PRÉPARER LES PARENTS POUR LES AIDER À APPUYER LEUR ENFANT APRÈS UNE AMPUTATION DUE AU CANCER DES OS

Auteurs :

Debbie Jaraway, IA, est infirmière en salle d'opération depuis 30 ans. Elle occupe actuellement le poste de chef d'équipe de la chirurgie orthopédique à l'hôpital pour enfants Stollery. Debbie porte un intérêt très personnel à l'amélioration des soins pour les enfants souffrant d'un ostéosarcome.

Shirley Perry, IA, IP, est une infirmière praticienne du département d'oncologie pédiatrique de l'hôpital pour enfants Stollery. Elle s'intéresse tout particulièrement à la collaboration avec d'autres professionnels de la santé dans le but d'offrir les meilleurs soins possible aux enfants et à leur famille.

Marjorie Phillips, IA, CSP(C), a récemment pris sa retraite après une longue carrière en tant qu'infirmière en salle d'opération. Marjorie connaît bien ce domaine et elle a émis l'idée d'avoir un club pour la revue, ce qui a permis aux soins infirmiers de reposer sur des données probantes.

Peggy Ziegler, IA, CSP(C), est depuis de nombreuses années une infirmière en salle d'opération. Elle s'implique depuis longtemps au sein de l'AIISOC, où elle a d'ailleurs occupé des postes de direction.

Amy Wolgemuth détient un baccalauréat avec une concentration en psychologie. Elle s'intéresse vivement à la recherche et travaille actuellement à des activités de recherche à l'hôpital pour enfants Stollery. Elle a beaucoup d'expérience dans le travail avec les familles d'enfants touchés par le cancer et elle les comprend.

Shannon D. Scott, IA, Ph. D., est professeure agrégée à la Faculté des sciences infirmières de l'Université de l'Alberta, à Edmonton. Elle est titulaire d'une bourse pour les nouveaux chercheurs des Instituts de recherche en santé du Canada et du Prix de chercheuse pour la santé de la population de l'organisme Alberta Heritage Foundation for Medical Research. Oute sa recherche qui se concentre sur les efforts déployés pour mettre de l'avant les meilleures données de recherche disponibles au sein de la pratique des soins infirmiers pédiatriques, elle aide les infirmières cliniques à offrir les meilleurs soins possible.

Nous tenons à remercier l'AIISOC d'avoir gentiment accepté de financer ce projet et de nous avoir permis de présenter nos conclusions de recherche lors de la Conférence nationale 2010 de l'AIISOC qui a eu lieu à St. John's, Terre-Neuve. Nous voulons également remercier le personnel du département d'oncologie et du bloc opératoire de l'hôpital pour enfants Stollery ainsi que Patricia Wade pour son inspiration à poursuivre une pratique reposant sur des données probantes.

Les normes de l'AIISOC relatives à cet article figurant dans la publication Normes, lignes directrices et énoncés de position pour la pratique en soins infirmiers périopératoires (11e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AIISOC) de mai 2011, section 2, pp. 127 et 129, normes 4.2.2 et 5.3.1; section 3, pp. 218 et 219, normes 2.8.1, 2.8.2 et 2.8.5 et section 3, p. 234, norme 2.12.11.

RÉSUMÉ :

L'amputation en raison d'un cancer des os chez les enfants est traumatisante tant du point de vue cosmétique que psychologique. À l'hôpital pour enfants Stollery, à Edmonton, en Alberta, on amène les familles voir leur enfant après son amputation, mais avant que les effets de l'anesthésie se soient complètement dissipés. Grâce à une étude rétrospective, nous avons découvert que les familles accordaient de l'importance à cette étape et que cette dernière les aidait à se préparer à appuyer leur enfant et à en prendre soin après son amputation.

KEYWORDS: AMPUTATION, BONE CANCER, VANNESS, WINKLEMAN

PREPARING PARENTS TO HELP SUPPORT THEIR CHILD POST-AMPUTATION FOR BONE CANCER

Authors:

Debbie Jaraway RN, has been an Operating Room Nurse for 30 years. She is currently the team leader for Orthopedic Surgery at the Stollery Children's Hospital. Debbie has a very personal interest in improving the care for children with Osteogenic sarcoma.

Shirley Perry RN, NP, is a Nurse Practitioner in Paediatric Oncology at the Stollery Children's Hospital. She has a keen interest in collaboration with other health care workers to provide the best care for children and their families.

Marjorie Phillips RN, CPN(C), recently retired after a long career as an Operating Room nurse. Marjorie is well read and initiated the idea of having a journal club, which would lead to evidence based nursing.

Peggy Ziegler RN, CPN(C), has been an Operating Room Nurse for many years. She has a long-standing involvement with ORNAC, including in leadership positions.

Amy Wolgemuth BA, has her BA majoring in Psychology. She is very interested in Research and is at present working with a Research endeavor at the Stollery Children's Hospital. She has a long history of working with and understanding families of children with cancer.

Shannon D. Scott RN, PhD, is an Associate Professor in the Faculty of Nursing at the University of Alberta, Edmonton. She holds New Investigator funding from the Canadian Institutes of Health Research and a Population Health Investigator award from the Alberta Heritage Foundation for Medical Research. Her research focuses on efforts to put the best available research evidence into paediatric nursing practice and she helps clinical nurses give the best possible care.

Thank you to ORNAC for kindly funding this project and for allowing us to present our findings at the 2010 ORNAC National Conference in St. John's, Newfoundland. Additional thanks to the oncology and surgical staff at the Stollery Children's Hospital and to Patricia Wade for the inspiration to pursue evidence-based practice.

ABSTRACT:

Amputation for paediatric bone cancer is cosmetically and emotionally disturbing. At the Stollery Children's Hospital, in Edmonton, Alberta, families are taken to see their child following amputation but before their child's anaesthetic has been reversed. Through a retrospective study we found that families found this step to be valuable in helping them prepare to support and care for their child post-amputation.

INTRODUCTION:

Bone cancers are rare in children and include Osteogenic sarcoma and Ewing sarcoma.[1] Osteogenic sarcoma is the most common bone cancer in children and the lower limb is the most common site of occurrence.[1] Osteogenic sarcoma is usually treated with chemotherapy but the curative treatment is surgical removal of the tumour. Ewing sarcoma, a less common bone cancer in children, is treated with chemotherapy, radiation, but in some cases requires amputation. In large malignancies of the lower limb, especially in Osteogenic sarcoma, removal of the tumour, while still salvaging the limb, may not be possible and amputation may be necessary. There are different types of amputations: direct amputation (or Rotation Plasty), the Van Ness procedure; and the Winkleman procedure.[1] In the Van Ness and Winkleman procedures the tibia, foot and ankle are preserved and fixed to the remaining femur after rotating it so that the foot points backwards. The ankle joint then acts as the knee joint. These patients can be fitted for a prosthetic, as a below-knee amputee, and will retain better function than with a standard above-knee amputation.[1] The appearance of the amputated leg, especially the rotation plasty, is cosmetically unsettling[2] and, although the procedure is justifiable from a functional and curative perspective ,

Operating Room Nurse preparing parents for surgery.

there is concern about the psychological impact and the patient's adjustment to this life-long disability.[3]

The look of an amputated leg can be quite disturbing. Amputation is a traumatic event with numerous life-long psychological and physical consequences.[4,5,6] Body mutilation of any sort, including amputation, can damage a person's sense of self-integrity and their feeling of wholeness.[7] The loss of a limb feels like the loss of a loved one[7,8] and Livench et al.[7] equate it to a 'symbolic castration'. The more extensive and disfiguring the amputation the greater the changes to the patient's body image and the more difficult the rehabilitation.[9] The psychological disorders that are linked to amputations are phantom pain, depression, anxiety, post-traumatic stress disorder, sexual dysfunction and chemical abuse.8 Psychological response varies based on age, gender, maturity and support.8 The less prepared the patient is for amputation, the higher the chance of depression and poor rehabilitation post amputation.[8] Psychological preparation is essential for an adaptive grieving process.[9] In paediatric medicine the family, as the child's primary support system,[10] needs to be empowered as primary caregivers.

Over the past decade Family Centred Care has, in paediatrics, become the gold standard of healthcare.[7,10,11] It is well documented that a parent's stress can create anxiety in a child.[12] Family centered pre-operative care and preparation helps to decrease the child's anxiety and this has been shown to improve pain control (and later phantom pain) and positively affect postoperative recovery.[4,13,14] The parents' and family's reaction to the child's surgery influences the child's adjustment to the surgery and to the realities of their amputation.[9,11] If a parent is not prepared then they cannot properly prepare or support their child.[4] When dealing with an amputation a parent has also to deal with his/her own grief and shock over the loss of their child's limb. Fitzpatrick 8 found that the majority of children will ultimately accept their amputation if parents remain optimistic, encouraging, and seek to find some positive meaning in this experience.[8] Assisting families in dealing with the stages of grief,[15,16] allaying their fears,[12,17] helping them care for themselves,[4,12] preparing them for the outcome, and encouraging them to express their concerns4 combines to empower them as primary caregivers.[15,16,17]

In the mid '90s, prompted by a family's devastated reactions to seeing their child's amputated leg, the Paediatric Oncology staff and the Paediatric Operating Room at the Stollery Children's Hospital began encouraging families to go in to the operating room (OR) to see their child's amputation before their child's anaesthetic was reversed. Families have reported, in an ad hoc fashion, that this practice has

Oncology nurse taking parents into the OR.

Family centered pre-operative care and preparation helps to decrease the child's anxiety and this has been shown to improve pain control (and later phantom pain) and positively affect postoperative recovery.[4,13,14]

been very helpful and that it should be continued. This practice could not be found documented anywhere in literature but there is, conceptually, strong support for the linkage between the level of family support provided and the patient's recovery and rehabilitation after limb amputation[4,12] and it is essential that good medical practice merges both science and psychology.[15] Because taking families into the operating room impacts on staff and operating room time it seemed beneficial to determine if the practice was worth the financial and human resource costs. To this end, a small group of nurses decided to a take a closer look at family's feelings about going into the operating room to view their child's leg for the first time following amputation.

With grant support from the Operating Room Nurses Association of Canada (ORNAC) a retrospective study was conducted to document the experiences of families, at Stollery Children's Health Center between 1996 and 2006, of paediatric patients with lower limb amputation for bone cancer. The study's goal was to capture the essence of their experience in seeing their child's amputated leg for the first time and to draw conclusions that will help to provide the most optimal Family Centered Care in the future.

Purpose:

The purpose to this study was to examine the experiences of families of children with cancer who were seeing their child's amputated leg for the first time, following surgery, and to provide family centered care based on our conclusions. An attempt was made to determine, based on the experiences of a

Parents spending time in OR.

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very small population, if it was valuable for families to have their first exposure to their child's amputated leg while the child was still anaesthetized and if this step helped in the grieving process and the child's post-amputation adjustment. Parents who are allowed to express their grief and shock at the appearance of their child's amputation, in a private situation and without concern for the child's reaction, may be better able to cope with the change and better prepared to help their child deal with the adjustment.

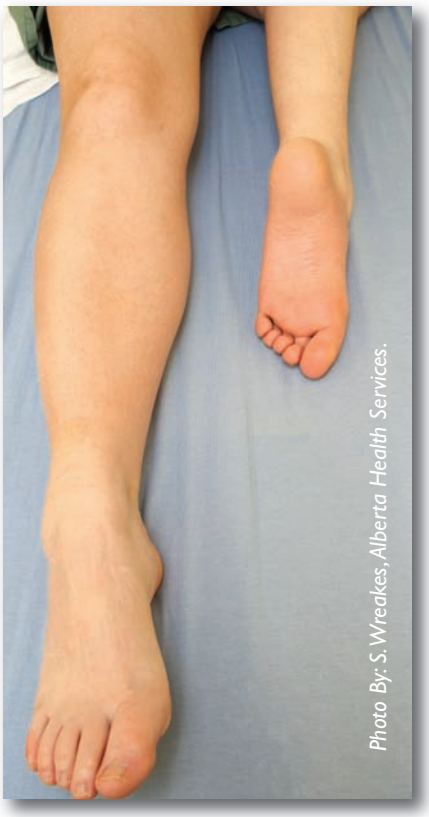
Hypothesis:

Viewing their child's leg following amputation, but prior to reversal of anaesthetic, is perceived by families to be valuable to the grieving process, recovery, and post-amputation adaptation.

Method:

The study is a retrospective study using an exploratory descriptive design and was conducted between September 2009 and May 2010. The secretary from the Paediatric Oncology Program telephoned all of the 20 families of children who had lower limb amputation, for bone cancer, at the Stollery Children's Hospital from 1996-2006. The families were asked if they would be willing to be contacted by a research assistant to discuss the study. The research assistant then called the 18 families who agreed , explained the study, and offered to send them the consent and a list of the types of questions they would be asked in an interview. The research team believed that having an understanding, in advance, of the type of questions being asked, they would be better prepared for the interview. The family members were then asked if they wanted to come into the hospital to be interviewed in person or if they would like to have a phone interview. All families opted to be interviewed by phone.

The study's research assistant, who interviewed all participants, was a Psychology student, who was working with the Kids with Cancer non-profit organization connected to our program but was not involved in the care of any of the children whose families were participating in the study. The interview consisted of a series of questions compiled by an expert group of medical and psychosocial staff. There is no extant validated tool available, in the nursing or psychosocial literature, to attempt to measure the value of a family member seeing their child's amputation in the perioperative period. The questions were related to the family's demographic, age of child, relationship to primary care giver, type of surgery, and whether or not the family members went in to the operating room to see their child before the anaesthetic was reversed. A set of Likert-type questions, using a 5-point scale from strongly disagree to strongly agree, was used. A separate, yet similar, set of questions was created for the two groups of families – those who did and those who did not go into the operating room. Asking very



VanNess Procedure.

similar questions, with slightly different wording, helped test the reliability of the questions. The questions had been pilot tested on five volunteers who had relevant knowledge and experience. The volunteers found the questions to be clear and easy to understand. The interview concluded with a set of open-ended questions encouraging the family member to share their feelings about how they felt they saw their child's amputation. An attempt was made to keep the interview short (approximately 15-30 minutes). If the respondents seemed interested in continuing to talk they were invited to be contacted to participate in a focus group that was to be organized at a future date.

Study Sample:

All 20 families of children who had surgery for bone cancer from 1996-2006, at the Stollery Children's Hospital, were invited to participate. Following the telephone contact letters were sent to 18 families requesting them to sign a consent form to be contacted to participate in the study.14 families returned their consent and were contacted to participate. 13 families participated in the phone surveys (72% response rate).

Description of Caregivers;

In total 22 parents, from the 13 families, participated in the survey and, of those, 13 were mothers and 9 were fathers. There were 9 families where both the mother and father participated and 4 families where only the mother participated.

Description of the Children with Bone Cancer:

Of the families who participated three of the 13 children were male and 10 were female. 10 of the children were in remission, one was in active treatment, and two were deceased. Eleven children had undergone the Van Ness procedure and 2 had undergone the Winkleman Procedure. The average age, at time of surgery, was 11.31 (3.376 SD) and the age range was 6 to 16 years. The average age of the children at the time of the interview was 16.82 (4.916 SD) with ages ranging between 8 and 25 years.

Inclusion Criteria:

Adult family members of children (up to age 17 when they had their surgery) who had surgery for lower limb bone cancer at the Stollery Children's Hospital from 1996-2006. All families, even if the child was deceased, were called and asked if they would like to participate. The primary caregivers at the time of surgery could have included a mother, father, boy/girl-friend, step mother/father, grandparent or guardian (or any other definition of the primary caregiver). The person must, by their own report, have been involved in the direct care of the child in the immediate post-operative period.

Table 1.
Results – Experiences of Caregivers in the Operating Room (n=16)

Survey Questions	Mean (out of 5, 1= strongly disagree, 5= strongly agree)
My ability to help my child after surgery was better because I had already seen the amputation	4.94 (0.250 SD), 4-5 range
I felt better prepared to see my child's leg the second time	**5.0 (0.00 SD), 5 range**
I felt comfortable in the operating room	3.81 (1.22 SD), 1-5 range
The leg looked better than what I expected	4.25 (1.065), 2-5 range
I was glad I was able to see my child's leg before they woke up	**5.0 (0.00 SD), 5 range**

Table 2.
Results – experience of caregivers who did not go into the Operating Room (n=6)

Survey Questions	Mean (out of 5, 1= strongly disagree, 5= strongly agree)
I believe that my ability to help my child after surgery would have been better if I had seen the leg already in the OR	1.83 (0.408 SD), 1-2 range
I believe I would have been better prepared to see my child's leg with my child after surgery if I had seen it first while my child was still sleeping	2.17 (0.753 SD), 1-3 range
I felt uncomfortable seeing my child's leg for the first time.	3.33 (1.033 SD), 2-4 range
When I saw the leg it looked better than I expected	**2.00 (0.00 SD), 2 range**
I wish I could have gone in to see my child's amputated leg before they woke in the OR	**2.60 (0.548 SD), 2-3 range**

Exclusion criteria:

Family members who, due to difficulties with English as a second language, were not able to read and understand the questionnaires without an interpreter.

Data-Analyses:

Data were entered, cleaned and processed using SPSS 16.0. Data preparation and analyses were conducted by a PhD prepared paediatric health researcher (who is also a paediatric nurse). The data were examined using descriptive statistics. The Likert-type questions were summarized, separately for both groups, using frequency distributions and measures of central tendency. The results from the individual questions were not totaled up for a final composite score but, rather, each question was analyzed individually using frequency and percentage response in each category. Due to the exploratory nature of the study there was no attempt to achieve statistical power or group comparison.

Childhood amputation for cancer is very rare. Interventions to assist families in recovery and adaptation are very limited and there is very little specific literature dealing with childhood amputations. The research group anticipated that the experience of going into the operating room, to view their child's leg following surgery, could be a valuable one for families. A mixed methods approach ensured a comprehensive, integrated approach that to help identify common experiences in the families.

Results:

Of the 22 parents interviewed, 16 went into the Operating Room and 6 did not go into the operating Room.

Experience of parents who went into the OR:
All 16 parents felt that they were given sufficient information to enable them to make the decision to go to the OR. All of the parents (100%) found the experience of going into the OR to be highly positive. They all agreed that they were better

PREPARING PARENTS (cont.)

Photo By: S. Wreakes, Alberta Health Services.

Knee joint with prosthesis after a VanNess procedure.

prepared due to the OR experience and were glad that they had the opportunity to first see the amputation while their child was still under anaesthetic. The findings of the study point to the fact that there is benefit for caregivers for viewing the child's amputation in the Operating Room. The parents were predictably undecided about their comfort level in the Operating Room (see Table 1).

Experience of parents who did not go into the OR:

Of the six parents who did not go into the OR all said that they were not offered that option. None of them, however, regretted not going in. Four of the parents saw their child's leg for the first time in the child's hospital room, the remaining two saw it in the recovery room once the child was awake. None of them perceived themselves as having been at a disadvantage. All expressed the fact that the amputation looked worse than they had expected. This pointed us to a potential need, that had previously not been anticipated, to better prepare families for this event and to debrief with families post-operatively (see Table 2).

Discussion:

Childhood amputation for cancer is very rare and there is very little written on interventions to assist families and children in recovery and adaptation. This research group was unable to find a suitable tool that could be used to measure the value of a family member seeing their child's amputation in the operating room. The hope is that this study will add to the knowledge base in the area of dealing with the loss of a child's limb. Our sample was small and,

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ORNAC Call for Nominations 2014

OPERATING ROOM NURSES ASSOCIATION OF CANADA

ASSOCIATION DES INFIRMÍERS ET INFIRMIERS DE SALLES D'OPÉRATION DU CANADA

1) ORNAC Call for Nominations:
Provincial Board of Director Positions with two year terms commencing May 2014:
Open Positions:
Alberta
Manitoba
New Brunswick
Prince Edward Island
Newfoundland

Sequence of 2014 Events:

- January 1 - ORNAC Nominations Package sent electronically to the Provincial Council President. The package will include the nomination/election process and electronic ballots.
- January 3 - The Provincial Council Presidents will be responsible for e-mailing the Nomination package to all members within their province.
- February 2 - The Nominations must be received by the Provincial Council President.
- February 5 - The Provincial Council President will determine which candidates meet the criteria for the ORNAC Board position.
- February 15 - Candidates will be notified whether they have or have not met the nomination criteria. If there is more than one candidate an election will be held within the specific province.
- March 1 - Electronic Ballots will be sent to all voting Provincial Members.
- March 20 - Election takes place.
- April 1 - The Provincial Council President submits the successful candidate's name to the ORNAC Nominations Chair (in writing).
- April 15 - The ORNAC Nominations Chair prepares the final Election Slate for the Annual General Meeting (AGM).
- May - At the ORNAC AGM the voting ORNAC members will vote on the final election slate (This is a requirement of the new Canada Not for Profit Corporations Act).
- June - The new Board is introduced via the ORNAC website and e-blast to the ORNAC membership.
- September - The new Board will be featured in the ORNAC Journal.

2) ORNAC Call for Nominations for Officer and Board of Director Position in 2014:
Position Open with a two year term:
ORNAC Treasurer

Sequence of 2014 Events:

- January 3 - A call for nominations will be available nationally through the ORNAC website, through the Facebook page, and via e-mail from ORNAC and the Provincial Councils.
- February 2 - Candidates must submit the nomination paperwork to the ORNAC Nominations Chair and express their intent to run for the position.

For further information on the ORNAC Nominations process please contact the ORNAC Nominations Chair (Pat Pocock) at patpocock@rogers.com.

- February 5 - The Nominations Committee will review all nominations and select the candidates who meet the ORNAC Board position criteria. The Nominations Chair will submit the successful nominees' names to the ORNAC Board of Directors.
- February 15 - Candidates will be notified if they have, or have not, met the nomination criteria. If there is more than one candidate, a national election will be held.
- February 20 - Electronic Ballots will be sent by the Nominations Chair to all voting ORNAC Members.
- March 10 - An election will take place.
- April 1 The Nominations Chair will notify the ORNAC President (in writing) of the successful candidate's name.
- April 15 - The ORNAC Nominations Chair will prepare the final Election Slate for the Annual General Meeting (AGM).
- May - At the ORNAC AGM the voting ORNAC members will vote on the final election slate (This is a requirement of the new Canada Not for Profit Corporations Act).
- June - The new Board is introduced via the ORNAC website and e-blast to the ORNAC membership.
- September - The new Board will be featured in the ORNAC Journal.

3) ORNAC Call for Nominations for the Board of Director Positions Representing the Seats of Leadership, Education and Advanced Practice Positions in 2014:

Positions Open with two year terms:

Leadership

Education

Sequence of 2014 Events:

- January 3 - A call for nominations will be available nationally through the ORNAC website, through the Facebook page, and via e-mail from ORNAC and the Provincial Councils.
- February 2 - Candidates must submit the nomination paperwork to the ORNAC Nominations Chair and express their intent to run for the position.
- February 5 - The Nominations Committee will review all nominations and select the candidates who meet the ORNAC Board position criteria. The Nominations Chair will submit the successful nominees' names to the ORNAC Board of Directors.
- February 15 - Candidates will be notified if they have, or have not, met the nomination criteria. If there is more than one candidate, a national election will be held.
- February 20 - Electronic Ballots will be sent to all voting ORNAC Members.
- March 10 - An election will take place.
- April 1 - The Nominations Chair will notify the ORNAC President (in writing) of the successful candidates' names.
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Appel de mises en candidature 2014 de l'AIISOC

OPERATING ROOM NURSES ASSOCIATION OF CANADA

ASSOCIATION DES INFIRMÍERS ET INFIRMIERS DE SALLES D'OPÉRATION DU CANADA

1) Appel de mises en candidature de l'AIISOC : Postes au conseil d'administration provincial ayant un mandat de deux ans à compter de mai 2014

Postes à pourvoir :

Alberta
Manitoba
Nouveau-Brunswick
Île-du-Prince-Édouard
Terre-Neuve

Fil des événements de 2014 :

- 1er janvier — La trousse de mises en candidature de l'AIISOC est envoyée par voie électronique à la présidente du conseil provincial. La trousse comprend le processus de mises en candidature/d'élection et les bulletins de vote électronique.
- 3 janvier — Les présidents des conseils provinciaux doivent envoyer par courriel la trousse de mises en candidature à tous les membres de leur province.
- 2 février — Les mises en candidature doivent être reçues par les présidents des conseils provinciaux.
- 5 février — Les présidents des conseils provinciaux déterminent quels candidats répondent aux critères pour les postes au conseil d'administration de l'AIISOC.
- 15 février — Les candidats sont avisés s'ils répondent ou non aux critères de mise en candidature. S'il y a plus d'un candidat à un poste, une élection aura lieu dans la province en question.
- 1er mars — Les bulletins de vote électronique sont envoyés à tous les membres provinciaux ayant le droit de voter.
- 20 mars — Tenue des élections.
- 1er avril — Les présidents des conseils provinciaux soumettent (par écrit) le nom des candidats sélectionnés à la présidente des mises en candidature de l'AIISOC.
- 15 avril — La présidente des mises en candidature de l'AIISOC prépare la liste de candidatures finale pour l'Assemblée générale annuelle (AGA).
- Mai — Lors de l'AGA de l'AIISOC, les membres de l'AIISOC ayant le droit de vote exercent leur droit de vote à partir de la liste de candidatures finale (une exigence de la nouvelle loi canadienne régissant les organismes à but non lucratif).
- Juin — Le nouveau conseil d'administration est présenté par le biais du site Web de l'AIISOC et d'un envoi par courriel en masse aux membres de l'AIISOC.
- Septembre — Le nouveau conseil d'administration est présenté dans la Revue de l'AIISOC.

Appel de mises en candidature de l'AIISOC pour les postes de membres de la direction et du conseil d'administration en 2014

Poste à pouvoir ayant un mandat de deux ans :

Trésorier/trésorière de l'AIISOC

Fil des événements de 2014 :

- 3 janvier — Un appel de mises en candidature est lancé à l'échelle nationale par le biais du site Web de l'AIISOC, par la page Facebook et par courriel de la part de l'AIISOC et des conseils provinciaux.
- 2 février — Les candidats doivent soumettre leurs documents de mise en candidature à la présidente des mises en candidature de l'AIISOC et exprimer leur intention de présenter leur candidature à ce poste.

Pour de plus amples renseignements sur le processus de mises en candidature de l'AIISOC, veuillez communiquer avec la présidente des mises en candidature de l'AIISOC, Pat Pocock, à patpocock@rogers.com

- 5 février — Le comité des mises en candidature révise toutes les mises en candidature et sélectionne les candidats répondant aux critères du poste au conseil d'administration de l'AIISOC. La présidente des mises en candidature soumet le nom des candidats sélectionnés au conseil d'administration de l'AIISOC.
- 15 février — Les candidats sont avisés s'ils répondent ou non aux critères de mise en candidature. S'il y a plus d'un candidat, une élection nationale aura lieu.
- 20 février — Les bulletins de vote électronique sont envoyés par la présidente des mises en candidature à tous les membres de l'AIISOC ayant le droit de voter.
- 10 mars — Tenue de l'élection.
- 1er avril — La présidente des mises en candidature avise (par écrit) la présidente de l'AIISOC du nom du candidat sélectionné.
- 15 avril — La présidente des mises en candidature de l'AIISOC prépare la liste de candidatures finale pour l'Assemblée générale annuelle (AGA).
- Mai — Lors de l'AGA de l'AIISOC, les membres de l'AIISOC ayant le droit de vote exercent leur droit de vote à partir de la liste de candidatures finale (une exigence de la nouvelle loi canadienne régissant les organismes à but non lucratif).
- Juin — Le nouveau conseil d'administration est présenté par le biais du site Web de l'AIISOC et d'un envoi par courriel en masse aux membres de l'AIISOC.
- Septembre — Le nouveau conseil d'administration est présenté dans la Revue de l'AIISOC.

3) Appel de mises en candidature de l'AIISOC pour les postes du conseil d'administration représentant les sièges des représentants en matière de leadership, d'éducation et de pratique avancée en 2014

Postes à pourvoir ayant un mandat de deux ans :
Leadership • Éducation

Fil des événements de 2014 :

- 3 janvier — Un appel de mises en candidature est lancé à l'échelle nationale par le biais du site Web de l'AIISOC, par la page Facebook et par courriel de la part de l'AIISOC et des conseils provinciaux.
- 2 février — Les candidats doivent soumettre leurs documents de mise en candidature à la présidente des mises en candidature de l'AIISOC et exprimer leur intention de présenter leur candidature à un de ces postes.
- 5 février — Le comité des mises en candidature révise toutes les mises en candidature et sélectionne les candidats répondant aux critères des postes au conseil d'administration de l'AIISOC. La présidente des mises en candidature soumet le nom des candidats sélectionnés au conseil d'administration de l'AIISOC.
- 15 février — Les candidats sont avisés s'ils répondent ou non aux critères de mise en candidature. S'il y a plus d'un candidat, une élection nationale aura lieu.
- 20 février — Les bulletins de vote électronique sont envoyés à tous les membres de l'AIISOC ayant le droit de voter.
- 10 mars — Tenue de l'élection.
- 1er avril — La présidente des mises en candidature avise (par écrit) la présidente de l'AIISOC du nom des candidats sélectionnés.
- 15 avril — La présidente des mises en candidature de l'AIISOC prépare la liste de candidatures finale pour l'Assemblée générale annuelle (AGA).
- Mai — Lors de l'AGA de l'AIISOC, les membres de l'AIISOC ayant le droit de vote exercent leur droit de vote à partir de la liste de candidatures finale (une exigence de la nouvelle loi canadienne régissant les organismes à but non lucratif).
- Juin — Le nouveau conseil d'administration est présenté par le biais du site Web de l'AIISOC et d'un envoi par courriel en masse aux membres de l'AIISOC.
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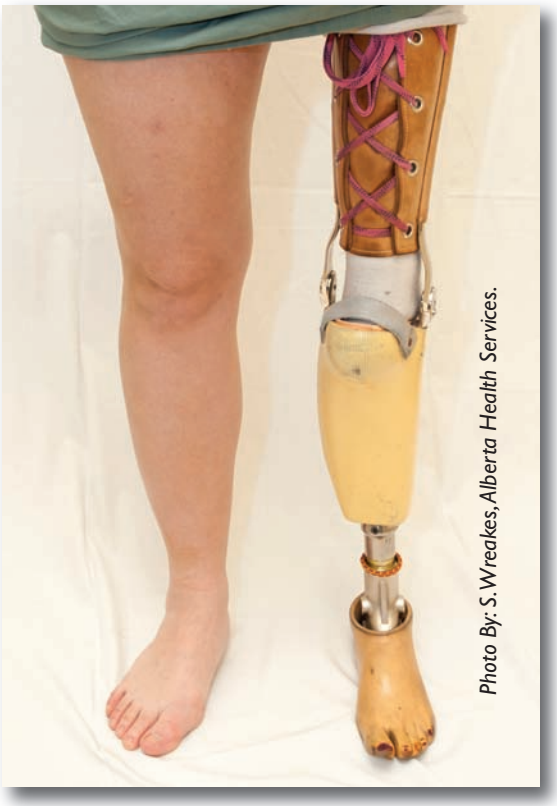

The VanNess Procedure with prosthesis.

as such, when being true to the methodological approach cannot represent the larger population of families of children with bone cancer who need amputation. Our project did determine that 72% of our parents did go into the OR and 100 % of those found the experience to be highly positive and valuable in coping with the grief of their child's amputation and helping their child deal with rehabilitation. The study determined that there was no harm in the practice of going into the OR to view the amputation and, as such, it should be offered to all of our patients. The results were presented to the OR management staff. Our particular institution felt that the outcomes were positive enough and promoted family centered care and that, though the steps were time-consuming and costly, the process was worth implementing.

The group has recommended that, in light of our findings, all caregivers of children with amputations at the Stollery be given the opportunity to go into the operating room while their child is still anaesthetized. The group is developing a care plan, which will include preparation for the family, a plan for room set-up, and details regarding who will take the family in to the room and who will support them after the viewing. The practice may later be extended to families of children having other mutilating and deforming surgeries.

The outcomes of this study will be used in the development of a future research tool for measuring parental experiences and for estimating the effect size in future studies. None of the participants expressed an interest in a focus group, however our research has inspired our "Long Term Follow Up Program to have regular meetings with the patients, who are now teenagers or young adults. In the future this research group hopes to implement a prospective study, involving other Childhood Cancer Centers to further look at the experiences of families dealing with the traumatic event of their child losing a limb to cancer. Our study was very small and specifically dealt with parents going in to the OR. We hope to be able to conduct a more comprehensive study of the many facets of dealing with this experience.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (April 2013) Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (11th edition). Section 2, pgs 110 & 113 , Standards 4.2.2 & 5.3.1. Section 3, pg 184 Standards 2.8.1, 2.8.2, & 2.8.5. Section 3, Pg 197, Standard 2.12.11.

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