MORNA GAUZETTE

November **2007**

President's Corner

I am pleased to welcome you to the 2007-2008 MORNA year. My first president's message is written with nervous anticipation and enthusiasm for what is ahead. I look forward to serving you for the next three years, as MORNA president following the departure of Audrey Hiebert last May. Thank-you to Audrey for her leadership and encouragement last year and I wish her all the best. I would like to welcome the new board members Leah Restall President-Elect for a one year term and Jackie Dutfield as Educational Coordinator.

This year started off in September with a Wine and Cheese that was hosted by HSC and Concordia. The October educational session was a very informative presentation by Dr Melannie Leppelmann ND, on herbal supplements/remedies and the effects on Anesthesia. There are four other educational sessions planned plus a workshop planned for March 15, 2008.

Our membership reached 170 members last year, our highest number yet in one year. This is encouraging as one of the objectives of the MORNA executive is to maintain or increase our membership in a non conference year.

I encourage you to invite a colleague who is not a member to join MORNA. There are many benefits of being part of a professional nursing organization. MORNA provides perioperative nurses with continuing educational opportunities through our MORNA meetings and Educational Sessions, and Workshops/Conferences. MORNA also provides funding opportunities for attending ORNAC Conferences or other conferences that a member requests funding for. Attending theses gives perioperative nurses an opportunity to network with other perioperative nurses to exchange ideas, find out how others handle hot issues, and learn new or best practices. It reminds us of the importance of our role as the patient's advocate in our pursuit of nursing excellence.

I look forward to seeing and talking with you at the MORNA Meetings.

Donna Fallis RN CPN (C)
MORNA President

2006-2007 EXECUTIVE

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CONFERENCES - INTERNATIONAL AND CANADIAN

DATES INTERNATIONAL

2008 Mar 30-Apr 3 — AORN's 55th Annual Educational Conference. "*Share Your Passion, Illuminate Our Profession" A*naheim CA

2008 May 21-24 ACORN 13th National Conference, "Between the Flags", Queensland Australia (conference brochure on line at www.acorn.org.au)

2008 June 25 – 27 "Healthy People for the Healthy World", Bangkok, Thailand; Mahidol University Faculty of Nursing in collaboration with Department of Nursing of Ramathibodi Hospital and is co-sponsored by the University of Michigan School of Nursing and the University of Alberta Faculty of Nursing. (www.healthyconf2008.com)

2008 June 29 – July 3 International Nursing Research Conference, Facing the Challenge of Health Care Systems in Transition; The Israel Society for Nursing Research; Jerusalem, Israel

2009—Durban, South Africa, ICN Congress

2009 Mar 15 – 19 – AORN Chicago, IL

2010 Mar 14-18— AORN Denver, CO

AORN also has many workshops available through out the year. (www.aorn.org)

DATES CANADIAN

2007 Nov 21 Manitoba Provincial Patient Safety Conference, Winnipeg Convention Centre www.mbips.ca/events

2008 March 15th MORNA Workshop, Sam Cohen Auditorium, St Boniface Hospital, Winnipeg, MB

2008 May 29 – June 5th, CHICA (Community & Hospital Infection Control Ass'n) Canada, 2008 National Education Conference, Palais des Congrès Montréal, Québec www.chica.org

2008 June 4 – 8 5th World Conference on Breast Cancer, Heart, Soul & Science "It's a Small World After All", Winnipeg Convention Centre www.wcbcf.ca

2008 June 15- 18 ORNAO (perioperative RN's Ass'n of Ontario) 10th Biennial Conference, Toronto, Ont

2008 Oct 29 – 31 32e Conférence Provinciale de la CIISOQ au palais des Congrès, Québec.

2009 June 7 – 12 St. John's NF for 21st **ORNAC** National Conference "Come to the rock for the view from our Atlantic Coast.



Any of these pique your interest?

Sources of funding

1. WRHA – $500.00 each year Jan to Dec, & 3 days salary replacement, to a maximum of 6 days per year. (Those outside of the WRHA contact your local HA).
2. MNU – $200.00 per fiscal year (available to all MNU members, contact your ward rep). Some locals have additional educational funds.
3. MORNA members – contact your rep for funding guidelines (must have been a member in the previous year).

HOSPITAL REPS

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ORNAC Standards

Module 1, 8th Edition
ORNAC Beliefs and Professional Standards
June 2007

This module from the ORNAC Standards has been revised. The new edition is available on the CSA website via www.ornac.ca or www.csa-intl.org/onlinestore. It costs $18.75 and includes a glossary for all modules, that replaces the separate module's glossaries. (I found it easier to locate via the ORNAC site).

Remember we must know our standards, the lawyers certainly do!!

Bursaries & Awards

1. Johnson & Johnson Medical Products Bursary – **The deadline for application for the J&J Bursary is January 15, 2007. ORNAC and J&J jointly fund this bursary to assist ORNAC members in furthering their education in areas that will enhance perioperative nursing practice. Go to www.ornac.ca education tab - bursary for more information. There are two awarded per year, numbers of applicants are often limited.**

2. National Conference Awards **Now is the time to start thinking about nominations for these awards. Applications must be obtained and submitted by December, 2008. They will next be awarded at the National Conference – 2009 in Newfoundland. Go to www.ornac.ca education tab – awards for more information**
   - Isabel Adams Award for Excellence in Perioperative Nursing Practice
   - Lorne Flower Award **Awarded to recognize the talents, knowledge, and outstanding contributions to the ORNAC Board.**

Election Announcement



This year we are to elect a new President Elect and a new Secretary!
They are elected for a 2-year term, which begins July 1, 2008.
Duties of the treasurer and education coordinator are found in the MORNA Constitution and Bylaws, ask your MORNA rep.

The election will be held at the MORNA Annual General Meeting, May 22, 2008.
Please forward nominations to Brenda Badger (Chair Nominating Committee)



A Night Out in Victoria ORNAC 2007

Important notice re Canadian Operating Room Nursing Journal (CORNJ) subscriptions

Please ensure that MORNA has your correct & current address. These addresses are submitted at the beginning of each year to Clockwork. If the journal is considered undeliverable, the cover is ripped off and the journal is discarded by Canada Post. The cover is then delivered back to the publisher with a C.O.D. charge of $0.65 for each cover. ORNAC pays for all returned journals decreasing final profits. Any changes of address also need to be submitted as soon as possible to prevent any delays in subsequent mailings. Subscription problem inquiries should be directed to the MORNA executive, not directly to Clockwork/CORNJ.

***Your change of address can be done directly on the ORNAC website. Go to www.ornac.ca, then journals, select subscriptions. The change of address window can be found here.



ORNAC Conference Report
Victoria, B.C.
April 22-27, 2007
By Pat Cuddy

Safety and Quality Makes a Difference in the Perioperative Setting

This session consisted of three different topics related to safety and quality in the OR presented by nurses from Hamilton Health Sciences in Ontario.

The first session was by Kelly Campbell, the Director of Perioperative Services for Hamilton Health Sciences and her topic was *Applying Operations Research in Improving the Quality of Inpatient Surgery Care.* Hamilton Health Sciences was expanding the cardiac program and wanted a tool to assist in creating a surgical booking policy. To create the policy Kelly and her colleagues looked at the historic data of surgical procedures and classified them into 5 categories according to the length of time. Then all the procedures were organized according to the 5 categories and it was determined what permutations and combinations could be done in a day. For example, the time frame would allow one case from category 1or two from category 2 but would not allow a case from category 1 and category 2 in the same slate on a certain day. If the combination of time frames fit, the cases would be slated and if the time frames did not fit the case would be rejected from the system. The hope was to plan the cases for the day instead of the cases planning the day.

Kelly did not discuss how they accommodated variations in anaesthesia time and I did not think to ask her at the time of the presentation. Kelly mentioned they were currently trying to get a software program developed to reflect this model.

The second speaker was Fran Riley, the Clinical Manager for the OR and PACU, and she spoke on *Improving First Case Start Time Performance.* She had some interesting numbers from the Council of International Hospitals. According to the Council, “the best performing hospitals start on time 50% of the time, with 83% of operating theatre first cases delayed 15 minutes or less.”

They were not happy with the start times at Hamilton Health Sciences and a working group was established to improve this problem. One solution was to have the porter and nurse in the holding area start fifteen minutes earlier, at 0645 instead of at 0700. This improved the time for the patients being ready in the holding area, however, no one else started earlier so it did not improve the time of patients arriving to the theatre.

I found this result interesting because there was a suggestion that nurses in our OR start the shift 15 minutes earlier to improve start times. However, there was no mention of anyone else starting earlier, such as in the admitting or day surgery departments. From the above example it appears that all players need to be involved for improvements to occur.

The third speaker at this session was Denise McLaughlin, the surgical liaison nurse at the General site of Hamilton Health Sciences, and her topic was *Surgical Nurse Liaison Pilot Project: A Quality Improvement Initiative.* This position was created from a vacant code to improve “family centered care through the development of intraoperative reports.” She discussed her role in this position and how it evolved.

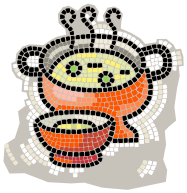
Denise's day starts in the pre-op holding area by introducing herself to patients and their families and then she connects with the specific operating rooms these patients will visit and PACU. She might take the families to PACU and she always accompanies the patient to the ward or the ICU. She also accompanies the surgeon when he is delivering bad news to the family and will assist with referrals to social work, pastoral care, etc. At first there was resistance from the surgeons when Denise accompanied them to visit the patients, however, they have grown to appreciate the position and there are plans to make this a permanent position.

I wondered if the liaison nurse delivered the message to patients that their surgery was cancelled when the slate ran over. Having one consistent person deliver this news might create less stress and animosity between surgeons and nurses.

This was one of many informative sessions I attended. Thanks MORNA for the funding assistance. It is always refreshing and energizing to attend the national conference.

MORNA at ORNAC April 2007





Chicken Soup for Manager's Soul

By: Loretta Morson

Loretta is a manager at Markham Stouffville Hospital in Ontario. Loretta has twenty years experience in the perioperative area. Her presentation was a humorous description of the challenges and successes of being an OR manager.

Today's perioperative issues: Wait list for surgery

- Benchmarking with other organizations
- Volume targets
- Workload issues
- Do more with less – The push for increasing efficiencies
- Recruitment and retention
- Aging workforce – "She is in the autumn of her career"
- Sick time due to family commitments
- Regionalization

Loretta's Famous Sayings:

- Don't prejudge until you judge yourself
- There are 3 sides to a story…. Yours, mine and theirs
- Happiness is a relative term
- Balance in life
- If life were perfect…
- Perception is 9/10th of the problem
- Search for common ground in everything
- Nothing is as it seems
- She is a pit-bull with lipstick
- Give me keen and green over seasoned and cynical
- Communication is the foundation of teamwork
- Save the drama for ya mamma
- The good, bad and the ugly
- Bottle your enthusiasm
- The credit/debit loans department is down the hall
- Come to work prepared to be busy and you will never be disappointed
- Morale – own it
- We have not failed until we fail to try
- We may not be able to change the past but we can influence the future
- Poor planning on your part does not constitute an emergency on my part.

Loretta's Top 10 List of Annoyances:



13. The pointy finger syndrome
12. I didn't get my afternoon coffee yesterday
11. Do you have a second
10. That's why they pay her the big bucks
9. "You versus we" or "they versus us" – We are all on the same side!
8. Gossip… it harmful and useless
7. We are short staffed again –I wish I could knit a nurse
6. Here comes the boss, let her make the decision
5. How could she not know I wanted the time off for…
4. Excuses
3. This won't cost you a cent
2. Whining
1. Dr….. I'll stay late for you!

12,000 – 24,000 preventable deaths per year in Canada.
Patient safety programs are key to preventing harm to our patients.

Professionalism:

- Different meaning to everyone
- Seize every opportunity to show it
- Art of listening is the start of communication

Conflict Resolution:

- Talk it out
- Timely (don't go bed angry)
- In a respectful and professional manor
- Create a "Win – win" situation
- Have encouraging conversations
- Avoid the tantrums

Difficult Personalities:

- Maintain professionalism and a respectful attitude
- Agree to disagree
- Find a common ground with everything
- Find your niche and develop it
- Communication

Technological Advance:

- Minimal Invasive Surgery
- Operating on a beating heart in cardiac
- Robotics
- Things are changing all the time

Why I went into Leadership:

- Influence change, be the change agent
- Ongoing enthusiasm, high energy
- Build relationship – with patients, staff, physicians and vendors
- Help build the future of health care
- Being able to take risks
- Able to have fun
- Always learning
- I love my job

Communication is the simplest of all yet the root of all evil when not done well. Be the best perioperative nurse you can be!

- Be the sunshine in the day
- A smile uses only 2 muscles
- Humor is healthy
- Make friends with multidisciplinary team members
- Network locally/nationally
- Deal with all generations in the work force – we can all learn from eachother
- Do in your heart what is right
- Treat life like a terminal illness
- Act to make a difference
- Ability to achieve research through people
- Know your best –get assistance with the rest.

Thank you to MORNA for your ongoing support of perioperative nursing education. The conference gave me the opportunity to network nationally with colleagues on common perioperative challenges.



Submitted Respectfully,

Lesia Yasinski RNBN, MSA
OR Continuing Education Instructor
St. Boniface General Hospital



20TH NATIONAL ORNAC CONFERENCE VICTORIA, BC APRIL, 2007

I was very fortunate to attend the ORNAC conference this year in Victoria with 4 of my colleagues from theConcordia Hospital in Winnipeg. We represented a wide range of nursing from General Duty to Educator to Manager and therefore, I am sure all of us were looking for different needs from the conference as well as something new. My particular requirements were of emerging technological information and exciting developments within the operating room and also support from the CORL group. The one thing that was apparent from almost everyone I talked to is, that we are not alone in our daily struggles in the OR as we always seem to think. Operating Rooms across the country, and indeed all over the world, are going through the same retention problems as we are, some more than others. We are all struggling with retaining the young nurses who cross our doorstep as we deal with the reality that these nurses may only stay in the profession for 5 years, never mind the OR.

***Lesley Fudge**, **an IFPN member from the UK**,* described an aging workforce and inadequate funding as just two reasons to support the demand for nurses. The UK currently has a shortfall of 14,000 nurses and the forecast for the US by 2020 is 800,000. Some of the solutions are taking care of the nurses we already have, using our mature nurses effectively, increasing current skills and even using other care givers. We need to recruit and retain a workforce for our future by luring nurses back into the fold, supporting education, and compensating appropriately.

Betty Schulz and ***Mary Jo Steiert*** talked to the delegates about **Correct Site Surgery.** In some of Florence Nightingale's notes from 1859, she wrote, "the very first requirement in a hospital is that it should do no harm."
In a 2000 Canadian study of hospitals, 33% of 192 patients had complications, 10 of those life threatening and 2 resulted in deaths.

If 99.9% were good enough:

- **12 babies would be given to the wrong parents every day**
- **There would be a plane crash every 3 days**
- **291 pacemakers would be implanted incorrectly this year**
- **107 erroneous medical procedures would be performed each day**



Root Cause Analysis tells us that the risk is increased by:

- Failure to engage the patient in the process
- Inaccurate/incomplete communication
- Absence of formal verification procedures
- Inadequate staffing levels
- Too much, too fast, too little time

After a March 2000 Surgical Site Identification Project was initiated, it was found that the factors for success were present in "7 Absolutes."

Pre-operatively:

1. each procedure involving laterality will be scheduled with left or right designation
2. each correct surgical site will be verified by the RN with the OR schedule and Chart Number
3. the patient, designee or care provider (varies) will verify the surgical site in the presence of an RN and mark
4. the circulator and anesthesia provider will interview the patient and review the record to re-verify the procedure and site

Intra-operatively:

5. the circulator, anesthesia provider and surgeon will review the patient's record, diagnostic results and verbally confirm the site
6. once the patient is draped, the surgical team will pause and verbally confirm the site
7. the circulator will document the verification process in the patient's record

The "7 Absolutes" engaging the entire surgical team across the perioperative process is the number one way to prevent errors!

Instrument Management Systems (IMS) was presented by ***Barbara Bolding from J & J.***
This presentation particularly peaked my interest as how often are we missing a set of instruments in the OR and the reaction is automatically referred to the sterile processing department (SPD) and vice versa? What about if there is a recall due to sterilization failure? IMS is a computer system that tracks instruments (singularly or in sets), mobile equipment and work processes in the SPD. There are a number of systems on the market, however, it has to be said that they are not all created equally and organizations must choose the one that suits them the best. The cost to install a system like this is in the region of $50-100,000. Typically, the system consists of the hardware (central server and workstations) and the software (Microsoft/Crystal). Information is input via a barcode, info dot, laser etching. The information obtained out of the system includes location of instruments, traceability to patients, work instructions to SPD, records of activities such as production, preventative maintenance, and repairs. It is based in the SPD and benefits many areas that uses reusable instruments, namely the OR, Endo and Ambulatory Care. It benefits finance, in the form of efficiencies such as repair costs, support for purchases and case costing. Also QA programs in the form of errors for follow up, cycle records, and traceability. In this age of ever increasing surgeries, this is a system that could help alleviate the frustrations of a lot of OR/SPD staff when we holler "Where is it?!"

Perioperative Nursing Data Set (PNDS) was a term that I was not familiar with until I heard this presentation by ***Susan Kleinbeck from the U. of Kansas***. PNDS has the basic principle of **"If we cannot name it, we cannot control it, finance it, teach it, research it, or put it into public policy."** PNDS is a standardized terminology designed to reflect the perioperative nursing process and its relationship to the healthcare system. It brings a common language and uniformity to nursing documentation and sets out the nursing contributions in the surgical setting. PNDS can be used across all settings and time shifts with unique codes to identify care given. It is not, however, a standard of care. It can be used in the development of policies and procedures, education, orientation, competencies, clinical pathways, benchmarking and more. Although new to Canada, there are facilities beginning to implement PNDS and it will probably set the pace for the future of perioperative nursing. Anyone interested in researching PNDS can find resources at www.aorn.org and there are a series of resource books by the presenter.

Regulations for Donation and Transplantation by ***Linda Socha from Saskatchewan*** was an extremely interesting presentation showing that is a complex procedure and requires all parties working "in concert" toward the common goal. She identified how facilities refer a donor, usually through the ER/ICU and described the various criteria required including brain death, functioning circulatory system, on a ventilator or DCD (Donation after Cardiocirculatory Death – situation where there is absolutely no hope for survival and the family agrees to donation). This has been an option in the US and Europe for over 30 years but the first case was performed in Ontario in 2006. There are no age restrictions for organ donation, however, for tissue donation it is more specific. Contra indications to donation (organ or tissue) include unknown cause of death, transmissible diseases,high risk behaviour, septicemia, malignancy, neurological diseases of unknown etiology, prolonged ischemia/ hypotension/asystole and if it is a coroner's case. Heart, lungs, kidneys, liver, pancreas, and small bowel can be transplanted (usually life saving). Corneas, sclera, valves, pericardium, bone, tendons and skin are tissue types that can also be transplanted (generally life enhancing). Consent is obtained from the next of kin even though there may be a donor card and is always informed. Assessments are performed such as ABO/tissue typing, infectious disease testing, medical/social questionnaire, physical examination and organ specific. Donor management includes hemodynamic, electrolyte, ventilation, acid base, temperature and treatment of coagulopathies to optimize utilization. There is a national wait list for all organs except for renal, which is provincial and availability of surgeons, OR and flights must be considered. The location and status of the recipient is also a strong consideration. The OR plays a key role in the retrieval of organs. The team is working in a very stressful, sometimes emotional situation and time is paramount as the clock ticks away after cross clamping. Feelings of failure and helplessness often invade the team as they struggle to come to terms with the loss of the patient. The result is often the emotional response of avoiding thinking the donor as a person to distance themselves. So, what does this mean for the OR? – always document tissue/organs for tracking purposes: bone/tissue source should come from an accredited facility registered with health Canada: if an OR stores tissue, is it being done to standards?? What does it mean for you? – fill in your donor cards and make sure your loved ones know your wishes.

The week was filled with many other excellent presentations, too many to mention. In submitting this report, I have touched on only a few, however, interested operating room staff may be pleased to know that many of the presentations in the form of notes have been posted on the **ORNAC** website at www.ornac.ca and it will give them an insight into the varied subjects of the conference.

Respectfully submitted by:
Karin Long RN CPN (C)
Clinical Manager OR/CPD
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Audrey Hiebert
MORNA President
2006-2007

REPORT FROM THE 20TH ORNAC NATIONAL CONFERENCE



The ORNAC conference held in Victoria, B.C. this year offered many interesting presentations. One of the presentations I really took interest in was by Susan Taylor, R.N., Nurse Educator/ Laser Safety Officer in London, Ontario. Her talk was on "Are You Still Smoking in a Designated Non-Smoking Area?"

She raised the question that if "Most provincial governments (Ontario, Manitoba, Saskatchewan, Northwest Territories, Newfoundland, Nunavut, New Brunswick, P.E.I., Nova Scotia and Quebec have now prohibited cigarette smoking in all buildings, including bars and restaurants. The dangers of second hand cigarette smoke are well documented and can result in catastrophic illnesses. Why then, are we still breathing in second hand surgical smoke in our Operating Rooms?" As operating room nurses are we at increased risk due to second hand surgical smoke?

Some of the side effects of second hand surgical smoke include,

- burning, watery eyes
- nausea, fatigue, weakness
- respiratory problems
- headaches
- pathogenic contamination.

Unfortunately smoke generated by ESU's has not been recognized as an inhalation hazard due to

- indifference
- lack of understanding and education
- lack of research
- lack of suitable evacuation methods
- lack of compliance.

The use of lasers and the dangers of laser plume was recognized and smoke evacuation methods were developed and used in the 1980's. A study done showed that laser plume held the same hazard as smoking 3 cigarettes. Smoke evacuators were initially developed to evacuate laser plume.

As perioperative nurses one of our roles is to advocate for our patients. We are usually so concerned about the well being of our patients that we tend to forget about ourselves. She encouraged us to educate ourselves on the risks of surgical smoke. Not only is the surgical smoke hazardous to O.R. nurses, but other O.R. staff including anesthetists, surgeons and even patients are affected. Unfortunately surgical masks are only able to filter about 20% of the particulate that is produced in surgical plume. We must insist on the use of proper smoke evacuators. As well our occupational health departments must be aware of our concerns in our individual workplaces.

Submitted by Colleen Ungrin



MORNA Article
ORNAC National Conference – Victoria BC June 23-27
Instrument Management Systems
Presentor- Barbara Bolding

Barb Bolding's presentation addressed the advantages, functionality, implementation, and operation of an instrument management system. The presenter detailed several different systems on the current market.

Instrument management systems are used to track instruments in their movement through the processes of decontamination, tray assembly, sterilization, stocking, usage and as they travel from the SPD to the OR and back. The tracking of instruments, sets and trays is performed using computers. There are two parts to an instrument tracking system:

1) Hardware – Actual computer system and its physical components for entering in data.
2) Software – A program from a vendor company which consists of a proprietary instrument management program.

Instruments can be tracked and data entered into computers via a bar code reader, keyboard, mouse or scanner. Several different methods can be used for identifying and labeling of instruments, trays and equipment. Methods include barcode labels, info dots, laser etching and "Enduramark".

There are many benefits of having a tracking system. Some include:

1) The system tracks exactly where trays and instruments are.
2) Tracing instruments back to trays and patients.
3) Provides for generation of label, images, reports and instructions for processing and sterilization.
4) Tracks productivity and activities within the SPD.
5) Provides a record of usage of equipment and instruments as related to repair, maintenance and on going operational cost.

Sterilization parameters can be interfaced directly from your sterilizer into the instrument management system for electronic storage of sterilization documentation and linked to the specific tray or instrument set.

It was identified that a hospital's instrument inventory is one of the largest investments in a health care facility. An instrument management system would be an asset in managing that inventory. In addition, the instrument management system would be a major capital purchase for the SPD in your facility and as such a facility may need to provide a sound business case to justify the purchase of the system. The audience was cautioned that all systems are not created equal. Facilities should be skeptical and asked lots of questions before purchasing a system to ensure it will provide the functionality and return on investment.

Ray Larkins RN CPN (C)

CUA Conference in Quebec City, June 2007

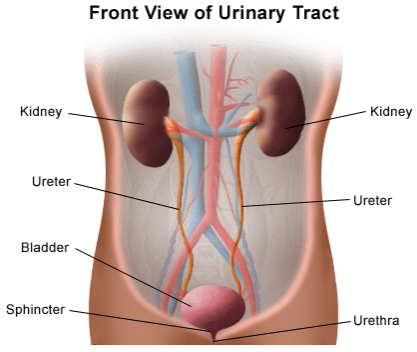
In June I had the opportunity to attend the Canadian Urology conference in Quebec. One of the opportunities for learning during conferences is contact and discussion with the representatives of the instrument and pharmaceutical industry. I was able to see and compare a lot of the endoscopic instruments used across North America. I was also given a number of learning cd's and pamphlets.

At St. Boniface we do all the urological endoscopic procedures in the operating room. Because these are not "hands on" procedures for the nursing staff, I find there is often a lot of confusion about the procedure and the equipment used. Learning a variety of techniques and equipment possibilities at the conference helped me to understand the procedures better and I was also able to make some judgments on streamlining our existing equipment or changing to more up-to-date items. These decisions are based on patient safety and also cost effectiveness.

For example, "ureteroscopy" can become a complicated procedure. Initially it may be indicated in a patient with hematuria or if positive cytology from the upper tract has been found even with negative imaging studies. Equipment needed during the procedure can vary extensively. The findings could be urolithiasis, upper tract cell carcinoma, ureteral stricture, or obstruction and presence of a foreign body (such as a migrated stent). Diagnosis then determines equipment needed. For the nurse, understanding the anatomic relationships of the ureter and the findings of the ureteroscopy assists in anticipating required instrumentation. Because the ureter is a thin walled structure and narrows at the ureterovesical junction, the ureteropelvic junction and the pelvic brim, there is a potential for damage and, therefore, post-op infection. The nurse might need to prepare for a variety of wires, stone baskets/graspers and balloon dilators. I was able to learn a lot about this ancillary equipment by talking to the representatives and familiarizing myself with equipment available by comparing a variety of instruments and having the opportunity to handle them directly.

Thank You to MORNA for supporting me in attending this conference and a great learning experience!

Ingrid Klassen, R.N. CPNC
CRN Urology, O.R.
St. Boniface General Hospital







Exposing the Leader Within

Cathy Knowles & Linda Bridge
Hopelessly Human Productions Inc.
Lethbridge, Alberta

"No system can endure that does not change.
Are we walking to the future or to the past?
Are we progressing or are we stereotyping?
… Don't let us stereotype mediocrity."
Florence Nightingale, 1893

I had the privilege of attending the Fourth Western Leaders Forum held at the Convention Center 15-17 Oct.

The session on Exposing the Leader Within was of particular interest to me as Linda Bridge and Kathy Knowles identified a need to return to respectful thinking and behavior in the healthcare system. Respectful thinking and behavior are significant factors to aid in the health of Canadian Nurses as well as any other staff within the healthcare system.

These two inspiring and delightful nurses started their presentation by play acting as Florence Nightingale and progressed to today's environment in the work place as nurses bearing the weight of deficiencies upon their shoulders. They indicated that the provision of respectful thinking and behavior by nurses towards themselves is the key to success. The mirroring/posturing from those with a growing self respect will advance self worth within the profession thus exposing the leader within each nurse. In order to fulfill the self respect of nurses, the emphasis is to focus on behaviors that inspire and excite nurses to heighten their self respect.

Reflection changes choices. How many times have nurses repeatedly apologized for circumstances beyond their control to their patients, doctors, co workers, other departments, families and the list goes on. Soon, every second sentence contains the words "I'm sorry". I'm sorry to keep you waiting. I'm sorry the doctor is late. I'm sorry you're sick. I'm sorry the stretcher is uncomfortable. Followed by I'm sorry, I'm sorry, I'm sorry….. In reflection, these are the circumstances the nurses, as individuals, cannot control. Apologizing and becoming engaged in circumstances beyond our control makes us feel sad and helpless. By feeling helpless and sad, we potentially weaken or hinder our ability to function and essentially this is a behavior that demonstrates a lack of respect. "Like a ripple in the water, one person's awareness and growth of self respect leads to another's and another's and another's."

In order to heighten the self respect of nurses, they are given tools that can assist them in changing their behavioral choices that can be adopted and implemented that would enhance the health care environment.

What are those tools? I can think of positive reinforcement, humor in the work place, education and enhanced training, confidence in their scope of practice by engaging in good leadership skills via role models etc.

"The key to successful leadership is influence not authority." by Ken Blanchard

As nurses from a wide scope of practice such as administrative board rooms to patient bathrooms, we are capable of heightening self respect. It will contribute to increased respectful thinking and behavior throughout the entire health care system. This will result in patient's who are more independent in, and accepting of, the responsibility for their own health.

"As people value themselves as unique and acceptable human beings, they take pride in the care of themselves. A leader lives in every Canadian Nurse and an exposure of it will create miracles".

Thank you for this opportunity.

Dianne Hyra-Kuzenko – Canadian Nurse
SBGH



A Tree Blooms in Victoria, April 2007; Lucette McLean



MORNA Meeting Dates 2007 – 2008*

Date	Day of Week	Event	Host	Location
Sept 13, 2007	Thursday	MORNA Annual Wine and Cheese	HSC & Concordia	Annie Bond Room
Oct 15, 2007	Monday	Business and Education Meeting	Selkirk & Grace	CRNM Building
Nov 20, 2007	Tuesday	Business and Education Meeting	St Boniface	CRNM Building
Jan 16, 2008	Wednesday	Business and Education Meeting	Pan Am & Victoria	CRNM Building
Feb 18, 2008	Monday	Business and Education Meeting	Women's & Misericordia	CRNM Building
March 15, 2008	Saturday	Saturday Workship	MORNA	Sam Cohen Auditorium
April 15, 2008	Tuesday	Business and Education Meeting	SOGH & Children's	CRNM Building
May 22, 2008	Thursday	MORNA Annual Dinner	MORNA	TBA

*Check back for any changes in dates/location and for more info about the workshop

MORNA Saturday workshop

March 15,2008	Saturday	MORNA Saturday workshop	Details to follow	Samuel Cohen Auditorium, St Boniface Hospital

MORNA Membership

Category	Fees	Send to
Active Member	$30.00 ($35.00 July 1, 2008)	Gladys Zinnick c/o OR Seven Oaks General Hospital 2300 McPhillips St Winnipeg, MB R2V 3M3
Associate Member	$15.00	
Affiliate Member	$15.00	
Honorary	complimentary	