

## *President's Message*

Wow, where did the Manitoba Operating Room Nurses Association (MORNA) 2008-2009 season go since the Wine and Cheese mixer in September?

Six Business and Educational sessions were hosted by the various hospitals, the Educational sessions provided new and interesting information. This helps perioperative nurses' practice to remain current with practice changes and techniques.

The March Workshop was another excellent educational opportunity and was a great success. There were over 90 registrants and booths

The ORNAC National Conference is in St John's Newfoundland in June. What a great opportunity to gain new knowledge, share knowledge.

Donna Fallis

MORNA President

### 2008-2009 EXECUTIVE

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## **CONFERENCES - INTERNATIONAL AND CANADIAN**

### **DATES INTERNATIONAL**

2009 June 27-July 4 (date change) ICN 24<sup>th</sup> Quadrennial Congress, Leading Change, Building Healthier Nations, Durban, South Africa [ICN 24TH QUADRENNIAL CONGRESS](#)

2009 Sept 30 – Oct 3 “Aim High” OR Excellence Where leaders Meet, Learn and Grow Together: San Francisco Hilton; San Francisco, CA, USA; sponsored by Outpatient Surgery Magazine [www.orexcellence.com](http://www.orexcellence.com)

2009 Oct 12 – 15, AfPP – Association for Perioperative Practice, Harrogate, UK AfPP 45<sup>th</sup> Annual Congress. [www.afpp.org.uk](http://www.afpp.org.uk)

### **DATES CANADIAN**

2009 May 23-24 NAPANc 8<sup>th</sup> Annual Conference, (Nat'l Ass'n of periAnesthesia Nurses Canada), “Canadian Heroes in Health Care”; Toronto, ON [napanc.org](http://napanc.org)

2009 June 7 – 12 St. John's NF for 21<sup>st</sup> ORNAC National Conference “The Depth of Perioperative Nursing...What Lies Beneath” [ORNAC conference link](#)

2009 June 26 to June 30; Canadian Anesthesia Society Annual Meeting, [www.cas.ca](http://www.cas.ca)

2009 Sept 24 – 9, Urological Excellence Conference, Westin Hotel, Edmonton, AB [mandy@pivotalevents.ca](mailto:mandy@pivotalevents.ca)

2009 July 11-16; 14<sup>th</sup> International Congress on Circumpolar Health, Yellowknife, NWT [icch2009.com](http://icch2009.com)

2009 Oct 5 & 6 Transformational Leadership “Building a Culture of Safety in Healthcare.” Renaissance Hotel, Toronto, ON [www.hiroc.com](http://www.hiroc.com)

### **DATES WINNIPEG**

2009 June 15, & Oct 5 “Life Support for Nurses”, Your Life Unlimited with Stephanie Staples, Studios in the Exchange, Winnipeg MB [www.yourlifeunlimited.ca](http://www.yourlifeunlimited.ca)

2009 June 19 CHICA Manitoba, Infection Prevention & Control, Conference 2009, Victoria Inn, Wellington Ave, Winnipeg, [kmaxwell@sogh.mb.ca](mailto:kmaxwell@sogh.mb.ca) for more information.

2009 Nov 21-23 SIGNEA (Society of International Gastroenterological Nurses & Associates), London, UK  
2010 Mar 14 – 18, 57<sup>th</sup> AORN Congress, Denver, Colorado, USA

2011 Mar 20 -24, 58<sup>th</sup> AORN Congress, Philadelphia, PA  
2012 Mar 25-29, 59<sup>th</sup> AORN Congress, New Orleans, LA  
2013 Mar 13-17, 60<sup>th</sup> AORN Congress, San Diego, CA  
AORN also has many workshops available throughout the year. [www.aorn.org](http://www.aorn.org)

2009 Oct 21 – 24, 27<sup>th</sup> Annual ORNAA(OR Nurses Ass'n of Alta)Conference, “Surgical Technologies Ongoing Practices”, Red Deer, AB [conference@ornaa.org](mailto:conference@ornaa.org)

2010 Apr 25 – 28, 11<sup>th</sup> ORNAO (OR Nurses Ass'n Ont) Biennial Conference, Niagara Falls, Ontario [conference.ornao.org](http://conference.ornao.org)

2010 May 16 – 19, 33<sup>rd</sup> Annual National Conference of the CONA (Canadian Orthopedic Nurses Association), Halifax, NS “Set Sail for the Next Decade in Orthopedics.” [www.cona-nurse.org](http://www.cona-nurse.org)

2011 May 8 – 13, 22<sup>nd</sup> ORNAC National Conference, Regina, SK

2013 May 5 – 10, 23<sup>rd</sup> ORNAC National Conference, Edmonton, AB

2009, Oct 15 – 17; AWHONN Canada (Ass'n of Women's Health, Obstetric, & Neonatal Nurses) 20<sup>th</sup> National Conference, The Fairmont Hotel, Winnipeg, MB “Open Skies, Open Minds, Open Hearts” [www.awhonncanada.org](http://www.awhonncanada.org)



### **Sources of funding to attend**

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

### **Concordia Hospital**

Colleen Ungrin  
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Fax 661-7222

### **Grace Hospital**

Leanne Moyer  
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300 Booth Drive R3J 3M7  
Fax 837 0493

### **Health Sciences Centre**

#### **Adult**

Monique Palmquist  
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### **Children's Hospital**

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### **Women's Hospital**

Karen Gilchrist  
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### **Misericordia Hospital**

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### **Pan Am Clinic**

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## **Fast Solutions: Problem Solving/Creative Thinking Skills** **By: Dave Connell**

On March 14<sup>th</sup> at the MORNA workshop the presenter Dave Connell gave a very entertaining and thought provoking presentation on Problem Solving and Creative Thinking Skills. Dave provided easy techniques for all to utilize.

When faced with a difficult problem, take a piece of paper write the problem down in the form of a question and write down every solution that comes to mind. Don't stop until you have at least 20 solutions. Dave states the answer is usually by number 18-20.

Dave used this formula for problem solving:

$$P = S = C = O = A$$

**Problem = Situation = Challenge = Opportunity = Answer**

Take a blank piece of paper "what are all the causes of this situation?" Write it down. What is the challenge here? (Within the list of challenges lies the answer). What is the seed of opportunity hidden within this situation? Dave states "I look within the situation itself for the answer. If at first I don't succeed I get an army of one or more people." If at first I don't succeed I try, try again. This also works in a group/team of six to eight.

"If you think you can or you think you can't, your right!" Henry Formula

"Strive for excellence, not perfection. Take the time to smell the flowers once in awhile." Utilize laughter to keep things in perspective and to face difficulties with courage and hope.  
"Where there is laughter there is hope."



Submitted by:  
Lesia Yasinski R.N.B.N., M.S.A.

### **CPN (C) Certified Perioperative Nurse Canada**

Consider becoming certified as a perioperative nurse.

You must plan now to write in 2010.

To be eligible for certification you must have completed 3900 hours as a registered nurse in your speciality over 5 years.

Applications for the Initial Certification Exam will be accepted by CNA between September 1 and October 16, 2009.

If you are renewing your certification by continuous learning or exam applications are accepted between September 1 and November 20, 2009.

The exam takes place Saturday April 17, 2010.

Application guidelines, eligibility criteria, and other information are available on the web at the CNA website

<http://getcertified.cna-aiic.ca>



## **BUILDING A SAFER PERIOPERATIVE ENVIRONMENT**

Reported by Joan Porteous, Nursing Educator, HSC Adult OR

Today, we attended a videoconference presented by Dr. Bryce Taylor from Toronto General Hospital. Dr. Taylor is also a member of HIROC, and he spoke about the World Health Organization's Safe Surgery Saves Lives Project, and how a safe site surgery checklist was implemented in his hospital in Toronto. Dr. Taylor spoke about the important role of preoperative checklists and team building among surgeons, nurses and anesthetists, in order to reduce intraoperative failures in communication. He indicated that the checklist processes of briefing, time-out and de-briefing are an integral part of this strategy.

At Toronto General Hospital's OR every patient is seen prior to surgery and *everyone* is marked. This ensures that the surgeon sees each and every patient prior to surgery.

At the Toronto General Hospital, 500 cases were studied before the implementation of the surgical checklist. Following this phase, 500 cases which implemented a surgical checklist that was modified for that hospital were studied. The briefing process included information about such things as adverse events, blood loss, cardio-pulmonary instability, RTS, pneumonia, shock, dialysis and infections. Documentation confirmed that these briefing, time-out and debriefing phases occurred and who participated. The process took about 2 minutes.

As CEO, Dr. Taylor ensured everyone received education beforehand. He supported and endorsed the checklist process, although it was not mandated. He went into every theatre everyday for several weeks to promote the surgical checklist process. Dr. Taylor stressed the importance of feedback from the surgeon, anesthetist and nursing participants during the briefing, time out and debriefing. Feedback would include a statement such as "I agree" or "Yes". An Occurrence Report was generated if the checklist was not completed.

The global trial of the surgical checklist decreased surgical morbidity from 7-11%, and mortality from 0.8 to 1.5%.


Dr. Taylor indicated that the National Post reported that 23,000 patients died in Canadian hospitals in 2004 because of preventable adverse events. He stated that surgical checklists would be implemented more quickly if surgeons shared the same fate as their patients as do airline pilots.

In Canada we perform about 2,000,000 surgical procedures in one year. Dr. Taylor indicated that this would mean that 60,000 patients might be spared complications if surgical checklists were implemented.

Dr. Taylor outlined the 7-step Kotter model of change management that could be used to implement a surgical checklist:

1. Understand the issue
2. Enlist participants and develop champions
3. Investigate and customize the checklist to meet your site's needs
4. Motivate participants (senior management support)
5. Communicate and educate
6. Take action
7. Consolidate by reporting success, communicate, collect data and implement a culture change

He indicated that reporting "nice catches" including times when errors were caught and therefore avoided worked well. Check out the Canadian Patient Safety Institute website. A surgical checklist implementation guide will be added to the website soon.





## Hazards of Surgical Smoke and Aerosols in the OR Funding article submitted by Ricardo Manalang

### General Info:

- surgical smoke might be even more hazardous than cigarette and BBQ smoke, because it potentially contains not only carcinogenic chemicals, but also viruses and bacteria
- laser plume and electrosurgical smoke are similar in composition and effect

### Cause:

- electrosurgical units (ESUs)
  - o used in 85% of all surgical procedures
  - o use radio frequency currents to vapourize or coagulate tissue by focusing intense heat at the surgical site that vapourizes cell walls
- o heat destruction of the cell produces visible smoke during electrosurgery
- lasers – laser plume
  - o release aerosols (inhaled/absorbed) e.g. carcinogens, bacteria, viruses
  - o rapidly heat cells, causing cell rupture and vaporization
- small but significant quantities of toxic and carcinogenic chemicals are produced by laser irradiation of tissue or electrocautery
- smoke produced from tissue interaction via electrosurgical and laser devices creates a toxic aerosol
  - o aerosol contains particles, gases, mutagens, carcinogens, and DNA constituents
- most airborne particles are not effectively filtered or evacuated by present operating room equipment

### Health Effects:

- smoke is absorbed primarily by the respiratory tract
- smoke interacts by skin and mucous membrane contact
- respiratory problems
  - myalgia
- headaches
  - rhinitis
- nausea
  - conjunctivitis
- eye irritation
  - chronic asthma-like symptoms
- eye infections with contact lens wearers
- increased methemoglobin levels in patients undergoing laparoscopic electrosurgical procedures
- possible effects: lung cancer, bronchitis, emphysema, pneumonia, influenza
- in most Class 4 laser operations, airborne contaminants cause:
  - o lacrimation
  - o abdominal cramping
  - o vomiting
- exposure to smoke of any type may affect the immune system of the trachea and bronchi

### **LASER = Light Amplification by Stimulated Emission of Radiation**

in studies of CO<sub>2</sub> laser surgery:

- o CO<sub>2</sub> laser surgeons have an increased risk of acquiring nasopharyngeal warts through the inhalation of laser plume (likely that lesions were transmitted by plume since gloves were worn and masks are known not to seal to the face)

## Work Effects:

- complaints that laser plume impaired visualization of the target tissue
- noxious odour
- source of irritation to surgeon and surgical assistants
- respiratory illness among O.R. professionals could represent a significant cost in health care dollars, adding to a facility's and nation's overall costs for health care
  - o nonproductive sick time
  - o replacement for sick workers
  - o costs for medication and treatment
  - o potential increases in benefit costs

## Concerns/Dangers

- the production of smoke material in the closed space of the peritoneal cavity allows for absorption of toxic chemicals via the respiratory tract and peritoneal absorption
- generated smoke is the consequence of heat transfer by tissue absorption and interaction
  - o interaction yields a water vapour aerosol cloud, suspending and transporting the resultant chemicals and light solid fragments
  - o this smoke is toxic and dangerous
    - biological-fungal, bacteria, virus and cellular
    - chemical-allergens, respiratory irritants, mutagens and carcinogens
- Vapourization of tissue at high temperatures has been assumed to produce sterile smoke, but several investigations have recovered viral DNA from surgical smoke
- Exposure to chemical byproducts due to pyrolysis of protein and lipids:
  - o Benzene (trigger for leukemia)
  - o Carbon monoxide
  - o Formaldehyde
  - o Hydrogen
  - o Cyanide
  - o Methane
  - o Phenol
  - o Mutagens
  - o Carcinogens
  - o DNA components
- HBV transmitted oropharyngeally in individuals wearing surgical masks (aerosol route of exposure)
- **Common surgical power tools**
  - o Capable of generating inhalable blood-containing aerosols
  - o Have ability to infect human T-cell tissue cultures with HIV
  - o Likely to generate blood splatter from which satellite aerosol might emanate, therefore those at greatest risk of exposure = primary and assistant surgeons due to close proximity to operative site and activities during surgery
- **mammoplasty procedures**
  - o airborne smoke = mutagenic to TA98 strain
  - o exposure time to smoke is relatively short, and most visible smoke dissipates quickly as it rises from the operative field, however, all personnel in the O.R. are exposed to a measurable amount of smoke, therefore operating and assistant surgeons have the greatest risk of smoke exposure
- **laparoscopic procedures**
  - o researchers found that carbon monoxide was present in the abdomen five minutes after electrosurgery
  - o as smoke is produced inside the abdomen, patients experience an increase in the methemoglobin concentration, which reduces the oxygen carrying capacity of red blood cells; this presence could represent a threat to the patient and prolong postoperative recovery

- when ESUs or lasers are used in the peritoneal cavity, the components of surgical smoke are absorbed through the peritoneum into the patient's bloodstream, resulting in potentially deleterious effects
- on patients who underwent repetitive laser surgery:
  - developed peripheral obstructive airway disease, though they had no prior episodes of asthma or bronchitis
  - inflammatory cells in the bronchoalveolar lavage were dramatically increased 24 hours after smoke inhalation
  - may cause transient hypoxia, depression of lung defense mechanisms, and delayed airway inflammation

## **Protective Measures**

- many agencies are providing regulations and recommendations to minimize potential health effects of surgical smoke:
  - The National Institute for Occupational Safety and Health (NIOSH)
  - The Occupational Safety and Health Administration (OSHA)
  - The American National Standards Institute (ANSI)
  - The Association of Operating Room Nurses (AORN)
  - The American Conference of Governmental Industrial Hygienists (ACGIH)
- should either remove oxygen deficient atmosphere or harmful dust, fumes, mists, vapours, and gases at the source
- smoke production requires prompt evacuation
- removal of the inciting agent minimizes smoke production
- unlike ESU smoke, laser plume has been evacuated and filtered since laser use became popular

## **A. Surgical Masks**

- function: protect patients from infection with bacteria and viruses exhaled/expelled by O.R. workers in the form of airborne droplets
- problem: coughing, sneezing, and talking generate large aerosol particles; surgical masks are designed to trap these rather than the significantly smaller surgical aerosols, that could carry pathogens
  - filtration efficiency of mask varies
  - small particle size of smoke makes it difficult to filter with simple face masks
  - they are designed to keep in particles from workers in, but the moisture that gathers diminishes the effectiveness of the barrier
  - aerosol particles are smaller than the filter and are inhaled by the worker
  - the space between the mask and the worker's face allows particles to enter (surgical masks do not seal to the face)
- protection provided by surgical masks depends on both the filtration efficiency and the degree of perimeter leakage through open spaces between the mask's edge and the wearer's face
- different filtering methods are being tested; the most successful are the triple filter systems equipped with ultra low penetrating air (ULPA) filters
- masks must be fitted to the wearer, but leakage will still occur
- wearers must be trained in the correct use of this equipment
- additional means are necessary to protect surgical team members from inhaling surgical smoke

## **B. Smoke Evacuators**

- function: to remove/vacuum all odour and smoke released by lasers and ESUs, minimize the acute health effects and further reduce the potential for any chronic health effects, and eliminate emissions that can impair the surgeon's vision
  - o use a three-stage filtration process:
    - pre-filter: capture gross particulate
    - high efficiency filtration system: captures submicron particulate
    - charcoal: gas adsorption and odour removal
  - o Ultra Low Penetrating Air (ULPA) filters are used in many smoke evacuators because they are able to trap 0.12 µm particulate with an efficiency of 99.9999%
- problem: method of removal
  - o hand-held – must be used approximately 2 inches from laser spot to effectively vacuum smoke
  - o loud (even quietest models) – communication is essential in an O.R. setting
  - o wall suction devices do not have enough power to capture smoke plume
  - o the smoke plume evacuation system must be a hands-free operation
  - o the performance of the vacuum system is dependent upon the power setting chosen, the distance between the capture device, the source of the plume, and the diameter and length of the capture device and accompanying tubing
  - o these machines are perceived as bulky, requiring the scrub nurse to hold them near the source of the plume, which is impractical since the nurse is busy with other activities and the location where electro surgery is being used varies
- efficient smoke evacuation must be maintained close to the operative field in order to remove the vapour before it is inhaled by operating room personnel
- small carriage units attach to electrosurgery pencils and capture smoke close to the site of generation
- perioperative nurses should anticipate the amount of smoke that will be produced for the procedure and choose the system most appropriate for the procedure

### **References:**

Chih-Chieh Chen, PhD.; Kalaus Willeke PhD.; (Aug 1992) America Journal of Infection Control. "Aerosol Penetration through Surgical Masks." No.4 pp.177-184: St. Louis, 1992. The Association for Practitioners in Infection Control.

Lanfranchi, Joy Anne, Smoke Plume Evaluation in the OR. AORN Journal 1997:65:3:627-633

Heinsohn, Jewett Don L. Exposure to Blood-Containing Aerosols in the Operating Room: A Preliminary Study: Am. Ind. Hyg. Association Journal 54(8) 446-453 (1993).

Gatti, J.E., Bryant, C.J., Noone R.B. and Murphy J.B. Mutagenicity of Electrocautery Smoke Plastic and Reconstructive Surgery 1992; 89:5:781-786

Ott, Douglas; Smoke Production and Smoke Reduction in Endoscopic Surgery: Preliminary Report; Endoscopic Surgery and Allied Technologies. 1993:1:230-232

Ulmer, Brenda C.; Air Quality in the Operating Room; Surgical Services Management; March 1997:3:3:18-21

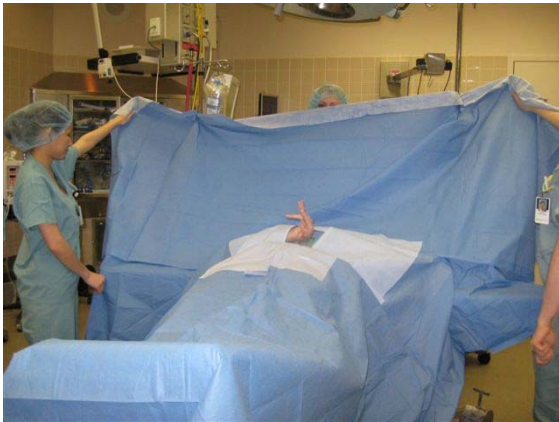
Surgical Smoke: What we know today; Hazard's of Surgical Smoke and Aerosols: Summary of Selected References valley Lab Inc. Pamphlet. 2000. Tyco Healthcare; Department A475970 Longbone Drive, Boulder ,Co 80301



# WRHA News Alert !

Did you know!

1. The WRHA Surgery Program in collaboration with Diagnostic Services Manitoba (DSM) has developed a new policy "Pathology Specimens – Acute Care Setting (Management of). New requisitions are now being used.
2. The Canadian Patient Safety Institute (CPSI) has adopted the WHO Safety Checklist. The checklist can be viewed at [www.patientsafetyinstitute.ca/initiatives/sssl.html](http://www.patientsafetyinstitute.ca/initiatives/sssl.html) Watch for more information coming soon related to implementation within WRHA.
3. The WRHA OR Educators in collaboration with Regional Infection Prevention and Control (IP&C) are working on standardized guidelines for Surgical Skin Preps. Watch for these guidelines and educational sessions in the near future.
4. In collaboration with IP&C types of disinfectants used for environmental cleaning in the OR/endoscopy is being reviewed.
5. CSA has released a standard Z305.13-09 "Plume scavenging in surgical, diagnostic, therapeutic, and aesthetic settings"
6. A Laser Safety Officer training session was held January 27, 2009. Thank you to Wanda Sawa and Taras Stecy for organizing this event.
7. Medical Device Reprocessing (MDR) update:
  - A Loaner Instrumentation Policy continues to be worked on with input from MDR, ORs, surgeons, vendors, and those responsible for finances.
  - CSA has released a revised standard Z314.3-09 "Effective sterilization in healthcare facilities by the steam process". This standard incorporates the previous Z314.3-01 "Effective sterilization in healthcare facilities by the steam process" and Z314.13-01 "Recommended standard practices for emergency (Flash) sterilization" into one standard.
  - A CSA Certification exam has been developed for MDR Technicians. Beta exams (trial of the exam) are currently taking place at various sites across Canada. Winnipeg hopes to be one of those sites.
  - The 2<sup>nd</sup> Annual MDR Workshop is being planned for June 29 and 30, 2009. There is no cost to participants. (See program information in this newsletter). To register contact Wendy Zikman [wzikman@wrha.mb.ca](mailto:wzikman@wrha.mb.ca) .
8. Perioperative Orientation sessions were held in September 2008, October 2008, January 2009, and March 2009. An additional session is scheduled to begin May 4, 2009. Additional sessions are tentatively being planned for September and November 2009 as well as January, March, and May 2010. Participants (calculated from May – September of each year) are as follows: 2006/2007 = 23; 2007/2008 = 25; 2008/2009 = 36 participants.



**Participants who have successfully completed the Orientation Sessions since the last newsletter include:**

- Anne Marie Brazau – CH
- Wesley Anderson - CH
- Rina DiGirolamo – GGH
- Tammy Pike – GGH
- Beverly Brown – GGH
- Karen Richards - GGH
- Rose Jimenez – SOGH
- Giselle Kornelsen – VGH
- Gail McGimpsy – VGH
- Shannon Hoogsteen – Child Health
- Jane Stone – Child Health
- Jennifer Schultz – Child Health
- Catherine Urbanik – Child Health
- Mary Dyck – Altona
- Lauren Silverside – Bethesda (Steinbach)
- Christine Turnbull – Boundary Trails
- Chrisie Friesen – Boundary Trails
- Audrey Klassen - Carmen
- Amelia Sommer-MacDonald – Portage Hospital

**Participants in the process of completing their clinical experience:**

- Kristen Hall – GGH
- Melissa Barroso – Women’s Health
- Bernadette MacKenzie – Child Health
- Sarah Kasala – Child Health
- Jennifer Hoepfner - HSC Adult
- Emily Ruth Laycock – HSC Adult
- Eugenia Mardli – Boundary Trails
- Charity McAuley – Boundary Trails
- Bev Clarkson – Portage Hospital

Preceptors (Alternate Preceptors) September 2008 – March 2009 without whom the Orientations would not be possible. Thank you!

<b>Seven Oaks</b>		
• Dale Mercer		• Glenda Osnach
<b>HSC Children's</b>		
• Karen Rodgers	• Terry Nicholson	• Tanya Fuksman
• Alison Desautel	• Eduardo Ronquillo	• Kim Fox
• Chris Cox	• Beatrice Zulak	•
<b>HSC Adult</b>		
• Jane Milner		• Kim Cellaire
<b>CONCORDIA</b>		
• Jackie Radtke	• Donna Fallis	• Karen Watchorn
• Lori Boyce	•	•
<b>VICTORIA</b>		
• Iris MacMillan	• Lorna Sinnaeve	• Cathy Schlosser
• Pat Cuddy	• Faye Hamlin	• Harold Passley
• Will Paget	•	•
<b>GRACE</b>		
• Leanne Moyer	• Patricia Dyck	• Leah McBride
• Chris McDougall	• Sharon Laggo	• Glen Brown
• Graciana Medeiros	•	•
<b>STEINBACH</b>		
• Iva Joslin(one month)	• Nicole Lafreniere	• Pearl Plett
<b>CARMEN</b>		
• Allen Peters		• Lal Froebe
<b>PORTAGE</b>		
• Winnie Walsh		• Heather Werbiski
<b>ALTONA</b>		
• June Schwartz		
<b>Boundary Trails</b>		
• Karen Hiebert	• Jennifer Sager	• Lottie Froese
• Karen Cowan	• Barb Derksen	• Carolyn Wiebe
• Johann Schaefer	• Karen Billing	•

Thank you to guest presenters:

<b>Presenter</b>	<b>Topic</b>
1. Jack Kress	• Anesthesia
2. Joan Porteous	• Forensics
3. Leah Restall	• Pregnant Patient
4. Cristy Pragides	• Children in Surgery
5. Dr Marie Edwards	• Ethics
6. Donna Fallis	• Orthopedics
7. Jackie Dutfield	• Malignant Hyperthermia
8. Wanda Sawa	• Endoscopy

## Mentoring in the Peri-Operative Setting

With today's nursing shortages, mentoring has become an important part of our daily jobs. Mentoring has long been recognized as an ideal approach to bridging the gap between theory and practise. With the W.R.H.A. Peri-Operative Nursing Orientation Course running four to six sessions per year, there is a critical need for mentors.

Mentoring is beneficial for both the mentor and the apprentice. The most obvious benefits to the student or new staff member are having someone to give them help, advice and to share knowledge with. The mentor helps to foster new skills and can be an important safety net during the development stage. The preceptor helps seek out learning opportunities and assists in familiarizing the student to equipment and procedures. The mentor can also clarify expectations as well as monitor progress. This is done on a daily basis as well as in the form of a written mid-term and final evaluation.

The mentoring process is also very valuable for the mentor. It is a chance to develop a relationship with a student or new staff member. You can become an integral part of their development. It gives the mentor a chance to share experiences and knowledge, as well as reflect upon one's own career. It can expand your own perspective by discovering new ways of thinking. Most importantly, is the satisfaction you gain from helping others.

There is a constant need for experienced nurses who are willing to mentor in the clinical setting. The peri-operative setting is highly specialized and unlike anything the new staff member or student has experienced. While some basic skills may be applied, most skills have not been taught in nursing school. For this reason, good preceptors are in high demand.

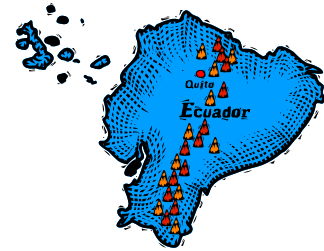
The peri-operative setting continually changes and throughout our careers, we find ourselves constantly teaching ourselves and our peers. Precepting is just one aspect of this education process. In the Canadian Code of Ethics, under the subheading 'Ethical Considerations in Relationship with Nursing Student Code G9,' it is stated, "Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other healthcare team members."

On a personal note, I have mentored two senior practicum nursing students and one new staff member. I have found all three experiences to be very rewarding. Each has brought their own experiences, hopes and expectations to the mentoring relationship. This contributes to my own development as both a leader and a mentor. John Owing Adams once said, "If your actions inspire other to dream more, do more and become more, you are a leader."

Submitted by Terry Nicholson  
Children's O.R.

## One Week in February

It was the end of January and I was anticipating my final week of vacation booked for February. I was dreaming of vacation at an all-inclusive resort, maybe Jamaica or Mayan Riviera; beaches, rum drinks, swimming, diving.... Then all my dreams were crushed when my husband told me he was too busy and would not be able to go anywhere, I was on my own. Realizing I did not want to stay at home and cook and clean and knowing I did not want to go to a resort on my own, I checked the calendar on the Medical Ministry International (MMI) web site, plugging in my dates.



Bingo!! The project to Cotacachi, Ecuador was leaving in 10 days and needed physicians, anesthesiologists and nurses. Most projects with MMI are two weeks in length, however they were willing to take participants for one week. I paid my registration, booked my flight and was on my way.

I arrived to Quito, Ecuador on a Saturday evening along with several others and we were met at the airport by MMI staff and the group of us was whisked through immigration and taken to a local hotel. The next morning we met the rest of the group, there were 50 of us, a large group from Maine, a smaller group from Massachusetts, one from Denver, three from Michigan, several Canadians, including three from Winnipeg. We were nurses, doctors, dentists, students, interpreters and general helpers, all with the same goal, wanting to help the people of Ecuador.

We traveled two hours north of Quito to the community of Cotacachi. Our accommodations were at Villa Paradisio, a very comfortable resort hotel. The group was divided into two with one group going to surrounding communities and holding medical and dental clinics. The second group would be working at the hospital. Many people in this group had been to Ecuador and Cotacachi before and were very organized with the supplies and equipment they brought. They had sutures, drugs, gloves and drape bundles. Some items were purchased and others were donated. I had taken some surgical gloves we no longer used; in fact they were in the boxes marked for International Hope, waiting to go on a mission project. We spent Sunday afternoon organizing supplies and dividing up the three laparotomy sets into smaller instrument sets; three for tubal ligation, three for hernia repairs, and two for cholecystectomy. The tubal consisted one scalpel handle, one tissue forcep, one metzenbaum scissor, one needle driver, two halsteads, one Babcock, one Army Navy retractor and one self-retaining retractor. The surgeons helped make the sets so they couldn't complain when something was missing.

Cotacachi is a community of about 14,000 people and has one hospital with two operating rooms. They had one obs/gyne physician but no general surgeons and no anaesthesia staff. We were here to help patients needing the services of general and vascular surgeons.

Monday morning was spent meeting the hospital administration and establishing ground rules. They were concerned with some of our practices such as the use of morphine and too much sedation. Plus last year the Ecuadorians were left with a surgical site infection. The session included discussion and teaching, through an interpreter, and our director explained that a 1% infection rate for surgical site infections was something we strived for in North America.

I spent the rest of the morning assisting in MDR, creating case carts with the supplies we brought. Mary, a retired seamstress and Karen, a respiratory tech learned the ins and outs of their sterilizer and by 1300 we were operating.

The two surgeons saw the patients in the emergency department and we set up a day surgery area for pre and post op care and a recovery area. One of the ORs had an anaesthetic machine where we did all the cholecystectomies; in the second OR we did all the surgeries under spinal or local and sedation. Most of the other surgeries were hernia repairs and lots and lots of varicose veins with venous stasis ulcers.

We were a motley crew. There were three of us that currently worked in the OR, another Mary who was a Manager, Martin, an ORT, and I. One of the circulators, Susan, worked in the OR years ago and Kathy, my circulator had a background in emergency and ICU. The day surgery and post op area was made up of nurses from ICU, oncology, and a transplant unit. Anaesthesia consisted of several certified registered nurse anaesthetists and we had a general surgeon and a vascular surgeon.

We did 35 surgeries the first week, the highlight being the C-section with the Ecuadorian surgeon. Their scrub nurse was recovering the first C-section patient so they asked if one of us could scrub. I let Martin do that one; I knew my limit.

I had to leave at the end of the first week, and I was sad. The Ecuadorian people were lovely and very appreciative of the services we provided for them. We were able to help some people that had been waiting a long time to see a Doctor. Once again this experience affirmed for me that I was glad I was a nurse and was able to help people that did not have access to universal healthcare. Plus I had met some wonderful Americans and they invited me to join them next year!

There are numerous opportunities for nurses to help those less fortunate; MMI is only one of those organizations. I know several of you have participated in a mission project and more of you have been thinking and talking about it. If you have a week of vacation and aren't sure where to go I suggest a mission project; it will change you.



Submitted by Pat Cuddy  
Victoria General Hospital  
Winnipeg

P.S. If you want more information about MMI the website is [www.mmint.org](http://www.mmint.org) or contact me by email: [pcuddy@vgh.mb.ca](mailto:pcuddy@vgh.mb.ca)



### **MORNA Membership Information**

1. Active Membership is \$40.00 as of June 1, 2009
2. Deadline for membership is Dec 1, 2009
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  
Winnipeg, MB R2V 3M3**



*Operating Room Nurses Association of Canada*

&

*Manitoba Operating Room Nurses Association*

Membership Registration July 1, 200\_ to June 30, 200\_



\*\*\*Registration Deadline Dec 1, 200\_\*\*\*

Active  Associate  Honorary  Affiliate

CRNM Reg # \_\_\_\_\_ CPN (C)  Year of (re)Certificaton : \_\_\_\_\_ CPN (C) # \_\_\_\_\_

Personal

Please Print

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_ (MORNA Gauzette will be received via email if email address submitted)

Hospital/Employer

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Area of Practice Please indicate if other than OR \_\_\_\_\_

Full time  Part Time  Retired

RN  CRN  Specialty: \_\_\_\_\_ RNFA  Educator

Staff Nurse  Management  Research  Other:  Please Indicate Area : \_\_\_\_\_

Education

Diploma  Post-Graduate OR Course  Baccalauteate  Master's  PhD

Currently enrolled in an educational program

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**For Signing Officer's Use**

Date Rec'd \_\_\_\_\_ Cheque  Cheque #: \_\_\_\_\_ Cash  Membership #: \_\_\_\_\_

District/Region: \_\_\_\_\_

## MORNA EDUCATIONAL FUNDING GUIDELINES

### **Purpose:**

Flexible funding guidelines to support and promote MORNA members' attendance at perioperative educational sessions. The "points system" outlined below is designed to recognize and reward individual contributions to perioperative nursing practice through participation in MORNA. The MORNA Board will administer all funding in accordance to the following guidelines. It is designed to promote fair and equitable allocation of funds to all MORNA members. This funding is for educational events only and funding for other educational purposes will be addressed separately.

### **Guidelines:**

1. The funding will only be approved for educational sessions related to perioperative nursing practice.
2. The amount for education funding is determined and budgeted annually by the MORNA Board and membership.
3. Funding will be allocated using a "points system". The applicant is eligible to receive \$150.00 for each point accumulated during the membership year previous to the year of application, up to a maximum of \$750.00 per year, according to budgeted funds. (\$1000 - 2009)
4. To be eligible, MORNA members who apply for educational funding must be active members for one membership year prior to the year of application and have attended at least three educational MORNA events in the year prior to the year of application. Educational events are general meetings, educational sessions, workshops or conferences, and annual or special meetings.
5. Confirmation of attendance at MORNA meetings is based on signatures on attendance records at the meeting.
6. The funding can only be applied to cover expenses related to travel arrangements (ticket costs or gas), hotel costs (equivalent nights as number of conference days plus one), and registration fees.
7. Applications for funding must be submitted to the treasurer four weeks in advance. Once approved and upon submission of proof of attendance and original receipts, the treasurer will issue the applicant a cheque for the approved amount.
8. In the event that a member wins a paid registration fee to any MORNA session or conference, this will not influence the amount of funding available to that member.