MORNA GAUZETTE

November **2009**

President's Corner

I am pleased to welcome you to a new and exciting year for the Manitoba Operating Room Nurses Association (MORNA) which was kicked off with a Wine and cheese Mixer in September. We have six educational sessions planned for this year plus a Workshop in March.

I want to thank Jackie Dutfield for remaining on as Educational Coordinator and Gladys Zinnick as Treasurer. If people did not step forward to fill the executive position, it would be difficult to keep MORNA going. I also want to thank all the Hospital Reps for their help.

Membership for the 2009-2010, is down at present, so encourage your colleagues. Remember that you must join by December 1, 2009 to become a member of ORNAC and get the Journal. 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 nurse with continuing educational opportunities through our MORNA Meetings and Educational Sessions, and Workshops / Conference. MORNA also provides funding opportunities for attending ORNAC Conferences or other conferences that a member requests funding for. Attending these gives perioperative nurses an opportunity to network with other perioperative nurse 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.

November 8 – 14, 2009 is Perioperative Nurse Week, hope you will take this time to celebrate with your colleagues and reflect on your practice. A little bit about the history of the week, this started out as a day in 1979. The AORN House of Delegates approved a resolution that AORN designate a day each year to promote consumer education and enhance public knowledge. November 14th was originally OR Nurse Day and later became a week. In 2000, OR Nurse Week was changed to perioperative Nurse Week to more accurately reflect the broad spectrum of patient care provided to the surgical patient by peioperative nuurses

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

Donna Fallis RN CPN (C)

2009-2010 EXECUTIVE

President
Donna Fallis
OR Educator
OR Concordia
(204) 661 7268
(204) 661 7222 Fax
djfallis@shaw.ca

President-Elect
Leah Restall
CRN Ob/Gyn
OR Women's
(204) 787-2325
(204) 787-1078 Fax
lrestall@HSC.MB.CA

Past President
Brenda Badger
OR Seven Oaks
(204) 632 3176
(204) 697 3077 Fax
brbadger@hotmail.com

Secretary
Michael Porco
OR Concordia
(204)661-7197
(204) 661-7222
mporco@concordiahospital.com

Treasurer
Gladys Zinnick
Patient Team Care Manager
O.R. Seven Oaks
(204) 632 3216
(204) 697 3077 Fax
gzinnick@sogh.mb.ca

Educational Coordinator
Jacqueline Dutfield
OR Educator
OR Victoria
(204) 477-3183
(204) 269-7683
dutfield@shaw.ca



Conferences

Dates INTERNATIONAL

2010 Feb 18 & 19, World Health Professions Conference on Regulation 'Shaping the future", Geneva, Switzerland www.whpa.org/whpcr2010

2010 Mar 13 – 18 AORN 57th Annual Congress, "Reaching the Peak of Perioperative Practice" Denver, CO AORN Congress

2010 Apr 11 – 14 NETNEP, 3rd Nurse Education International Conference, Sydney, Australia www.NETNEP-conference.elsevier.com

2010 May 19 – 22 ACORN (Australia) 14th National Conference in W Australia, Perth, AU www.acorn.org.au

DATES CANADIAN

2010 Apr 10 – 12 CPSI (Canadian Patient Safety Institute) 2nd Annual Canada's Forum on Patient Safety & Quality Improvement www.patientsafetyinstitute.ca for more info

2010 Apr 25 – 28, ORNAO (periOp RN Ass'n of Ont) Biennial Conference, "Empowering Perioperative Nurses 2010: Update your professional practice toolkit", Nigara Falls, ON conference.ornao.org/

2010 Apr 28 – May 1 PRNABC (Periop RN Ass'n BC), Biennial Conference, Penticton, BC www.bcorng.ca

2010 May 9 to 11,CORL Network Conference 2010 www.operatingroomleaders.com

2010 May 28 – 30 9th Annual NAPANc Conference

2010 June 7 – 9 CNA (Canadian Nurses Ass'n) Biennial Conference, Halifax, NS "You have the power to make a difference!" www.cna-nurses.ca

2010 28th Annual ORNAA (OR Nurses' Ass'n of Alberta) Conference, Red Deer, AB

2010 Aug 29 to Sept 2 13th World Congress on Pain, Montreal, PQ www.iasp-pain.org/Montreal

2010 Nov 9 -12, SOOR Corporation des infirmières et infirmiers de sale d'opération du Québec, le 33e congrès de la CIISOQ, a Laval, Québec www.ciisoq.ca/Congres

2011 22nd National ORNAC Conference, Regina, SK



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 3 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

Concordia Hospital
Colleen Ungrin
OR 661 7198
1095 Concordia Ave R2K 3S8
Fax 661-7201

Grace Hospital
Leanne Moyer
OR 837 0120
300 Booth Drive R3J 3M7
Fax 837 0493

Health Sciences Centre Adult
Monique Palmquist
OR 787 3524
820 Sherbrook St R3A 1S1
Fax 787 3095

Children's Hospital
Terry Nicholson
OR 787 2240
840 Sherbrook St. R3A 1S1
Fax 787 1178

Women's Hospital
Karen Gilchrist
OR 787 2087
735 Notre Dame Ave R3E 0L8
Fax 787 1078

Misericordia Hospital
No rep at present
OR 788 8380
99 Cornish Ave R3C 1A2
Fax 788 8529

Pan Am Clinic
Carey McGregor
OR 925 1553
75 Poseidon Bay R3M 3E4
Fax 475 9486

St. Boniface Hospital
Iva Joslin
OR 237 2585
409 Tache Ave R2H 2A6
Fax 237 2587

Selkirk Hospital
Karen Warcimaga
204 482 5800 ext 209
Selkirk, Manitoba R1A 2M2
Fax 204 482 1293

Seven Oaks Hospital
Dorota Szurlej
OR 632 3176
2300 McPhillips St R2V 3M3
Fax 697 3077

Victoria Hospital
Iris MacMillan
OR 477 3183
2340 Pembina Hwy R3T 2E8
Fax 269 7683

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

CPN (C) Certified Perioperative Nurse Canada

CNA CERTIFICATION/RECERTIFICATION

Consider becoming certified in your specialty as a perioperative nurse. October 16, 2009 was the deadline for applications for first time certification, to write the certification exam April 17, 2010. These deadline are sometimes extended so check out the website or plan now to write in 2010.. The deadline for certification renewal application is November 20, 2009.

What about writing next year? You must have completed 3900 hours in your specialty prior to applying. Applications are accepted from Sept 1, of each year to ~mid October. Visit www.ornac.ca and www.cna-aiic.ca for more information. MORNA has funding available for active members, $150.00 toward certification or recertification fees. This is separate from the educational funding and does not influence the amount of educational funding available to you. There are other sources of funding available follow the financial assistance link under obtaining certification on the CNA website.

The fee schedule is available on the CNA website noted above. Click on **Become Certified!** on the left hand side of the home page.

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 http://www.ornac.ca, then journals, select subscriptions. The change of address window can be found here.





21st National ORNAC Conference
St John's, Newfoundland
June 7 -12, 2009









Conference Funding Articles

Robotics in the OR by Dr. Mehran Anvari

One of the most interesting and exciting parts of O.R. nursing is the technological advances that can improve patient outcomes. When I began my career in the O.R. a cholecystectomy patient would have a 6" subcostal incision and would be hospitalized for days post-op. The development of fiberoptic telescopes and advancements in endoscopic instrumentation allowed laparoscopic gallbladder removal to become the norm. Our O.R.'s are constantly changing and one of the next major changes will involve robotics in the operating room. This drew me to attend the presentation, 'Robotics in the O.R." at the ORNAC Convention in St. John's, Newfoundland in June.

The developments in the field of robotics will have the potential to bring about monumental changes to patient care. Hearing Dr. Mehran Anvari speak was fascinating and exciting. He has done groundbreaking work in the field of robotics. Although there are huge costs to the technology; a single surgical robot could cost as much as $200,000.00, the savings to be realized can be substantial as well. Imagine the costs, both financial and otherwise of transporting a critically ill patient from some remote centre far in the north down to a major centre in the south. Many patients could not survive the trip. Especially in a country like Canada, with our population spread out over vast areas, access to specialists can be limited. The use of robotics in remote telepresence surgery can decrease the need for a risky airlift to transport a patient to a larger centre where an expert surgeon can address their problem. Instead, they can be stabilized and prepped for surgery in their own hospital, close to loved ones. A local surgeon would make the incisions and place the three robot arms into the patient's abdomen. These three arms translate the surgeon's natural wrist, hand and finger movements into the corresponding micromovements of the instrument tips inside the patients. The expert then takes over.

Dr. Anvari performed the world's first remote telepresence surgery on Feb. 28, 2003. Dr. Anvari performed the operation in Hamilton, Ontario. His patient was in North Bay, Ontario, 400 miles away. The O.R.'s were connected by a VPN (Virtual Private Network) telecommunication link which carried all the data, the visuals as well as the robotic movement information. Besides the surgical information being transmitted, the O.R.'s are linked by both audio and video so that both teams can be aware of both the operative field as well as what is going on in the larger O.R. As Dr. Anvari said, it enables you to ask the scrub nurse 400 miles away for another suture. He has now performed 22 remote surgeries; 15 lap Nissens, 5 colon resections and 2 inguinal hernia repairs.

Besides allowing more patients to be seen with lower costs (neither surgeon nor patient need travel), teleremote surgery also fascilites telementoring. The robot arm allows seamless transition between expert and local surgeon so that teaching can occur. The expert can act as primary surgeon, and then 'step back' into the role of first assist as the local surgeon gains expertise.

There are still some limitations to these technologies. Besides prohibitive costs, our telecommunication networks still have a ways to go to be able to handle all the data. Presently, the surgeon has only visual

clues for feedback. Eventually, the computers will be able to simulate tactile feedback as well so that the surgeon will be able to 'feel' how much tension he/she is applying to a tissue.

Dr. Anvari has also teamed up with NASA for a further application of robotic surgery; to explore the possibility of delivering life saving care in an extreme environment, such as during space travel to the moon or Mars, in the absence of a surgeon. Using NEEMO 9, an underwater capsule operating off Key Largo, Dr Anvari performed a surgical procedure (on simulated tissue). The computer was programmed to perform at a 2 second delay. This delay is the time between when the surgeon makes a movement and the time the instrument replicates the movement. Two seconds is the amount of delay which would occur between the earth and the moon. (The delay normally occurring with remote telesurgery here on earth right now is 150 miliseconds.) It was found that only a few surgeons can accommodate for a 2 second delay, so that type of surgery may have to wait for more sophisticated technologies.

Other advances that are being explored are "semi-autonomous" robots, pre-programmed with patient specifics to perform certain functions, like suturing, without a physician in direct control. Eventually the possibilities of image guided partial knee replacements and MRI guided neurosurgery will become realities. Better robotics are now allowing the pioneering of 'Single Incision Laparoscopy' (SIL) whereby all the instruments are inserted via a single port. 'Natural Orifice Transluminal Endoscopic Surgery" (NOTES) will allow surgery with no external scars at all. Gallbladders are removed through the mouth, stomachs are removed through the vagina or rectum – the possibilities seem endless!

Dr Anvari brought his presentation to an end by outlining a robot which, although it sounds far-fetched even by science fiction standards, may someday be a standard of care; - an intraluminal robot that you would swallow in several tiny pill-sized pieces. The pieces would then *assemble themselves into a robot* inside you and proceed to perform its function; perhaps controlling hemorrhage deep within you or ablating an otherwise inaccessible tumour! Wow - it boggles the mind!

With improvements in these technologies in the future, these surgeries will eventually become more cost effective and more commonplace. It will be interesting to see how O.R. Nurses will be involved in this new world of surgery.

I would like to thank MORNA for the funding which enabled me to attend such an interesting and inspiring conference.

Submitted by Karen Watchorn

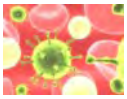




REPORT FROM THE ORNAC CONFERENCE



SURGICAL SITE INFECTION AND PERIOPERATIVE HYPOTHERMIA



Presented by Dr. Claude La Flamme at an ORNAC Conference Breakfast Session Sponsored by Associated Health Systems: Submitted by Joan Porteous, HSC

Patients who experience intraoperative hypothermia are at a higher risk for surgical infections, coagulopathy, cardiac events, decreased pulmonary function, decreased metabolism of medications and increased length of hospital stay.

The induction of a general anesthetic alters the body's thermoregulation processes. Core temperatures drop by 1% within 30 minutes of induction. The body's heat production decreases by 5% in the absence of shivering. It takes 3-4 hours with re-warming for post-surgical patients to return to a normal body temperature.

Complications of mild hypothermia include increases in duration of hospitalization, intra-op blood loss, adverse cardiac events, shivering in PACU and infection rates. Complications of mild hypothermia include platelet, clotting and fibrinolytic activity dysfunctions. Vasoconstriction due to mild hypothermia impairs neutrophil activity.

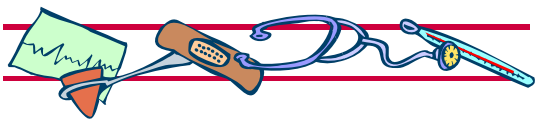
Intraoperative hypothermia may be reduced by pre-warming, pharmacologic vasodilatation, cutaneous warming, fluid warming and core temperature monitoring. Pre-warming warms the patient's periphery. This will decrease the amount of temperature shift from the core to the periphery after the induction of a general anesthetic. The most accurate method for temperature monitoring is a temporal artery probe, which scrolls from the temporal artery. A tympanic probe which uses infrared technology reads 1 degree C lower.

Each patient should be assessed for their risk of inadvertent perioperative hypothermia and potential adverse consequences before transfer into the theatre. The theatre temperature should be at least 21 degrees C while the patient is exposed. It is important not to lose the advantage of pre-warming by having the patient exposed to a cool environment during skin prep and positioning. Once forced air warming is established, the room temperature may be reduced to allow better working conditions.

Intraoperatively, the patient's temperature should be measured and documented before the induction of anesthesia and every 30 minutes until the end of surgery. Ideally, the patient's temperature should be 36 degrees C or above before induction begins. IV fluids should be warmed to 37 degrees C using a fluid-warming device. Patients who are at a higher risk for hypothermia and who are having anesthesia for more than 30 minutes should be warmed with a forced air device. The temperature setting on forced air warming devices should be set on maximum and then adjusted to maintain a patient temperature of at least 36.5 degrees C.

Postoperatively the patient's temperature should be monitored and documented every 15 minutes. The patient should not be discharged from PACU until their temperature is 36 degrees C or above. Patients who have a temperature below 36 degrees C should be actively warmed in PACU.

Neurosurgery is an exception to the warming rule, as hypothermia may be desirable as it protects the brain. In cardiac cases, where the patient is on by-pass pump, warming may also not be desirable.





Group Photo courtesy of Joan Porteous, go to www.ornac.ca/chapters/MORNA/newsletter/ for colour image

MORNA Members in St John's, Newfoundland June 2009







Can I Do More?

As I reflected on the conference, with its multiple sessions of information, one of the talks kept haunting me with this question, 'Can I do more'. This session spoke about 'Working towards Zero Surgical Site Infections'.

Maureen Spencer took a step back and looked at this process from all imaginable avenues.

She broke down the different influences of the patients visit to the O.R. and reviewed the impact of his/her outcome.

Time was spent in monitoring the traffic flow in/out of the theater, what was brought into the theaters, ie backpacks and briefcases, and the attire of the staff. She addressed her concern of the cloth surgical caps and the cleaning of the same, and the uniforms the staff wore, were they brought from home or possibly worn the day before?

Then she focused in on the instrument processing area and reviewed the cleaning of the surgical instruments. Some of the surgical instruments, she found, could not be clean by the staff, in a manner enabling the use of these tools in the O.R. suites. The manufacturers were contacted with these concerns and some instruments could not be used, because of this inability to process them for use in a sterile field. The list of surgical infractions continued with surgical hand scrubs and air handling systems.

All of this being said, her talk served its purpose, a point well made. Can we do more? I am now looking at all the possible avenues that determine the patient's outcome. Hearing her, voice her passion, in identifying the challenges in maintaining a sterile surgical field, gives us the energy to go back and meet these challenges in our own workplace.

In closing, I'd like to take this opportunity to thank MORNA for their funding made available to take in such a great learning experience.

Lia Jonk-Anderson
CRN Pre-op Holding Area
St. Boniface General Hospital



An Important Message to Pass On - By Louan Gladish RN.

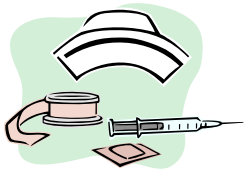
I had the privilege to attend the ORNAC conference this spring in Newfoundland. This years' theme was, "What Lies Beneath"; a theme which eludes that knowledge is acquired by looking deeper that what appears superficially. A presentation that I found personally interesting and educational was on Organ Tissue Donation and Transplantation. My assumption prior to attending this session was that this program was well established and successful. This is not entirely so. Historically, provincial transplant teams felt there was a great need in Canada to improve the delivery of organ transplantation and tissue donation, ultimately to decrease wait times for respective potential recipients'. To address this need, the Canadian Council for Donation and Transplantation (CCDT) had been establish to develop national standards, guidelines, best practice recommendations, consensus priorities, market strategies and educational resources. As a national body, the CCDT was hoping that they would be in a stronger position to organize, promote and enhance their cause across Canada. Despite their efforts, waiting lists unfortunately continue to grow nationally. We are simply unable to meet our patients' needs.

Other countries, such as Spain and Belgium, have highly successful donor programs, enabling them to export unused/excess tissues. In contrast, Canada imports nearly 90% of their tissues. Realistically, a country the size of Canada should be more than capable of meeting their transplantation needs. Recently, many complex hindering problems have been identified. On going changes in leadership and organization have improved the collection and delivery system, yet despite these positive changes, Canada is still not meeting the recipients' needs. The CCDT believes a commitment from all levels of government is necessary to develop an effective public awareness and educational campaign aiming to heighten the awareness of donor program.

In 2008, the CCDT merged with the Canadian Blood Service which expanded their mandate and operations beyond the traditional blood service. A pilot project was launched establishing a national registry to connect and match recipients (with potential donors?). Public awareness workshops were held in various locations in efforts to inform the public of how the Organ Tissue Donation and Transplantation (OTDT) system works and how tissues and organs are used. There is, in part, a misconception that if you donate your tissues that they can be used for any purpose (including research). It is imperative the public realizes that tissues are used only medical reasons. Once people realize that the donation of their tissues / organs will only be used save others, the hope is more individuals will sign their donation cards. Additionally, the OTDT encourages family members to discuss openly their donation wishes in case the situation arises were a decision is needed without the direction of a signed donor card.

There is still a lot of work to be done to make our Canadian system more effective. Through the cooperation of all levels of government, a national delivery system meeting the needs of all Canadians in a timely fashion can be developed. No one should have to die because the waiting is just too long!!





ORNAC 21st National Conference Report

Keynote Address- Politics, Heath Care and How the Two Meet by Rex Murphy

Mr. Murphy spoke of his very humble beginnings in Atlantic Canada and his fascination with politics. His opinion of current Canadian politics is it is often boring and lacking luster. American politics on the other hand is interesting and at a historical time with Barack Obama. Expectations are high for hope and change. There is a thirst for leadership with integrity, honesty and passion.

Mr. Murphy spoke of Heath Care changes over the last century and what revolutionary changes have transpired. We have participated in one of the most advanced health care system; with a wealth of science advancement and technology. There has been advancement beyond ones wildest dreams.

In Canada we have chosen health to be a social policy; "Health is for all Canadians." Medicare is a focal point in Canadian politics for this reason. No Canadian should suffer economic calamity while suffering ill health. It is a central social virtue of Canadian altruism.

Mr. Murphy spoke very passionately about nursing. Nurses are present at epic moments of stress and distress in human life. This significant role is a vocation. He spoke of the character, professionalism, knowledge, and skills of a nurse. Nurses earn the respect of the public and are the most respected profession in Canada. Nurses get the privilege of intervening in the lives of others in the most acute times of life. It is the greatest human interaction.

Mr. Murphy shared a touching personal story of a nurse in his home town "Nurse McGraw" who had the respect of all in town. His father was suffering ill health and many in the family were strongly encouraging him to go to see the doctor. At the time his father felt he wasn't sick enough to seek out the doctor. One day as his father was driving down the road he was not feeling well and stopped at the side of the road. Nurse McGraw was driving along and stopped to see if she could assist a person in need. When she took one look at the man she ordered him to get out of the car and drove him to the hospital. He suffered a mild heart attack. Nurse McGraw intervened at a critical point in this man's life. Mr. Murphy spoke of his profound gratitude and respect of this nurse as she intervened to assist another at a moments notice.

Mr. Murphy urged us to keep foremost in our consciousness in the 20th century we have achieved so much. Keep in mind where we came from and how far we have yet to go. At the core of nursing there is tremendous human exchange. We operate at crucially sensitive moments of human life. This is a responsibility, an honor and a privileged. He ended his speech by giving nursing a standing ovation.

Respectfully Submitted,
Lesia Yasinski R.N.B.N., M.S.A.
O.R. Program Team Manager St. Boniface General Hospital



MILITARY O.R. NURSING Submitted by Elisabeth Gray

I really enjoyed the 21st National ORNAC Conference and found the talk by Captain Auger and Major Hennecke on Military OR Nursing very interesting. I really appreciated the opportunity to attend.

Military nurses routinely work within large national hospitals and military facilities. They are aware of deployment six months ahead so they can go through pre-deployment training to maintain their skills, basic military refresher ex: shooting and the use of gas masks etc. They attend an intensive trauma training course in Vancouver B.C., and mission specific training in Petawawa, ON where they learn the area, religions, etc. They are expected to adapt to the stresses of deployment such as fatigue and extreme temperatures. Their goals are promote, protect, and heal. Sometimes by 08:30 the temperature can be 42 degrees Celsius. They have to get used to the huge bugs, scorpions, camel spiders, sandstorms and increased altitude. It is advised not to eat local food due to poor cleanliness. They have been deployed to Afghanistan; Kabul and Kandahar. There is a team with three surgical, medical, mental health and dental services. When they arrive they help set up the hospital and they place cement blocks by the tents. Challenges can be for example in Kabul if there are no patients, boredom and loosing their skills. In Kandahar it can be busy with two teams on 24hrs at a time. Staffing is multi-national and specialists do two month tours. There are Canadians, Americans, Dutch, Danish and some from New Zealand. It is a challenge sleeping with planes flying over frequently, and helicopters every hour. The nurses circulate, scrub, recover, clean rooms, sterilize equipment, work in CSR, stores, sterile core, and manage the OR department. Most surgery is done excluding hearts. When they work in the OR they lock up their guns in an office. Casualties go up in the summer. Soldiers are dehydrated and hemodynamically unstable. The soldiers carry their own tourniquet at all times. They treat the patient not the nationality including insurgents and children. Supplies can take two weeks to get if shourt ex: plates and screws. Notification of patients in number or arrival time is not accurate. Room have to be set up after each case. Time out is important because often they don't know the names and must identify by a number on their tags. They must know where resuscitation equipment it is at all times and how to use it. Laryngoscopes are cleaned immediately after each use and some anaesthetists use more than one. Often they have to do damage control surgery and bring the patient back at a later time for further surgery. You muist know how to use blood saving devices, auto transfuser, and know what blood products are available and prioritize their use. Patients are evacuated to Germany.

They stressed how important team effort is and to take care of your team. This is important for all OR nurses wherever you work.

WRHA News Alert

Did you know?

1. The Canadian Patient Safety Institute (CPSI) has adopted the WHO Safety Checklist.
    - The OR educators have been working on a Surgical Safety Checklist that will be implemented at all sites within WRHA.
    - A trial will begin in November with anticipated implementation beginning late December.
    - Educators will be providing education to all nursing staff prior to the roll-out.
    - The Surgical Safety Checklist will provide us with an additional tool to provide ongoing safe patient care.

2. Roll-out of the Surgery Program's first Evidence Based Practice Tool (EBPT) "Recommended Surgical Skin Prep Guidelines" will be coming soon to your OR theatre.
    - These were developed by the OR educators in collaboration with Infection Prevention and Control.
    - A learning package and Power Point Presentation will be available for educational purposes.
    - Included in these guidelines is information related to single-unit dose alcohol/chlorhexidine or alcohol/povidone combination prepping agents.
    - The Surgery Program has approved these agents as an option for surgeons. To date these can not be included in custom packs as approval from Health Canada has not been received.

3. Guidelines for management of Infectious Diseases in the OR
    - Enhanced Droplet/Contact Precautions Guidelines
        i. Developed by the OR educators in collaboration with Regional IP&C
        ii. Guidelines available at your sites including a sign for the door (developed by IP&C)
        iii. For use with H1N1 Patients
    - Guidelines for contact, droplet, and airborne precautions are being developed.

4. Currently the OR educators are working on Guidelines for management of fires in the OR

5. Standardization of names for consumable products and reusable items
    - Work is being done with the WRHA supply chain, MDR and ORs (each site has representation) on standardizing the names of items. It will help when requesting product that we all understand one another.

6. Medical Device Reprocessing (MDR) update:
    - The second annual MDR Workshop was held June 29th and 30th, 2009. The third annual MDR workshop is tentatively planned for June 28 and 29, 2010. This workshop is free to all attendees.
    - A Loaner Instrumentation Policy continues to be worked on and is awaiting WRHA corporate approval.
    - A CSA Certification exam has been developed for MDR Technicians. Winnipeg was one of the Beta exams (trial of the exam) sites with 9 MDR technicians writing the exam.

7. Endoscopy Patient questionnaire and teaching information
    - Regional Pre and Post endoscopy patient information pamphlets are being developed. These would be used by all endoscopists/surgeons and facilities where endoscopy procedures are being performed.
    - A regional endoscopy Preprocedure patient questionnaire is also being developed for use for all endoscopy procedures.
    - Certified Endoscopy Reprocessing Training (CERT) session was held October 16th and 17th. This will be held every 5 years for those who are responsible to train front line staff in endoscopy. Thank You VGH for hosting this session.
    - An endoscopy workshop for front line staff is tentatively planned for the Spring of 2010. Stay tuned for additional information.

8. Perioperative Orientation sessions were held in May 2009 and September 2009.
   Another session is scheduled to begin November 2nd with participants expected from Concordia Hospital, Victoria Hospital, Misericordia Health Centre, Portage, and Boundary Trails. Perioperative theory sessions are now being held at the Concordia Hip and Knee Institute with labs being held in the evenings in the Concordia OR. A **HUGE** Thank You to SBGH for accommodating labs at their site from January 2007 until May 2009. Additional sessions are planned for January, March, and May 2010.

Participants completing their clinical experience since March 2009 include:

Kristen Hall – GGH
Melissa Barroso – Women's Health
Bernadette MacKenzie – Child Health
Tara Jonasson – Child Health
Charissa St-Cyr- Child Health
Sarah Kasala – Child Health
Mary Dyck - Altona
Jennifer Hoeppner - HSC Adult
Emily Ruth Laycock – HSC Adult
Eugenia Mardli – Boundary Trails
Charity McAuley – Boundary Trails
Bev Clarkson – Portage Hospital
Gloria Mowat - Selkirk

Participants currently doing Clinical:

Sara Cranwell – HSC L&D
Louise Matthys – VGH

Preceptors (Alternate Preceptors) March and May 2009 who made the Orientations possible. Thank you!

HSC Children's

- Alison Desautel
- Chris Cox
- Terry Nicholson
- Tanya Fuksman
- Eduardo Ronquillo
- Kim Fox
- Beatrice Zulak

GGH

- Leanne Moyer
- Chris McDougall
- Leah McBride
- Glen Brown
- Graciana Medeiros

HSC Adult
- Jane Milner
- Kim Celaire

Carmen
- Allen Peters
- Lal Froebe

Portage
- Heather Werbiski

Altona
- June Schwartz

Selkirk
- Linda Romaniuk
- Donna Shead

Boundary Trails
- Karen Hiebert
- Lottie Froese
- Karen Cowan
- Carolyn Wiebe
- Jennifer Sager
- Barb Derksen
- Johann Schaefer
- Karen Billing

Thank you to Guest Presenters

- Jack Kress – Anesthesia
- Joan Porteous – Forensics
- Leah Restall – Pregnant Patient
- Cristy Pragides and Willow Yakiwchuk – Children in Surgery
- Dr. Marie Edwards – Ethics
- Donna Fallis – Orthopedics
- Jackie Dutfield – Malignant Hyperthermia
- Wanda Sawa – Endoscopy

Trivia:

- 4% alcohol in prepping solutions serves no purpose as a skin antisepsis. The purpose of 4% alcohol is to act as a preservative.
- According to Baker et al in the article "The Canadian Adverse Events Study; the incidence of adverse events among hospital patients in Canada" 37% - 51% of Adverse Events (unintended injuries or complications that are caused by health care management, rather than by the patient's underlying disease, and which may lead to death, disability at discharge, or prolonged hospital stays) have been judged in retrospect to have been potentially preventable.
- Results of the same study mentioned above suggests that, in 2000, between 141,250 and 232, 250 of 2.5 million admissions to acute care hospitals in Canada were associated with an Adverse Event and 9250 – 23,750 deaths could have been prevented.
- It takes nine (9) minutes to remove 90% of airborne contaminants in the air when you have 15 air exchanges per hour in your operating room. It takes 18 minutes to remove 99% and 28 minutes to remove 99.9%.
- A two (2) month project related to loaner instrumentation was conducted in the MDR department of a Medical Centre in the US. Over the two month period 139 sets of sterilized loaner instruments were visually inspected and then chemically tested for blood residue. Twenty-three (23) of these sets (16.5%) tested positive for blood residue. Twenty-two (22) of the twenty-three (23) were hand-delivered by vendors and six (6) were visibly contaminated. AORN Journal March 2007, Vol 85, No 3 p. 569.

Submitted by Carol Shack Regional Perioperative and MDR Nurse Educator



MORNA Meeting Dates 2009 – 2010*

Date	Day of Week	Event	Host	Location
Sept 24, 2009	Thursday	MORNA Annual Wine and Cheese	St Boniface	
Oct 19, 2009	Monday	Business and Education Meeting	Women's & Concordia	CRNM Building
Nov 19, 2009	Thursday	Business and Education Meeting	Children's & HSC Adult	CRNM Building
Jan 21, 2010	Thursday	Business and Education Meeting	Seven Oaks & Selkirk	CRNM Building
Feb 18, 2010	Thursday	Business and Education Meeting	Victoria & Pan Am	CRNM Building
March 13, 2010	Saturday	MORNA Spring Workship	MORNA	Sam Cohen Auditorium
April 20, 2010	Tuesday	Business and Education Meeting	Grace & Misericordia	CRNM Building
May 18, 2010	Tuesday	MORNA Annual Dinner	MORNA Executive	Norwood Hotel

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

MORNA Saturday workshop

March 13,2010	Saturday	MORNA Saturday workshop	Details to follow	Samuel Cohen Auditorium, St Boniface Hospital

MORNA Membership

Category	Fees	Send to
Active Member	$40.00 ($45.00 July 1, 2010)	Gladys Zinnick c/o OR Seven Oaks General Hospital 2300 McPhillips St Winnipeg, MB R2V 3M3
Associate Member	$20.00	
Affiliate Member	$20.00	
Honorary	complimentary	