MORNA GAUZETTE

01/05/12

President's Corner

This will be my last greeting as President of MORNA. The people I have met and the experiences I have had over the past five years have been incredible. I am so thankful that I have had the opportunity to be involved in such a wonderful organization and for the relationships that have developed through my involvement with ORNAC.

"Learning is a treasure that will follow its owner everywhere" (Chinese proverb) I would like to offer sincere praise to all MORNA members who see the value of continuing education and who are committed to expanding and advancing your perioperative practice. Another quote to inspire you is"develop a passion for learning, if you do, you will never cease to grow" (Anthony d'Angelo)

We are so fortunate to have people who are devoted to managing this association and it is by their hard work and dedication that MORNA will continue to thrive and grow. In particular, I would like to say thank you to Gladys Zinnick, Iris MacMillan, Karen Warcimaga, Monica Palmquist, Donna Fallis and all the hospital representatives. It has been a tremendous pleasure working with you and I truly value and appreciate the time, energy and enthusiasm that you have given over the years and wish you continued success and development. I would recommend and encourage other members to get more involved and consider running for an executive position. I promise it will be a worthwhile and rewarding experience.

I passed the gavel on to Monica at our Annual general meeting and I know you will give her your continued support as she transitions into her role as President. I have no doubt she will be a valuable asset to MORNA and I hope she enjoys her tenure as much as I have.

With Kind Regards,

Leah Restall

2011-2012 EXECUTIVE

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CONFERENCES - INTERNATIONAL AND CANADIAN

DATES INTERNATIONAL

Any of these pique your interest?

Sources of funding

1. WRHA – $500.00 each year Jan to Dec, plus 2 days salary replacement, to a maximum of 2 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 or go online at (must have been a member in the previous year). www.ornac.ca/chapters/MORNA/ for funding guidelines

2 Sept 20-22 New Zealand- 39th Annual Conference of Perioperative Nurse **2 June 13-15** France- 4th Annual SERGS meeting on Robotic Gynaecological Surgery**2 Oct 11-12,** ICN (International Council of Nurses) Conference and CNR, 3rd International Orthopedic Nursing Conference-Malta, Qawra www.icn2011.ch/

2 June 2-6 10th Nordic Nutrition Conference, (Nordic OR Nurses Ass`n), Reykjavik, Iceland www.meetingiceland.com

2 June 17-20- 4th International Nurse Education Conference- Renaissance Baltimore Harborplace Hotel, Baltimore, USA

2 SATS (South Africa Theatre Sisters) Congress, Wesstern Cape, South Africa (TBA) www.theatrenurse.co.za

2 June 18-20 38th World Hospital Congress, Oslo, Norway

2 Spring TBA- 3rd Aseptic Surgery Forum, Paris, France, - International Expert Meeting on Good Surgical Practices and Technological Innovations to Prevent and Cure Infections www.aseptic-surgery-forum.com/en/

2 Mar 2-7 AORN 60th Annual Congress, San Diego, CA, USA AORN Congress

2 April 26 – 29 6th EORNA European OR Nurses Ass`n Congress, "Sailing to the Future" Lisboa, Portugal www.eorna.org

2 May 23 – 26 ACORN (Austrailian College of OR Nurses) 15th National Conference in Darwin, NT ``Territorial Boundaries, Dare to be Diverse`` www.acorn.org.au

2 April 21-25 23rd ORNAC/ IFPN Conference "International Alliance for Perioperative Best Practices" Ottawa Ontario, Canada

DATES CANADIAN

2 June 16-21 CHICA (Community & Hospital Infection Control Ass'n) Canada, 2012 National Education Conference, "Growing for the Future" Saskatoon, Saskatchewan www.chica.org

2 May 27- 30 e-Health 2012: Innovating Health e-Care Vancouver BC www.e-healthconference.com/

2 June 4-6 CONA (Canadian Orthopedic Nurses Ass'n) 35thAnnual Conference,Ottawa Convention Centre. Ontario "Capital Ideas in Orthopaedics" www.cona-nurse.org

2 June 17-20 11th Biennial Provincial Conference-"Perioperative Nursing in 2012: Challenges...Changes...Collaborations"- Toronto Ontario

2 June 1&2- ORNANS (Perioperative RN's Ass'n of Nova Scotia) AGM. Keating Millennium Centre, St. FX University, Antigonish www.ornans.ca

2 Sept 26-28 25th Atlantic Conference "Bridge to Perioperative Nursing Future" Delta Prince Edward Hotel-Charlottetown,P.E.I.

2 March 23 CSGNA (Canadian Society of Gastroenterology Nurses & Associates,- Southwest Alberta (Lethbridge) Education Day

2 Oct 31-Nov 2 Provincial Conference-Quebec City, QC,

2 April 25-27 2nd Advances in Health

Informatics Conference- “Towards Integrated Diagnostics” York University, Toronto, Ontario http://www.ahic.nihi.ca/

2 April 25-28 PRNABC 23rd Biennial Conference, Nanaimo, BC,

2 April 21-25- 23rd ORNAC/IFPN National Conference- “International Alliance for Perioperative Best Practices” Ottawa, Ontario, Canada
2015 May ORNAC Edmonton AB (TBA)

2 Oct 19-21, The 10th Annual NAPANc (National Ass’n of PeriAnesthesia Nurses of Canada) “Leading the Way...in PeriAnesthesia NursingConference;Dartmouth Nova Scotia napanc.org

2 June 17 to 20 the (CNA)Canadian Nurse Association Biennial Conference, Vancouver, BC.
Future CNA biennial conferences

- 2014, June 15-18 Winnipeg, MB
- 2016 June 19-22, New Brunswick
- 2018 June 17-20, Alberta
- 2020 June 20-23, Prince Edward Island

Atlantic Conference- 2014-NewBrunswick
Atlantic Conference- 2016-Nova Scotia **2 May** ORNAC National Conference, Edmonton, AB (TBA)

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Certified Perioperative Nurse Canada

CNA CERTIFICATION/RECERTIFICATION

Consider becoming certified in your specialty as a perioperative nurse – CPN(C). The deadline for applications to write in 2012 is usually in November 2012, so check out the website and plan now to write in 2012. The deadline for certification renewal application for 2012 will be around the same time (Nov. 2012).

You must have completed 3900 hours in your specialty prior to applying. Applications are accepted from Sept 1, of each year to ~mid Oct/Nov. 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.

Manitoba Operating Room Nurses Association
2011-2012 Executive

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Standing Committee Chairpersons

Communications Committee & Newsletter — Iris MacMillan, Karen Warcimaga, Monica Palmquist, Leah Restall (Ex-Officio)

Constitution & By-Laws Committee — Donna Fallis, Leah Restall (Ex-Officio)

Education Committee — Karen Warcimaga

Nominations — Donna Fallis

Manitoba Operating Room Nurses Association

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HSC - Adult	Monica Palmquist	820 Sherbrook St Winnipeg, MB R3A 1S1	Wk#(204) 787-3524 Fx#(204) 787-3095
HSC - Children's	Charissa St-Cyr	840 Sherbrook St Winnipeg, MB R3A 1S1	Wk#(204) 787-2240 Fx#(204) 787-1178
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St. Boniface	Lilian Brown	**409 Taché Winnipeg, MB R2H 2A6**	**Wk#(204)237-2585 Fx#(204) 237-2587**
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Maples	Marlene Dieter	**Maples Surgical 7-1291 Jefferson Ave. Winnipeg, MB R2P 1S7**	**Wk# (204) 633-1108 Fx# (204) 633-1148**

MORNA Membership Information

1. **Active Membership is $50.00 as of June 1, 2012**
2. **Deadline for membership is Dec 1, 2012**
3. **Send completed application form and fees (cheques payable to MORNA) to: MORNA Treasurer**

Ms Gladys Zinnick
Seven Oaks Hospital
c/o OR
2300 McPhillips Ave
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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.



Canadian
PLASTIC SURGERY
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FOR FURTHER INFORMATION
PLEASE CONTACT KAREN SAGNESS AT
cpsnursingsymposium@gmail.com

CANADIAN PLASTIC SURGERY NURSES SYMPOSIUM PROGRAM

1300 – 1400 LUNCH WITH VENDORS IN EXHIBIT HALL

1400 - 1405 WELCOME MESSAGE
Mrs. Karen Sagness
Symposium Chair

1405 – 1410 WELCOME MESSAGE
Dr. Patricia Bortoluzzi
President, Canadian Society of Plastic Surgery

1410 – 1415 WELCOME MESSAGE
Ms. Tracey Hotta
Board Member, Canadian Society of Plastic Surgical Nurses

1415 – 1430 BOTOX FOR RAYNAUD'S DISEASE AND CHRONIC PAIN
Dr. Michael Neumeister
Southern Illinois University
Springfield, Illinois

1430 – 1445 BIONIC ARMS
Dr. Jaret Olson
University of Alberta, Edmonton

1445 – 1500 FREE FLAP BREAST RECONSTRUCTION: UNLIMITED OPTIONS
Dr. Edward Buchel
University of Manitoba, Winnipeg

1500 – 1515 BREAST RECONSTRUCTION: PATIENT EDUCATION AND FOLLOW-UP CARE

Heather Chapko, RN, BN
Shaney Weirich, RN, BN
Plastic Surgery Clinic Nurses
Health Sciences Centre, Winnipeg

1515– 1530 PEDIATRIC BURN CARE UPDATE

Dr. Joel Fish
Toronto Hospital for Sick Kids

1530 – 1545 NUTRITIONAL BREAK

1545 – 1610 NUTRITION AND BURNS: AN OVERVIEW OF METABOLIC CHANGES AND NUTRITION SUPPORT REQUIREMENTS IN THE ADULT AND PEDIATRIC POPULATION

Ms. Kathryn Hall, Registered Dietitian
Sunnybrook Health Sciences Centre
Toronto, ON

1610 – 1655 CHANGING FACES

Dr. Lonny Ross
University of Manitoba, Winnipeg

1655 – 1700 CLOSING REMARKS AND EVALUATIONS

Further comments regarding the symposium may be forwarded to Karen Sagness at cpsnursingsymposium@gmail.com

REPORT FROM ORNAC 2011 NATIONAL CONFERENCE
HIGH PERFORMING SYSTEMS

Submitted by Joan Porteous

Presented by Steven Lewis, Health policy and Research consultant and Adjunct Professor of Health Policy at the University of Calgary and Simon Fraser University

Steven Lewis was the speaker for the Val Shirreff Memorial Lecture at the 2011 ORNAC conference. His talk focused on patient- centered care, work force well-being issues and public interest in health care wait times. The lecture was very thought-provoking and was a great beginning for the conference. The report below is a brief summary of his talk.

He identified that the goals of health care today are to achieve better quality health care, better value for our health care dollar, and to decrease disparities between professional groups. Productivity should not be described only in terms of volume, but should include work force well-being. Things that improve work force well-being include:

- Specialization with a high degree of regulation;
- An elevated entry to practice credentials within specialties;
- Less turf claims and protection within turfs: and
- Reducing hierarchies and power inequalities.

Dr Lewis indicated that **competency**, and not only credentials, **should define competency**. The health care system has evolved into what it is today, because of:

- Increased complexity;
- Increased scientific knowledge;
- A rise of new technologies;
- Regulation was seen to be the foundation for quality and safety;
- More credentials results in a higher status
- Turf control = control = power = money

Within this system the quality of health care has suffered because:

- Productivity is defined as volume, not result;
- Funding systems do not distinguish between good and bad care;
- Clinical autonomy resists standardization of work;
- There are no expectations that variations in practice will narrow;
- The public is fixated on access and not quality; and
- Canadian Health Care information technology is underdeveloped.

Accountability today should focus on quality, efficiency, value for money, time lines and improved patient experience. When considering improvement and standardization, teamwork trumps autonomy. Physicians should use decision-support technology to prescribe drugs. Standardization transforms practice in many ways:

- Less latitude for judgement
- Less variation about how things are done
- Increased reliability
- Emphasis is shifted from what one knows to how one does things;

This breaks down hierarchies, because every member of the team can stop the assembly line. A quality-organized standardized system works.

Standardization enhances work life because it:

- Frees time to spend on higher value-added issues;
- Reserves judgement for areas where genuine uncertainty exists;
- Removes clutter from daily work; and
- Decreases anxiety and stress.

Wait times are defined as a capacity problem. Sometimes the solution is money, capacity or re-engineering. The volume of diagnostic imaging services in the last 15 years has increased 5-fold. This has bottle-necked consultations and specialties. Dr Lewis reported that typical wait times for primary care in Canada is 5-7 weeks.

In order to work towards patient- centered care and workforce well-being, health care requires more than technical excellence to succeed. Great service industries are organized around clients needs, not technical supplies. Human interactions are of high importance when the customer is sick, vulnerable and scared. What does this mean for nurses? It means:

- Less time for useless work to improve the patient experience;
- Great workplaces;
- Freeing up time to care, as technology and standardization free up time.

Professional autonomy is not about control….it is about teamwork. Protocols and standardization free up time. It is not a loss to delegate work….it is a gain of space to maximize our capacities. Challenging questions increase growth and development. Efficiency can liberate the workforce to enhance relationships and devote talent to solve complex problems. A general model for health care improvement would include:

- Patient centered care;
- Value for the dollar;
- Evidence-based and needs-based practice; and
- A population-oriented focus.







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Amniotic Membrane Transplantation

It has been many years since I have worked in an Operating Room that performs eye surgery. And, to be honest, I didn't like it! Surgery on the eye is one procedure I have a difficult time watching. So when I decided to go to a session on eye surgery, at the 2o11 ORNAC National Conference in Regina, I was surprised.

The session was entitled Amniotic Membrane Transplantation (AMT), presented by Dr. Jeffery Judelson. From the title I had no idea what to expect, but from the moment the session started I was intrigued.

The amniotic membrane is the inner most lining of the placenta, and is known to have properties that prevent scarring and inflammation. This delicate tissue is placed onto the corneal surface and used as a "bandaid" for the eye. Clinical indications for use include: corneal ulcers, neurotrophic keratitis, limbal stem cell deficiency, and high risk penetrating wounds. The main function of the amniotic membrane is to aid in the healing process, provide a protective barrier, promote epitheal healing, and decrease neovascularization.

Brief overview of the surgical procedure:

1. Amniotic membrane arrives, frozen, in the OR. Takes 20 minutes to thaw. Piece sent for C&S.
2. Amniotic membrane is rinsed three times with BSS.
3. Corneal pannus is removed via blunt superficial keratectomy.
4. Corneal surface, if uneven, is polished with a dental burr.
5. Corneal surface is covered with three layers of amniotic membrane.
6. Amniotic membrane is sutured, purse string, with 10-0 nylon, or secured with tiseel. The amniotic membrane stays in for one to three weeks, but most of the tissue dissolves.

The surgery takes 15 minutes.

Complications of this procedure include: tissue infection, microbial infection, and surgical complications.

The amniotic membrane is harvested from the placenta that is retrieved from c-section patients. The woman is screened for any diseases prior to the retrieval. Harvesting the placenta is done by the eye bank. Sixty pieces of amniotic membrane are obtained from each placenta, which is harvested twice per year. Once harvested, the tissue is stored at -70 degrees C, and costs between $600 -$1200 US.

The Manitoba Tissue Bank (eye bank) was the first, in Canada, to harvest the amniotic membrane, and Saskatchewan, the second.

Jennifer Dutka
12 April 2o12

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STANDING TALL

I attended the ORNAC Conference in Regina from May 8-13th,2011. Although there were many great topics discussed the one that stood out the most for me was the session "Standing Tall" presented by Dr Wayne Halliwell.

Dr Halliwell was a professional hockey player in Switzerland and a hockey coach before pursuing a PHD. He worked with many amateur and professional athletes including a few Olympic Medalists. The link between Standing Tall and OR nurses stems from our Canadian Athlete Joannie Rochette and her Olympic performance at the 2010 Olympics. As OR Nurses we need to Stand Tall and make our voices heard as we are the patient's advocate when they are the most vulnerable. He feels an OR Nurse has a privilege and a great opportunity to be part of the patient's experience when they are about to have an operation and make a difference in their lives. We are there to help them feel safe, comfortable, focused and connected. A patient needs mental preparation to get through an operation just like an athlete does just before their performance and we are there to help them through it.

He went on to talk about an OR TEAM. Everyone has a role with an important contribution. He related the team like spokes on a wheel. They all have to be sturdy in order to function well as a team and work together to be effective. There is no letter I in the word TEAM. It's an array of spokes all working together. As a TEAM we all need to contribute to make a difference. He had some powerful terms he used.

"The deepest principle to human motivation is craving to be appreciated."



"Make the Unnoticed, NOTICED."

Three powerful motivators are: Recognition, Appreciation and Gratitude

So as OR Nurses let's "STAND TALL" and strive for excellence and do the best we can to make a difference in our patient's lives. I know we are faced with the challenges of nurse shortages and are challenged with priority setting on a daily basis. We must remember we are professionals and must continue to strive for excellence in the work place. We are the patients advocate when they are the most vulnerable. Let's be proud of our profession and "Stand Tall", strive to be appreciated and realize we are definitely in very great need.

Submitted by: **Louan Gladish R.N.**
St Boniface General Hospital



The Pressure is on!

Perspectives on the Care of a Patient with a Pheochromocytoma

As the CRN of General Surgery at St Boniface we perform approximately 15-20 Laparoscopic Adrenalectomies annually. Most of these are not for a Pheochromocytoma. When we do have one scheduled the OR is definitely on high alert for any difficulty whether surgically or anesthetically. I was interested to hear this talk as it also included the patient's perspective, Marcy herself. Marcy's journey from diagnosis to surgery was a long and difficult one as they tried to find the medications that would control her blood pressure and optimize her for a safe surgical excision of her "Pheo". As Marcy was a colleague, with a right adrenal " pheo", I am sure the tension in that operating room was intense! Following is a review of the adrenal gland and what a pheo is.

The adrenal gland is the triangular shaped gland located retroperitoneal and immediately anterior to the kidneys at the level of the 12th thoracic vertebra. Usually buried in an island of fat, their yellow coloring can be attributed to their high cholesterol content. Their primary responsibility is regulating the stress response through synthesis of corticosteroids and catecholamine including cortisol and adrenalin.

There are three arteries that supply each adrenal gland: the superior suprarenal artery, the middle suprarenal artery and the inferior suprarenal artery .Venous drainage is achieved via the suprarenal veins. The right suprarenal vein is short and drains directly into the inferior vena cava while the left suprarenal vein drains into the left renal vein. The adrenal glands and the thyroid gland are the organs that have the greatest blood supply per gram of tissue!

Pheochromocytomas are rare tumors of the catecholamine producing cells of the adrenal medulla. They occur in 2-8 people/million with most occurring during the 4th and 5th decades of life ,with equal gender distribution. Pheos are often referred to as the 10% tumor:10 % have a family member with the same type of tumor, 10% will recur in 5-10 years, 10% of the patients have the rare Multiple Endocrine Neoplasia (MEN) syndrome and 10% will present after a stroke.

As the symptoms are numerous ranging from palpitations, nausea/vomiting, headaches, chest pain, fatigue, flushing, to weight loss, any person with difficult to control Blood pressure and requires more than 4 Antihypertensives or have onset of hypertension before age 35 or after age 60 should be examined for a pheochromocytoma.

The "classic triad" consists of headache, palpitations and diaphoresis. Symptoms are often episodic and occur suddenly, usually lasting no longer that 15 minutes but increase in severity and frequency as time progresses. The single best test for screening and diagnosing of a "pheo" is a 24 hour urine to measure catecholamine, metanephrines and vanillymandelic acid. Once diagnosed the tumor should be localized and the extent of the disease identified on CT or MRI .The patients require a pre op visit to PAC so that they can be optimized and then a surgery date can be determined.

These patients will be admitted prior to surgery and have a group and match , large IV, Art line, foley catheter and SCD's. Most patients do not require a PCA or epidural for post op pain management. Until the tumor is removed from its blood supply, manipulation of the tumor is minimalized and all are on alert for any hypertensive episodes. Once surgery is completed the patient is transferred to a step down bed overnight with the average hospital stay being 48 to 72 hours .

I would like to thank MORNA for the funding to attend ORNAC.

Nancy Lackey

Sterilization and Infection Control: A Systems Approach

Charles A. Hughes

Submitted by Sandra Schultz

One of the most interesting sessions I attended at the 2011 ORNAC National Conference in Regina was Sterilization and Infection Control: A System Approach, presented by Charles (Chuck) A. Hughes. Chuck Hughes is the General Manager and lead educator for SPS Medical, which is the largest sterilization- testing laboratory in North America. He has worked for over 25 years in the manufacturing industry in areas of regulatory affairs, research & development marketing, microbiology and sterilization training. He has extensive lecturing experience to medical manufacture and health care facilities around the world.

Chuck explained how sterilization requires a systems approach involving the Operating Room (OR) personal, medical device reprocessing (MDR) department and infection control using ORNAC and Canadian Standard Association (CSA) standards. He discussed CSA standards where:

1) "shall" is used to express a requirement- the user is obligated to satisfy.
2) "should" is used to express a recommendation- advised but not required.
3) "may" is used to express an option or that which is permissible within the limits of the standard.
4) "can" is used to express possibility or capability.

Standards are important and need adherence to as they reflect the values of that profession. In the OR, adherence to sterilization standards is critical to ensure patient safety.

He discussed the statistics of Healthcare Acquired Infections (HAIs) in the USA and Canada with people dying the increase of healthcare costs due to HAIs. While the delivery of non-sterile instruments is not a leading cause of surgical site infections it has been documented as one of the causes. As healthcare professionals, we must do everything to reduce HAIs which means compliance with best practices not some of the time, not most of the time, but all of the time.

Sterilization is a patient safety issue and requires a "systems approach" as OR nurses we must prepare soiled items properly for decontamination. The MDR department needs to:

- Clean and disinfect soiled items in decontamination area
- Inspect and assemble items in prep and pack area.
- Process items in Sterilization area.
- Maintain sterility of items in Sterilization Storage area.
- Distribute items **STERILE**, **ON TIME** & **COMPLETE.**
-

Infection control is responsible to audit surgery- MDR for compliance with standards.
He discussed CAS Standards of which some are:

Point of Use

- immediately after use, the user **shall** clean medical devices of gross soil if present. The device **should** be kept moist in a transport container by adding a towel moistened with water (not saline) or a foam spray or geel product specifically intended for this use.
- Disposable sharps such as needles and blades **shall** be removed and disposed of by the user.
- Delicate devices **shall** be segregated to prevent damage.

Transport-

- Reusable human waste containers and suction containers **shall** be emptied and rinsed before transport.
- Contaminated items **shall** be transported in covered fully enclosed containers that are designed to prevent spills of liquids.
- Retrieval and transport of contaminated items **shall** be scheduled so that decontamination procedures can be initiated immediately after use. All carts containing contaminated items **shall** be identified.

Decontamination

- Devices with lumens shall be checked during cleaning to ensure they are unobstructed and do not leak.
- Reusable cleaning accessories shall be decontaminated, dried, and stored in a clean, dry location between uses.
- The device manufacture's cleaning instructions shall be followed, including detergent types, water temperature and cleaning methods.
-

There are many other CSA Standards involving drying and inspection, packaging, sterilizer loading, steam sterilization, sterilization unloading, sterilization storage, sterilization assurance and implants.

The MDR department plays an important role in following all the CSA Standards to ensure that our instruments are sterile, come on time and are complete. We must remember that behind every instrument is a patient. A non-sterile instrument in surgery is like a loaded gun. To reduce HAIs we can be compliant with best practices some or most of the time but to truly reach the goal of eliminating HAIs each and every one of us must be compliant with best practices all of the time. We in the OR need to do our part to ensure patient safety and follow best practices all of the time.









I had the opportunity to attend the ORNAC National Conference "Elevating the Field of Perioperative Nursing" held May, 2011 in Regina, Saskatchewan . I would like to thank MORNA for providing me with their continued support. It was a great week of networking with many Perioperative nurses to renew existing friendships and make new ones.

The MORNA Spring Workshop was held Saturday, March 17, 2012. This was another day of educational sessions and exchanging of information. The theme for the workshop was "Keeping It Green in the OR." This is a hot topic as we all share in the same focus of "what can we do in the OR to reduce, reuse and recycle." This environmental issue is present in every OR, everywhere in one form or another. The green decorations highlighted the theme for the day. One of the articles provided at the workshop featured the importance of greening up the OR.

The article I have chosen to review is entitled *Going green in the OR brings financial, environmental gains*, and was published in the OR Manager, Vol. 27 No. 6, June 2011. While the article has a decidedly American slant, there are many interesting and useful suggestions that can be applied here in Canada. It can be as simple as reducing the amount of waste generated in the OR, using reusable supplies and equipment instead of using single use items, reducing energy consumption, and reducing the amount of waste designated for bio-hazardous disposal by separating regular waste from bio-hazardous waste.

The first item that attracts your attention is that Practice Greenhealth, a non profit organization dedicated to environmental sustainability, estimates that the OR generates a whopping 20% to 30% of a hospital's total waste. Furthermore, its panel of experts identified five practical strategies that an OR could use to reduce, reuse, and recycle, including OR waste reduction and segregation, reprocessing of single-use medical devices, environmentally preferable purchasing, energy consumption management, and pharmaceutical waste management. While all of these areas would certainly contribute to an OR becoming green, some of these initiatives are much more suited to Canadian OR's and as such, would be easier to achieve than others.

Reducing waste can be achieved in the areas of regulated medical waste (biohazards or infectious medical wastes), supplies not used, and energy consumption. Separating regulated medical waste (RMW) from regular waste would go a long way. According to the authors of *Green surgical practices for health care*, as much as 90% of waste designated as RMW doesn't belong there. For example, Foley bags and catheters, ventilator tubing, as well as masks, dressing, suction tubes and IV bags are typically not considered bio-hazardous unless they are caked with blood or body fluids, but they often end up as RMW. All of this ends up as unnecessary and expensive incineration of common waste. The authors suggest that OR staff could use a clear trash bag to divert solid waste during surgical setup and close it before surgery starts. Typically anything opened before surgery isn't infectious and can often be recycled or disposed of as solid waste. Regardless of your approach, training should be undertaken and signage used to clearly indicate which materials are indeed designated as RMW, and staff should be made aware of how they are doing at waste segregation.

Another way for management to reduce waste is to keep a close eye on supplies. It can sometimes be as simple as removing an unneeded small item such as a cup or extra clips, or removing light handles from laparoscopy packs. Unused items create unnecessary waste or increased energy costs for reprocessing unused medical equipment.

Management and staff can work together to reduce energy consumption in the OR. Besides the above mentioned energy savings from not having to reprocess unused equipment, it can be as simple as shutting off the lights or reducing the frequency of air exchanges at night when OR's are unoccupied. If the OR is required, the air exchanges could be manually bumped back up to what would be required for

an occupied room.

Reusing items such as surgical gowns, drapes, and table covers can significantly reduce waste. This of course would have to be weighed against the costs of buying and cleaning reusable items versus the costs of buying and disposing of single use items. A possible existing factor may be to: re-sterilize and re-use some items such as sharps containers, once the needles have been disposed.

Reprocessing single use items may result in savings of up to 50%, but the practice comes with controversy. Most manufacturers claim that the sterility and safety of reprocessed single use items by a third party cannot be assured. As well, most manufacturers will not spend the money to prove that a single use item could be safely reprocessed; after all, they are selling a single use item or instrument. Any cost savings must be carefully weighed against the safety and well being of the staff and patients.

Opportunities to save on waste exist due to recycling. Replacing the blue wrap that is used to cover and store sterilized instrument trays might be accomplished with the use of rigid metal containers, although this would not be realized till the cost of the trays was recovered, typically in 3 to 4 years. Potential savings would come in the form of the cost of the blue wrap itself, costs from reprocessing damaged packs, and waste reduction. Besides the blue wrap, medical plastics are well suited for recycling, and the cost savings from not disposing of them in the landfill is justification enough to send them to be recycled. As well, clean, unused medical supplies might be given to the medical school for training purposes, or to staff going on missions in developing countries. Staff can participate by bringing their own plates and cups to work, instead of using disposable ones.

Hospitals of any size can go green. Having staff "buy into" green practices is imperative to success. Most staff can become enthusiastic as they realize that their green efforts at work are already mirrored by what they do at home. One manager summed it up as follows. "Once people understand that it saves money and its' the right thing to do, it's hard not to get support. You're helping the environment, helping the patient, and saving money". It is a great win-win situation. Green practices should become an integral part of our OR culture. A commitment to "going green "can begin with the grassroots.

Respectfully Submitted,
Karen Warcimaga RN CPN(C)







I am writing to thank MORNA for the funding I received to attend the 22nd National ORNAC Conference held in Regina May 8- 13, 2011.

The opening Val Shirreff Memorial Lecture left me with much food for thought. Steven Lewis challenged us to look at a model of care delivery that allows all members of the health care field to function at the full extent of their training. His model better utilizes all parties involved.... for example having access to care established through more clinics which employ Nurse Practitioners. This model frees up Family Medicine Physicians to concentrate on those who are unwell and require further investigation rather than the healthy. This model may show that we in fact do not need more MD's in many areas in Canada but instead need to allow Nurse Practitioners to fully utilize their training and abilities.

This topic was explored in a different way by a presentation made by two nurses who work in Halifax, Nova Scotia. One was an LPN and the other an RN. LPN's have been successfully employed in Nova Scotia in the scrub role for sometime and they are exploring the circulating role. The difference in these roles revolves around the critical thinking expected of the RN to make changes in the patient's nursing care plan versus the LPN's mandate to report things to the RN that require a re-examination of the nursing care plan.

As an RN who came to the OR with many years of bedside nursing, I have worked with many LPN's. While their role is different there are many fine nurses who work in this capacity. I know that many of them could do very well in the scrub role or second circulator role. This means that the first circulator would be responsible for making nursing care decisions, making changes to preference cards, bringing concerns to the surgeons or anaesthesiologists that necessitate a change in usual procedures, etc.

Some sides of OR nursing have been somewhat disappointing to me. The major one is that OR nurses are not really encouraged to use their critical thinking skills at times. One example of this is limiting the people who have access to procedure preference cards. I understand the issue is that having too many people with access increases the number of errors or damage that can be done to the system. While I understand this I don't agree because we are professionals- this means that if we make changes that are not in the best interest of the team or (heaven forbid) are malicious we are liable to be disciplined or in the worst case, prosecuted for them. While it creates more work for someone to undo something that's done wrong with practice it becomes easier to do things without mistakes. I think by limiting the use of these skills you lessen the ability to use them, this includes critical thinking. I have heard on more than one occasion, “What's the use of saying anything, I'll just get shot down.”

Another disappointment is how some nurses expect someone else to know and enforce the standards of Perioperative nursing care. As professional nurses it is not someone else's responsibility to find out and report,m then use or not use according to our discretion. The standards are based on soundly researched data. We, as professionals are expected to uphold and work within those standards. The public has a right to expect this of us. Deviations should be documented and brought to the attention of management so that where the standard is impossible to apply we are making this clear.

I also had a brief conversation with a young ORT from Newfoundland who reluctantly

revealed her OR role to me on the bus to one of the many great social events. She told me she is considering doing her BN and I encouraged her to do so to the best of my ability, if only because of the many areas of practice this would open for her. She was already taking university courses to explore other career options.

Unfortunately I had to cut my conference stay short due to a family health issue, but I did enjoy the t three days I spent there. I relish the ability to network with other nurses from across Canada, although I'm now in Endoscopy the industry reps had plenty of material that can be utilized in that area. I also had an interesting conversation with one of the industry reps, Chuck Hughes, who did a presentation on sterilization. The limited time he had at this event really didn't do justice to his presentation. The power point of his presentation is on the ORNAC website but if you ever have the opportunity to attend one of his presentations I for one would



highly recommend it.

Http://www.ornac.ca/conference/presentations/Chuck_Hughes_Sterilization_and_IC.pdf

Thank you

Glenda Osnach RN, CPN (C)Joan Porteous wrote an

Congradulations to **Joan Porteous** who wrote an article which is submitted in the Journal about their "**HSC Mock Fire Evacuation"**, which was carried out this year. **Fire safety officer- Cindy Harrison** also wrote an article, which was written " **Evaluating the OR Through the Eyes of a Fire Safety Officer**. There was much to learn from this Mock Fire Evacuation and many things learned. We all benefit from these drills, and evaluations.

The winner of a brand new iPod 8G fourth generation was **Nancy Lackey**, from **St-Boniface General Hospital**! The draw had been completed as planned in the offices of **NOVATECH MEDICAL** on May 25th, 2011. Thanks for attending the ORNAC Conference in Regina.



Operation Walk Manitoba

Operation walk was founded in 1995 by Dr. Lawrence Dorr of Los Angeles, California. It is a private not for profit volunteer medical service organization. Operation Walk provides free surgical treatment for patients with disabling arthritis or other debilitating bone and joint conditions in developing countries. As well, Operation Walk seeks to provide education to in country surgeons, nurses and therapists on the most advanced treatments and surgical techniques for hip and knee joint disease. Operation Walk has several teams throughout the United States, and one team in Canada in London, Ontario.

Operation Walk Winnipeg is an organization dedicated to providing hip and knee replacement surgery for patients in developing countries who suffer from disabling bone and joint disease. While in the country of mission, the Operation Walk team improves health care by teaching and sharing knowledge with local health care providers.

History of Operation Walk

Operation Walk was founded in Los Angeles by Dr. Lawrence Dorr. He conducted the first Operation walk mission in Havana Cuba in 1995.

In 2009, surgeons and nurses from Winnipeg joined the Operation Walk team from London for a mission in Guatemala. They saw first hand the difference a total joint replacement made in the lives of people in Guatemala. This mission motivated the nurses and surgeons in Winnipeg to form team of their own and become the newest member of the Operation Walk.

Operation Walk Manitoba Mission Statement

To travel to Nicaragua and complete total joint replacement surgeries on patients who are severely disabled as a result of arthritis.

Operation Walk Needs Your Support

There are different ways you can donate. Every donation large or small goes directly to improving someone's quality of life by restoring mobility.

What we can do with your gift:

$20 will pay for crutches or walkers

$50 will pay for vitamins and supplements for 1 patient

$100 will pay for post operative pain meds for 1 patient

$250 will pay for antibiotics for 1 patient

$500 will pay for 2% of the cost to ship freight and supplies to Nicaragua

$1000 will pay for I.V. fluids for 20 patients

Support Operation Walk

Operation walk will also accept new or gently used assistive devices including walkers, crutches and canes. Donations will be accepted at the Concordia Hip and Knee Institute surgeons' office. Assistive Devices may also be dropped off to Sharon Irwin on the second floor of Concordia Hospital.

How to Donate

Operation Walk Winnipeg is a charity registered under the Concordia Foundation. A tax receipt will be provided for all monetary donations. Please fill out the following and include in the attached envelope with your payment addressed to the Concordia Foundation (Please print"Opwalk" in memo line).

First Name: _____

Last Name: _____

Address: _____

Postal Code: _____

Phone: _____

Email: _____



Operation Walk, Winnipeg

Changing lives in Nicaragua one step at a time.

In 2008, Alison Bartel, an OR nurse from Concordia Hospital heard a presentation by the London group at a conference she was attending. She began to wonder if the team from Winnipeg would be able to participate in Operation Walk. A few phone calls later, and an invitation came from Dr. Bourne of the London Operation Walk team.

In 2009, a surgical team consisting of four nurses and 2 surgeons from Concordia Hospital had an opportunity to join the London Ontario group on their mission to Antigua, Guatemala. Alison Bartel, Shelley Thiessen and Karen Watchorn are all operating room nurses from Concordia Hospital, and Sharon Irwin is a nurse from the ward at Concordia. On this mission, 68 life changing joint replacement surgeries were performed, in 3 and a half surgical days. It was exhausting work, but incredibly rewarding.

Following that trip, the Winnipeg group was hoping to join London the following year to return to Antigua. Instead, they were contacted by the parent group in Los Angeles, to see if Winnipeg would be interested in forming the second Canadian Operation Walk team. After some discussion, and much trepidation, Operation Walk Winnipeg was born.

The first mission for this team will happen in October 2012, to Managua Nicaragua at the Roberto Calderon Hospital. Approximately 55 medical professionals from Winnipeg will be donating their time to perform approximately 60 joint replacements for people in need. This group includes operating room nurses, ward, recovery and pre-op nurses, surgeons, anesthetists, physiotherapists and internal medicine doctors, and will spend approximately one week in Nicaragua.

Surgeries take place at the beginning of the week, with time to ensure that patients are well on their way to recovery, and started on their phyiotherapy before the team leaves for home. Medical professionals in Nicaragua will be educated on the long term care of these patients.

Currently, Operation Walk Winnipeg is actively involved in gathering supplies for the October mission. As well, an enormous amount of fundraising is required to cover the costs of shipping the supplies, as well as patient costs in Nicaragua. The team has held bake sales, a bud spud and steak, and various raffles. A wine tasting event is planned for May 30, as well as a benefit concert in the fall. For information on any of Operation Walk Winnipeg events, or for information on how to make a donation, please contact the team at opwalkwpg@gmail.com. Donations are being accepted online at the Concordia Foundation website – just follow the link to donate and select Operation Walk from the drop down menu.









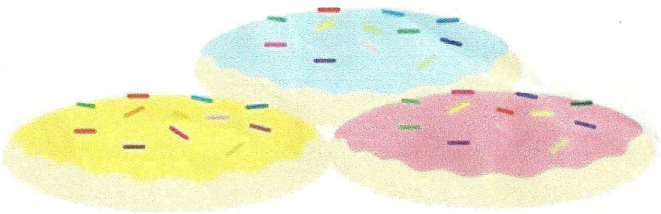
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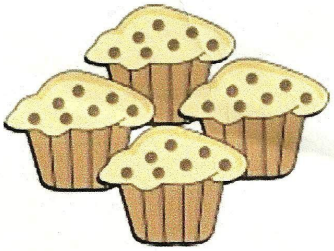
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Hello everyone,

I am looking forward to doing the best that I can as your new president. It is starting to come together. I feel a part of ORNAC more than ever after attending my first board meeting. It was very nice meeting new people and talking to them about their experiences and struggles in the different workplaces.You really get a sense that everywhere in Canada ,we all care deeply about our patients and each other.All members are genuinely concerned with other hospitals and types of programs.We have in common that we all work with policies ,budgets,different personalities,equipment issues, and more.

The standards committee that Leah is part of takes great care in phrasing and wording to be strong and usable for different centers.It is used as a framework for practice but also as a reference in disputes and questions of standards.They work very hard.

In the new year we will have to set up our website .I am hoping it is not too hard!! And until we do ,there will not be any updates on the ORNAC website for Manitoba.

I would really encourage all of our membership to consider being president elect.We could learn together and the sooner you hop on the more time you will have to learn.It really is a worthwhile endeavor.It is an evolving organization and many changes are coming,so everyone will be learning.

I joined the awards committee and in my brief exposure,I found out that many awards available are not applied for so look into it for further education or research projects.I'm sure they are many times funding would come in handy.

I would like to thank Leah for being very helpful and kind. She helped me a lot right down to helping me get logged on with my daughter's net book! She made me look less helpless with the technology.Leah has done a wonderful job for us as president.She has done it for 3 years and it will seem strange that she will not be chairing the meetings but I am very glad she will still be there to lean on'

Anyway that is enough from me I hope everyone has a great summer.

Enjoy your work and off time

Monica Palmquist

Incoming President

I would like to thank all the Executive Members for their continued energy and support this past year. To our Hospital Reps., a big Thankyou for forwarding all the information to our members at each site. To our Rural members, who have joined us this year, and to those Rural Reps., who continue to forward information to members at each site... We have had many exciting events occur. Our biggest one was the TeleHealth connection setup to our four rural sites, Brandon, Boundry Trails, Dauphin, and The Pas. It has been an awesome experience, having all of you a part of our meeting, sharing your updates and technology, and keeping updated with everyone else's. A very big Thankyou goes out to Kristin Hall (Grace) and Jade Chambers (Seven Oaks), ALWAYS present to set up the Telehealth. Also we have established & set up electronic mail, so look forwards to correspondence-- Gauzettee via the internet. Please keep all emails current with MORNA

Our Spring Workshop was a big event this year, as so many rural members were in attendance, and many enjoyed the door prizes. We hope to see everyone out to the September Wine & Cheese, our first meeting in the Fall.

Your Secretary,

Iris MacMillan

Once again the presenters during this 22nd National ORNAC Conference held in Regina SK., shared a wide variety of educational sessions, which truly elevated the field of Perioperative Nursing for all those delegates who attended.

A big Thank you, to Morna for giving me this opportunity to attend the Regina National Conference where together with colleagues and friends, we were impressed daily by the wide variety of speakers, their knowledge, expertise and passion felt during their presentations. There were shared memories of events, which we were eager to bring home with us, only to share with colleagues and peers- of new technology, innovative products on display from our many industry reps., who continue to promote and provide new and improved safe technology, through research and education, which only encourages a safer surgical experience and outcome for our patients and preoperative team.

The week proved to be exhilarating from dawn to dusk, and into the wee hours of the morning, as many delegates were up at the crack of a Saskatchewan dawn, to attend daily pre-conference workshops/educational breakfasts, then continue the day with the daily various educational sessions, poster presentations, exhibit venues, the tasty and hot lunches where conversations were shared with new friendships form coast to coast. Each evening proved to be an new adventure- where delegates were encouraged to go back in time with a fun filled Western night of cowboys & cowgirls costumes, western hats, line dancing, fiddle playing, and the talent of a World Champian Australian whip-cracker. You could be creative and transform into your favourite movie star or dress your group up as your favourite fairy tale caricature, during a "Night at the Movies" and be entertained by the "Laryngospasms" musical group. A "Little Taste of Saskatchewan" would be a memory of some of the best tasting food in Saskatchewan- followed by a great dance party with "Rory Allen- Tribute to the King". Yes I am sure that many of us crawled into bed each night with sore feet, worn soles, and energy to get up and take on the day, when the alarm went off, a few hours later. Just thinking about that week of events, both day and evening, puts a smile on my face, as it went by so fast, friendships were established and old one reinforced, as conversation was promoted at every corner of the convention.

One of the numerous educational sessions that I attended was with Warrant Officer Mike Hurtubise, Canada's Air Force Search & Rescue Technician (CFSAR), who is part of a group of highly trained specialists who provide on the scene medical aid & extraction from some of Canada's harshest & remote areas including the Arctic, mountains, glaciers, & forests, to the open ocean. He is currently (since July 2010) posted at the Canadian Forces School of Survival & Aeromedical Training located in Manitoba as the D/SERE (Survive, Evade, Resist, & Escape) Flight Commander.

Mike shared many experiences & stories of search and rescue missions and the concerns of safety with each event. These individuals are advanced trauma life support para rescue specialists trained in military free fall, diving, mountaineering, rappelling, wilderness survival in extreme conditions, hoist rescue operations and various other rescue- related tasks, ie, securing landing zones/drop zones, or leading mountain rescue operations in coordination with civilian agencies and volunteer organizations. After a 2 week selection period, these SAR Techs undergo 11 months initial training in British Columbia. SAR Techs generally work in teams of two and operate under all Canadian climatic (high altitude & arctic) and terrain (land, sea and air) conditions. At any time they could be 200 miles out in sea, rescuing an overturned sailboat casualty, parachuting at night into the high arctic to save a stranded Inuit, rescuing a fisherman from an overturned fishing boat, or on the edge of a glacial crevasse- clinging precariously close to the edge, or coordinating a mountain rescue of a fallen climber or skier.

They are provided with state of the art clothing, equipment and top-notch training to carry out their tasks. Their bright orange suits make them easily identified on the field, during a rescue.

I really enjoyed this session as my youngest son has plans to enter into this field of work, so it was great to get first hand stories and information on the training and safety issues.

Thanks once again,
Iris MacMillan