

Chapter Presidents may request a membership list for Chapter meetings and events. Please send a request for your list 1 week prior to your event. That way, you will have the most up-to-date list of your local members.

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

Respectfully submitted
Elaine Burgis
burgis@rogers.com

DIRECTOR PRACTICE REPORT

Please review in this issue of Guiding Light, the two new position statements and the updated infection control. Do send in your comments and suggestions, I am looking forward to your input. My email address is bstefanac@smgh.ca

Good luck to all who are writing in April. I am looking forward to seeing many of you in Regina in September.

Submitted by:
Branka Stefanac

DIRECTOR OF CANADA EAST REPORT

Time to come out of winter hibernation!

Much work is to be done.

Our face to face CSGNA Board Meetings in Ottawa March 3 – 5/2006

New Brunswick/Prince Edward Island
No reports submitted.

Nova Scotia
Waiting for report.

Newfoundland
Last meeting was October/2005 – 10 Members attended.

WOCG high lights, stories and pictures were shared.

Special Guest: Tracey Lynn Faulkner BN BSN doing post graduate study on Young adults with IBS.

A dinner meeting was held at the Keg – Topic Hepatitis C – Dawn King RN.

Traveled to Corner Brook over Christmas to encourage members to form a new Chapter – Seed is planted.

No one is planning to write Certification Examination 2006.

NL Chapter CSGNA: “Special Interest Group” status from the Provincial Nursing Association (ARNNL).

Early March meeting is planned.

A Full Education Day in June/2006.

Submitted By: Mabel Chaytor

MARKET PLACE –
The search is on for items to bring to the Regina Conference in September/2006.

Any Ideas!!!
mabelchaytor@hotmail.com

On November 5th, 2005 the Nova Scotia Chapter held its Annual Fall Education Day. We’d like to thank our contributing sponsors – Abbott, Boston Scientific, Carson, Con Med, Cook Canada, and Johnson & Johnson for their continuing support for these events. The topics for the day included Professional Practice, Colonic Stents, Central Venous Access Devices, P E G tubes, Virtual Colonoscopy, and Motility Studies. We held our Annual Business meeting during the day and elections took place for Chapter Executive. Evelyn Mc Mullen remains as President, and Lisa Mc Gee remains as Executive. Evelyn Mc Mullen remains as Treasurer. A “big welcome” to Edna Lang who assumes the position of Secretary and many thanks to Suzanne Winter for a job well done as Secretary for the past two years. The thirty nurses who attended also enjoyed an open forum as we discussed the 2005 World Congress and the upcoming National Conferences. We also discussed timely subjects pertaining to our practice. Things will remain quiet now until the spring.

Evelyn Mc Mullen
President Nova Scotia Chapter

DIRECTOR OF CANADA CENTRE REPORT

The Christmas holidays are finished. We are now planning for the next educational events and are also getting ready to write the Gastroenterology Certification Exam.

The Ottawa Chapter is in the process of organizing a day conference on May 13, 2006. It will be a very educational day with interesting subjects such as hepatitis, legalities of charting, ergonomics, GI bleed, laparoscopy surgery for colon cancer and more. Approximately eight to ten companies will be demonstrating their products.

On February 8, 2006 the Greater Toronto Chapter organized an evening seminar on “Managing Menopause in 2006: Hormone Treatment is still “ON” presented by Dr. C. Drerko and sponsored by Novartis Pharma Canada. It was well attended.

The Golden Horseshoe Chapter is organizing a day conference for April 1, 2006 at the Grey Silo Golf Course in Waterloo. The topics will include PPE equipment in the Endoscopy suite, upper GI bleed management, intero-vascular fistulas, GI equipment, endo-loops, clips and lithotripsy.

The southwestern Chapter had an evening educational session on instruments and accessories presented by Carsen. They will also be holding an election for a new President – your participation would be greatly appreciated.

The Central Ontario Chapter is planning an evening educational session in April. Carsen will be presenting “New Innovation and Technology for Endoscopy” and Dr. Yvon Murray will be discussing “Prophylactic antibiotics for Endoscopy”.

The Guiding Light, March 2006
The London Area Chapter is preparing a CSNGA inservice on March 13 by infection control nurse on bronchoscopies and outpatient care with TB, MRSA and VRE. A dinner and educational session will be organized for March 20 with Dr. Richard Inculet, a thoracic surgeon; his topic will be dealing with anti reflux. This event will be sponsored by Cook. In June Dr. Brian Feagan will be presenting on Crohns disease.

The Montreal Chapter Executive will meet to organize an educational session for April.

Submitted by: Monique Travers

DIRECTOR OF CANADA WEST REPORT

Okanagan:
The Okanagan group got together for an education session involving antibiotic resistance in November, sponsored by Altana Pharma. This included discussing a few case studies and was very informative, especially with ARO’s becoming prevalent in hospital settings. Bethany Rodes, President, says that they are hoping to organize some GI-based information or teaching sessions within their hospital this spring.

Kamloops:
The Kamloops Chapter celebrated their first year as a CSGNA Chapter on January 26. Maryanne Dorais is happy to report that two nurses will be writing their certification in April and another three next year. Way to go!

Regina:
The focus for Linda Buchanan and the Regina Chapter has been preparing for the fall conference. Everyone is pitching in and working hard on making this conference one you will not forget. They are very excited about the educational aspects of their conference as well as the fun they have planned.

Four of their members have formed a study group in preparation for the certification exam in April. Good luck to all in their studies.

Calgary:
An evening educational session was held on Thursday, January 26, 2006 at Luciano’s Restaurant. Advances in Endoscopic Imaging was presented by Dr. Mamoon Raza. Chromoendoscopy, confocal endoscopy, narrow band imaging and double balloon endoscopy were covered. It was very interesting and informative. The presentation was followed by dinner. Evelyn Matthews states that they are very appreciative to Pentax for sponsoring this event.

They are planning a spring conference “Liver Rounds” which will be held on Saturday, April 29, 2006.

Manitoba:
The members of the Manitoba Chapter are actively preparing for the May, 2006 SGNA Annual Course in San Antonio. They have submitted an abstract for a poster presentation in San Antonio and are waiting for acceptance.

They are involved in a research project, but since all the details have not been completed at the ethics review level, they are not able to make their intentions public. They are anxiously awaiting the approval of their project because it involves the input and cooperation of all their members.

Another exciting experience is an up and coming public information session about GI health and illness which will be held in the community of St. Pierre on Feb. 28, 2006. Sue Drysdale, Secretary, and Jennette McCalla, President, will be representing the local chapter as guest speakers at this session.

At the December meeting they were pleased to have an educational session presented by Erin Loehrer of Beutlich Pharmaceuticals. Erin gave an informative presentation on methemoglobinemia.

Regina G.I. Days in October was attended by one member from Winnipeg. The session was informative, as usual. It was good to share information and concerns with friendly and familiar faces.

One of the current topics of interest for the chapter is ergonomics in the G.I. suite. They hope to move forward with this issue in order to improve the health and safety of nurses in the workplace.

Two members in Brandon are studying very intensively in order to write the certification exam this spring. The Manitoba Chapter is proud of their work and look forward to having an increased number of members with their certification.

The May meeting will be held in Kenora, Ontario. The membership is on the move again in order to share and promote a commitment to the discipline of G.I Nursing.

They promise to have some interesting stories to share when this season of travel and education is over.

Vancouver Island Chapter:
Irene Ohly, President, reports that they have been having monthly inservices on topics from the Montreal Conference as well as new equipment/accessories.

Jason Rudd, Boston Scientific, presented in Inservice on Colonic Stenting.

Edmonton:
One of the goals of the Chapter when they regrouped last year under the leadership of Yvonne Verklan was to see new faces at the meetings ... and they are happy to report that they have! Nurses from Westview Community Health Center in Stony Plain have been attending and now they also have nurses from Sturgeon Hospital in St. Albert attending. Because of a suggestion from one of those St. Albert nurses at the Jan. meeting, they have formed a sub-committee to make an Orienta-
tion Information Package about the CSGNA for potential new members so they can have information about what the chapter is about. Thank you to Yvonne Suranyi for her input and for joining the committee as well!

With the drive for more education and the upcoming Continuing Competency, Anna Stephenson, from the Stollery Children’s Hospital, came up with the idea of a Journal Club. She will be the facilitator of the first topic at the next meeting, Feb. 22. Attendees will have researched the topic and will meet to discuss “Pre-drawing medications in the Endo Theater – or not” and the recommended standards and guidelines. They plan to follow up with this in the March meeting when they are hoping to have an AARN Policy and Practice Consultant come and speak to them on the matter.

The Jan. meeting was held in the new Zeidler-Ledcor Gastrointestinal and Liver Disease Research Centre of Excellence at the University Hospital. Refreshments and snacks were provided by Altana’s Cledwin Thomas and a grand tour was given by Donna Fisher, a member who is a research nurse at that centre. The U of A members also provided an “Inservice Segment” presented by Anna Tsang, Marla Wilson and Jo-anne Satkunas about various topics from the WCOG in Montreal last fall. It was all very interesting and informative and generated good discussion. Not only did this segment add to each attendee’s “education portfolio”, but it also awarded each presenter from within the Chapter’s Point System. The chapter decided that whenever a member attends a conference or seminar, she would present an inservice to the rest of the members who did not go, so that all could benefit.

The Point System was re-designed by last term’s Education Committee to provide not only funding to members applying to go to conferences, but also to encourage participation by members within the chapter’s scope of activities and to promote new membership.

Points are awarded based on participation and then can be redeemed when requesting funding to attend a conference. New members are awarded points just for joining!

Later spring meetings will be evening physician-presented topics with dinner sponsored by a couple of rep companies. They are looking forward to one of these in April and one in June.

Yvonne has decided to add a little fun into each of the meetings by giving away a door prize to someone who attended the meeting. January’s winner of fine bath products and candle was Cherry Weatherman (“Oprah” at the October Celiac Conference).

The next chapter meeting will be held for the first time at the Sturgeon Hospital in St. Albert on Feb. 22. Something to look forward to!

Submitted by: Joanne Glen

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**NEWSLETTER EDITOR REPORT**

Hello from the keyboard of your newsletter editor. It’s been a busy year with some exciting changes still to come. Congratulations and best wishes to all of you studying to write the certification exam. It’s a rewarding and challenging experience. Look for the new scholarship award, chapter of the year award, as well as the new membership level, in this issue of The Guiding Light. There are 5 executive positions up for election this year. I encourage everyone to get more involved. Run for the National Executive you will grow from the experience!

Comments and ideas are always welcome for the newsletter. Keep them coming. I want each chapter to shine in the Spotlight so please send in your submissions. Just a reminder that submissions for “The Guiding Light” are due the month before each issue comes out. For the March issue the deadline date is February 15th, for the July issue the deadline date is June 15th and for the November issue the deadline date is October 15th.

Education is our mandate at the CSGNA so continue to send in your information on upcoming education sessions. You never know who might be in “your neck of the woods” and would love to attend.

Preparations are in high gear for the National Conference in Regina this September. I look forward to seeing all of you, sharing a fun time and a great educational experience.

Leslie Bearss RN CGN[c]
Newsletter Editor
lesliejoy@sasktel.net

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**Olympus Discovery Seminar with Adrienne Winslow and Pete Bresee**

*at Red Deer Hospital – Nov/05.*
SYNOPSIS OF CSGNA EMAIL MEETING
NOVEMBER 14 -28, 2005

1. REVIEW AND ADOPTION OF WCOG MINUTES: Minutes from the WGOC minutes required some minor corrections. Once this was done the minutes were passed by Usha and seconded by Joanne.

2. REPORTS: Canada WEST, CENTRE, EAST- NFLD, NS, PEI/NB chapter.

3. TREASURE: GST update, GST only needs to be collected if the group makes more than $30,000; this will be investigated further prior to the face to face meeting.

4. BYLAWS: Bylaws: A lot of time was spent on editing and updating the wording on the bylaws. This is now completed and will appear in the next Guiding light.

5. NEWSLETTER: We are always looking for any interesting articles or stories that you would like to share with the members. Please contact the newsletter editor. There will be information in the on the “New member scholarship” and “the chapter of the year award” in the March edition of the Guiding light.

6. EDUCATION: CSA update on October 12 there was a teleconference to finish draft on decontamination of endoscopes. Michelle will attend the next meeting in Quebec City January 18-20 which will be for only one day; the decontamination of the scopes will be on the agenda. Following the January meeting, the next meeting will be in Gimli, Manitoba June 19-21 2006. CSA has agreed to pay part of the trip. The ERCP module is being revised by the education committee. Hopefully it will be completed by the end of January. We now have for sale the orientation manual, the study guide, the reprocessing manual and the certification prep guide.

7. CERTIFICATION UPDATE: We need to promote certification exam. Anyone interested in giving their names as a resource person for helping with study groups should contact C N A at www.cna-aiic.ca

8. PUBLIC RELATIONS: The website is updated with new information as it arrives. There has been a prompt response from the Webray. Time frame from submission to posting on website has seemed to improve. There was an email request from a member wondering if there were any photos from WCOG for the website. Pictures from Lesley will be forwarded for posting on the website. During our vendor meeting in April 2005, the suggestion of developing sponsorship categories was addressed. Jennifer will pursue this idea further, information will be provided once this is available. Schering Canada Inc. (Remicade) and Abbott Laboratories (Prevacid) were contacted, and they are interested in becoming new sponsors to our group.

9. PRACTICE: Both the flexible sigmoidoscopy and bronchoscopy should be on the web by now. PPE; infection control; nails and jewelry ready as soon editing changes have been received from the other board members.

10. REGINA UPDATE: Lorie will have a meeting November 28th. The proposed budget is not complete due to a couple of outstanding requests for costs; they hope to have all of this by Nov 28th and will send a report after our meeting.

11. MARKET PLACE: Items so far Stress Ball, Screen Sweep, Mouse Pad, and Big Grip Jar Opener. Samples and quotes for final decision will be available for the face to face meeting. We are still waiting for the quote on the Market place banner.

12. UPCOMING BOARD POSITIONS: coming up for renewal this year-President Elect, Public Relations, Canada Centre, Newsletter Editor, Membership director. Nancy is very pleased to announce that Elaine has accepted to be our incoming President Elect. Congratulations and I know that you & Deb will be a great team. Meredith Wild from Calgary has submitted her nomination for Membership Chair.


Submitted by Usha Chauhan
National Director Positions for Nomination

Elaine Burgis, Membership Director

It’s time again to consider becoming actively involved in CSGNA by sending in your nomination form for a National Executive position. National positions are a two-year commitment and open only to active members. With this term comes the enriching experience and personal growth that can only be gained by promoting our speciality.

Along with National positions comes a commitment to CSGNA. Directors must attend all Annual Conferences and Face-to-Face meetings, and participate in teleconferencing meetings or e-mail meetings. They must submit reports to each issue of the Guiding Light, so that our membership stays up to date with the association and its activities.

Positions open for nomination and a short job description follow. Full duties of the National Directors can be found on our web site at www.csgna.com.

Regional Director – Canada Centre: encourages and assists chapters in the region, is the liaison with the Chapters, reports on Chapter activities. You must be a member of Canada Centre to be eligible for this position.

Membership Director: collects and maintains records of membership, issues membership cards and receipts, forwards membership lists to National Board members and Chapter Presidents upon request.

Newsletter Editor: sets guidelines and deadlines for submission to “The Guiding Light” three times a year, approves final version of edited newsletter prior to printing, and ensures mail out of newsletter, stores copies of all previous newsletters.

Public Relations Director: maintains and updates the website, acts as Chair of Vendor Relations Committee, serves as resource person for the vendors, acts as Chair of GI Nurses Day by establishing a theme.

President Elect: accedes to President when President’s term ends, is Chair of Bylaws Committee, serves as CSGNA liaison to SIGNEA.

Nominations for National executive positions are due by April 20th and are to be sent to the CSGNA President Nancy Campbell at 6596 Delorme Ave, Orleans ON, K1C6N6. Nomination forms are available in each issue of the Guiding Light and on the CSGNA web site. Along with the nomination form, a current curriculum vita (CV) is required.

In June, the annual report is sent to all members. The annual report contains the CVs of the candidates for positions. A ballot form is included. Please take the time to read the CVs of all the candidates, and forward your vote.

Members! It’s time to get involved!

Just a reminder that we need donations for door prizes and the silent auction for the National Conference in Regina September 2006!

GUIDELINES FOR SUBMISSION to “THE GUIDING LIGHT”

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

C.S.G.N.A. DISCLAIMER

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

The Canadian Society of Gastroenterology Nurses and Associates does not assume any responsibility for the practices or recommendations of any individual, or for the practices and policies of any Gastroenterology Unit or endoscopy unit.
Kamloops and Region CSGNA Chapter celebrate first year as a CSGNA Chapter

January 26th 2005, seven staff nurses met at Royal Inland Hospital for the first time to become Kamloops and Region CSGNA Chapter. These members are excited and keen to be apart of this growing specialty, in Gastroenterology. Our membership has increased to 11 and future growth will increase as our unit expands.

The Gastroenterology Suite is part of the Ambulatory Care Unit of Royal Inland Hospital. We have many clinics, Urology, Gynecology, Diabetic Foot Clinic, Laser Eye Surgery, IV Therapy, Minor Surgery, and Gastroenterology. Our hours of operation are 0700-1630 from Monday to Friday. We are a regional hospital and service an area of 150,000 people. We provide service to our patients' with both staff on call after hours, and 24 hour call on weekends.

Additionally, we have 27 permanent and casual staff, all of which rotate through Gastroenterology. One permanent staff member now specializes in Gastroenterology while another specializes in Minor Surgery.

We now have 3 Gastroenterologists, one of whom has recently joined us. Furthermore, seven surgeons and two general practitioners also perform endoscopic procedures.

With our Expansion, we will have 8 beds in our unit for admission and preparation of patients prior to procedures, as well as a 12-bed recovery room. Our Endoscopy unit provides care to patients who are undergoing Colonoscopy, Gastroscopy, Bronchoscopy, PEG insertions, ERCPs, and we perform many therapeutic procedures. Of our RNs, 4 have been trained for Esophageal and Anal Motility Studies and 3 RN’s specialize in 24 Hour PH Monitoring.

One of our staff members is GI certified and 2 more plan to be writing the CNA exam this April. We have study sessions every week with these members. Many other CSGNA members are showing interest in the certification program and may take the challenge next year.

As a CSGNA Chapter, we have accomplished a lot this year. For example, we have held a couple of evening Educational sessions. Chris Shultz, and her staff of Kelowna General, warmly welcomed us to their conference and educational meetings. We have attended these and appreciated the invites. A couple of staff attended the Vancouver Chapter Educational Day and 3 Members attended the World Congress in Montreal. Collectively, the attendees found the presentations both enriching and enjoyable. However, our greatest accomplishment was holding our own Chapter Educational Day!

We had wonderful support from our medical staff.

Our Gastroenterologists, Dr. Taralyn Picton gave a wonderful presentation on Iron Deficiency Anemia and Dr. Chris Stabler gave us a very interesting talk on the Etiology of Crohn’s Disease. One of our surgeons, Dr. David Hanks, gave a very entertaining talk on Hiatal Hernia Repairs and Fundoplications. Dr. Jerry James, one of our pathologists, spoke to us on Potpourri of Common GI Pathology. We all gained a new appreciation of specimens and biopsies. Lastly, Kim Winters, our Chief in Pharmacy, was extremely enlightening, as he promoted great discussions in Pharmacology in the GI Setting.

Each and every one of our members worked very hard to ensure this Day’s success. This conference was well attended. Total attendance was 52, from many areas of British Co-
lumbia including Prince George and Vancouver Island. Also, from Foothills Hospital in Calgary, Alberta, we had the pleasure of having Debbie Taggart, our CSGNA President Elect and our past Canada West Director Nala Murray, of St. Paul’s Hospital in Vancouver attending. The present Canada West Director, Joanne Glen from Red Deer Hospital, gave a warm welcoming speech on behalf of the CSGNA. We had great support from our Vendors – AMT, Boston Scientific, Carsen, Cook, Janssen-Ortho, Keir Surgical, Pentax, and Pri Med. A very enjoyable day had by all!

We celebrated our First Year with a fun filled evening supported by Boston Scientific. Dale Sturge spoke on some of the highlights from the World Congress and Maryanne Dorais talked about the Sedation Spectrum and included a discussion on Propolol. The evening ended with a cake, pictures and great optimism of the year to come.

Please contact me about any comments you may have about this newsletter or any ideas for future issues.
Leslie Bearss, Newsletter Editor.
Email lesliejoy@sasktel.net

CSGNA MEMBERSHIP FEES ARE NOW $50.00 PAYABLE BY JUNE 1st.

Kamloops and Region
Back Row: Pat Kaatz, Lori Taylor, Dr. Taralyn Picton, & Lisa Porath
Front Row: Sandra Henderson, Audrey Bouwmeester & Maryanne Dorais

Sandra & Maryanne hanging Kamloops and Region
CSGNA Chapter Charter

Liz DesMazes, Penny Hennen Dr. Chris Stabler, & Stephanie Carr
THANK-YOU NALA

In 1999, I attended Gastro 99 in Vancouver with a colleague of mine. At this conference, I became excited in gastroenterology. The CSGNA members attending the conference were excited, motivated, and willing to share information in this specialty. At the 2001 national CSGNA conference in Edmonton, our mission was to evaluate various scope washers. Again, I was extremely impressed with CSGNA and thought someday I would like to be apart of this dynamic group and possibly start a CSGNA Chapter in Kamloops. At the Edmonton conference there was discussion of a future certification program. A few months later, I attended the Vancouver Chapter Seminar in Richmond; there, I met Nala Murray, our past Canada West Director. All members seemed excited and eager to improve their practice and standards, to provide the best possible care to their patients. Nala participated in many discussions and I was impressed with her leadership. This was a smaller group where we shared information and no topic was too small.

Our unit in Kamloops under went many changes with scopes, washers, equipment, staffing, and management. Gastroenterology continued to be passion of mine because there was so much to learn. In late spring of 2004, I had a few questions regarding the processing of duodenoscopes. I e-mailed Nala and she promptly replied. In “The Guiding Light” there was an article from Nala regarding the Certification Program and the challenges she faced to take this exam. She was the only person in her unit at that time to do so! I admired her enthusiasm and dedication to this specialty in nursing and I agree with this statement.

Furthermore, some of us were interested in going to the World Congress in Montreal and Nala got us all the information we needed. Lastly, with her direction a Kamloops and Region CSGNA Chapter was initiated. Nala’s dedication, positive attitude, and her goal to increase Nursing standards in GI Nursing have been motivating. I had the honor of meeting up with Nala again in Montreal. She is an asset and valuable resource not only to Gastroenterology, but also to Nursing.

THANK-YOU NALA MURRAY

Submitted by
Maryanne Dorais RN CGN (c)
FUTURE CSGNA CONFERENCES
REGINA 2006
HALIFAX 2007
VANCOUVER 2008
TORONTO 2009

CSGNA 22nd ANNUAL NATIONAL
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Contact us today to see how we’re working with you to build a strong future for endoscopy in Canada.
A Review of the Use of Herbal Remedies
And the Impact on the GI System:
from a Canadian Perspective.

By Monique Travers RN CGN(c)

The use of herbal remedies has greatly increased in the last decade to the point where more than half of all Canadians use these products.

In 2000, the sale of the natural health products was estimated between $1.1 billion to $1.8 billion.

Natural health products include traditional herbal medicines (Chinese, Ayurvedic and Native North American), and homeopathic preparations, as well as vitamin and mineral supplements.

There are several reasons why people are taking herbal supplements:
Cheaper and more accessible than most conventional drugs, there is a growing disenchantment with conventional drugs and some believe that herbal products offer a “cure all” for chronic or life threatening illness, such as cancer, arthritis, migraine headaches, cardiovascular diseases and even AIDS.
Users believe that herbal supplements are less toxic and thus safer than most conventional drugs. Consumers are interested in self medication and believe that herbs are useful for disease prevention.

Many herbal products are used for diverse GI conditions such as nausea, diarrhea, constipation, indigestion and liver problem. Some herbal remedies cause GI side effects such as hepatic failure, cancer, interfere with laboratory tests (se. creatinine, liver enzymes thyroid function, WBC), alters metabolisms of other drugs, interfere with other medication, cause bleeding and increase the effect of sedatives and amount of anesthesia needed.

Problems with these products arise because they may contain items that are not listed on the label, may contain ingredients that are not safe or may contain too much or too little of some ingredients.

On January 1, 2004 new regulations came into force which helps ensure that Canadian consumers had safe, effective products to purchase in Canada.

By December 31, 2005 all manufactures required site licenses and must follow good manufacturing practices: this means quality control, standards including quality assurance, stability, sanitation and recall reporting.

These requirements are for all manufacturers, packagers, labelers, importers of natural products.

By December 31, 2007 all natural health products will have NHP license and a natural product number NPN, or in the case of homeopathic medicine a DIN-HM. In order to obtain this number, the manufacturer will have to provide evidence of safety and effectiveness.

Standard labeling requirements are established to ensure consumers can make an informed choice. Label information should include: Product name, quantity, recommended condition of use such as dosage form, route of reactions as well as special storage conditions.

Manufacturers must monitor adverse reactions of their products and report any serious reaction to Health Canada.

Some herbal remedies used for various GI indications:
Constipation: Cascara, aloe, psyllium, flax
Nausea & vomiting: Ginger
Digestive aids: Angelica, blessed thistle, bog bean, chicory, Chinese cinnamon, dill, fennel, ginger, peppermint, rosemary.
Anti-diarrheals: Agrimony, psyllium, barberry.

Anti-spasmodic: Celandine.
Others: anorectal preparation, anti-flatulent, GI stimulant, anti-spasmodic, liver protectant and colitis.

G.I. Procedures – Caution with Natural Products
Liver: Kava - toxicity
St. John’s Wort – alters metabolism of other drugs such as Cyclosporine and Warfarin.
Milk Thistle – hepato-protective effect.
Black Cohosh – liver failure, autoimmune hepatitis.
Sedation: Kava – (sedative, hypnotic) increase sedative effect of anesthesia.
Addictive
Valerian – increase sedative effect, long term could increase amount of anesthesia needed.
St. John’s Wort – increases sedative effect.
Coagulopathy: Garlic – risk of bleeding especially when combined with drugs that inhibit clotting. Ex: aspirin
Ginkgo – risk of bleeding when combine with drugs that inhibit clotting.
Ginseng – increases risk of bleeding, may interfere with warfarin.
Ginger – inhibits platelet aggregation.
Chamomille – contains coumarin constituents with anticoagulant activity.

One professional association, the American Society of Anesthesiologist has developed the following guidelines for pre-operative assessment:
– Discontinue herbal remedies two weeks pre-surgery.
– Bleeding risks: stop gingko three days pre-surgery, garlic and ginseng seven days pre-surgery.
Stop St. John’s Wort five days pre-surgery.
Patients taken herbal remedies fail to disclose this during pre-procedure assessment. Gastroenterology nurses need to be aware of all forms of health care used by patients to provide them with thorough and comprehensive care. Nurses have a unique opportunity to expand their roles in patient education and advocacy with the increased use of natural remedy. They have a professional obligation to be informed and willing to discuss both conventional and alternative therapeutic options with their patients.

The physician should explicitly elicit and document a history of herbal medication use during the patient’s assessment. Physicians should be familiar with the potential effects of the commonly used herbal medication to prevent, recognize and treat potentially serious problems associated with their use and discontinuation.

To control the quality of herbal preparation, strict legislation must be implemented and adhered to.

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Monique Travers is the CSGNA Director of Canada Centre and works on the GI Unit at the Ottawa General Hospital.
POSITION STATEMENT
Hand Hygiene, Artificial Nails and Jewellery

BACKGROUND
Policies and procedures practicing aseptic technique, good body hygiene and developing a caring attitude comprise the important steps in preventing transmission of microorganisms and therefore practicing infection control. The major components of asepsis: handwashing, disinfection and sterilization; personal hygiene and dress code are all essential to this practice. The endoscopy nurse shall adhere to these steps, as they will become the fundamentals in preventing adverse events.

Infectious diseases may become a major health hazard to healthcare workers and patients. Knowing the hazards and following established guidelines and policies can reduce the risk of transmission of disease and infection. Safety guidelines are established to protect the endoscopy nurse and the patient.

To protect disease transmission, you must consider all patients to have a potential infectious disease or, in other words, universally apply the same precautions to all body substances regardless of the source patient.

PURPOSE
The purpose of this position Statement is to prevent the harbouring, transmission and spread of organisms and the puncturing or scratching of patient’s skin thus causing infection of the patient. Literature has documented several infectious outbreaks in patients associated with unclean hands. Especially implicated in this study are long or artificial fingernails. In addition to this, all staff and physicians who perform or assist in patient care are directed not to wear any hand jewellery.

LEVELS OF ASEPSIS
The strictness (or level) of aseptic technique increases as you perform more invasive procedures. For example, taking a blood pressure requires only clean technique, while starting an IV requires sterile technique. The most invasive procedures (entering a sterile body cavity) require sterile technique.

MICROORGANISMS LIVE IN AND ON OUR BODIES
Transient: Transient microorganisms are easily picked up on hands, clothing, inanimate objects, etc., and are easily removed by handwashing and cleaning (physical removal of “germs”), antisepsis and disinfection. Antisepsis (or handwashing and pre-op skin preparation) is the removal of transient microorganisms from the skin with a reduction in the resident flora.

Resident or Normal Flora: These are microorganisms that are constantly present on our bodies; no amount of scrubbing will totally remove them (the skin cannot be made sterile). These organisms cause “trouble” when introduced into normally sterile areas (like the bladder or bloodstream).

Pathogens: Microorganisms that nearly always produce disease. For example: Salmonella and Shigella cause diarrheal illness upon the ingestion of enough organisms. Normal flora can become pathogens when introduced into areas where they don’t belong, for example, through insertion of a catheter or through surgery. Staph epidermis, (normal flora of the skin), causes most central line infections.

METHODS OF TRANSMISSION OF INFECTION
Direct: Contact with a patient’s blood and body fluid, secretions or excretions or by contact with items soiled with these substances (example: over-the-bed table, instruments, etc.).

Indirect: Contact with food/drink or vermin.
  a. Vehicle: Contaminated food, water or article (VRE, Hepatitis A, Salmonella).
  b. Vector: Rats, roaches or insects (malaria, plague, hantavirus, West Nile virus). Vector is an uncommon means of transmission of nosocomial infections; in other words, “two-legged rats” (or humans) transmit more infections in the hospital than those with four legs!

Airborne: Transmitted through bacteria contained in dust particles that remain airborne for long periods of time (chicken pox and tuberculosis). These diseases are highly infectious. A mask is needed for protection from these diseases. A special respirator is needed for tuberculosis.

JEWELLERY
All personnel entering the endoscopy procedure room should confine or remove all jewellery and watches.

Rings, watches and bracelets should be removed as these may harbour organisms that cannot be removed during handwashing. Higher bacterial counts have been noted when rings are worn.

Several studies have demonstrated that skin underneath rings is more heavily colonized than comparable areas of skin on fingers without rings. Some studies have found that 40% of nurses harboured gram-negative bacilli (e.g., E. cloacae, Klebsiella, and Acinetobacter) on skin under rings and that certain nurses carried the same organism under their rings for several months. Therefore, jewellery should not be worn on the hands because it harbours microorganisms and may puncture gloves.
FINGERNAILS, NAIL POLISH AND ARTIFICIAL NAILS

Personnel in the endoscopy area should keep their fingernails short, clean and healthy. The subungal region harbours the majority of microorganisms found on the hand. Studies have documented that subungal areas of the hand harbour high concentrations of bacteria, most frequently coagulase-negative staphylococci, gram-negative rods (including *Pseudomonas* spp.), Corynebacteria, and yeasts. Freshly applied nail polish does not increase the number of bacteria recovered from periungal skin, but chipped nail polish may support the growth of larger numbers of organisms on fingernails.

Removing debris from fingernails requires the use of a nail cleaner under running water; additional effort is needed for longer nails. The longer nails increase the risk of tearing of gloves and may cause injury to the patient during the procedure if repositioning of the patient is necessary. Even after careful handwashing or the use of surgical scrubs, personnel often harbour substantial numbers of potential pathogens in the subungual spaces.

Health care workers who wear artificial nails are more likely to harbour gram-negative pathogens on their finger-tips than are those who have natural nails, both before and after handwashing. Personnel wearing artificial nails have been epidemiologically implicated in several outbreaks of infection caused by gram-negative bacilli and yeast. These studies provide evidence that wearing artificial nails poses an infection hazard.

RECOMMENDED PRACTICE

- Fingernails should be kept short to prevent the puncturing of gloves.
- False fingernails should not be worn because they harbour organisms and prevent effective handwashing. Fungal growth occurs frequently under artificial nails because moisture is trapped between the natural and artificial nails.
- Meticulous handwashing should be done:
  - between patient contact, after glove removal
  - when entering or leaving the Endoscopy area
  - if hands and other skin surfaces are contaminated with blood or body fluids
  - before and after performing invasive procedures, whether or not sterile gloves are worn
  - before and after contact with wounds, whether surgical, accidental, or associated with an invasive device (e.g., an intravenous cannula entrance wound) whether or not sterile gloves are worn
  - before contact with particularly susceptible patients
  - after contact with a source that is likely to be contaminated with virulent microorganisms or hospital pathogens, such as an infected patient (MRSA, VRE, Hepatitis) or an object or device contaminated with secretions or excretions from patients (e.g., a oral, bronchial or colonic excreta, colostomy, and mucus).
  - between procedures when the patient is having more than one procedure and after removing gloves
  - between direct contacts with different patients
  - before and after your shift
  - before and after eating, drinking or handling food
  - after using the toilet, coughing or sneezing
  - whenever hands are visibly soiled, they should be washed immediately.

SELECTION OF ANTISEPTIC AGENTS

Selecting the most appropriate antiseptic agent for hand hygiene requires consideration of multiple factors. Essential performance characteristics of a product (e.g., the spectrum and persistence of activity and whether or not the agent is fast acting) should be determined before selecting a product. Health Care Personnel acceptance is a major factor regarding compliance with recommended hand hygiene protocols. It is important to take into consideration any chemical allergies, skin integrity after repeated use, compatibility with lotions used, and offensive agent ingredients (e.g., scent).

EFFICACY OF ANTISEPTIC AGENTS AGAINST SPORE-FORMING BACTERIA

The widespread prevalence of health-care – associated diarrhea caused by *Clostridium difficile* is of great concern. Especially since of the agents (including alcohols and chlorhexidine) used in antiseptic handwash or antiseptic hand-rub preparations are effective at eradicating *Clostridium difficile*. Washing hands with non-antimicrobial or antimicrobial soap and water may help to physically remove spores from the surface of contaminated hands. Health care workers should wear gloves when caring for patients with *C. difficile*-associated diarrhea. After gloves are removed, hands should be washed with a non-antimicrobial or an antimicrobial soap and water or disinfected with an alcohol-based hand rub.

Handwashing products, including plain (i.e., non-antimicrobial) soap and antiseptic products, can become contaminated or support the growth of microorganisms. Soap should not be added to a partially empty dispenser, because this practice of topping up might lead to bacterial contamination. Know your product and follow the manufacturer’s directions.

The primary defence against infection and transmission of pathogens is healthy, unbroken skin. Frequent hand washing can cause damage to the skin changes skin flora, resulting in more frequent colonization by staphylococci and gram-negative bacteria. Lotions are often recommended...
to ease the dryness resulting from frequent handwashing and to prevent dermatitis from glove use. Petroleum-based lotion formulations can weaken latex gloves and increase permeability. For that reason, lotions that contain petroleum or other oil emollients should only be used at the end of the workday.

**CONCLUSION**

Diligence and common sense are keys to prevention of transmission of disease. Good hand and personal hygiene; proper use of skin preparations and disinfectants, adherence to the removal of all jewellery on hands; and avoidance of all artificial nails while maintaining short, clean and healthy nails – the endoscopy nurse reduces the risk of unnecessary disease transmission.

These recommendations are designed to improve hand hygiene practices of health care workers and to reduce transmission of pathogenic microorganisms to patients and personnel in endoscopy setting.

**DEFINITIONS**

**Alcohol-based hand rub.** An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%—95% ethanol or isopropanol.

**Antimicrobial soap.** Soap (i.e., detergent) containing an antiseptic agent.

**Antiseptic agent.** Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, and triclosan.

**Antiseptic handwash.** Washing hands with water and soap or other detergents containing an antiseptic agent.

**Artificial Nails**: Substances or devices applied or added to the natural nails to augment or enhance the wearer’s own nails. They include, but are not limited to, bonding, tips, wrappings, and tapes.

**Disinfection**: Removal of most pathogens (or disease-causing organisms) by the use of friction (cleaning) and a use of a disinfectant. Use disinfectant that destroys most of the pathogens on contact.

- Clean semi-critical equipment with a disinfectant frequently (bed rails, door knobs, over-the-bed tables, faucet handles, phones, blood pressure cuff, pulse oximeter, ECG leads etc.).

**Visibly soiled hands**: Hands showing visible dirt or visibly contaminated with proteinaceous material, blood, or other body fluids (e.g., fecal material or urine).

**DISCLAIMER**

The Canadian Society of Gastroenterology Nurses and Associates does not assume responsibility for the practices or recommendations of any member or other practitioner or for the policy and practices of any Endoscopy Unit.

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Recommended Guidelines for the Endoscopy Setting

RECOMMENDATIONS FOR SAFETY OF PERSONNEL AND PATIENT

Safety is of the utmost importance and should be in the forefront of each employee’s mind. Consistent practice must be maintained to prevent the spread of disease and to protect by implementing the Universal precautions at all times.

Purpose:
These guidelines identify practices that can be employed to protect patients and health care workers from exposure to bloodborne and body fluid pathogens, which are primary potential sources for transmission of disease. They are inclusive of all personnel at risk for exposure to bloodborne pathogens. The rapidly changing health care environment presents health care workers with continuing challenges in the form of newly recognized pathogens and long-known microorganisms that have become more difficult to eradicate using today’s therapeutic measures. Protecting patients and their health care providers from pathogen transmission continues to become more difficult and thus more imperative. Following these guidelines consistently may well be the most effective method to prevent the spread of medication-resistant and disease-causing microorganisms:

• All personnel should be immunized against Hepatitis B.
• Eye protection and moisture resistant masks or face shields should be worn to prevent contact with splashes from the gastrointestinal tract during the endoscopy procedure.
• Moisture resistant gowns should be worn to prevent contamination of personnel due to splashes of blood or other body fluids. The gowns should be changed between procedures.

• Protective apparel (gown and mask) should be removed when leaving the procedure room and cleaning room.
• Gloves should be worn for handling and cleaning of dirty equipment as well as for any potential contact with blood or body fluids.
• All needles and sharps are to be appropriately disposed of in puncture resistant containers at their point of use. Do not recap needles.
• Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.

GENERAL CONSIDERATIONS

Principles
Procedures that generate droplets and aerosols can expose staff to respiratory pathogens and should be conducted using infection control practices designed to reduce exposure to respiratory secretions.

During high risk circumstances protection must be undertaken for all procedures that have the potential to generate droplets or aerosols, such as:
• nebulized therapies,
• aerosol humidification,
• non-invasive ventilation,
• use of bag-valve mask to ventilate a patient,
• endotracheal intubation,
• airway suctioning,
• bronchoscopy or other upper airway endoscopy, tracheostomy, and open thoracotomy.

Some evidence suggests that droplet precautions are sufficient to prevent transmission of SARS. N95 respirator or equivalent mask is recommended for all aerosol-generating procedures. Laser procedures also require appropriate masks to be worn or a properly fitting N 95 respirator.

Principles of Transmission of Microorganisms
In hospital epidemiology, routes of transmission of infectious agents have been classified as contact, droplet, airborne, common vehicle and vectorborne transmission. Contact transmission is the most common route of transmission of microbes from symptomatic or asymptomatic patients in hospitals.

Some diseases, such as anthrax, can be transmitted in more than one way. Anthrax can be spread through direct contact to a cut on the skin, producing cutaneous anthrax. It can also be spread through airborne spores which are inhaled, producing a more serious type of infection. Gastrointestinal anthrax can occur when anthrax spores are ingested.

A. Contact transmission
Contact transmission includes direct contact, indirect contact and droplet (large droplet) transmission. Although droplet transmission is a type of contact transmission, it is considered separately as it requires different precautions.

Direct and Indirect Contact
Direct contact transmission occurs when transfer of microorganisms results from direct physical contact between an infected or colonized individual and a susceptible host (body surface to body surface).

Indirect contact involves passive transfer of microorganisms to a susceptible host via an intermediate object, such as contaminated hands that are not washed between patients or contaminated instruments or other inanimate objects in the patient’s immediate environment.

Routine patient care practices should prevent most transmission by this route.

Additional precautions are required when routine practices are not
sufficient to prevent transmission of certain microorganisms. The need for additional precautions will depend on the routine practices used by an institution, the degree of compliance with these practices, and the microorganisms encountered. Patients infected or colonized with epidemiologically important microorganisms that may be transmitted easily by contact with the patient’s intact skin or with contaminated environmental surfaces (e.g. *Clostridium difficile*, MRSA, VRE).

**Droplet Transmission**
- Droplet transmission is a form of contact transmission but requires special considerations.
- Droplet transmission refers to large droplets, 5 μm in diameter, generated from the respiratory tract of the source patient during coughing or sneezing, or during procedures such as oral suctioning or bronchoscopy. These droplets are propelled a short distance, < 1 m, through the air and deposited on the nasal or oral mucosa of the new host. Other organisms expelled in large droplets, especially respiratory viruses, remain viable in droplets that settle on objects in the immediate environment of the patient. Viruses such as respiratory syncytial virus (RSV), influenza, parainfluenza and rhinovirus survive long enough on surfaces to be picked up on the hands of patients or personnel. Respiratory viruses may be transmitted by direct deposition of infectious droplets onto the nasal mucosa or conjunctiva (large droplet), or by inoculation of these membranes by contaminated hands (contact).

**B. Airborne transmission**

Airborne transmission refers to dissemination of microorganisms by aerosolization. Organisms are contained in droplet nuclei (the small airborne particles, < 5 μm, that result from evaporation of large droplets) or in dust particles containing skin squames and other debris that remain suspended in the air for long periods of time. Such microorganisms are widely dispersed by air currents and inhaled by susceptible hosts who may be some distance away from the source patient, even in different rooms or hospital wards. Control of airborne transmission is the most difficult, as it requires control of air flow through special ventilation systems.

There is evidence for airborne transmission from source patients with tuberculosis, and Varicella.

Contact with respiratory secretions and large droplets account for most transmissions.

All personnel not essential to the procedure must remain outside of the room; if attendance is necessary for non-medical reasons, persons must use at minimum N95 respirator or equivalent masks, gloves, and eye protection.

**C. Common vehicle transmission**

Common vehicle transmission refers to a single contaminated source such as food, medication, intravenous fluid, equipment, etc., which serves to transmit infection to multiple hosts. Such transmission may result in an explosive outbreak. Control is by maintenance of appropriate standards in the preparation of food and medications and in decontamination of equipment.

**D. Vectorborne transmission**

Vectorborne transmission refers to transmission by insect vectors and is prevented by appropriate hospital construction and maintenance, closed or screened windows, and proper housekeeping. Such transmission has not been reported in Canadian hospitals.

**Personal Protection**

Protective equipment must be removed in such a way as to not contaminate the health care worker or others.

The following process is recommended (the process is dependent on level of precautions in use) to remove Personal Protective Equipment:

- Remove gown (discard in linen hamper in a manner that minimizes air disturbance).
- Remove gloves and discard using a glove-to-glove/skin-to-skin technique.
- Use alcohol hand rinse or, if available, a hand sink; **do not use** patient bathroom to wash hands.

**Just prior to leaving or immediately after leaving the room:**

- Use alcohol hand rinse.
- Remove face shield/fluid shield and eye protection and discard or place in clear plastic bag and send for decontamination.
- Use alcohol hand rinse again.
- Remove N95 respirator or equivalent mask and discard.
- Use alcohol hand rinse again.

**Personnel**

Personal protective equipment must be properly used, fit and maintained in a manner consistent with *Regulation for Health Care and Residential Facilities* under the Occupational Health and Safety Act. Staff requiring N95 respirator or equivalent masks must be fit-tested to ensure maximum mask effectiveness. Measures and procedures for worker protection and training must be developed in consultation with the facility’s Joint Health and Safety Committee/Health and Safety Representatives.

**Technical Considerations**

Gowns may be reusable or disposable, and are available in a range of permeability options. Material composition may include fabric, paper, plastic, or combinations.

1. **Permeable (cloth patient-type):**
   - Body fluids may permeate through the gown into the worker’s clothing.
2. **Semi-permeable (paper-type):**
   - If the splash is not excessive this type will protect the worker.
3. **Masks are available in a variety of materials and shapes (half-sphere, flat, or pleated) with ties or an elastic band to secure to the face.**
   - Some masks contain latex. Face shields combining mouth and eye protection are available. The objective of wearing a mask during endoscopy procedures is to protect
the wearer from splashing. Therefore, an N95 respirator would not be required, procedure mask is sufficient. N95 is not recommended except for airborne precautions

4. Gloves are available in latex, non-latex, powdered, powder-free, hypoallergenic, or non-allergic. The wearer must determine which is most appropriate for his/her needs. Non-latex gloves may have a diminished puncture resistance after an extended wearing period.

5. Radiation Protection. All persons exposed to ionizing radiation with any frequency or during prolonged procedures may be required to wear a monitoring device according to government regulations. Radiation Protection Acts of each province and CSA Standards must be followed. Leaded eyewear is available. Two dosimeters should be worn, one inside and one on the outside. (AORN 2003, p.333).

6. Laser protection. Risks to endoscopy personnel include eye or skin injury, and respiratory exposure to pathogens. The primary mechanism against eye injury is laser safety eyewear. Eyewear must be specific to the wavelength of the laser being used. Vaporization of tissue can result in airborne infectious particles. All personnel in the room must wear eye protection, appropriate for the laser being used, and an N95 respirator. The patient requires eye protection and a laser mask. Adequate local exhaust ventilation and use of respiratory filter masks is recommended. The laser safety standard adopted by the Canadian Standards Association specifies that facilities using class 4 lasers (most medical applications) should designate a Laser Safety Officer to oversee safety for all operational, maintenance, and servicing situations.

**SUMMARY**

Personal protective equipment, when used properly, can protect the wearer from harmful exposure. The selection of appropriate PPE should be individualized to the type and degree of exposure anticipated. The onus is on the individual institution, the infection control personnel and endoscopy personnel to interpret, implement and evaluate the need and compliance for PPE.

Attention must be given to the implementation of infection control standards. Contaminated endoscopes and accessories are potential sources of infection for both patients and personnel. Strict guidelines are needed to standardize what type of attire should be worn in the endoscopy setting. The human body is a major source of microbial contamination in this environment. Various articles of attire (e.g., imperious gowns, hair covering, masks, protective eyewear, and other protective barriers) are worn to provide a barrier to contamination that may pass from personnel to patient as well as from patient to personnel. Clothing is worn to promote high level cleanliness and hygiene within the endoscopy environment.

**DISCLAIMER**

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

**TERMINOLOGY**

**Aerosolization**: The process of creating very small droplets of moisture (droplet nuclei) that may carry microorganisms. The aerosolized droplets can be light enough to remain suspended in the air for short periods of time and facilitate inhalation of the microorganisms.

**Airborne transmission**: Occurs by dissemination of either airborne droplet nuclei or evaporated droplets (submicron particles) containing microorganisms that remain suspended in the air for long periods of time. These microorganisms can be widely dispersed by air currents and may be inhaled by persons even when standing a distance away from the source patient.

**ALARA** – (As low as reasonable achievable). The amount of radiation one should strive toward.

**Assisting Nurse’s attire**: Clothing worn in the Endoscopy unit that consists of a two-piece pantsuit made especially for the practice setting. Non sterile surgical apparel items designated for assisting the endoscopist in the endoscopy unit setting that includes head covering, shoes, masks, protective eyewear and other protective barriers as may be deemed necessary and procedures specific.

**Blood-Borne Pathogens**: are pathogenic microorganisms that are present in human blood and can cause diseases in humans. These pathogens include but are not limited to hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

**Cluster**: A grouping of cases of a disease within a specific time frame and geographic location suggesting a possible association between the cases with respect to transmission.

**Droplet Precautions**: The type of precautions used to protect health care workers when caring for patients with respiratory infections. These infections are transmissible principally by large respiratory droplet, particularly when the health care worker is within 1 metre of the ill patient. They are spread more effectively when the patient is coughing or sneezing. The precautions consist of a water resistant surgical or procedure mask and eye protection or face shield for the health care worker. Droplet precautions are also used to protect the mucous membranes of the eyes, nose and mouth of the health care worker during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions (e.g., airway suctioning).
Film Badge – An assembly containing a packet of unexposed photographic film and filters. When the film is developed, the dose and type of radiation exposure can be estimated (Adler & Carlton, 1994).

Film Dosimeter – A radiation dose measuring device.

High risk procedures: With droplet-spread respiratory illness, high risk procedures are defined as those activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions, particularly those procedures that create aerosols.

Other Potentially Infectious Material (OPIM): is defined as the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

Personal Protective Equipment (PPE): Personal protective equipment for standard precautions and specialized clothing worn by an employee for protection against a hazard, which does not permit blood or OPIM (other potential infectious material) to pass through clothes, skin, eyes or mouth. Clothing includes intact gloves, gowns, masks, and eye protection (e.g. face shields, goggles, N95 masks, and glasses with side shields). General work clothes (uniforms, pants, shirts, lab coats) not intended to function as protection against a hazard is not considered PPE.

Occupational Exposure: is a reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or OPIM that may result from the performance of an employee’s duties.

Primary Care Provider: For purposes of this document, primary care provider is defined as a health care professional who has the skills, training and scope of practice to diagnose a condition such as FRI (i.e., physician, nurse practitioner) and who has responsibilities under the Health Protection and Promotion Act to notify public health upon diagnosing a reportable disease.

Respiratory Symptoms: New or worse cough (onset within 7 days) OR new or worse shortness of breath (worse than what is normal for the patient).

Routine Practices (See also “Droplet precautions”): The Health Canada term to describe the system of infection prevention recommended in Canada to prevent transmission of infections in health care settings. These practices describe prevention strategies to be used with all patients during all patient care, and include:
- Hand washing or cleansing with an alcohol-based sanitizer before and after any direct contact with a patient.
- The use of additional barrier precautions to prevent healthcare worker contact with a patient’s blood and body fluids, non intact skin or mucous membranes.
- The wearing of surgical masks and eye protection or face shields where appropriate to protect the mucous membranes of the eyes, nose and mouth during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.
- Gloves are to be worn when there is a risk of body fluid contact with hands; gloves should be used as an additional measure, not as a substitute for hand washing.
- Gowns are to be worn during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions that could contaminate uniform or clothing.

Universal Precautions (UP): assumes that the blood and body fluids of all patients are considered potentially infected with the AIDS virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other blood-borne pathogens, and must be handled accordingly to protect employees.

REFERENCES


(See NIOSH website at www.cdc.gov/niosh -Publication No.99-143, and Canadian Standards Association Z94.4-02 Selection, Use, and Care of Respirators, October 2002).

The full description of routine practices to prevent transmission of nosocomial pathogens can be found in the Health Canada website: http://www.hc-sc.gc.ca/ewh-smt/occup-travail/whmis-simdut/application/msds-fiches_signaletiques_e.html#10
Infection Control – Recommended Guidelines in the Endoscopy Setting

RECOMMENDATIONS FOR THE SAFETY OF PERSONNEL

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

- All personnel shall be immunized against Hepatitis B.
- Health care workers who have respiratory problems (i.e. asthma) should be assessed by Occupational Health prior to working with chemical germicides. Personal protective equipment (eye protection, face shield or a moisture resistant surgical mask that will not trap vapours, gloves, eye protection, and impervious gown) shall be worn.
- Moisture resistant gowns shall be worn to prevent contamination of personnel due to splashes of blood or other body fluids or injury due to chemical disinfectant/sterilant contact. The gown shall be changed between procedures.
- Fingernails should be kept short to prevent the puncturing of gloves. False nails (including gel nails) should not be worn because they harbor microorganisms and may puncture gloves. Jewelry should not be worn on the hands because it harbors microorganisms and may puncture gloves.
- Meticulous handwashing should be done between patient contact, after glove removal and when entering or leaving the Endoscopy area. If hands and other skin surfaces are contaminated with blood or body fluids, wash immediately.

BACKGROUND

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

RECOMMENDATIONS FOR ENDOSCOPES

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

EDUCATION IN THE ENDOSCOPY SETTING

Infection control education is a crucial part of the orientation and continuing education hospital program for all personnel. All staff including endoscopists, nurses, and all assisting personnel who work in the endoscopy setting must be a part of an initial and then ongoing routine educational updates. Once the education is completed all personnel must adhere to infection control principles in order to maintain a safe environment, free from the possibility of transmission of disease regardless of setting (all health care and public service settings, including acute and long-term care inpatient facilities and outpatient clinics) corresponding to any and all types of Gastrointestinal procedures that may be performed. Orientation and educational programs must include but are not limited to: universal precautions; prevention of transmission of bloodborne pathogens between patients and from hospital care workers to patient; endoscope and accessory equipment reprocessing routine; continuance of a safe work environment; safe handling of high level disinfectants (HLD) and sterilants including WHIMIS training; and proper handling of waste products.

When new models of endoscopes or reprocessors are introduced to the facility, additional training with documented competency must be completed. Annual updates are recommended to ensure compliance with current standards and manufacturers’ guidelines (Rutala & Weber, 2004).

All individuals who reprocess endoscopes and accessories require detailed knowledge of the instruments and the specific methods required to produce an instrument safe for use. The development of this knowledge is obtained through repetition and the guidance of a preceptor. Individual/s, who reprocesses instruments, should
complete the initial infection control orientation/reprocessing competency followed by annual competency review and infection control updates. Documentation should accompany each review (ASTM, 2000).

Each endoscopy setting is unique and must make their own decisions regarding the number and category of personnel who will be responsible for instrument reprocessing. All persons involved must be properly trained and their performance subject to periodic review and annual updates to ensure compliance with current standards and manufacturers’ guidelines (Rutala & Weber, 2004).

Decision-making personnel must be familiar with the principles and practices of instrument reprocessing if they are to properly train and monitor staff. Knowledgeable supervisors also serve to impress upon peer groups and subordinates the importance of these functions.

One individual in each endoscopy setting should be designated and assigned to monitoring compliance with the reprocessing protocol. Policy must be in place to ensure consistency and adherence to the reprocessing protocol is followed. The protocol should be reviewed according to institutional policy to ensure that it is being followed routinely and that there is no new information that would require modification to current practices. Modifications should be made with consultation of an infection control advisor prior to modifying reprocessing practices. The review process and protocol modifications should be documented for each update or training.

Monitoring of reusable HLDs and sterilants for minimum effective concentrations should be done by staff at least each working day and results documented. HLDs and sterilants must be changed when the solutions fail to meet minimum effective concentration or exceed the HLD manufacturer’s recommended use life, whichever comes first (ASGE, 2001; Nelson et. al., 2003).

High-level disinfectant and sterilant vapour levels should be monitored and documented when: a change in the disinfection phase of the reprocessing protocol occurs; a different high-level disinfectant or sterilant is used; or a staff member exhibits symptoms of overexposure.

**INSPECTION**

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

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

Ensure immersion cap is placed on all videoscopes.

If a leak is detected, follow your service provider’s instructions concerning disinfection of the endoscope prior to sending to the repair service immediately. If the scope cannot be cleaned prior to transport, ensure that it is clearly labeled ‘contaminated’.

**CLEANING**

These steps occur in the endoscopy room immediately after the endoscope is removed from patient. Meticulous manual cleaning is the most important step in the cleaning process. It is imperative that all channels, removable parts and all immersible parts of the endoscope be cleaned. The rationale for cleaning the scope at the bedside is to prevent drying of organic and inorganic debris on lumen surfaces and to remove microbial burden from endoscope. Retained debris may inactivate or interfere with the capability of the active ingredient of the chemical solution to effectively kill and/or inactivate microorganisms.

Therefore, immediately after the endoscope is removed from the patient, wipe the outer surface with enzymatic solution soaked lint-free cloth. Light source must be turned off, but suction remains on – the nurse places distal end of the scope and suction channel for 30 seconds, and then removes the distal tip from the enzymatic solution and suction air for 10 seconds. Remove air/water channel cleaning adapter; with the light source being on, the distal tip is placed into clean water for 30 seconds, observing that the air is flowing from the distal end by watching for bubbles, then remove the distal end from the water, depress the air/water channel tester button and observe for water squirting (from the water bottle) from the distal end for 10 seconds. Detach endoscope from light source and suction pump. Attach protective cap (if videoscope scope) and transport endoscope to the reprocessing area in an enclosed container.

**REPROCESSING AREA**

Reprocessing of contaminated patient equipment should be done in an area designated and dedicated for this function. This should be a room separate from where endoscopic procedures are performed. The reprocessing area should be constructed in such a way to include adequate space for reprocessing activities, proper airflow and ventilation requirements, work flow patterns, work surfaces, lighting, adequate utilities such as electrical support and water, handwashing and eye washing facilities, air drying capability, and storage.

Tap water and/or water that has been filtered by passage through a 0.2 micron filter or water of equivalent quality (i.e., suitable for drinking) should be available in the reprocessing area. Bottled sterile water may be used.

Agents needed for reprocessing include a low-sudsing, enzymatic detergent formulation recommended for endoscopes, a Food and Drug Administration (FDA)-cleared high-level disinfectant or sterilant, and 70% isopropyl alcohol. An EPA-registered hospital-grade disinfectant should be used for surface cleaning.

- Perform a leakage test on the scope by following your manufacturer’s instructions recommendations.
- Fully immerse the scope in a solution with an enzymatic cleaner to prevent the drying of secretions.
Brush biopsy/suction channel to remove the organic material and decrease the number of organisms present. Ensure that access to the air/water/biopsy channel is attained with proper channel irrigator attachments, as these channels are very difficult to clean. Ensure the outer surface of the scope is thoroughly cleaned.

- Wash all debris from the exterior of the endoscope by brushing and wiping the instrument while submerged in the detergent solution. Leave the endoscope submerged in the detergent solution when performing all subsequent cleaning steps. Note that the instrument should be left under water during the cleaning process to prevent splashing of contaminated fluid.
- Clean all non-immersible parts with a hospital recommended surface disinfectant.
- Non-immersible endoscopes should be replaced because they are very difficult to clean and disinfect.
- Detach the suction and air/water valves, the biopsy channel cover, the distal end hood, if present, and all other removable parts. Discard those parts that are designated as disposable. Note that the endoscope must be completely disassembled so that all surfaces may be reached for thorough cleaning.
- Use a small, soft brush to clean all removable parts, including inside and under the suction valve, air/water valve, and biopsy port cover and openings. Use non-abrasive and lint-free cleaning tools to prevent damage to the endoscope.
- Brush all accessible endoscope channels including the body, insertion tube and the umbilicus of the endoscope. Use a brush size compatible with each channel.
- After each passage, rinse the brush in the detergent solution, removing any visible debris before retracting and reinserting it.
- Continue brushing until there is no debris visible on the brush.
- Clean and high-level disinfect reusable brushes between cases. Note that reusable brushes should be inspected between uses and replaced when worn, frayed, bent, or otherwise damaged. Worn bristles are ineffective in cleaning, and damaged brushes may damage endoscope channels.
- Attach the endoscope manufacturer’s cleaning adapters for suction, biopsy, air, and water channels.
- Flush all channels with the detergent solution to remove debris.
- Soak the endoscope and its internal channels for the period of time specified by the label of the enzymatic detergent. If, due to time constraints, it is not possible to complete the reprocessing immediately, the endoscope should be leak-tested, flushed, brushed, rinsed and dried until it can be thoroughly reprocessed.

**STERILIZATION AND DISINFECTION**

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

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

- High level disinfection of the endoscope internally and externally must be performed after scrupulous mechanical cleaning has been completed. All processes will be rendered ineffective if any organic material or moisture is present on or in the endoscope.
- Chemical agents registered with Canada Health and Welfare, as sterilant/disinfectants are appropriate for high level disinfections. To ensure efficacy, the manufacturer’s instructions regarding use of disinfectant must be adhered to.
- All internal and external surfaces and channels must be in contact for the length of time that is recommended by the manufacturer.
- Disinfectant agents must be chosen carefully and must be used according to the manufacturer’s instructions including monitoring chemical concentrations. Effective use-life is more dependent on frequency of use rather than on a predetermined time or duration of use.

**RINSING**

To remove all traces of the disinfectant, adequate rinsing with copious amounts of clean water (bottled sterile water may be used) must follow the disinfection process. Any residual chemical can cause toxic effects in a patient if it is transmitted during the next endoscopic procedure. Purge all channels with air.

After each reprocessing cycle, each and every scope must be irrigated with 70% alcohol rinse; followed by drying with compressed air:

- all the channels must be purged with air
  - bacteria such as Pseudomonas aeruginosa have been identified in both tap and filtered water and may multiply in a moist environment
  - Avoid using excessively high air pressure. High-pressured air can cause damage to the internal channels of the flexible endoscope.
- all channels, including any accessory channels, are flushed with alcohol until the alcohol can be seen exiting the opposite end of each channel
70% isopropyl alcohol is used to aid in drying of the interior channel surfaces.

- Alcohol flushes are recommended even when sterile water is used for rinsing.
- Alcohol must be properly stored in a closed container between uses. If alcohol is exposed to air, it rapidly evaporates, and if below recommended percentage level, cannot be relied upon to assist with the drying process.

- all the channels must be purged with air again following the alcohol flush.
- alcohol mixes with the remaining water on the channel surfaces and acts to encourage evaporation of the residual water as air flows through the channel.
- remove all channel adapters after the endoscope has been reprocessed.
- dry the outside of the endoscope with a soft, clean and lint-free cloth.
- Thoroughly rinse and dry all removable parts. Do not attach removable parts (valves, etc.) to the endoscope during storage.
- Storage of endoscopes with removable parts detached lowers the risk of trapping liquid inside the instrument and facilitates continued drying of the channels and channel openings.

**STORAGE OF SCOPES, CASE-TO-CASE, DAY TO DAY:**

- Endoscopes should be hung vertically with the distal tip hanging freely in a well-ventilated, dust-free area (or placed in aerating cupboard).
- a storage area with good ventilation will encourage continued air drying of the surfaces and avoid undue moisture build-up thus prevent any microbial contamination.
- Wipe down the storage cupboard with disinfectant solution weekly.

**DOCUMENTATION**

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

Documentation is required as part of a quality control program, and may include the following (Nelson et al., 2003; Muscarella, 2001):

1. the endoscopy procedure date and time;
2. the patient’s name and institutional identifying number;
3. the name of the endoscopist;
4. the endoscope’s model and serial number;
5. the Automatic Endoscope Reprocessor (if used) model and serial number;
6. the printout of the AER for all reprocessing steps should be kept with the log sheet;
7. the personnel who reprocessed the endoscope.

Immediately report any suspected or identified infections to the infection control person or those responsible for infection control in the endoscopy setting.

Accurate documentation must be done to ensure and provide adequate tracking and follow-up should there be an epidemic.

**CULTURING**

Culturing requires very precise techniques done in close consultation with an infection control department. Institutional policy may dictate when and how culturing of scopes should be carried out. Biological testing of the reprocessing equipment shall be carried out as per institutional policy and manufacturer’s recommendations.

Performing routine cultures of endoscopes is not recommended, but may be done in the event of an identified outbreak.

**SPECIAL CONSIDERATIONS**

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

**RECOMMENDATIONS FOR ACCESSORIES**

Non-disposable accessories require meticulous manual cleaning and disinfection or sterilization after each use according to manufacturer's guidelines and as directed by institutional policy.

- Cleaning Brushes should be disposable or thoroughly cleaned as per manufacturer's recommendations and should be cleaned separately from the endoscope.

**BIOPSY FORCEPS**

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

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

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

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

**WATER BOTTLE**

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

For endoscopic irrigation, fill the bottle with sterile water.

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

**OTHER ACCESSORIES**

Clean all reusable accessories meticulously with an enzymatic agent followed by rinsing thoroughly with water. Use the ultrasonic cleaner prior to steam autoclave.

Consult the manufacturer if steam sterilization is not applicable.

Injection needles should be discarded in the sharp container after each use.

Discard suction tubing after each procedure.

**MEDICAL EQUIPMENT**

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

If significantly soiled, use an intermediate disinfectant after cleaning.

**RECOMMENDATIONS FOR ENVIRONMENT GENERAL CLEANING**

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

**SPILLS**

Each endoscopy setting should have a spill containment plan specific for the high-level disinfectant or sterilant used. The information from the specific Workplace Hazardous Materials Information System (WHIMIS) should be incorporated into the plan. The plan should include written procedures for actions to contain the spill and deactivate the chemical, an intra- and inter-departmental communication plan, and an evacuation plan. Upon assignment to the department and annually thereafter, all persons working in the setting must be trained in the safe handling of high-level disinfectants or sterilants, and spill containment procedures. Refer to the manufacturer’s instructions for information on the specific solution.

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

**WASTE**

Minimal handling of all medical waste should be encouraged.

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

**REPROCESSING AREA**

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

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

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

Periodic air quality monitoring of glutaraldehyde levels should be performed.

**AUTOMATED WASHERS/ DISINFECTANTS**

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

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

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

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

- Enzymatic and/or disinfectant should be circulated through all channels at equal pressure without trapping air.

- Washing and disinfecting cycles should be followed by thorough rinsing cycles followed by forced air to remove the used solution.

- Disinfectant should not be diluted with wash or rinse water.

- Routine disinfection of the washer/dishwasher according to the manufacturer’s recommendations and institutional policy must be done.

- Cycles for alcohol flushing and forced air drying are desirable.

- A print out of all reprocessing steps of the machine

**Other considerations:**

- A channel irrigator may miss a blockage of one channel.

- Attach the manufacturer’s cleaning adapters for special endoscope channels (e.g., elevator channel, auxiliary channel and double-channel scopes).

- To achieve adequate flow through all lumens, various adapters or channel restrictors may be required. Refer to the manufacturer’s instructions.

- Because the elevator channel of duodenoscopes is a small lumen, force greater than can be generated by an automated reprocessor is needed to force fluid through it. This channel requires manual reprocessing (all steps) using a 2- to 5-ml syringe. Although the elevator channel of these scopes has channel adapters that may be made to fit reprocessors, this channel must be manually reprocessed.

- All endoscope channels must be flushed with 70% alcohol and dried with air after each reprocessing cycle. Note that alcohol evaporates and concentration levels change when open to air, therefore use alcohol from a capped container only.

- Colonization of bacteria may be caused by residual water remaining in the water hoses and reservoirs. This could lead to contamination during subsequent instrument processing.
CLEANING DISINFECTION AND STERILIZATION PROCEDURES

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

Alcohol – 70% isopropyl or ethyl alcohol

Air – Airflow provided by a pump or compressor.

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

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

DISCLAIMER

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

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Muscarella, L., “High-level disinfection or sterilization of endoscopes” Infection Control and Hospital Epidemiology, 2000.


TERMINOLOGY

Clean – Visibly free from debris

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

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

Elaine Burgis, Membership Director

At our annual conference, in Montreal last September, CSGNA unveiled a new award designed to encourage Chapter involvement and growth. The “Chapter of the Year” award was introduced to all Chapter executive at the Chapter dinner meeting.

The award was created to encourage and support educational growth, increase involvement at the National level, actively recruit new members and retain existing members, and to promote GI Nursing. This challenge was well received by all the Chapter executives who attended the meeting.

Application for the award is due to the Education Director June 30th (the same date that the education report is due). Chapter executives will fill out the application form with details on the education hours that were provided to their Chapter, noting any certification support that was provided through study groups, a list of members who provided articles for “The Guiding Light”, and members who presented at the Annual Conference. Points will be awarded to Chapters who forward names of their members for National positions and for the number of votes returned for National elections and by-laws. The Membership Director will provide the Chapters’ membership statistics, noting the Chapters who have a new member growth of 10% and maintain their renewing membership at 90%.

The “Chapter of The Year” award will be presented for the first time this September at our annual conference in Regina. The successful Chapter will be notified by July 31st. The award is $1000. In addition, the Annual Conference fee will be paid for one of the Chapter’s executive to accept the award. All members of the winning Chapter who attend the Annual Conference will be provided with ribbons to wear, announcing they are members of the “Chapter of the Year”. Oh, and yes, bragging rights that your Chapter was the winner are also included!

All Chapters have been given a package with award criteria and application forms. A note was sent to all Chapter Presidents in February to remind them to apply for the award. Chapters must apply to be considered.

Don’t miss out on an opportunity to promote your Chapter and spotlight all the great things your Chapter does. How can you help your Chapter? Write an article for “The Guiding Light” and send it to our Newsletter Editor, Leslie Bearss, at: LeslieJoy@sasktel.net. Start a study group for the CNA certification exam. Send back your vote for National positions and for the number of votes returned for National elections and by-laws. Encourage others to join CSGNA – your sales representatives, infection control practitioners and other support personnel.

This is a great opportunity for Chapter members to participate in promoting their skills and abilities in the field of Gastroenterology, by sharing their expertise and encouraging others to become active in CSGNA.
The GI Professional Nursing Award

CRITERIA:
• Promotes and enhances the image of GI nurse in her hospital or the community.
• Participates in professional organizations and National activities for CSGNA.
• Demonstrates creative and innovative methods in patient care.
• Acts as a role model and mentor.
• Contributes to improving quality of care of patients and their family.
• Does volunteer work.
• Encourages certification among peers.
• Is committed to continuing education.

RECOGNITION CRITERIA:
• Member of CSGNA
• Completion of specialty certification.
• Completion of Bachelor’s degree
• Completion of Master’s degree
• Completion of a post-graduate Nursing certificate.
• Award Recipient: Recognized with Provincial, National or International Award.

• Publication: Article, Abstract Editorial in a Journal.
  Author or co-author of a book
• Presentation: Presented or co-presented at a conference (either oral or poster).
  Presented at a hospital in service
• Unit contribution: Has written policies and procedures.
• CSGNA Chapter member, who actively supports and attends CSGNA functions

The GI nurse must be nominated by at least two nominators who must submit a written statement to support the nomination.

Nominations must be submitted to CSGNA Education Director by May 31, 2006
M.Paquette CGRN, CGN(C)
501 Smyth Road, Ottawa, Ontario K1H 8L6
or fax at 613-737-8385
or e-mail at mpaquette@ottawahospital.on.ca
(a nomination form can be sent upon request)
The GI Professional Nursing Award

Nomination Form

I _____________________________Name and I _____________________________Name
would like to nominate __________________________________________________________Name
Hospital_____________________________________________________ for the following reasons:
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deal educational degree (RN, Bachelor, Master etc.) specialty certification, any
publication, presentation, unit contributions.

Nominations must be submitted to CSGNA Education Director by May 31, 2006.
M.Paquette 501 Smyth Road, Ottawa, Ontario K1H 8L6 or fax at 613-737-8385 or by e-mail to
mpaque@ottawahospital.on.ca (upon request a nomination form can be emailed to you)
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A Survey of Inpatients prior to Colonoscopy

P Hopkins-Dargavel, K O’Grady, J Macnab

At the Ottawa Hospital we perform 70 Colonoscopy procedures on inpatients every month. The reasons for performing a colonoscopy include investigation of anemia, abdominal pain, constipation, bleeding, and diarrhea and tumor diagnosis. The inpatients we perform these tests on are generally quite sick and often debilitated. Our patients were often having their procedures cancelled due to incomplete orders and poor bowel preparation. We knew there must be a way to improve the continuity of care for our patients.

A nurse at each of our inpatient Hospitals was assigned to visit the patients prior to coming to the Unit for a colonoscopy. In a 3 month period in 2005 the nurses visited 400 patients. The nurse would visit each patient before the test and read the orders. Each patient had a complete explanation of the test. All the patients were encouraged to ask questions. The visit was very important because it gave the nurse time to teach about the procedure ahead of time. As a result of these visits, we have a far better understanding of what the issues are and now have several new projects to work on to improve the orders and continuity of care for our patients.

SURVEY FINDINGS

Not all the preparation orders were written the same way.

Many patients, who were ordered the Colonic lavage (Golytely), could not drink the required 4 litres. Some of the orders stated NPO at midnight. It is our experience that fluids should be pushed in order to have a clean bowel.

Many patients did not have a consent signed on the unit at the time the test was explained. The absence of informed consent often leads to a delay of the test or cancellation of the test if a relative were required to sign the consent. The INR was found to be elevated. The patient was still on ASA compounds or anticoagulants. An IV access was not inserted as ordered. The findings of the chart review and patient visits confirmed for us that there was more work to do.

NEXT STEPS

First we surveyed the physicians and found quite a variation in the Colon prep orders. The orders included Golytely prep, Fleet PhosphoSoda, and Royvac prep. A research study done in our Units the previous year by Rostom et al. (1994) showed the effects of Fleet PhosphoSoda on the patient’s electrolyte balance. The Golytely prep of 4 litres was associated with more colonic fluid in the bowel but it was associated with significantly less electrolyte changes. The Golytely prep was felt to be safer for the elderly and sick inpatients. We asked the doctors to discuss and agree on a standard prep for all inpatients. The Doctors agreed on the following prep for all inpatients.

COLONOSCOPY PREPARATION

Start at 4 PM evening before

Drink a minimum of 3 litres of a 4 Litre bottle of Golytely. It should be ingested @250ml every 20 minutes. The entire prep should be ingested in 5 hours. Clear fluids should be given once the prep has started. Clear fluids can be given up to 6 hours before the Colonoscopy

If the patient is unable to drink the prep an order must be obtained to administer the preparation via NG tube. The NG tube must be confirmed by X-Ray first.

Patients with Renal insufficiency or cardiac problems should drink 2 litres Golytely and take 2 tabs Dulcolax starting at 6 PM night before test.

Once the prep was formalized there has been ongoing communication with the residents and the staff to ensure orders are completely followed and understood.

Second we realized the need for revised references for the unit nurses to refer to on the procedures we do. The procedures include: Gastroscopy, Colonoscopy and Bronchoscopy are currently being revised for the Corporate Nursing Policy/Procedure manual.

Third we decided another way to ensure compliance with Doctors orders is to develop Preprinted Doctors orders. Preprinted orders allow the resident a check list for each procedure. Over time the nurses on the units will also become more familiar with our procedures and the type of orders required. We will trial these preprinted orders soon.

A fourth project we are working on is a check list for the nurses to fill out prior to the patient leaving the floor to come to the Endoscopy Unit.

An outcome of standardizing the bowel preparation has been improved awareness by nursing staff of the importance of patient compliance. The inpatient Unit nurses are now calling the Endoscopy unit ahead of time if the prep is not complete, or calling to ask for advice if the patient is not taking the preparation. As a result we are canceling less patients when they arrive in the unit and dealing with the issues ahead of time

Another outcome of the study was education of the nurses on the inpatient Units caring for these patients. The Endoscopy nurses interviewing the patients ahead of time had the chance to educate the unit nurses.

We still are working on improving our orders but we feel we have succeeded in improving the patient teaching,
increasing awareness and standardizing the preparation for the Colonoscopy procedure

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Pam Hopkins-Dargavel works as a staff nurse at the Ottawa Civic Campus, Kathy O’Grady works as a staff nurse at the Ottawa General Campus and Jean Macnab is the Manager of the Ottawa Riverside, General and Civic Endo Units.

We Need You To Get Involved With CSGNA!

We welcome all members to become involved with CSGNA. We have committees that need membership participation. Please contact the following executive for more information:

By-law committee – Deb Taggart – President Elect – debra.taggart@calgaryhealthregion.ca
Standards of Practice – Branka Stefanac – Practice Director – bstefanac@smgh.ca
Education – Michele Paquette – Education Director – michpaquette@rogers.com
Membership – Elaine Burgis – Membership Director – burgis@rogers.com
Newsletter – Leslie Bearss – Newsletter Editor – lesliejoy@sasktel.net

If you would like to become more involved at the local level, please contact your Chapter President or the National Director in your area:

Canada West – Joanne Glen – jgg@telus.net
Canada Centre – Monique Travers – mtravers@rogers.com
Canada East – Mabel Chaytor – mabelchaytor@hotmail.com

CSGNA Announces A New Level of Membership!

After listening to our members, CSGNA is proud to present a new level of membership. Many of our members have told us that they would like to continue their association with CSGNA after they retire from nursing. In order to meet the changing needs of our association, we now have a membership level for members who are retired from GI nursing, effective this year.

This membership level is available to any member who has retired from Gastroenterology or Endoscopy nursing and would like to remain involved with CSGNA. The annual membership rate for retired members is $25.00.

Membership renewal forms will be sent out to all current members in April. If you are retired from gastroenterology nursing practice, but would like to continue to be a member of CSGNA, this new option will be available to you on the renewal form.

Membership forms are also available on our website: www.csgna.com, in our newsletter, or through any member of the National or Chapter Executive.

Even in retirement you can stay involved and up to date with gastroenterology news!

CSGNA Executive.
The following was presented in a panel format at the World Congress of Gastroenterology in September 2005. Also presenting on the panel were Australia, The United States, and England. In researching this paper I discovered information that I feel Canadian nurses are unaware of regarding their profession. I wanted to share this with all my GI colleagues.

A Canadian Perspective of Professional Development In GI Nursing

Submitted by: Nancy Campbell RN CGN[c]

Nursing is a dynamic and rewarding profession. This statement still holds true for me as I celebrate my 35th anniversary as a registered nurse.

Canada is a world leader in providing high quality nursing education programs and in developing and using new information technology. Quoting a joint position statement from The Canadian Association of Schools of Nursing (CASN) and Canadian Nurses Association (CNA) It states that they believe:

A baccalaureate degree in nursing is the educational entry-to-practice standard for registered nurses in Canada. There is growing evidence that baccalaureate prepared nurses are able to provide safe, ethical, cost effective and high quality nursing care to Canadians, however myself included, graduated as an RN and although I have taken courses I do not have a BSCN. A lot of my learning was through experience.

The responsibility for supporting baccalaureate entry to practice is shared among individual nurses, nursing regulatory bodies, nursing organizations, employers, educational institutions, and governments.

The National Student and Faculty Survey of Canadian Schools of Nursing, 2003-2004 indicate that of 240 respondents (an 87% response rate) there were 57 Diploma Programs, 87 Baccalaureate Programs, 35 post RN programs, 26 Masters Programs, 12 Doctoral Programs, and 23 Nurse Practitioner Programs offered in Canada in 2003-2004.

Once an individual completes the required curriculum for RN he/she then writes an exam. The successful candidates are given a certificate of competence and are designated RN or BSCN according to the program they have graduated from.

In Canada nursing at the federal level is represented by the Canadian Nurses Association (CNA). The role of CNA is to ensure there are no barriers to nursing initiatives throughout the country. It is comprised of nursing leaders from the provinces and territories. Its main focus is public policy, international relations, coordinating the approach to health initiatives from a nursing perspective. In Canada there are 11 provincial nursing regulatory bodies. They are: Registered Nurse Association of British Columbia, Alberta Association of Registered Nurses, Saskatchewan Registered Nurses Association, College of Registered Nurses of Manitoba, College of Nurses of Ontario, Nurses Association of New Brunswick, College of Registered Nurses of Nova Scotia, College Of Registered Nurses Of Prince Edward Island, Association of Registered Nurses of Newfoundland and Labrador, Registered Nurses Association of the Northwest Territories and Nunavut and Registered Nurses Association of Yukon. The responsibility for licensing and assuring competence rests with the provincial bodies. These self-regulating bodies have an enormous responsibility to develop standards to guide the nursing practice. Standards are necessary to demonstrate to the public, government and other stakeholders that our profession is dedicated to maintaining public trust and upholding criteria of its professional practice. The nurse profession has been a leader in the field of standards development.

(4) When a nurse graduates she has a broad base of knowledge but then must go on to learn specifics if and when she/he enters a specialty such as Gastroenterology.

It is the belief of CNA and the provincial organizations that learning in the nursing profession is a life-long requirement. To enable the nurse to have access to lifelong learning a flexible delivery of programs has been adopted. By offering part time studies, internet courses, shortened, lengthened or condensed programs the nursing profession in Canada has attempted to address this situation while still maintaining high quality nursing education. However, it is the responsibility of the individual nurse to voice his/ her education requirements to appropriate educational resource people. Interestingly enough nurses continue to perceive barriers to attending and accessing educational programs. Highest ranked barriers are distance, family & work obligations, expense of tuition and travel, lack of employer financial support, lack of available relevant educational activities and lack of replacement for educational leave. Continuing education is necessary for continued competence. In my mind these two go hand in hand. Continuing competence is the ongoing ability of a nurse to integrate and apply the knowledge, skills, judgment and personal attributes necessary to practice safely and ethically in a designated role and setting. This directly contributes to the quality of patient outcomes and to the evidence base for nursing practice. For example if a nurse with several years of nursing experience comes to work in a GI unit there are a number of skills pertinent
to GI that she/he will have to learn i.e.: polypectomy, variceal banding and ERCP to name a few. GI is constantly evolving and as time goes on and new procedures are introduced into the GI area new skills and knowledge will have to be learned.

We have two professional organizations in Canada for gastroenterology nurses. They are the Association Quebecoise des Infirmieres et Assistants en Gastroenterologie that is based in the province of Quebec. This organization conducts its business in French and has a membership of approximately 120. The other is CSGNA (Canadian Society Of Gastroenterology Nurses And Associates) In a nutshell CSGNA is the largest GI nurses group in Canada boasting a membership of about 600. The organization is committed to excellence of client care while enhancing the educational and professional growth of the membership within the resources available. CSGNA has developed Position Statements and Guidelines to assist Canadian GI nurses in their practice. Support is offered to GI nurses. We hold an annual national conference. In addition to a 12 member National Executive there are 18 chapters across Canada who each gives a minimum of 4 hours of education per year to the members. A website is maintained to keep members informed. Our website address is www.csgna.com.

A newsletter is published 3 times a year which all members receive. “The Guiding Light”, as it is aptly called. It is the CSGNA communication tool. Members are encouraged to write and submit articles including research findings to the “Guiding Light”. Another wonderful tool offered by CSGNA is an Orientation package. Orientation varies amongst settings and the length of time required by each nurse to be able to feel comfortable and to work effectively depends on several factors. Previous work experience will have a definite influence on how quickly a nurse integrates into an Endoscopy suite. I have found that OR nurses often have superior manual dexterity. Deftness with technology is yet another factor i.e. how does that new plasma coagulator work? Or that new computer program for charting? Our annual fee is $50; pretty good value for the money don’t you think? 12 CSGNA scholarships are awarded yearly to attend the national conference.

In 2004, Gastroenterology nursing was recognized as a specialty area by the Canadian Nurses Association. CSGNA in collaboration with CNA developed a Gastroenterology certification exam that is offered yearly. The exam itself was written by nurses working in the specialty. I am proud to say that I wrote that first exam in 2004 and I am now Canadian certified. RN’s who are Canadian certified may use the initials CGN® – meaning Canadian Gastroenterology Nurse Certified- after their names. There are presently 146 certified Gastroenterology nurses in Canada! The certification exam is based on five competencies as they relate to Gastroenterology. They are: 1. Anatomy & Physiology, 2. Pharmacology, 3. Diagnostic Tests & Therapeutic Procedures, 4. Care of the Gastroenterology patient and 5. Performance assurance. The competencies, exam development and maintenance are overseen by CNA. This point is significant because it ensures a national standard with relation to credentialing. Therefore certification has been envisioned to be an excellent tool to be used when hiring a nurse to work in a GI setting. If a nurse applies for employment and is GI certified that indicates to the employer that she/he has attained a level of competence in GI. CSGNA offers a course called “Foundations” that provides a review of anatomy & physiology and this year we have added some practice exam questions. This course will help prepare a candidate who feels they would like to write the certification exam but is also an excellent review for any GI nurse. Foundations are offered in conjunction with our annual conference.

In the last ten years while health care has become increasingly complex, 5,500 Canadian nurse management jobs have been lost (Canadian Nursing Advisory 2002) Novice nurses find themselves without proper supervision and support. Canadian research released in 2004 showed that 7.5% of hospital admissions are associated with an adverse event. (Ross Baker et al;2004) While this number is in line with research in other countries, governments and health care community are discussing and developing national strategies to address the issue. Among these strategies is a call for greater leadership. What is leadership? Leadership is not reserved for a few charismatic individuals. It is a process that ordinary individuals use when they are bringing forth the best from themselves and others. From the study of leadership prominent traits emerge. Themes like

- courage
- change
- vision and goal setting
- enabling and inspiring
- enlisting others to getting things done
- relationships
- honesty and integrity
- fostering leadership in others

Leadership is usually associated with a title such as Head Nurse. These people would enable, inspire, and demonstrate leadership in their professional relationships. In reality, nurses anywhere can initiate or seize opportunities to make a positive contribution or inspire others. This is an example of informal leadership. As a result of advances in technology, cost cutting measures in hospitals, downsizing, increased work loads, nursing shortages, reluctance of people to enter the nursing profession and reluctance to take on the leadership roles with their long work hours and multiple work challenges. It is suggested that we need to look at new ways to provide leadership. One suggestion is that formal leaders must create an environment that allows nurses at all levels to exercise some degree of leadership. In Canada we are privileged to have leadership programs where participants are supported to apply concepts in real life situations through reflective learning. The Dorothy Wylie Nursing Leader-
Another program is the Acute Care Nurse Practitioner Master prepared program that is offered at the University Of Toronto. I am very pleased to announce that 2 of our National Board Executive members are enrolled in this course beginning in September. Both of these nurses have aspirations to becoming GI nurse practitioners. Congratulations to Usha Chauhan our secretary and Jennifer Belbeck our Public Relations Director!

Conclusion: In the health field today, with increased public scrutiny and accountability, declining numbers of registered nurses, together with the fast pace that technology is evolving in medicine, no one can ignore the magnitude and importance of keeping abreast of our profession. GI nursing in Canada I think is an exciting and dynamic career. Learning is not a destination but it is a journey. I would like to leave you with this quote “Do not follow where the path may lead. Instead go where there is no trail” Author anonymous

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OTHER SUGGESTED READING:
Canadian Medical Association & CNA Recognizing the Valuable Contribution Of Health Care Providers-Thrust of National Advocacy Campaign, May 18th, 2005
CNA http://www.cna-aiic.ca/CNA/practice/standards/default_e.aspx Standards and Best Practice, March 17th, 2005
CNA, www.cna-aic.ca, March 1998, Educational Support for Competent Nursing Practice
SGNA http://www.sgna.org/resources/Standards.html,Standards Of Clinical Nursing Practice and Role Delineation Statements, 2001

Nancy Campbell is the current President of the CSGNA and works at the Montfort Hospital in Ottawa.

Answer Key
Everything GI
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eartg
neksre
trgsopascoe
totimyl
umcsou
mespidcoosgio
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seocpaon
emctru
nigdnab
cresfop
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pcrnaase
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diverticulosis
terminal ilieum
tongue
diverticulitis
bile
anus
tumour
bicap
lavage
crohns
snare
gastoenterologist
ulcerative colitis
basket
screening
ulcer
loop
prep
angiodysplagia
clip
sedation
pancreas
coagulation
npo
stomach
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cardia
glue
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fundas
saline
duodenum
SciCan, in conjunction with the CSGNA, is pleased to again offer the annual educational scholarship in the amount of $1500, to be awarded to a member of the CSGNA for use in attending the National CSGNA conference (conference registration, hotel, flights, meals, etc.). The award will go to a person who has made a significant contribution to GI advancement and education in her/his hospital or community.

In order to encourage applicants from all parts of Canada, each CSGNA Chapter will be asked to submit one qualified candidate for the SciCan Educational Scholarship. The choice of a candidate to submit rests with each Chapter. The application should consist of a one-page description of the candidate’s contributions to endoscopy in the region. All other selection criteria that pertain to CSGNA educational awards apply. Applications should be sent to the Education Director of the CSGNA by May 31st of each year.

Choosing a winner from among the seventeen candidates will not be an easy task! We expect that the caliber of applicants will be very high, and neither SciCan nor the CSGNA executive believes that they we should stand in judgment of the applicants and deem that one are more deserving than the others. Therefore, assuming that the seventeen candidates all meet the criteria, a draw will be made for the winner. That person will be announced in the June/July issue of The Guiding Light and will be presented a commemorative plaque at the CSGNA annual meeting. The winner’s name and photograph will also be published on SciCan’s website. Applications for this scholarship are due May 31, 2006.

SciCan is a Canadian manufacturer and distributor of medical and dental products. Our medical products in Canada include the Innova endoscope washer-disinfector, Statim sterilizer, Fujinon endoscopy systems, US Endoscopy endoscopic accessories, Medicart endoscope transport systems, SciCan endoscope storage cabinets and Medisafe instrument cleaners. SciCan is pleased to support the CSGNA and its goal of keeping its members abreast of developments in the field of Gastroenterology. We are privileged to work with such a dedicated, professional and fun-loving group of people.
Typhlitis

Submitted by: Mabel Chaytor RN CGN[c]

DEFINITION
Typhlitis means inflammation of the cecum. Typhlon is from the Greek word meaning cecum. Typhlitis also known as neutropenic colitis, ileocecal syndrome or cecitis. Typhlitis is usually confined to the cecum, appendix and terminal ileum; however it can cause pancolitis. Typhlitis is a consequence of overgrowth of clostridia, particularly Clostridium septicum, in granulocytopenic patients.

BACKGROUND
In 1960 Bierman and Amronin first coined the term ileocecal syndrome to describe inflammation and/or necrosis of the cecum, appendix and/or ileum in patients with leukemia. It has been associated with aplastic anemia, lymphoma, AIDS, and immunosuppression following renal transplantation or during treatment of malignancy. The etiology of typhlitis is unknown. Profound neutropenia appears to be a universal predisposing factor.

MANIFESTATION
Typical presenting symptoms (of which time course and severity can vary considerably) include watery or bloody diarrhea, fever, nausea, vomiting, abdominal pain (may be localized to right lower quadrant [RLQ]), possible shock secondary to septicemia or colonic perforation. Physical examination findings include abdominal distension, absence of bowel sounds, tympany, palpation tenderness (usually most marked in RLQ), occasionally, a palpable mass, diffuse direct and rebound tenderness (suggesting colonic perforation, peritonitis).

DIAGNOSIS
Computed tomography (CT) and ultrasonography (US) can demonstrate bowel wall thickening and exclude other intra-abdominal processes. CT and MRI are most sensitive for diagnosis. Findings at colonoscopy include mucosal erythematous, edema, friability and ulcerations. Colonoscopy should be done cautiously to minimize the risk of perforation. To date, a predictor of this syndrome has not been identified.

MANAGEMENT
Patients with Typhlitis are often very ill. The management of typhlitis is controversial. Management includes bowel rest, decompression, intravenous fluids, nutritional support and broad spectrum antibiotics. There are anecdotal reports of successful treatment with oral vancomycin; antiperistaltic agents should be avoided. Surgical therapy has been successful in rare patients who fail medical treatment.

SUMMARY
Typhlitis is life threatening with an increased mortality rate of 40 - 50%, attributable to cecal perforation, bowel necrosis, and sepsis. In the US: Typhlitis was found in 10% of leukemia children who died while undergoing chemotherapy.

REFERENCES

Mabel Chaytor works at The Health Sciences Center in St John’s. She is also Canada East Director of The CSGNA.
Fresh Fruit Salad

Creamy Dressing

- Frozen orange juice from concentrate: 3 tbsp
- Lemon juice: 1 tbsp
- Dijon mustard: 1/2 tsp
- Non-fat plain yogurt: 3/4 cup
- Liquid Honey: 2 tbsp
- Pinch of ground cinnamon
- Pinch of ground cloves

Mixed salad greens: 4 cups
Fresh strawberries, halved: 8
Fresh raspberries or blueberries: 1 cup
Ripe pears, peeled and cut into thin slices: 2

Creamy dressing: Combine first 7 ingredients in small bowl. [Makes 1 cup of dressing]. Cover and chill.

Divide salad greens into 4 servings. Arrange pears, strawberries and raspberries on salad greens. Drizzle 2 or 3 tbsp of dressing over each salad.

Spicy Carrot Bread

- Finely shredded raw carrot: 1 cup
- Eggs: 2
- Sugar: 1/2 cup
- Salad oil: 1/2 cup
- Flour: 1 1/2 cups
- Baking Powder: 1 tsp
- Baking Soda: 3/4 tsp
- Cinnamon: 1 tsp
- Orange rind: 2 tsp
- Grated orange rind: 1 tbsp
- Grated ginger: 1 tsp
- Raisins: 1/4 cup
- Nuts (optional): 1/4 cup
- Salt: 1/8 tsp

Preheat oven to 350°F. In a large bowl beat eggs and add sugar. Beat until thick. Add oil gradually and continue beating until thoroughly combined. Stir in flour and the rest of the dry ingredients including raisin and nuts. Add orange juice, rind and ginger to carrot then combine with mixture. Stir the mixture until well blended. Pour batter into well greased loaf pan. Bake for 1 hour or until done.

Meatless Chili

- Medium onion, chopped: 1
- Garlic clove, minced: 1
- Cooking oil: 1 tbsp
- Kidney beans: 2 cans
- Diced tomatoes: 2-398 ml cans
- Ketchup: 1/4 cup
- Medium red or green pepper, chopped: 1
- Sliced mushrooms: 1 can or 2 cups
- Small eggplant, peeled and diced: 1
- Packed brown sugar: 2 tsp
- Chili powder: 1 1/2 tsp
- Salt: 1 tsp
- Pepper: 1/4 tsp
- Ground cumin: 1/4 tsp

Sauté onions and garlic in oil in a large skillet or Dutch oven til onions soft and golden. Add next 11 ingredients. Mix. Bring to boil on medium high heat, stir frequently. Reduce heat to medium. Simmer, uncovered, for about 10 mins stir occasionally.

Shrimp and Asparagus Wraps

- Use fresh thin asparagus, trimmed: 1/2 lb
- Cut thick spears in half
- Boiling water
- Ice water
- Frozen cooked medium shrimp: 1 lb [peeled and deveined], thawed
- Mayonnaise: 1/3 cup
- Wasabi paste: 2 tsp
- Large flour tortillas: 4
- Thinly sliced red onion: 1/4 cup

Cook asparagus in boiling water for about 3 min. Drain, and put into a bowl of ice water. Let stand 5 min. Cut shrimp in half length wise. Combine mayonnaise and wasabi in a small bowl. Divide and spread on one side of the tortillas. Layer asparagus, shrimp and red onion down the center of each tortilla to within 2 inches of bottom edge. Fold bottom edge up over filling. Roll up like a jelly roll from the sides. Slice in half on the diagonal. Makes 4 wraps.
NOMINATION FORM

Please complete this form and submit to the Chair of the Nominations Committee (currently the President of the CSGNA) 150 days (April 20th, 2006) 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.

Please include a curriculum vitae with the nomination form.

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
CGN(C) 3 Points
CBGNA certification 1 Point
Typed format 1 Point

REVISED September 2002
M. Paquette, Education Director
APPLICATION FORM

FOR CSGNA ANNUAL SCHOLARSHIP AWARD

The Annual New Member National Conference award of $1,000.00 is to be used for travel and accommodation to the Annual National Conference in Canada. Open to members new to CSGNA in the year prior to the conference.

EXCEPTIONS:

1. New member is defined as never previously holding membership with CSGNA.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarship is 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. Outline projected financial needs to attend this meeting.
4. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.
5. Copy of CSGNA Membership Card.

APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY 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 _________________________
APPLICATION FORM
FOR CSGNA ANNUAL SCHOLARSHIP AWARD

The Annual National Conference award of $1,000.00 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 ___________________
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).

☐ RETIRED $25.00
Open to members not actively engaged in gastroenterology nursing practice.

☐ 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.

☐ RETRAITÉ 25,00$ 
Ouvert aux membres non engagés activement dans la pratique infirmière en gastroentérologie.

☐ Membre à vie
Nomme par l’exécutif.

APPLICANT INFORMATION / INFORMATION DU MEMBRE

Please print or type the following information / S.V.P. imprinter ou dactylographier l’information

SURNAME
NOM DE FAMILLE ____________________________________________

FIRST NAME
PRÉNOM ____________________________________________

MAILING ADDRESS
ADDRESS DE RETOUR ______________________________________________________________________________________________

CITY
VILLE ____________________________  PROV. _________  POSTAL CODE  CODE POSTAL ________________  HOME PHONE  TELEPHONE (   ) __________________

E-MAIL: ______________________________________________________________________________________________________________

HOSPITAL/OFFICE/COMPANY NAME
NOM DE HÔPITAL/BUREAU/COMPAGNIE ________________________________

BUSINESS PHONE
TELEPHONE TRAVAIL (   ) ____________________________  EXT. _________  LOCAL _________

TITLE/POSITION _________________________________________________________________

CHAPTER NAME
NOM DU CHAPITRE _______________________________________________________________ 

EDUCATION (CHECK ONE)
ÉDUCATION (COCHEZ UN)
☐ RN  ☐ RPN/LPN ☐ TECH ☐ OTHER ((EXPLAIN))
☐ IA  ☐ I AUX ☐ TECH ☐ AUTRE (SPÉCIFIER) _______________________________________

CNA MEMBER YES/NO
MEMBRE AIC OUI/NON ☐ CNA CERTIFICATION IN GASTROENTEROLOGY
CERTIFICATION EN GASTROENTÉROLOGIE DE L’AIIC

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

Please make cheque payable to CSGNA
(Mail with this completed application to the above address)

Prière de libeller le chèque à CSGNA
(Envoyez avec cette formule d’application dûment remplie à l’adresse ci-haut mentionnée.)
CSGNA 2005-2006 Executive

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PUBLIC RELATIONS ________________
Do to the recent resignation of the PR Director please forward all inquiries regarding The CSGNA website to Joanne Glen. Director Canada West.
Email: jgglen@telus.net

www.csgna.com