The Monitor

Ontario PeriAnesthesia Nurses Association

OPANA

THE ROAD TO RECOVERY

July 2016

Inside The Monitor:

Upcoming Conferences:

Contact OPANA today: www.opana.org

ONTARIO PERIANESTHESIA NURSES ASSOCIATION

Ontario PeriAnesthesia Nurses Association OPANA THE ROAD TO RECOVERY

OPANA'S VISION, MISSION AND VALUES

Vision:

A respected nursing practice that leads high quality patient care throughout the perianesthesia road to recovery

Mission:

To recruit and retain high caliber nurse leaders who influence excellence in perianesthesia patient care

Values:

- Promote respect, positive communication and collaboration among all members of the patient/family/healthcare team
- Value excellence and integrity in all interactions
- Be accountable and ethical in our nursing practice through our actions and decisions
- Commit to excellence in nursing by promoting a culture of lifelong learning that integrates evidence-based practice, research, professional development and competence
- Demonstrate genuine respect for uniqueness and diversity
- Face our challenges through innovation, creativity, shared knowledge and experiences
- Collaborate with inter-professional colleagues to deliver the best quality of care

Goals:

- To promote and subsidize research that leads to evidence-based best practices
- To provide venues to share education and learned experiences
- To build a data base of topics that influences perianesthesia nursing practice
- To promote interconnectedness (universal oneness) with perianesthesia nursing associations and related interest groups around the world (e.g. NAPANc, ICPAN, ORNAC, Ambulatory Clinics, Surgical Specialty Groups)

OPANA is an Affiliated Interest Group of the RNAO

RNAO Registered Nurses' Association of Ontario L'Association des infirmières et infirmiers autorisés de l'Ontario

ONTARIO PERIANESTHESIA NURSES ASSOCIATION

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Hello Everyone!

Yeah! It is finally summer! My favorite season!
And what a gorgeous summer it is!!! I've been spending a lot of time in my gardens and always look forward to outdoor concerts, bar-b-q's and spending time in cottage country with friends. Would you like to share a picture of one of your favorite events this summer? Please email me at president@opana.org with your favorite picture, and then stay tuned on the OPANA website. If your picture is shared, you will receive a special gift from me, at the conference in November!

And the upcoming National Conference registration is now open!!! Thank You, to those of you who have taken advantage of the *special early bird offer for OPANA members only!!!*
Your names will be mentioned at the conference!

Have you marked your calendar for the....

National Association of PeriAnesthesia Nurses (NAPANc)

Annual PeriAnesthesia Conference 2016

TUNE IN TO YOUR PRACTICE!

Hosted by none other than OPANA!!!

So Let's get this party started!!!!

The list of speakers is FANTASTIC!!!!

Early Bird Registration is now open!!!

As you may know, many of the BOD members share responsibility of roles and/or take responsibility of more than one role.

ONTARIO PERIANESTHESIA NURSES ASSOCIATION

I would like to personally thank two of the BOD members who have also taken on the role as Co-Chairs of the NAPANc Conference Planning Committee:

Nancy Poole who is also Co-Director of Membership and Treasurer Elect
And
Lynn Haslam-Larmer who is also Secretary and Co-Director of Educational Resources

We are very fortunate having such dedicated, passionate nurses on the OPANA BOD!

If you are interested in finding out more about volunteering to the OPANA BOD why not join us at our next BOD meeting?? Our next meeting is scheduled for Friday September 9, 2016 and will be held at the RNAO headquarters in Toronto. Please email me for more information.

OPANA currently has the following Board of Director positions open:
Regional Directors:
Dentistry and Free Standing Clinics *(at large) Vacant*

Directors at Large:
Central Ontario (Georgian Bay Area) *Vacant*
Northeast Ontario (Thunder Bay Area) Vacant

Volunteering as a leader on the OPANA BOD is a wonderful opportunity to make great friends, learn a lot about yourself, your profession, and how you can truly impact our specialty practice!
The opportunities are endless.

Thank you for considering joining us and representing your regional colleagues! If you would like to learn more about these roles, please email me at president@opana.org

All of your contributions will be recognized and appreciated and you will be rewarded in so many ways!

Thank You All, for everything that you do to positively impact PeriAnesthesia Nursing! I look forward to seeing you at the Conference in November!

Sincerely
Carol Deriet
OPANA President
president@opana.org

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BOARD OF DIRECTORS 2016

Executive:

President: *Carol Deriet*

President Elect: *Ramona Hackett*

Treasurer: *Marianne Kampf*

Treasurer Elect: *Nancy Poole*

Secretary: *Lynn Haslam-Larmer*

Regional Directors:

General Toronto Area - *Linda Marshal-Masson and Sherry France*

Southern Ontario – *Marianne Kampf and Caroline Fellows-Smith*

Central Ontario (Georgian Bay Area) *Vacant*

Western Ontario (London Area) *Nancy Rudyk*

Eastern Ontario (Ottawa Area) *Katie Poser and Morag Mercer*

Northwest Ontario *(Greater Sudbury, Sault Ste. Marie Area) Farah Khan Choudry*

Northeast Ontario *(Thunder Bay Area) Vacant*

Directors at Large:

Dentistry and Free Standing Clinics *(at large) Vacant*

Director of Educational Resources: *Lynn Haslam & Katherine Poser*

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Ontario PeriAnesthesia Nurses Association OPANA THE ROAD TO RECOVERY

Conference registration is now OPEN!

Register at www.opana.org

Early bird rate closes on August 15th !

ANIPA NAPAN

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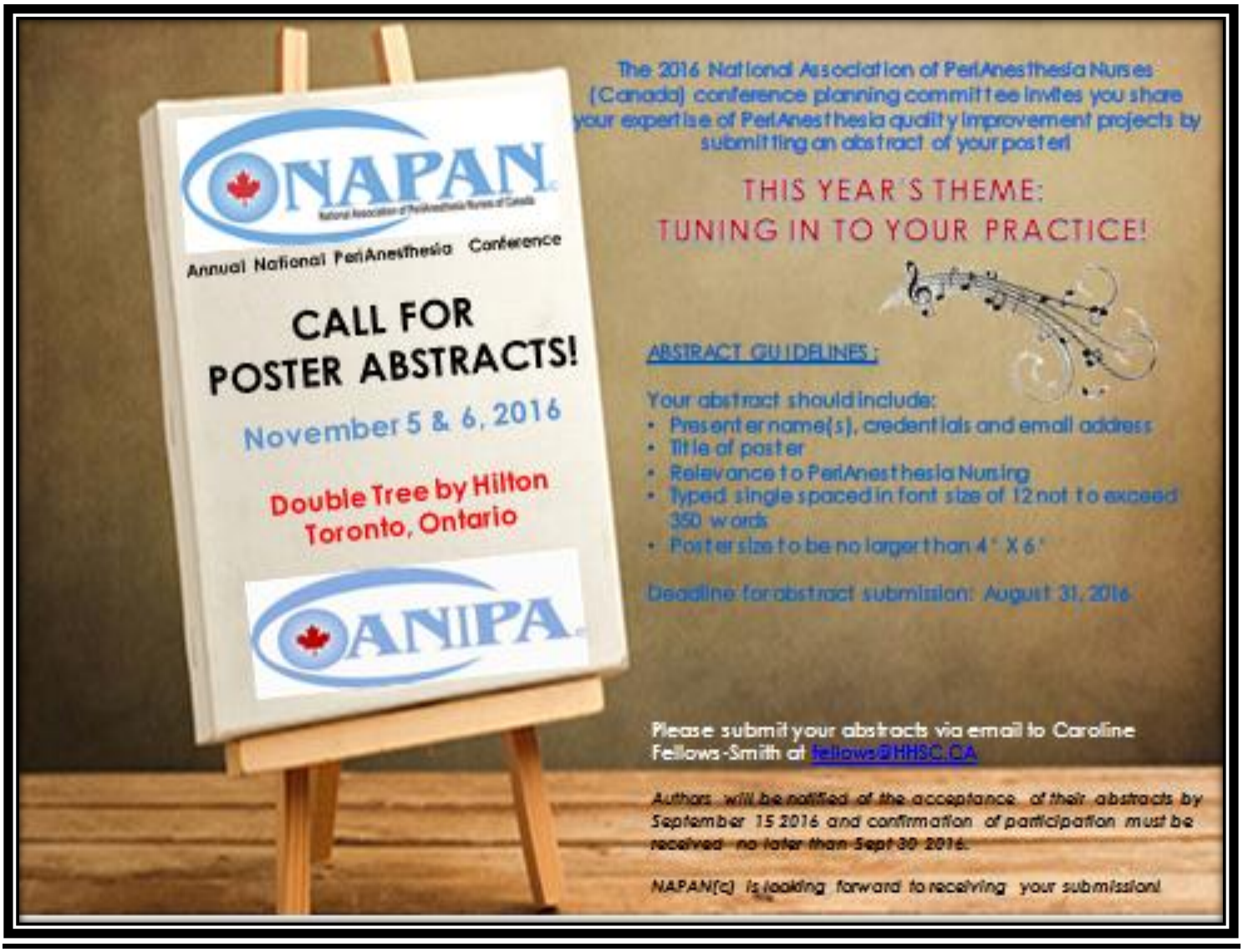
Call for Abstracts!



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Ontario PeriAnesthesia Nurses Association OPANA THE ROAD TO RECOVERY

Scholarly Work

Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy

Daniel P. Alford, MD, MPH; Peggy Compton, RN, PhD; and Jeffrey H. Samet, MD, MA, MPH

More patients with opioid addiction are receiving opioid agonist therapy (OAT) with methadone and buprenorphine. As a result, physicians will more frequently encounter patients receiving OAT who develop acutely painful conditions, requiring effective treatment strategies. Under treatment of acute pain is suboptimal medical treatment, and patients receiving long-term OAT are at particular risk. This paper acknowledges the complex interplay among addictive disease, OAT, and acute pain management and describes 4 common misconceptions resulting in suboptimal treatment of acute pain. Clinical recommendations for providing analgesia for patients with acute pain who are receiving OAT are presented. Although challenging, acute pain in patients receiving this type of therapy can effectively be managed. Ann Intern Med. 2006;144:127-134. www.annals.org For author affiliations, see end of text.

Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy

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Scholarly Work

Pediatric Pain Management

An Evidence-Based Approach

Maria Luisa Ramira, DNP, APRN, FNP-BC, CEN; Susan Instone, DNSc, APRN, PNP-BC; Mary Jo Clark, PhD, RN

Disclosures

Pediatr Nurs. 2016;42(1):39-46.

Abstract

Numerous studies have shown that in comparison to adults, children do not receive analgesia (oligoanalgesia) and are not adequately treated for pain. Several organizations, including The Joint Commission and Institute of Medicine (IOM) have emphasized patients' rights to pain management and the need for initial assessment and ongoing evaluation. Nurses are responsible for assessing patients' pain and implementing appropriate pain management in the emergency department (ED). Evidence suggests that nurses' lack of knowledge about pain assessment in children contributes to inadequate pain management. Studies also show that the use of pain assessment tools appropriate to a child's age and cognitive development play a vital role in improving pain assessment documentation, prompting nurses to provide pain medication. The purpose of this quality improvement project was to improve nurses' assessment and management of children's pain in an emergency department. A total of 1,200 EMRs of pediatric patients ages 3 months to 6 years of age were reviewed before and after an educational intervention (600 before and 600 after the intervention). Pain education for ED nurses improved pain assessment and management among children.

Pediatric Pain Management (for full article)

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Regional Reports

June 2016 update from Sunnybrook HSC Peri-Anesthesia areas:

Ramona Hackett, Pre-Anesthesia Clinic:

We currently working on a pre-op blood grid to limit the amount of sampling required for patients going for surgical or interventional procedures, and concentrating on necessary tests. This grid will utilize best practice principles based on the Choosing Wisely Canada campaign recommended by the Canadian Medical Association. This campaign helps clinicians engage patients in discussion about unnecessary testing and treatments; and with regards to pre-hospital care, will reduce the amount of unnecessary blood tests thereby being fiscally responsibly while providing quality care. The future goal is to develop a medical directive for RNs to be able to determine necessary tests based on our newly developed grid. One of the presentations at the 2016 National Conference pertains to the Choosing Wisely Canada campaign.
Another project involving the Pre-Anesthesia clinic is the development of a patient educational booklet for oncology patients requiring hysterectomies. Based loosely on our current ERAS program, the premise is that the patient will receive the same information from each health care professional they speak to throughout their surgical journey. A pilot project is currently in place to determine if repeated information assists the patient with increasing their knowledge of expectations related to their pre- and post-op care, ultimately leading to a more streamlined plan of care, including discharge planning.

Same Day Surgery Admissions: Surgical Site Infection committees have been developed for pancreatic surgeries and vascular surgeries. Pre-warming patients to promote normothermia intra-operatively continues to be an on-going trend for best practice guidelines.

PACU: our corporate ethics committee has developed a policy within the No CPR policy to include the “Temporary Revision of Existing No CPR Order during OR Procedures and the Phase 1 Recovery period in PACU”. This is currently in the approval process; however, will certainly assist PACU nurses should a cardiac arrest occur during the Phase 1 recovery period. The PACU is also expanding to accommodate more bays and therefore, are currently hiring experienced PACU RNs in

permanent full-time positions. If interested, please contact Sunnybrook Human Resources, and/or keep an eye out for job postings which will be published on career websites soon.

Surgical Short Stay Unit (Level 2 Recovery) is also ever-expanding with the ongoing additions of procedures requiring shorter hospital stays.

Further Update from Sunnybrook:

An Alternate Reversal Drug for Rocuronium: Sugammadex (Bridion™)

A new binding agent for reversal of neuromuscular blocking agents called Sugammadex (Bridion™) is now available in Canada and being introduced to SHSC. Sugammadex is indicated for reversal of moderate to deep neuromuscular blockade induced by rocuronium when use of the usual reversal agent, neostigmine, would be ineffective or inadequate. Sugammadex does not reverse the blockade induced by nonsteroidal NMBAs such as atracurium, cisatracurium, or succinylcholine.

This reversal agent is very expensive ($107 for 200 mg vial and $214 for a 500 mg vial); therefore is currently restricted to staff anesthesiologists ONLY. Suggamadex is to be used in the following situations:

1. "Can't intubate / can't ventilate" scenario
2. PROMPT reversal of deep blockade for a short procedure
3. PROMPT reversal of deep blockade after an aborted procedure

Suggamadex is NOT to be used when neostigmine would be appropriate (both effective and adequate) for the clinical situation. This drug may be administered in the OR or PACU environment by the anesthesiologist ONLY.

Usual dose for routine reversal:

Moderate neuromuscular blockade: 2mg/kg

Deep neuromuscular blockade: 4mg/kg

For emergent/urgent reversal of neuromuscular blockade following administration of a single dose of 1.2mg/kg rocuronium for intubation, 16mg/kg sugammadex is recommended

Onset: Patients recovered from moderate neuromuscular blockade with sugammadex within 2-3 minutes, compared to 18-19 minutes with neostigmine. Patients recovered from deep neuromuscular blockade with sugammadex within 3-5 minutes, compared to 50-66 minutes for patients who received neostigmine.

Half-life: approximately 2 hours, mainly excreted via kidneys. Not recommended for use in patients with severe renal impairment, including dialysis.

Precautions & Monitoring: vigilance is required of Anesthesiologists during and for 5 minutes following administration of sugammadex due to the 1% potential for anaphylaxis. Patients must also be monitored for hemodynamic changes, especially bradycardia during and after reversal of neuromuscular blockade. Airway protection and ventilatory support is necessary until adequate spontaneous respiration is restored and a patent airway is maintained by the patient. PACU nurses must be aware of ongoing monitoring and assessment requirements when receiving transfer of accountability from the anesthesiologist.

For more information on sugammadex, please view the following links: BRIDION -Merck, http://www.medscape.com/viewarticle/586327_3

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June 2016 Regional Report: Nancy Rudyk

Many hospitals across the province are currently reviewing their preoperative programs to ensure that their patients are receiving efficient and effective preoperative preparation prior to surgery. This includes, ensuring that practice reflects fasting guidelines based on the CSA/ASA standards, patient record that flows from the pre-admission assessment to PACU, medication reconciliation of ambulatory day surgery patients and transfer of accountability (TOA) between the various perioperative units.

At St. Michael's hospital the Pre-Admission Facility moved to a new facility in May: Approx. 9,400 square feet, 16 exam rooms with a staff of 30. Based on the feedback from patients and families and to improve efficiency, the facility is increasing its use of telephone and telemedicine consultations to increase the patient experience. In the new space we have five exam rooms that are connected to enable telemedicine, a new conference room connected to all hospital systems and improved technology for web-based meetings.

The PAF is a patient's first step in preparing for surgery. It provides a centralized approach to perioperative care by uniting all pre-admission services and day surgery preparation in one physical area. Preparing for surgery includes pre- and post-op education and required medical testing. Patients learn what medications to take before surgery and what to expect after surgery.

The facility is now able to conduct about 15 per cent of all appointments by either telemedicine or telephone. Telephone consultation is best-suited for patients who are undergoing low-risk surgery and meet specific criteria. A preoperative grid was developed to identify low risk to high risk patient and surgery and the appropriate pre-admission testing required. Choosing wisely was used to review the preoperative test guidelines. In collaboration with the hospital's anesthesia department, nurses can conduct the standard pre-operative assessment over the phone, saving patients and their families' personal time.

The telemedicine program, in collaboration with the Kingston Regional Bariatric Care Centre, allows physicians and clinician at St. Michael's to connect camera-to-camera with those in Kingston. Lab tests are conducted by a patients' personal health-care team and they are able to stay close to home until it's time for their surgery. While based on patient and family feedback, the changes are also a part of the hospital's Improvement Program, an initiative to improve efficiency while maintaining – or even improving – patient care. I look forward to any comments. Please email: rudykn@smh.ca

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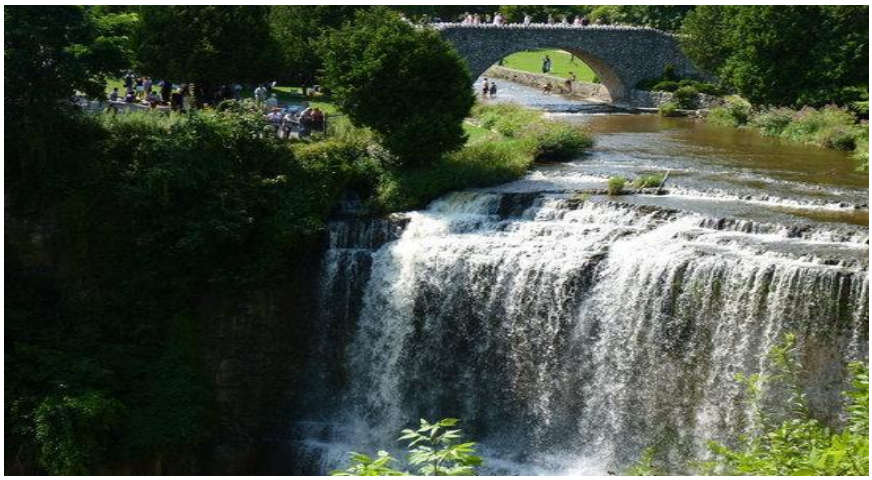
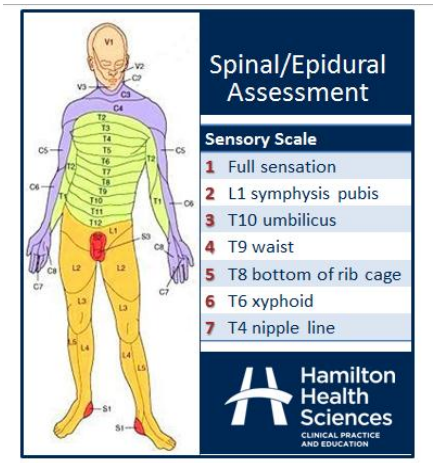
June 2016 Hamilton Niagara Regional Report

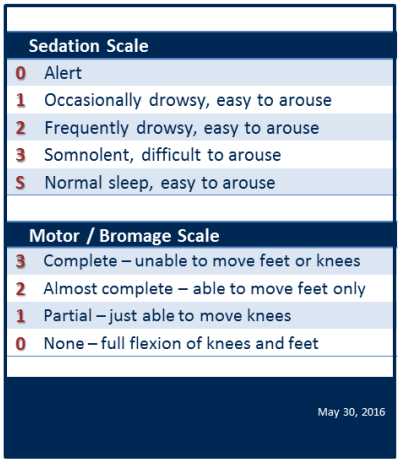
Happy summer to all, it's officially here. Did you know the Hamilton region is known as the Waterfall capital of the World! Yes that's some trivia for you as this is an area that has the most waterfalls in one region. Surrounded by plenty of protected conservation land here are the names of a few of my favourites: Webster's, Albion, Canterbury and Tews! Of course, Niagara Falls remains one of the 7 wonders of the world in size and generating power.



Webster's Falls

Our sister hospital West Lincoln Memorial in Grimsby has implemented best practice in their PACU, SDU & L&D areas with respect to assessment and monitoring of spinal regression. There was no proper assessment that was a standard practice at the site. Staff were educated and given a tip card following a detailed gap analysis and post plan & implementation. Safer care for patients. Here is tip pocket card given to staff and now to all new hires at the HHS sites for quick reference.





Over the summer the Juravinksi H Hospital site plans to be the 3rd area to participate in a study by 3M on normothermia. What does normothermia mean to you? When does the patient become hypothermic?

Temperature is:

1. < 36 C
2. < 35 C
3. < 36.5 C
4. < 34.5 C

If you selected #1, you are right! Core Body temperature of a person will drop by 1.6% in the 1st hour of surgery as stated in the literature. However, there are many ways to prevent this from happening. We are providing slippers and warm blankets to patients prior to entering the OR suite but it is when induction takes place we have room to make improvements. The study will involve measuring the patient's temperatures during all points of care pre, intra and post-surgery. In the Fall we will have some preliminary data to share with you and discussion of what changes we hope to make.

Finally please seriously consider writing and signing up for the CNA PeriAnesthesia nursing exam. As your colleague I have written this exam and passed! ☺ Have partaken in development of exam and study questions for the exam and study guide. I would be most happy to lead a study group in the Hamilton area, please contact me at kampf@hhsc.ca.

Have a great summer!

Yours in Perianesthesia Nursing,

Marianne Kampf & Caroline Fellows-Smith

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June 2016: REGIONAL REPORT SOUTH WESTERN ONTARIO

CAROLINE FELLOWS-SMITH: DIAGNOSTIC IMAGING & DIAGNOSTIC SERVICES HHS ALL SITES

Hello Everyone,

It has been a busy spring throughout my DI & DS areas. Technology is changing. Imaging and services that were previously delivered in more controlled settings, are now creeping into nontraditional areas. I feel this is happening throughout all of our organizations. This is where my affiliation with OPANA and looking through that Perianesthesia lens has provided a good grounding for implementation of approved standards in these non-traditional areas where moderate sedation is administered for procedures. IN MDU (Medical Diagnostic Unit) one of the procedures that is done is TEE: Trans esophageal Echo. I have over the spring been able to effect change by:

- Changing the staffing model to align with the moderate sedation policy : this included an RN to administer the moderate sedation(Previously the Cardiologist was administering, monitoring and performing the TEE procedure)
- Standardize the charting and documentation in this area
- Introduce an order set to standardize the process
- Introduce the procedural pause/ safety checklist, which is a checklist done at the beginning of any procedure, a time out to review and capture any errors or omissions surrounding the case. (follows the OR model)
- Standardizing the monitoring post procedure. Documentation and monitoring assures that the patient is in a safe phase of recovery prior to going back to the floors if an inpatient or requires further monitoring and assessment , going to a SDS like area prior to being discharged home if an outpatient.

All across Diagnostic Imaging: Specifically in Interventional Radiology there has been discussion about screening our patients. Patients are sicker with multiple co-morbidities. These are the types of patients that are often seen in Interventional Radiology for minimally invasive surgery. Since these patients are not always a good surgical candidate. One of the areas we have been exploring, since our program has now been aligned under Periop is screening for OSA. I have been working with our newly appointed Clinical Leader: Denise McLaughlin to standardize processes within DI. Screening for OSA has always fallen under the Anesthesia umbrella, and is captured and monitored by their group, when administering GA's. Interventional offers GA (General Anesthesia) support for patients, depending on the nature of the procedure at HHS With the growth in Interventional applications for minimally invasive procedure done under Fluoroscopy has grown exponentially. Most of the work done in Interventional involves moderate sedation: Midazolam and Fentanyl administered by the Circulating Nurse throughout the procedure.

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Recent discussions and dialogue has been surrounding the patient screening. Currently the only established process for screening for OSA is captured by Anesthesia when they are involved in the GA cases. We as a program have been challenged by our friends from the OR (Denise) to ask ourselves is this best practice? Realizing it isn't routinely done in areas that administer moderate sedation. After consulting our friends in Anesthesia (Dr Liz Ling Anesthesia HHS) we are moving towards updating our long procedure record to have a spot to indicate the question was asked about OSA. The screening tool we have chosen is a modified STOPBANG screening specific for DI. It is early days yet but our goal is to roll this out in all our areas that administer Moderate Sedation across DI & DS at all sites in HHS.

Below is the modified screening tool that we want to implement in our areas:

Pre Screening Tool for Moderate Sedation Use

STOP-BANG Sleep Apnea Questionnaire for DI

Patient Name: _____**ID #**_____

Date: _____

HCP (Signature and Designation): _____

STOP

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)	**Yes** **No**
Do you often feel TIRED, fatigued, or sleepy during daytime?	**Yes** **No**
	Yes

Has anyone OBSERVED you stop breathing during your sleep?	**No**
Do you have or are you being treated for high blood PRESSURE?	**Yes** **No**
BANG BMI more than 35kg/m2?	**Yes** **No**
AGE over 50 years old and male?	**Yes** **No**

TOTAL SCORE and Classification:

High risk of OSA:	**Yes 4- 6**
Intermediate risk of OSA:	**Yes 3 -** **4**
Low risk of OSA:	**Yes 0 -** **2**

Denise McLaughlin Clinical Leader DI

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Health & Wellness

In appreciation of nurses:

https://www.facebook.com/ZDoggMD/videos/10154102169127095/

DARK CHOCOLATE FRUIT AND NUT CLUSTERS

Yield 18 medium clusters.

Ingredients:

- 6oz (175g) bittersweet chocolate (at least 70% cocoa solids), coarsely chopped
- ½ cup quinoa puffs (or any puffed cereal)
- ½ cup dried cranberries
- ½ cup whole toasted almonds, chopped in half (can also use pumpkin and/or sunflower seeds)

Directions:

1. Line a large baking sheet with parchment paper and set aside.
2. Place the chocolate in a large glass bowl, microwave for 1 minute. Stir with whisk. Microwave for 30 second intervals until the chocolate is completely melted. This should take about 2 minutes.
3. Fold the quinoa puffs, dried cranberries and almonds into the melted chocolate. Stir to combine.
4. Drop 18 equal spoonfuls of the chocolate mixture on the prepared baking sheet.
5. Let set until firm, about 30 minutes, or refrigerate until firm.
6. Serve at room temperature.

TROPICAL SLAW WITH SWEET AND SOUR DRESSING

Ingredients:

- ¼ cup cider vinegar
- ¼ cup canola oil (preferably organic)
- 2 tbsp cane sugar
- Kosher salt and freshly ground black pepper (to taste)
- 2 cups pineapple (about ½ pineapple) cut into ½ inch cubes
- 1 large ripe mango, cut into ½ inch cubes
- ½ head purple cabbage, finely shredded
- 4 green onions, green and pale green parts only, thinly sliced
- 1 cup roughly chopped fresh cilantro leaves

Directions:

1. Combine the cider vinegar, canola oil, sugar and a sprinkle of salt and sugar in a bowl and whisk until smooth.
2. Combine the pineapple, mango and red cabbage in a large bowl. Season with salt and pepper, add the dressing and toss to coat. Add the green onions and cilantro and toss again. Cover and refrigerate for at least 1 hour before serving.

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WARM QUINOA SALAD

(Makes 4 meal size portions)

Ingredients:

- 1 cup uncooked quinoa or spelt berries
- 1 ½ cup vegetable broth
- 1 leek, sliced into rounds or half moons
- 2 garlic cloves, minced
- 1 bunch asparagus, ends broken off and chopped into 1 inch pieces
- 1 cup diced strawberries
- 1 cup frozen edamame
- 1 ½ cup fresh parsley, roughly chopped
- 2-3 tbsp extra virgin olive oil
- 3 tbsp fresh lemon juice
- ½ tbsp pure maple syrup
- ¼ tsp kosher salt
- ½ tsp pepper
- Lemon zest for garnish

Directions:

1. Rinse quinoa in a fine mesh strainer and place into a medium pot. Add 1 ½ cups vegetable broth (or water) and bring to a low boil. Reduce heat to low-medium, cover with tight-fitting lid, and cook for 13-15 minutes, or until fluffy and the water is absorbed. Fluff with fork, remove from heat and let sit covered for 5 minutes.
2. Meanwhile, using a very large skillet saute the leek and garlic in the oil for about 3-4 minutes over medium heat. Season generously with salt and pepper. Add the asparagus and saute for another 5 minutes or until the asparagus is just tender, but still crisp. Stir in the strawberries, edamame and parsley. Heat for a few minutes, then remove from heat.
3. Whisk together the dressing ingredients (olive oil, lemon juice, maple syrup and ¼ tsp salt to taste). Pour dressing onto skillet mixture and stir in the cooked quinoa. Enjoy!

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2016 PeriAnesthesia Nurses Certification Exam:

CANADIAN NURSES ASSOCIATION

ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

CNA Certification Program

Join the growing network of more than 18,000 CNA-certified RNs at the leading edge of health care.
Being CNA certified shows that you're committed to an advanced standard of professional competence and have a comprehensive understanding of your nursing specialty.
Become CNA certified! Show that you Care to Be the Best.

Registration and Exam Information

The next CNA certification exams will be offered **September 19 to October 7, 2016**.
Deadline for online applications for initial certification and renewal by exams is **August 8th, 2016**

Visit https://www.nurseone.ca/en/certification to register today!

Benefits of Certification

Becoming CNA certified is one of the most positive and powerful achievements for a nursing professional. As a certified RN, you will have:

- the only nationally recognized RN credential for nursing specialties
- an advanced level of knowledge, expertise and commitment to show patients, colleagues and employers
- a stronger sense of accomplishment and personal confidence in your practice
- greater opportunities for career advancement
- a broader network of nursing peers and more ways to showcase your knowledge, skills and experience
- a more focused continuous learning and continuing competence plan

What makes certified nurse's stand out?

CNA-certified nurses have:

- an advanced clinical expertise, knowledge and commitment
- specialty knowledge, authenticated by exacting national standards
- a clear dedication to quality, evidence-based care
- a resolve to pursue life-long learning, patient advocacy and professional practice
- a demonstrated commitment to continuing competence and specialized education

- maintained recognized standards of proficiency and professionalism

When you add the official certification credential after your name, patients, employers, licensing bodies and the public will be able to recognize your experience and competence in your nursing specialty or area of nursing practice. Once you're CNA certified, you'll stand out as an RN who cares to be the best!

JOIN OPANA TODAY!

Being a member promotes:

- ✓ **O**pportunity to network with peers
- ✓ **P**ride in having a professional organization
- ✓ **A**ffiliation with NAPAN©, our national association
- ✓ **N**ursing excellence
- ✓ **A**dvocacy with other qualified perianesthesia nurses

Membership Benefits include:

- ✓ Quarterly newsletters
- ✓ Reduced registration fee at OPANA-sponsored educational events including our bi-annual conference and Annual General Meeting (AGM)
- ✓ Reduced registration for workshops
- ✓ Opportunities for members to apply for financial support for continuing educational activities (conference bursaries)
- ✓ Discounts on NAPANc Standards of Practice
- ✓ Membership in the National Association of PeriAnesthesia Nurses – Canada (NAPANc)
- ✓ Opportunity to vote on important OPANA issues
- ✓ Networking opportunities
- ✓ Access to our on-line forum

Ways to register to become an OPANA member:

- ✓ Use our website: www.opana.org and join online. Cost per membership is $50.
- ✓ Member of RNAO? Add OPANA to your membership.
- ✓ Even better, if you are already a member of RNAO and paying your fees with an employer payee deduction, consider adding OPANA to your membership. It would calculate out to less than $13.00/pay for RNAO & OPANA. No hassle, renewal or fuss!
- ✓ Membership runs from November 1-October 31. Membership is aligned with the RNAO membership dates, as well as the annual OPANA conference. Renew your membership when you register for our conferences. A great reminder!

For more information on OPANA membership
Visit www.opana.org