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Volume 32, Issue 2

ORNAC JOURNAL



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ORNAC MISSION

The Operating Room Nurses Association of Canada (ORNAC) is an organization of Perioperative Registered Nurses and Associates dedicated to the:

- Promotion and advancement of excellence in the provision of safe perioperative care for patients;
- Professional growth, competence and personal enhancement of the ORNAC membership; and
- Progression of perioperative professional practice at a regional, provincial, national & international level.

MISSION DE L'AIISOC

L'Association des infirmières et des infirmiers de salles d'opération du Canada (AIISOC) est un organisme d'infirmières et d'infirmiers autorisés en soins périopératoires et d'associés se consacrant :

- À la promotion et à l'avancement de l'excellence quant à la distribution de soins périopératoires sécuritaires à nos patients;
- À l'amélioration des compétences tant sur le plan professionnel que personnel; et
- À la progression de la pratique professionnelle des soins périopératoires à l'échelle provinciale, nationale et internationale.



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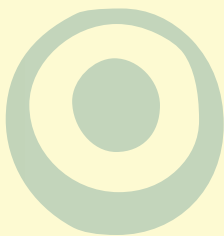
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PRESIDENT'S MESSAGE

Rupinder Khotar RN, BScN, CPN(C), ORNAC President is the OR Nursing Supervisor at Providence Health Care – St. Paul's site, Vancouver, BC, and the Past Chair of the ORNAC Standards Committee.



“Enlightened leadership is spiritual if we understand spirituality not as some kind of religious dogma or ideology but as the domain of awareness where we experience values like truth, goodness, beauty, love and compassion, and also intuition, creativity, insight and focused attention.”

- Deepak Chopra

I am fortunate to know many learned individuals. I have been mentored, coached and taught by some exemplary people. They have influenced my professional and personal life over the years. I recently approached a few of them to help me work through a major professional decision and they stepped forward, when asked, and never denied me the attention that I sought. Each person contributed valuable insights and shared life experiences that helped to shape my decision-making process. I experienced deep gratitude and humility in their presence.

One person, in particular, helped me grow – I will call him Sam. I turned to him because he is well respected, experienced, and authentic. I knew he would provide the mentorship and guidance that I needed and I was confident that I would get honest feedback from him. What I did not know, initially, was how much I would learn from him about the fundamental aspects of leadership. My interactions with Sam began with discussion of a basic task and quickly evolved into conversations rich in valuable content. Sam demonstrated the values of authenticity and self-awareness through his stories. He prompted that awareness in me by asking questions and making comments that often elicited pause and reflection. Sam was always patient. He waited and watched. There were times when I was not able to answer the question, no matter how long I contemplated it, and those moments also provided life lessons.

On a few occasions Sam started a statement with “this is what I know.” I began to wonder what I knew with that level of confidence. It made me think... a lot. This is, apparently, a pathological condition that I have. I confess it and know it to be true (another believe I solidified with Sam). So what I know is that I am called to be a nurse. It is not just a job but is something I feel compelled to do. I like to be around people and to have the opportunity to serve and care for them. I endeavour to serve and care for my team, as well as my patients, and I hope that I can inspire them in the ways that my mentors have inspired me. Very few experiences parallel the experience of being exposed to enlightened leaders. I can only aspire to Sam's abilities... but at least I have a goal!

Wishing you all your own inspiration and a warm and fun filled summer to enjoy with family and friends. 🍁

Warmest Regards,

Rupinder Khotar



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MOT DE LA PRESIDENTE

Rupinder Khotar, IA, B. Sc. Inf., CSP(C), présidente de l'AIISOC est infirmière surveillante du bloc opératoire de Providence Health Care – site de St. Paul, à Vancouver, en C.-B. et l'ancienne présidente du comité des normes de l'AIISOC.



« Le leadership éclairé est un élément spirituel si nous comprenons que la spiritualité n'est pas une sorte de dogme religieux ou d'idéologie, mais qu'elle fait partie du domaine de la conscience où nous prôtons des valeurs comme la vérité, la bonté, la beauté, l'amour et la compassion, et aussi l'intuition, la créativité, la perspicacité et l'attention exclusive. »

- Deepak Chopra

J'ai la chance de connaître de nombreuses personnes cultivées. Ces personnes exemplaires m'ont offert du mentorat, de l'encadrement et des formations. Elles ont influencé ma vie professionnelle et personnelle au fil des ans. Récemment, j'ai contacté quelques-unes d'entre elles pour m'aider à prendre une importante décision professionnelle et, à ma demande, elles se sont portées volontaires et ne m'ont pas refusé l'attention dont j'avais besoin. Chacune de ces personnes m'a fait part de son précieux point de vue et de ses expériences de vie, ce qui m'a aidée à orienter mon processus de prise de décision. En leur présence, je ressens une profonde reconnaissance et beaucoup de respect.

Une de ces personnes en particulier m'a vraiment aidée à grandir personnellement — je l'appellerai Sam. J'ai fait appel à lui, car c'est un homme respecté, qui possède de l'expérience et qui est sincère. Je savais qu'il pourrait m'offrir le mentorat et les conseils dont j'avais besoin et j'étais convaincue que sa rétroaction serait honnête. Ce que je ne savais pas au début, c'était combien j'apprendrais de lui quant aux aspects fondamentaux du leadership. Au début, nous discutons des tâches élémentaires, mais le contenu de nos conversations est rapidement devenu très utile. Dans ses histoires, Sam faisait preuve des valeurs d'authenticité et de conscience de soi. Avec son aide, j'ai pu faire une prise de conscience grâce à ses questions et ses commentaires qui demandaient souvent de s'y arrêter et de réfléchir. Sam était toujours patient. Il attendait et observait. Par moment, j'étais incapable de répondre à ses questions, peu importe le temps que je prenais pour y réfléchir et j'en ai tiré des leçons de vie.

C'est arrivé que Sam commence une phrase en disant : « voici ce que j'en sais ». J'ai commencé à me poser des questions sur ce que je savais avec une telle assurance. Ça m'a beaucoup fait réfléchir. Apparemment, je souffre de ce type d'état pathologique. Je dois vous l'avouer et je sais que Sam a raison (une autre croyance que j'ai renforcée avec Sam). Donc, ce que je sais, c'est que je suis faite pour être infirmière. Ce n'est pas seulement un emploi, mais c'est aussi quelque chose que je me sens obligée de faire. J'aime être entourée de gens et avoir l'occasion de les aider et de prendre soin d'eux. Je m'efforce d'aider et de prendre soin de mon équipe, de même que de mes patients, et j'espère pouvoir les inspirer de la même façon que mes mentors l'ont fait pour moi. Il n'existe que très peu d'expériences pouvant égaler celle d'avoir été exposée à des leaders éclairés. Je peux seulement aspirer aux aptitudes que possède Sam... mais au moins j'ai un objectif!

Je vous souhaite de trouver l'inspiration et j'espère que vous passerez un bel été en compagnie de votre famille et de vos amis. ✨

Bien à vous,

Rupinder Khotar

P.S. : Sam n'est pas parfait! Ces blagues au sujet des taureaux qui courent ne sont pas terribles.



EXECUTIVE DIRECTOR'S MESSAGE

Catherine Harley, RN, eMBA, ORNAC Executive Director
executivedirector@ornac.ca



In order to prepare ORNAC for the future, and to establish a national database of Perioperative Registered Nurses and Associates, ORNAC has launched a centralized on-line registration process. This project is being implemented in three phases in order to give the ORNAC Provincial Councils the time to align their By-laws with the new membership process.

Phase one is complete and allows for on-line registration, directly with ORNAC, for members and associates in Ontario, Saskatchewan, New Brunswick, Prince Edward Island, and Newfoundland & Labrador. This phase has created a central database, managed directly by ORNAC, with the capability for on-line registration and address updates for those five provinces.

Phase two is underway and will be implemented with a mid-year transitional phase for members/associates from Alberta and Nova Scotia. As these provinces are experiencing a 6 month lag time they are now able to register or renew online at the normal annual fee but with their

membership effective until the end of 2015 (to synchronize them with the other provinces). New members/associates from Ontario, Saskatchewan, PEI, New Brunswick, and Newfoundland & Labrador are now also able to join on-line and their membership will also remain effective until the end of 2015. This will ensure all provinces renewal dates are synchronized by Dec 31, 2015.

The final phase will allow members and associates in British Columbia, Manitoba, and Quebec to renew on-line, starting on September 1st, 2014, for next year (registrations for 2015 must be completed by December 15, 2014).

Every person who joins ORNAC will be receiving an ORNAC Membership/Associate Kit in the mail. This kit will include a membership/associate card and important information about the association.

ORNAC is also continuing to build value provided to members and associates through work that is underway in the five ORNAC Pillars.

ORNAC began a new journey after the Board of Directors and members voted to pass the new ORNAC By-laws and Articles of Continuance which are now aligned with the new Canada Not-for-profit Corporations Act. The ORNAC Board of Directors and Executive have, throughout the transition, remained focused on the core of the association
– the members and associates!

MESSAGE DE LA DIRECTRICE GÉNÉRALE

Catherine Harley, IA, M.B.A. pour cadres, directrice générale de l'AIISOC
executivedirector@ornac.ca



L'AIISOC amorce un nouveau chapitre de son existence après que son Conseil d'administration et ses membres aient voté pour adopter les nouveaux règlements administratifs et clauses de prorogation de l'AIISOC qui sont maintenant conformes à la nouvelle loi canadienne régissant les organismes à but non lucratif. Les Conseils d'administration et de direction de l'AIISOC sont, tout au cours de la transition, demeurés axés sur ce qui constitue le cœur de l'association, soit les membres et les associés!

Dans le but de préparer l'AIISOC à affronter l'avenir et à établir une base nationale de données d'infirmières et d'infirmiers en soins périopératoires et d'associés, l'AIISOC a lancé un processus centralisé d'adhésion en ligne. Ce projet sera mis en œuvre en trois phases afin de donner le temps aux conseils provinciaux de l'AIISOC d'adapter leurs règlements administratifs au nouveau processus d'adhésion.

La phase un a été complétée et cette dernière permet maintenant aux membres et aux associés de l'Ontario, de la Saskatchewan, du Nouveau-Brunswick, de l'Île-du-Prince-Édouard et de Terre-Neuve-et-Labrador d'adhérer en ligne, directement avec l'AIISOC.

Cette phase a généré une base centrale de données, gérée directement par l'AIISOC, avec la possibilité d'effectuer les adhésions en ligne et de mettre à jour les adresses pour ces cinq provinces.

La phase deux est en cours pour les membres/associés des provinces de l'Alberta et de la Nouvelle-Écosse et elle sera mise en œuvre au milieu de l'année par une période de transition. Étant donné que ces provinces font l'objet d'un décalage de six mois, elles peuvent maintenant s'inscrire ou renouveler en ligne au tarif annuel normal, mais leur adhésion sera valable jusqu'à la fin de 2015 (pour les synchroniser avec les autres provinces). Les nouveaux membres/associés de l'Ontario, de la Saskatchewan, de l'Î.-P.-É., du Nouveau-Brunswick et de Terre-Neuve et Labrador peuvent aussi maintenant adhérer en ligne et leur adhésion sera également valable jusqu'à la fin de 2015. Ainsi, les dates de renouvellement de toutes les provinces seront synchronisées à compter du 31 décembre 2015.

La phase finale permettra aux membres et aux associés de la Colombie-Britannique, du Manitoba et du Québec de renouveler leur adhésion en ligne à compter du 1er septembre 2014, pour l'année prochaine (les adhésions pour

2015 doivent être effectuées avant le 15 décembre 2014).

Les personnes adhérant à l'AIISOC recevront une trousse de membres/associés de l'AIISOC par la poste. Cette trousse inclura une carte de membre/d'associé et des renseignements importants au sujet de l'association.

L'AIISOC s'efforce également d'offrir une valeur ajoutée à ses membres et associés grâce au travail en cours au sein des cinq piliers de l'AIISOC. Le développement des nouvelles initiatives de l'AIISOC sera interactif et offrira des occasions de collaboration et de consultation afin d'assurer une amélioration continue de la qualité lors de chaque étape du processus. Parmi ces initiatives, nous retrouvons :

1. La validation, par le biais de la recherche, des Normes de l'AIISOC dans la pratique des soins périopératoires. Ce projet a été lancé sous le pilier Informatique et recherche afin de faire progresser et de renforcer les normes de l'AIISOC;

L'AIISOC amorce un nouveau chapitre de son existence après que son Conseil d'administration et ses membres aient voté pour adopter les nouveaux règlements administratifs et clauses de prorogation de l'AIISOC qui sont maintenant conformes à la nouvelle loi canadienne régissant les organismes à but non lucratif. Les Conseils d'administration et de direction de l'AIISOC sont, tout au cours de la transition, demeurés axés sur ce qui constitue le cœur de l'association, soit les membres et les associés!

MESSAGE DE LA DIRECTRICE GENERALE (cont.)

2. La conférence nationale 2015 de l'AISOC (Edmonton, AB). L'équipe responsable de la planification de la conférence nationale travaille déjà depuis plusieurs mois à élaborer pour vous une conférence offrant un programme éducatif passionnant et dynamique qui se tiendra du 3 au 7 mai 2015, au palais des congrès Shaw à Edmonton; et
3. Les webinaires éducatifs de l'AISOC. De l'enseignement en ligne, créé par le pilier de la pratique professionnelle, sera lancé plus tard cette année afin d'aider à la préparation de l'examen d'agrément de l'AIC et à la mise en œuvre des normes de l'AISOC.

Cette période de transition est une période trépidante pour l'AISOC et la

mise en œuvre de ces nouvelles initiatives bénéficiera aux membres et aux associés. Ces derniers ont l'occasion de faire du bénévolat et de s'impliquer dans des projets intéressants. L'AISOC réévaluera régulièrement l'impact de ses actions et de ses plans sur les membres et les associés en tenant compte du point de vue de l'association qui est de toujours se baser sur la rétroaction individuelle des membres et des associés qui comptent sur l'AISOC pour obtenir des conseils et du soutien. Faites parvenir vos commentaires à ExecutiveDirector@ORNAC.ca. Pour adhérer à l'AISOC ou renouveler votre adhésion, visitez www.AISOC.ca. ✨



EXECUTIVE DIRECTOR'S MESSAGE (cont.)

The development of the new ORNAC initiatives will be interactive and will provide opportunities for extensive collaboration and consultation in order to ensure ongoing quality improvement during each step of the process. These initiatives include:

1. Validation, through research, of the ORNAC Standards for Perioperative Registered Nursing Practice. This project has been launched under the Informatics and Research Pillar to advance and strengthen the ORNAC Standards;
2. ORNAC 2015 National Conference (Edmonton, AB). The national conference planning team has been working for several months on developing an exciting and dynamic educational program and conference for you to attend May 3-7, 2015, at the Edmonton Shaw Convention Center; and
3. ORNAC Educational Webinars. On-line education, created through

the Professional Practice Pillar, will be launched later this year to address CNA Certification preparation and implementation of the ORNAC Standards.

This is an exciting time for ORNAC as it transitions in to a new phase and implements these new initiatives to benefit members and associates. There are opportunities for everyone to volunteer and get involved in interesting projects. ORNAC will constantly re-evaluate the impact its actions and plans on members and associates with the association's perspective always being shaped by the individual feedback from the members and associates who count on ORNAC for guidance and support. We look forward to your comments at ExecutiveDirector@ORNAC.ca. To join ORNAC, or renew your membership, visit www.ORNAC.ca. ✨



IRM PEROPÉRATOIRE : LES DÉFIS POUR OFFRIR UN ENVIRONNEMENT SÉCURITAIRE POUR LES PATIENTS ET LE PERSONNEL

Auteure : Joan Porteous, IA, B. S. Inf., CSP(C) est une éducatrice en soins périopératoires au département du bloc opératoire pour adultes du Winnipeg's Health Sciences Centre (un important centre hospitalier tertiaire et centre de traumatologie). Joan a participé à l'élaboration des normes de pratique pour ces nouvelles procédures.

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes de l'AIISOC pour la pratique des soins infirmiers périopératoires (11^e édition) de l'Association des infirmiers et infirmières de salles d'opération du Canada (AIISOC) d'avril 2013, section 4, pp. 237 à 241, normes 4.6.

RÉSUMÉ :

L'imagerie par résonance magnétique peropératoire en temps réel (IRSp) offre d'énormes avantages pour les patients ayant à subir une chirurgie pour l'ablation d'une tumeur cérébrale. Cet article traitera de l'expérience du Winnipeg Health Sciences Centre lors de la mise en œuvre d'un nouveau programme d'IRSp dans un nouveau bloc de salles d'opération neurochirurgicale. Il passera en revue la technologie de l'IRM et abordera les mesures de sécurité à respecter pour les patients et le personnel.

Remerciements :

Nous remercions sincèrement les infirmières/infirmiers en soins périopératoires de l'hôpital de l'Université de l'Alberta à Edmonton et de la Calgary Foothills Hospital, à Calgary qui ont généreusement partagé leur expertise et leurs ressources dans le domaine de l'IRM, en plus d'accompagner notre personnel lors de leur visite. Leur soutien a permis de faire progresser de manière efficace ce programme.

KEYWORDS: PATIENT SAFETY, CHECKLISTS, EDUCATION

INTRAOPERATIVE MRI: THE CHALLENGES OF PROVIDING A SAFE ENVIRONMENT FOR PATIENTS AND PERSONNEL

Author: Joan Porteous RN, BN, CPN(C) is a Perioperative Nursing Educator in the Adult Operating Room Department at Winnipeg's Health Sciences Centre (a large tertiary hospital and trauma centre). Joan was involved in developing the practice standard for these new procedures.

ABSTRACT:

Real-time intraoperative magnetic resonance imaging (iMRI) provides a tremendous benefit to patients undergoing brain tumour surgery. This paper will discuss the Winnipeg Health Sciences Centre's experience implementing a new iMRI program in a new neurosurgery

operating room suite. It will review MRI technology and discuss related safety considerations for patients and personnel.

INTRODUCTION:

The ability to offer high resolution intraoperative Magnetic Resonance Imaging (iMRI) at any time during a



The intraoperative MRI theatre with the shielded doors to the magnet storage area closed.

surgical procedure provides a great benefit to patients. In June 2013 Winnipeg's Health Sciences Centre began to offer iMRI procedures for patients undergoing surgery for brain tumours. Surgeons now have the ability to consult a real-time image during the surgical procedure and make decisions based on the findings of an iMRI. This technology will expand to include other types of surgery in the future.

While developing and implementing this new program, in a new operating room suite located in a new iMRI environment, the support and help from other experienced sites provided a tremendous boost.

Benefits of Intraoperative MRI:

Intraoperative MRI scans allow the surgeon to see the difference between healthy and diseased brain tissue during the surgical procedure. This enables them to more completely remove tumours. This ability to determine whether resection is complete is a great benefit in the resection on many types of primary or metastatic tumours. A randomized controlled trial demonstrated that patients undergoing surgery with intraoperative MRI had complete resection 96% of the time as compared to only 68% in the standard operative group. There was no increased

risk of neurological problems associated with the more complete resection. The authors suggest that the extent of resection correlates with survival rates in glioma surgery.¹

McGill University Health Centre reports that intraoperative MRI procedures, during tumour resection in children, are beneficial to reducing or eliminating epileptic seizures.²

Other advantages of intraoperative neurosurgical MRI include:

- Reliable imaging that reflects the situation in the surgical field in real time;
- The ability to identify bleeding in the brain, during surgery, beyond the field directly observed by the surgeon;
- Accurate anatomical identification of brain structures and avoidance of damage to them; and
- At the end of surgery a final MRI scan can determine if all the aims of surgery were achieved.³

Our Experience:

As the surgical team began to plan, along with the MRI technologist, the iMRI manufacturer representatives, and with consultation with other sites, it was quickly determined that there are many safety considerations associated with bringing an extremely powerful MRI magnet into an operating room.⁴ Patient and personnel safety depended on the establishment of clear departmental and procedural regulations that met national safety standards, along with consistent and firm enforcement of the resulting policies, practice guidelines and standards of care. Clinical practice standards were developed specific to our physical environment and resources.

The MRI safety program was established with comprehensive preliminary education and training of champions that included:

- Educational sessions from the new iMRI scanner's manufacturer;
- An MRI safety video;
- Review of the site's iMRI Clinical Practice Standards;

- Completion of MRI environment and personal screening for all personnel which included screening for ferromagnetic objects and/or implants that may be affected by the magnetic force;
- Orientation to the MRI theatre and surrounding physical space;
- Repeated simulations, with the complete surgical team, that included every step of the neurosurgical procedure from the pre-operative assessment to the transfer of the patient to the recovery area; and
- Simulation of an intraoperative cardiac arrest.

Safety checklists were developed, tested, and revised as necessary. These checklists are consistently utilized by the surgical team so that no safety precaution is missed at any time, thus ensuring the safety of the patient and of theatre personnel. Safety checklists are completed, with pause, by the entire surgical team and are performed:

- Pre-operatively, before the patient enters the theatre;
- Immediately prior to draping; and
- Immediately prior to each time the MRI magnet advances into the theatre.

Surgical counts are also conducted by nursing and anaesthesia personnel immediately prior to each magnet entry and immediately following its exit from the theatre.

MRI Technology:

In order to expand on the safety issues involved MRI technology, the access zones, and MRI fields have been briefly outlined below.

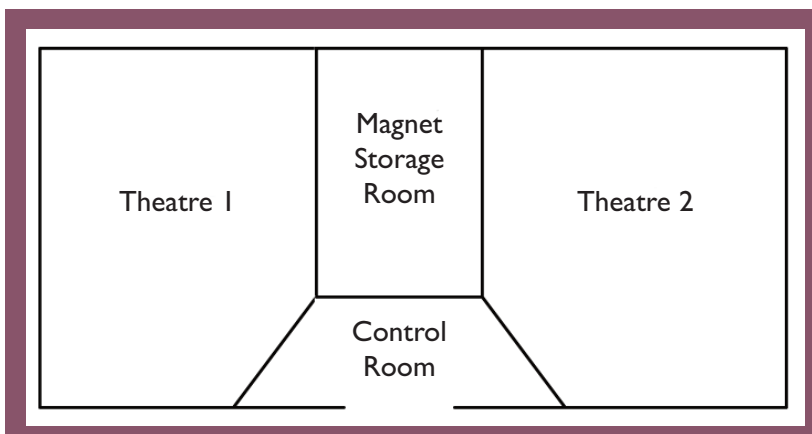
During an iMRI the patient is positioned in the central opening of a large electromagnet and is exposed to bursts of alternating radiofrequency energy waves. This, essentially, stimulates the magnetic nuclei of hydrogen atoms in the water of body cells thus altering their state of equilibrium. The nuclei, as they return to their original state of equilibrium, emit radiofrequency signals that are converted into three-dimensional color images.⁵

The ultra-powerful MRI magnet is contained within the protective walls of the machine's bore. At Winnipeg Health Sciences Centre the MRI scanner is stored in a secure storage area, between 2 ORs, and enters into each theatre via shielded metal double doors on the OR walls. See Figure 1 for the basic floor plan. The doors slide open to each side and the magnet advances into each theatre and retracts back into the storage area using ceiling-mounted tracks. Operation of the MRI magnet is controlled by technologists who are located in a control room adjacent to both theatres. The control room has windows into each theatre and into the central magnet storage room. There is also a shielded doorway into the magnet storage room from the control room. **The magnet is always on...** even when it is not in use. When the shielded metal doors are securely closed there are no risks posed by the magnet to the inside of the theatre.

Strengths of the magnetic fields are designated in units of tesla (T) for ultra-powerful magnetic fields, and units of gauss (G) for less powerful magnetic fields. The strength of the magnetic field within the magnet's bore at this site is 3T.⁶ 1T = 10,000G.

A 3T MRI magnet, such as the one at this site, is 60,000 times the force of the earth's magnetic field.⁷

Figure 1: Basic Floor plan of MRI suite at this site



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Theatre shielded doors are open to reveal the MRI magnet in its storage area.

Different coloured circular flooring patterns around the MRI scanner allow personnel to easily identify the following fields:

- The 5 gauss line identifies the perimeter surrounding an MRI scanner within which the static magnetic fields are higher than 5 gauss;
- 5 gauss and below are considered safe levels of static magnetic field exposure for the general public; and
- Electromagnetic and ferromagnetic items outside the 5 gauss line are not affected by the magnet

The circular inner (closest to the magnet) 50 and outer 5 gauss lines on the floor of the MRI theatre demonstrate that the magnetic intensity diminishes with greater distance from the magnet.

Access Zones:

Health care facilities may restrict access to MRI suites by establishing four conceptual zones around the MRI scanner. Each zone, as recommended by the Joint Commission that accredits and certifies US health care facilities, is described in relation to its purpose and distance from the MRI scanner.^{8,9} In brief they are:

- **Zone 1** is open to the public and offers the least exposure to magnetic fields;
- **Zone 2** should be restricted from

public access. Ferromagnetic objects are safe in this zone, but must remain here and not be taken into zone 3;

- **Zone 3** at Winnipeg Health Sciences Centre this zone is inside the MRI theatre. Entrance is restricted to personnel who have been orientated and screened for access to this area. Warning signage is clearly posted; and
- **Zone 4** is located within the 5 gauss line immediately surrounding the MRI scanner in all directions. During an intraoperative MRI the patient remains in zone 4 on a non-ferromagnetic OR bed and the magnet advances toward the patient. The MRI technologist and theatre personnel also enter zone 4 to position the anaesthetized patient safely in the scanner's opening. The anaesthetic machine is not MRI safe and, therefore, has long tubing extensions so that it can remain outside zone 4 at all times. Once the magnet storage room doors are opened, into the theatre, any ferromagnetic object in zone 4 may be pulled into the magnet with tremendous velocity resulting in injury to the patient or any person in its path of travel or damage the MRI scanner itself.

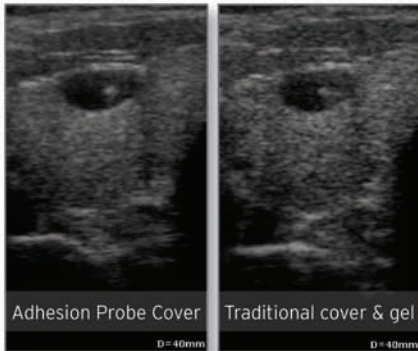
The MRI-safe OR bed remains, within the MRI theatre, in a fixed location within the 50 gauss perimeter line. During anaesthesia induction the bed is positioned so that the patient's head is closest to the anaesthetic machine. The bed is turned on a swivel, just prior to prepping and draping, so that the patient's head faces in the opposite direction (toward the closed MRI doors). This allows room for the surgical team and their equipment and also aligns the patient for entry into the magnet once the shielded doors are opened and the magnet advances into the theatre.

The patient often has the first intraoperative MRI scan following the anesthetic induction and positioning. Because of this, the sterile surgical equipment is set up in the periphery of the theatre outside the 5 gauss line.



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INTRAOPERATIVE MRI (cont.)

After draping is completed, the sterile equipment is moved inside the 50 gauss line and positioned beside the operative field at the patient's head. This equipment is moved back outside the 5 gauss line prior to each subsequent magnet entry into the theatre and remains there until the magnet retreats and the shielded doors are closed. With this process no ferromagnetic surgical instruments or equipment are affected by the magnet.

MRI Fields:

MRI technology uses three types of magnetic fields to create images. They are the very strong static field, smaller time variant magnetic fields called "gradients", and a radio frequency electromagnetic field:¹⁰

- The **static field** is an ultra strong magnetic field created by the superconducting coils and is

measured in units of Tesla. The static field does not vary and is **always on**. When the doors to the magnet storage area are opened, the static field extends into the theatre. The main safety risks in this field are from ferromagnetic objects accelerating into the bore as projectiles and from movement, or malfunction, of implanted ferromagnetic medical devices and metal debris.

The best method to eliminate this risk is to conduct a comprehensive screening of all patients and personnel for ferromagnetic objects such as pagers, some pens, some eyewear, etc on their person and implants within their bodies prior to their entry into the magnet room. Constant vigilance is required.

- **Smaller time variant gradient magnetic fields** are constantly turned on and off during scanning. The main safety risk

from these fields is from the generation of currents that may cause peripheral nerve stimulation and can disrupt the operation of implanted medical devices. Patients with implanted medical devices must be identified and may not be an iMRI candidate.

- **Radio frequency electromagnetic fields** can cause tissue heating and burns. In high-frequency electromagnetic fields the energy can be transmitted across open spaces and through insulators.

Conductive materials such as wires and leads, could act as a radio frequency antenna, should not be looped or come into direct contact with the patient's skin as this may cause burns.

Accidents and Injuries in the MRI Suite:

The Joint Commission published a Sentinel Event Alert⁸ reporting that the most common patient injuries in the MRI suite are burns and the most common objects to undergo significant heating are wires and leads. Projectiles, such as oxygen cylinders being pulled in to the MRI, have also been reported. This Alert also discussed a database developed, over a 10-year time, span by Jason Launders (a former medical physicist with the Emergency Care

Research Institute) that monitors health care technology and patient safety. The US database revealed 389 reports of MRI-related events including nine deaths. Three of the deaths were related to pacemaker failure, two to insulin pump failure. More than 70% of the 389 reports were burns and 10% were projectile-related.⁹

Risk-Reduction Strategies:

Risk-reduction strategies to prevent accidents and injuries include the following:

I. Restricting access to the iMRI environment:

- Before entering the iMRI theatre, to assist with any aspect of a clinical procedure, all clinical team members and support staff must first have received the required education, orientation and pre-screening.
- No one may enter the iMRI theatre without approval from the MRI technologist. At Winnipeg Health Sciences Centre the technologist maintains a list of individuals who have been pre-screened and orientated to the iMRI theatre. S/he will remind personnel to perform a personal check for ferromagnetic objects prior to entry as those items have the potential to become projectiles when the magnet enters the theatre. These items include cell phones, stethoscopes, pens, watches, body jewellery, hairpins, some styles of glasses, etc. If any individual refuses to comply with the safety requirements, s/he will not be permitted to enter the theatre until after s/he has attended additional education and demonstrates compliance with safety regulations;
- When the door to the magnet is open the theatre doors will automatically lock to prevent theatre entry and exit through that door. Emergency entry and exit may be made via the door to the magnet storage room; and
- Brightly lit warning signs outside the theatre are clearly visible to anyone in the hallway.



The MRI technologist uses a remote controller to advance the magnet into the theatre towards the MRI-safe OR bed.

INTRAOPERATIVE MRI (cont.)

2. Providing as much MRI-safe equipment as possible:

- MRI-safe versions of equipment are available for fire extinguishers, oxygen tank, stretcher, anaesthesia monitors and cables, etc. However, many pieces of essential equipment are not MRI-safe. For easy identification, each item should be labelled by the health care facility with MRI hazard level symbols as defined by the American Society for Testing Materials (ASTM)⁸ for MRI-safe, MRI-conditional and MRI-unsafe items.
- Caution is advised for supply carts. While non-ferromagnetic supply carts may be labelled as MRI-safe it is possible that ferromagnetic items may be stored on that cart. It would be prudent to not label the cart as MRI-safe in that situation.
- A hand-held magnet should be readily available to test items if it is not known whether they are ferromagnetic.

3. Taking precautions to prevent patient burns:

- Conductive materials, such as wire leads in a looped configuration, may absorb radiofrequency energy during the MRI which will focus the energy in a small area and cause a local burn if in direct contact with the patient's skin.¹⁰ As a precaution it is important to always:
 - a) Ensure wire leads are not looped; and
 - b) Place padding between any wire leads and the patient's skin.
- Conductive loops may also be inadvertently created by the patient's limb placement.¹⁰ This can be avoided by positioning the patient so his/her hands, legs or knees are not touching each other.

4. Providing hearing protection for all individuals:

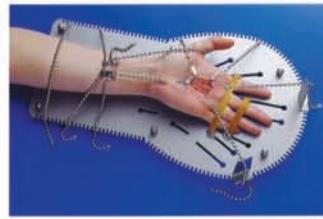
- The MRI scan creates a high acoustic level of sound and so it is essential that hearing protection devices be provided for the patient and for any individuals who will remain inside the theatre during the iMRI.

5. Simulating the management of emergency situations and providing readily-accessible guidelines for personnel in these situations:

- Simulation of emergency procedures provides an excellent learning opportunity for the surgical team and promotes evaluation of developed emergency processes;
- If the patient undergoes a **cardiac arrest**, during the iMRI scan, the MRI magnet retraction process is immediately initiated by the technologist in the control booth. It may, however, take a few minutes for the magnet to retract and the storage area shielded doors to completely

cont. on page 22

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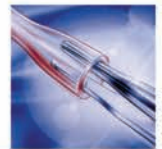
Westcott Scissors, 20mm blades, 11cm
Ciseaux Westcott, lames 20mm, 11cm



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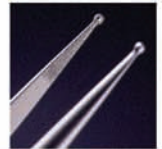
Vessel Dilator, 0.3mm tip, 11cm
Dilatateur à vaisseaux, pointes 0.3mm, 11cm



TFS-15 RM-8 TC



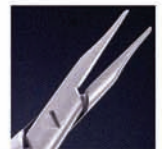
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close. Treatment, including cardio-pulmonary resuscitation, may begin immediately but the cardiac defibrillator is not MRI-safe and may not be brought into the theatre until the magnet is retracted, the shielded metal doors are closed, and the warning sign outside the door is no longer illuminated.

If the patient is to be in prone position during surgery an MRI-safe stretcher is placed in the magnet storage room, prior to surgery, so it is accessible during the procedure in order to reposition the patient into supine position for resuscitation.

Code blue posters with guidelines are easily accessible in the theatre.

- In the event of a fire, during an iMRI scan, the technologist in the control booth will immediately initiate retraction of the magnet from the room, activate the fire alarm, and call the code. External fire safety personnel should not enter the theatre until the magnet is retracted, the doors to its storage room are closed, and the warning sign outside the theatre door is no longer illuminated.

Theatre personnel should remove any burning material from the patient and ensure the patient and personnel are

not in immediate danger. The theatre's MRI-safe fire extinguisher may be used until it is safe to evacuate and for fire-safety personnel to enter. Fire orders and building **evacuation** routes and plans should be clearly posted.

- MRI machines are cooled by liquid helium. In order to quickly de-energize the MRI magnet, in an extremely urgent situation, the helium may be quickly released into the atmosphere during an emergency process called **quenching**.¹¹

Quenching may be necessary in a situation where a patient is experiencing severe injuries as a result of being pinned against the magnet by a ferromagnetic object. The decision to quench is made by the MRI technologist or the surgeon.

Once the quenching process has been initiated, the helium is vented from the machine (which takes about 20 seconds) before the patient can be moved. Quenching is an extremely expensive process as the magnet must later be restored, at a very high cost, but may be necessary in a life-threatening emergency.

6. Patient pre-screening:

- Patient pre-screening is essential to

Figure 2: Pre-Drape Patient Positioning Checklist:

- Patient's hearing protection in place and secured
- Head positioned with MRI-safe fixation devices
- Lower MRI coil in place
- Patient's arms secured at sides
- Skull clamp, coil arm and navigation attachment secured
- Padding to axilla, breast and scrotum as appropriate
- No skin-to-skin contact
- Wires, leads, cables and breathing circuits positioned apart and parallel and padded with no loops
- Leads, electrodes and temperature probes are MRI-safe
- Velcro safety belt is secured
- OR bed is locked and facing the MRI magnet entry



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avoid inadvertent injury. Patients who are to have an intraoperative MRI are often pre-screened prior to their admission into hospital. Contraindications to undergoing an MRI include, but are not limited to, patients who have pacemakers, insulin pumps, certain cranial aneurysm clips, and some implants.^{12,13,14}

Transdermal patches may contain aluminum or other metals that can overheat during a scan. Ferro-

magnetic debris, such as a piece of metal lodged in the eye, may move during the scan and cause further injury. Allergies to MRI contrast media are also assessed.

Comprehensive pre-hospital admission screening is performed by the MRI technologist and involves reviewing information on the screening form, as completed by the patient, a verbal interview to verify the accuracy and thoroughness of

Figure 3: Pre-Magnet Entry Checklist

- Wire removed from craniotomy drape
- Fluid collection pouch drained and no wet area under patient's head
- Anaesthesia counts are correct
- Anaesthesia machine brakes are on and it is outside the 50 gauss line
- Anaesthesia supply cart/blades/laryngoscope handle outside the 5 gauss line
- Vital signs monitor and infusion pumps outside the 5 gauss line
- Pressure bags are secured with tourniquets
- Nerve stimulator removed from patient and outside 5 gauss line
- Nursing counts are correct
- No ferromagnetic objects on the sterile field
- ESU grounding pad removed
- Pneumatic compression stockings disconnected
- All navigation accessories removed
- The following items are outside the 5 gauss line
 - o Hair clipper
 - o Patient warming devices
 - o Microscope
 - o Fluid warmer
 - o All foot pedals
 - o Ceiling booms and lights
 - o Instrument tables
- Charting computer is positioned outside the 5 gauss line and turned off
- Top MRI coil secured in place over protective drape
- MRI-compatible stretcher available
- Anaesthetist has hearing protection
- Surgical team pocket check: no jewellery, hair pins or clips, wallets, keys, etc

ALL CLEAR declared by the surgical team

information on the form, and allowing time for discussion and clarification by the patient and technologist.

- The patient must also be assessed and screened immediately prior to admission to the theatre. The team must ensure there are no ferromagnetic items on the patient and no contra-indicated implants. The patient's hospital gown should have no metal snaps, hair accessories must be removed, and identification tags should not be pinned to the hospital gown. If the patient requires supplemental oxygen an MRI-safe oxygen tank must be used in the theatre. At Winnipeg Health Sciences Centre the immediate preoperative assessment and screening is completed in the pre-surgical waiting area and is performed together with the patient, perioperative nurse, anaesthetist and the MRI technologist.

environment. Safety check lists, conducted with pause by the entire surgical team, are critical to providing a safe environment for the patient and for the surgical team.

- The pre-operative checklist provides confirmation that pre-screening has been completed.¹⁴
- Following the induction of anaesthesia, and patient positioning for brain tumour surgery, and prior to covering the patient with surgical drapes, the team at Winnipeg Health Sciences Centre pauses to complete a pre-drape patient positioning safety checklist. Checklists are specific to each site. See Figure 2 for indicators that could be included in a Pre-drape Patient Positioning Checklist.
- Immediately prior to the entry of the MRI magnet all ferromagnetic equipment, instruments, etc. are moved to the 'safe zone' outside the 5 gauss line in the theatre. A pre-magnet

7. Developing Safety Checklists:

- Checklists should reflect each unique

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entry “All Clear” checklist is conducted prior to the opening of the shielded doors and magnet entry. Counts are completed of every sterile surgical instrument and every anaesthesia item that remains on the top of the anaesthetic machine during the procedure. The counts are conducted outside the 5 gauss line, by two individuals, prior to magnet entry and immediately following magnet exit. See Figure 3 for indicators that may be included in the Pre-magnet Entry Checklist.

CONCLUSION:

The ability to provide real-time imaging, during the surgical procedure, supports the best possible surgical outcome for patients undergoing surgery for brain tumours. Providing a safe environment for patient and personnel, during these new and unique procedures, continues to provide ongoing challenges to the surgical team, and the range of surgical clinical applications for iMRI will only continue to expand. Specific perioperative nursing standards for intraoperative MRI procedures must be developed to provide a new and dynamic resource for the perioperative team.

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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 4, pg(s) 215-218, Standard 4.6.

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26th Atlantic OR Conference	Fredericton, NB	Sept 24 - 26, 2014

ORNAC CONFERENCES www.ORNAC.ca

24 th ORNAC National Conference	Edmonton, AB	May 3 - 7, 2015
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INTERNATIONAL CONFERENCES

EORNA (www.eorna.eu)	Rome, Italy	May 8 - 10, 2015
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SPOTLIGHT ON ORNAC MEMBERS

AN INTERVIEW WITH PAT POCOCK RN, DIPNE, BNS

Submitted by: Catherine Harley, RN, eMBA, ORNAC Executive Director.

Pat Pocock is a Registered Nurse who has worked in the perioperative field for fifty years. She started her career as a Perioperative Registered Nurse at the Grace Hospital in Windsor, ON, followed by a year working in the Operating Room at the University of Alberta Hospital in Edmonton. The next 14 years were spent in leadership and teaching roles in Windsor. The last 28 years of her hospital career were spent in leadership roles at St Joseph's Hospital in London, ON. Pat is past Co-Chair of the Canadian Operating Room Leaders (CORL) network and has committed her career to issues related to leadership within perioperative nursing.



Pat Pocock RN, DipNE, BNS

How long have you worked in the OR and what is your current role?

I have worked in the perioperative area/operating room for more than fifty years. I graduated from Grace Hospital, in Windsor, ON, and in 1960 went to work in the Operating Room as I had spent much of my student experience there. I had intended to take a post-graduate program, in perioperative care, but in 1961 I went to work for one year at the University of Alberta Hospital in order to gain practical experience. I started as a staff nurse in the OR and moved into a charge nurse position. I scrubbed for the first Harrington Strut procedure that was performed in Alberta for scoliosis. Fast forward to 2005 and, before I knew it, I was retiring from the position of Director of Perioperative Services, Urology Clinic, Lithotripsy Program (Provincial) and Central Processing after 28 years in leadership positions at St. Joseph's Hospital in

London, ON!! Since then I have worked as a perioperative leadership, management, and practice consultant. For close to three years I was a Senior Consultant, with the Ministry of Health in Ontario, on the Surgical Efficiency Targets Program.

What was it about perioperative nursing that attracted you?

I really enjoyed working in the operating room. I thought that it was a changing environment and I saw a promising future with the great strides being made in the field of surgery. The potential for the advancement of surgery and technology was exciting and I believe working in the OR touches people's lives at the most vulnerable moment. I really wanted to be there as a patient advocate. The interdisciplinary practice and teamwork also attracted me as I like to work in a team environment.



SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH PAT POCOCK RN, DIPNE, BNS

My passion has always been that leadership is accepted by any nurse who fulfills his or her accountability for the role.

Question: How has your role in the OR changed over the years?

I have experienced the roles of student, staff nurse, charge nurse, leader and director. The roles have evolved so much due to the explosion of technology and new knowledge over the years. Early in my career I would never have believed the progress I would see. In the early days of my career removing a kidney would have resulted in a very large incision across the patient's body a more than six week recovery time. Now they remove a kidney through an incision no greater than an inch and the patient is back at work in a few days.

What value do RNs bring to the leadership of OR teams?

My passion has always been that leadership is accepted by any nurse who

fulfills his or her accountability for the role. RNs have the skill ability, and the heart, to influence the level of care given to patients and to make a difference in the outcomes. Every RN who works in the OR has the potential and responsibility to be a leader. It is a shared leadership that creates accountability, equity, partnerships, and ownership. People in administrative leadership roles are accountable for the context and people in staff roles are accountable for the content. Decisions need to be made by those who do the work at the point of care or service. Leaders need to ask questions, guide, and ensure that the key stakeholders are involved in the process.

What continuing education has supported your journey?

I believe in life-long learning where learning is a continuous journey. I went to the University of Windsor and Huron University College in London, ON, and studied courses at the baccalaureate level. After developing an interest in burn care, through my work in the OR, I completed a Burn Nurse Certificate and set up a Burn Unit in Windsor. I also attended many annual CORL workshops and courses on Leadership including the Achieve Leadership program: Crucial Conversations and Crucial Accountability and have been involved in the planning of all of the CORL Conferences.

Who do you consider a key mentor and how did s/he influence you as a leader?

I would say that all of my colleagues have had an influence on my career. I admired Isabelle Adams and Victoire Odette from Quebec. Muriel Shewchuk from Alberta and I were mentors to each other. Dr. Tim Porter-O'Grady influenced my views on shared leadership and worked quite a lot with our staff. Mentorship is a two-way street

and I do hope that I have also been a mentor to people I have come in contact with during my career.

Tell us about the Canadian Operating Room Leaders (CORL) Network and your involvement.

In 1998, Muriel Shewchuk and I talked about starting a network for OR leaders across Canada. We saw a need for leadership development and knowledge sharing. We met with Peter Goodhand, VP of J&J Medical Products, and discussed our dream. He encouraged us to put a group together. Muriel and I established CORL, and took on the role of Co-Chairs, and Valerie Zellermeier (retired from St Michael's hospital in Toronto) joined us as Treasurer. CORL began with a small group of people and hosted its first conference following the ORNAC Conference, in Halifax, in 1999. CORL's goal is to provide an opportunity for Canadian OR leaders and staff to share knowledge that will enable everyone to thrive in their roles. We were hoping to provide an opportunity for leaders to share their experience and provide mentorship and thus strengthen the number of Operating Room Nursing Leaders across Canada. We felt this was important for the development and growth of our profession and our colleagues. We wanted to work in conjunction with ORNAC so as to stay aligned with, and be a support to, Perioperative Nurses across Canada.

At CORL conferences we have had many presentations related to all areas of leadership -- Shared Leadership; Leadership Competencies; Transformational Leadership; The Perioperative Nursing Data Set and Research in Ambulatory Care; Leadership Safety and Bench Marking; and presentations from the Canadian Patient Safety Institute. We believe that leadership and patient safety are intertwined so patient safety has always been a strong theme. CORL has also

SPOTLIGHT ON ORNAC MEMBERS (cont.)

AN INTERVIEW WITH PAT POCOCK RN, DIPNE, BNS

Nurses need to embrace shared leadership, demonstrate accountability at the point of care or service, contribute to excellence in care, and serve with enthusiasm and engagement throughout the journey of their career.

supported a Leadership Stream at several ORNAC Conferences.

CORL needs to continue to support leadership development... and nurses need to step up to the plate to take on administrative level leadership roles. There are people from different healthcare areas that are moving into leadership roles in the Operating Room and they don't have the same knowledge about the OR that a nurse has. We need leaders who understand the system and can provide knowledge about the impact to the care of patients.

CORL is now in the hands of the next generation of Perioperative Nurse Leaders. Muriel and I have stepped down now as Co-Chairs and Carol Kirkwood from Sudbury, ON, and Kelly Chapman from Calgary, AB, have now taken on those roles. Valerie Zellermeier remains the CORL Treasurer and Deborah Roberts is now our Education Coordinator. ORNAC members can now, when joining ORNAC, choose to also become a member of CORL for an additional \$10/year.

What was your motivation to become an ORNAC Board Director?

Being on the ORNAC Board, for the past 5 years, has allowed me to bring leadership skills and issues to this national organization and to be active in a decision making and voting capacity. I felt that being involved with ORNAC would help to create a strong organization that could collaborate and advocate for excellence in the perioperative environment and to

ensure that Leadership issues remained a strong part of this progress.

What future do you see for Perioperative RNs interested in developing leadership skills?

Perioperative nurses will continue to exist but their role will evolve into a different form. I believe the future holds three key things for our profession:

- 1) Self-awareness: Being able to accept ownership of one's self and our ability to influence others;
 - 2) Collaboration: Creating and sustaining a high level of communication;
 - 3) Connection: networks of people who can move together and develop and prepare for leadership roles, adapt to change, and learn to do things differently.
- Perioperative nurses will continue to exist but their role will evolve into a different form.

Any last words of wisdom?

Nurses need to embrace shared leadership, demonstrate accountability at the point of care or service, contribute to excellence in care, and serve with enthusiasm and engagement throughout the journey of their career. They need to love what they are doing and always promote the growth and development of others. Seize every opportunity develop, motivate and empower yourself and those around you! That is the key to true leadership!

L'EXCELLENCE POUR L'INFIRMIÈRE AUTORISÉE EN SOINS PÉRIOPÉRATOIRES

POUR REHAUSSER LA QUALITÉ DES SOINS AUX POINTS DE SERVICE – RENDEMENT EXCEPTIONNEL

Auteure : Muriel Shewchuk, IA, B.Sc.Inf., CSP (C), possède plus de cinquante ans d'expérience en soins périopératoires cliniques exhaustifs, en enseignement, en administration et en consultation. Elle a travaillé de près avec les conseils d'administration de l'AIISOC et de l'ORNAA, notamment pour la planification des conférences nationales et provinciales, le développement des normes de la pratique, la publication d'articles sur le leadership en plus d'avoir été conférencière lors de conférences internationales, nationales et locales sur les soins périopératoires. Muriel occupe actuellement le poste de coprésidente du Canadian Operating Room Leaders Group (CORL) qui se concentre sur l'éducation en matière de leadership au Canada.

INTRODUCTION :

Le rôle de l'infirmière autorisée professionnelle (IA) travaillant au bloc opératoire / en salle d'opération est l'un des rôles les plus sous-estimés, mal compris, craints, complexes, intégrés, tout en étant l'un des plus enrichissants dans le domaine des soins infirmiers. Les patients traversent une période où ils sont plus vulnérables et ils dépendent des connaissances et des compétences exceptionnelles des infirmières, de leur esprit critique et de leur capacité de défenseure au sein de l'équipe. Il n'existe tout simplement aucun autre rôle de ce genre dans le domaine des soins de la santé. Si votre passion est d'exceller par le biais de l'apprentissage continu, si vous possédez un esprit critique et des compétences de réaction de type A, si vous tolérez bien les comportements liés au stress des autres, si vous avez l'endurance pour travailler fort et que vous êtes un leader, que vous faites preuve d'attention et de respect pour

offrir du mentorat ou de la formation continue et que vous vous épanouissez pleinement au sein d'une équipe multidisciplinaire, les soins périopératoires peuvent être la carrière idéale pour vous. La longue liste d'attributs est essentielle, mais peu les possèdent tous.

Si vous envisagez cette profession comme un « emploi » où vous aurez les fins de semaine de congé, il sera alors difficile pour vous de vous épanouir dans ce choix de carrière! Toutes trouvent leur place. Sans excellence dans la pratique, attribut distinguant les IA en soins périopératoires, le choix de travailler en salle d'opération peut s'avérer un choix de carrière très difficile, ayant possiblement des répercussions à long terme négatives sur l'IA et ses collègues.

Cet article vise à déterminer les attentes en matière d'excellence dans la pratique pour toutes les IA travaillant aux points de service en service interne et externe.

Le rôle de l'infirmière autorisée professionnelle (IA) travaillant au bloc opératoire / en salle d'opération est l'un des rôles les plus sous-estimés, mal compris, craints, complexes, intégrés, tout en étant l'un des plus enrichissants dans le domaine des soins infirmiers

PERIOPERATIVE REGISTERED NURSE EXCELLENCE

RAISING THE BAR AT THE POINT OF CARE – STAR PERFORMANCE

Author: Muriel Shewchuk RN, BScN, CPN(C), has over five decades of comprehensive perioperative clinical, teaching, administrative and consulting experience. She has been extensively involved with ORNAC and ORNAA Boards including National and Provincial Conference Planning, Standards of Practice development, publication of leadership articles, and presenter at international, national and local perioperative conferences. Muriel is currently Co-Chair of Canadian Operating Room Leaders Group (CORL) that focuses on leadership education in Canada.

INTRODUCTION:

The role of the professional Registered Nurse (RN) employed in the Surgical Suite/ Operating Room (OR), is one of the most misinterpreted, misunderstood, feared, complex, integrated, yet rewarding roles in the nursing field. Patients are at a vulnerable time, are depending on the outstanding knowledge, skill, critical thinking and advocacy of the RN within the team. There is simply no other place like it in health care. If your passion is to excel through continual learning, possess Type A critical thinking and response skills, have tolerance for stress related behaviours of others, stamina for “hard work”, are a leader, exhibit kindness and respect, providing continual teaching/mentoring, and thrive within a

multidisciplinary team, Perioperative nursing can be the best life long career. The long list of attributes are essential, but also a very tall continuous order.

If you are viewing the position as a “job” with weekends off, then it will be difficult to thrive in this career choice! There is a right place for everyone. Without the excellence of practice attributes embedded within the Perioperative RN, the OR can be a very difficult career choice, with potential long term and negative impact on the RN and teammates.

The focus of this article is to define the expectation for excellence of practice, for all RN’s, working at the point of care for the scrub and circulating role.

EXPECTATIONS FOR ALL SURGICAL SUITE/ OR REGISTERED NURSES

“You can make or break the surgeon’s day!”

- **Orientation and Continual Training:** Conscientiously practice the detailed skills and patient care taught in orientation. Ensure the full orientation has been completed. Always aim for a high level of competence. Take advantage of continual learning, online opportunities, ensure a Bachelor Degree and start working on a Master’s Degree. Most leadership and education position opportunities require advanced education, hence be prepared for your future in Perioperative services.
- **Surgical Specialty skills and practice:** Each surgical specialty builds on the orientation base and requires RNs to advance from novice to expert over a period of months. Expert levels of patient care, by the scrub and circulating team, must be provided on all shifts, whether the situation is elective, urgent or emergency status.
- **Role Models:** Associate with, and model your practice, after star performers. Acknowledge and commend your role models!! Strive to become a role model, teacher and mentor.
- **Gown & Gloving:** During orientation practice gowning and gloving yourself and others, to ensure you are confident, credible and competent, before arriving at the point of care! Closed gloving and re-gloving are challenging skills to master, for novice nurses, however, once learned never forgotten!

Unlike other areas of practice, a single OR room/Theatre is a “unit of care for each patient”.

- **Standardized Practices:** Comply with standardized practices to reduce the risk of errors, delays, stress, and mediocre performance. Expect all team mates to comply. Politely point out the approved practice, always in the interest of patient safety best practice.
- **Policies & Procedures:** It is mandatory for employees to comply with facility Policies, from a legal perspective. Use due process to inform Management/Education members for updates/clarification/changes required for outdated or conflicting information. Procedures may have some variability, based on a number of factors including patient needs, interdisciplinary practitioners, and situations. Policies and Procedures should be current and accessible on the room/theatre computers.
- **Standards of Practice:** Comply with ORNAC and Infection Prevention Standards, understanding principles, rationale and evidence-based reasons, as opposed to ritual traditions and outdated practices. Current ORNAC Standards should be accessible for all staff and preferable loaded on all OR computers.
- **Documentation:** Ensure documentation is accurate, complete, timely, and legible. Upon reflection, ask yourself “will I be credible and proud of my accurate and legible documentation?” You may have to defend your actions and could face a challenging prosecutor, during a court case, some five years from the incident. You have nothing to refer to except compliance with Policies and Procedures and your accurate legible documentation! In the legal system, “You are what your documentation is!” Ensure discussion with surgeon to confirm accuracy of documentation of procedure details performed, and specimen specifications.
- **ON TIME!** It is very important to arrive at work before the beginning of the shift and in full OR dress code. Arriving late is a sign of disrespect to all. Arrive at the specified theatre, immediately after shift reports, commence work – make use of very minute to expedite efficiency, patient care, time, scheduling and cost implication for the team members. Expect the same from all team members. On time is also important expectation for patients and families.
- **Hand Signals:** A seemingly forgotten art and skill. Focused attention, credibility of the scrub nurse, nonverbal communication, noise and distraction reduction, are base requirements throughout a surgical case. Nurses should use as many hand signals as possible to communicate so as to not distract the team. Hand signals can be used for “need more sponges or another suture”, “going to coffee”, and “doing a good job.” The scrub nurse should have in-hand the next anticipated instrument and a second option in the alternate hand.
- **Volunteer/Influence Decisions:** Take the opportunity to serve on Department Committees such as Clinical Practice, Safety, Quality Improvement, and social activities. Experience and credibility, especially from the point of care team, influences good decisions, best practice, ensuring care can be more efficient, effective, safe and satisfying for all.
- **Leadership:** Unlike other areas of practice, a single OR room/Theatre is a “unit of care for each patient”. In every case the circulating nurse for the case must always take a leadership role in organizing the room, supporting the scrub nurse, managing efficiencies, and supervising the team and safety activities.
- **Medical Device Reprocessing (MDR):** Establish a good working relationship and communication with MDR members to reduce the stress related issues surrounding supplies, case carts, device and instrument sets. Treat staff with respect! Practice assembly/disassembly of complex devices in MDR, to ensure skills and competency in handling and use of all instrumentation, for the surgical team.
- **Attitude and Behavior:** Maintain a positive attitude; and ensure negativity does not invade your practice environment. Follow facility direction, for handling bully, intimidation, mediocre performance, risks and errors. Poor/mediocre/average performance, and unacceptable conduct, both verbal and non-verbal, must be managed in a professional, zero tolerance manner to order to achieve effective sustained outcomes.

cont. on page 35

Editorial Review Panel

If you're interested in joining the ORNAC Editorial Review Panel review panel e-mail journal@ornac.ca for more information.

Betty Barrett, RN, BN, CPN(C), Manager Surgical Suite Chinook Regional Hospital, and Content Expert for Curriculum Development of Perioperative Program Lethbridge College, Lethbridge, AB.

Audrey Cook, RN, CPN(C), BN, B.Sc, BA, Staff Nurse, South Shore Regional Hospital, Bridgewater, NS.

Chris Downey RN, CPN(C), MSc, RNFA, CMLSO, Registered Nurse First Assistant, Clinical Practice Leader, Perioperative Services, Clinical Educator-Operating Room, Kingston General Hospital, Kingston, ON

Margaret Farley, RN, CPN(C), Perioperative Clinical Development Educator, Regina Qu'Appelle Health Region, Regina, SK.

Kimberly Ferguson, RN, BSN, CNOR, Surgical Services Program Manager, BC Children's Hospital, Vancouver, BC.

Donna Gramigna, RN, BSN, CPN(C), VIHA Regional Clinical Nurse Educator, Royal Jubilee & Victoria General Hospitals, Victoria, BC.

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Lesia Yasinski, RN, BN, MSA, Manager of Nursing Initiatives, Winnipeg Regional Health Authority, Winnipeg, MB.



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Manage the Change-Over between surgical procedures / patients to the minute!

- **Computer Skills:** Excellent computer skills are necessary to support the documentation, associated medical supply, lab, radiographic, education and other systems. Take advantage of facility and community training sessions. Facilitate colleague's computer use by using positive approach. Computer use is the now the "way of the world, including the full scope of Perioperative care.
- **Set Learning Goals:** Establish, with Management, learning goals and request timely guidance and performance appraisals to assist in achieving the goals as well as areas for improvement. Attend and support professional organizations, functions and educational sessions. Maintain personal, current records of achievements, certificates, educational topics, with dates, subject and length of time to support continuing education units(CEU) reporting.
- **Certification:** Once two years of experience has been attained, every perioperative RN should become Canadian Nurse Association (CNA) Certified in Perioperative Nursing – CPN(C) – followed by recertification every five years. Certification demonstrates professional accountability to the patient and teammates.
- **TEACH, TEACH, TEACH:** It is the professional responsibility of all RN's to teach colleagues, using a professional respectful and supportive manner to promote a learning environment that is focused on excellence and patient safety.
- **Personal Cell phones and Tablets:** Personal electronic communication devices shall not be brought into the point of care by staff. Personal messages can be checked on regular break times. All attention must be focused on the patient and team. Personal urgent/emergency calls, to staff members, should to be directed to the main OR desk. Yes, Surgeon and Resident cellphones and pages need to be answered by the Circulators. Remember there are many patients, other physicians, unit staff and office staff that require the surgeons' attention.

CIRCULATING RN ROLE – EXPECTED EXCELLENCE

"You make or break the day for your team"

- **Point-of-care Team Lead (TL)/ Charge:** The lead circulating RN plays a major role in the efficiency, safety, quality and tone of each room. A designated position of TL/ Charge Nurse may be accountable for one to several rooms with specific responsibilities and accountabilities. When the TL is not in the room senior circulating RN must assume leadership of the room. It must be clear to all member "who is charge" of theatre activities. Duties include direction of professional and support staff caring for the patient, noise control, full attention to and support of the scrub nurse. Included is general supervision, teaching for any member of the team, or visitors, preparation for subsequent procedures and monitoring an efficient changeover.
- **Advance Surgeon Preparation:** Ensure advance conversations occur regarding surgeon/patient special needs, over and above the standard "Pick List", in order to reduce delays, stress and potential cancellation. Ensure all arrangement and sterilization time lines can be met especially in the case of loaner and complex orthopedic sets.
- **Staff Assignment:** Assign the scrubs on the previous day. Expect full preparation, by the scrub nurses, which includes review of the "Pick List", surgical steps involved in the procedure, skills required for handling instruments/ devices /tools/devices, standardized efficient organized setups and counts, and a rapid, safe, organized end-of-case including dismantling.
- **Support Staff:** Coordinate support staff for positioning assistance, change-over, and supply/case cart acquisition. Treat support staff with respect. Include in staff huddles, at beginning and end of day, to determine issues for discussion/ resolution; always assessing "what could we have done better." Listen to the issues of support staff!

cont. on page 37

CORRECTION

The Essay Writing Contest Winners, published in September 2013, contained an incorrect photograph. Alma Dirpaul, of SK, was the recipient of the 3rd place award but the photograph used, in the bottom right corner of page 27, was not of Ms. Dirpaul.

Our apologies to Ms. Dirpaul and to our readers.

La publication de septembre 2013 annonçant les gagnants du concours de rédaction d'essai contenait une photo incorrecte. Mme Alma Dirpaul, de la Saskatchewan, a été la lauréate du prix de la 3e position, mais la photo utilisée dans le coin inférieur droit de la page 27 n'était pas celle de Mme Dirpaul.

Toutes nos excuses à Mme Dirpaul et à nos lecteurs.

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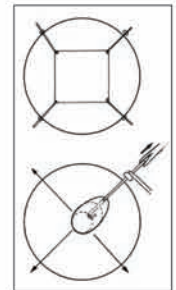
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OP.5067.1 Round polypropylene fiber
Fibre ronde de polypropylène

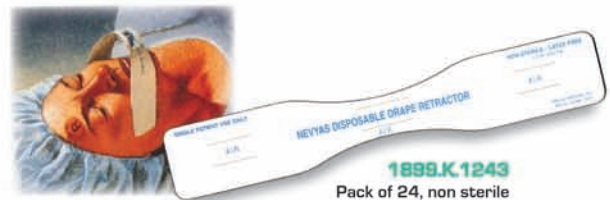


OP.5213.1 Flat polypropylene fiber
Fibre rectangulaire de polypropylène



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- **Patient Admission:** Follow all legal requirements, provide stress relief, review key issues with patient and family and facilitate pre-warming procedures, introduction to team members, and pre-operative comforts. Ensure positioning prep, draping, and placement of equipment and tables are efficiently done. Patient safety is the top priority.
- **Anesthesia Support:** Ensure full attention and support for the anesthesiologist during pre-operative preparation and induction. Be alert for any sign of distress or potential complications throughout the procedure. Provide the focused immediate support during emergence, extubation, patient transfer and admission to Post Anesthetic Care Unit.
- **“Time Out Practice”:** Provide full support and facilitate a fully detailed, accurate and thorough “Time Out Process” for each patient according to Facility Policy.
- **Standards:** Monitor behavior, aseptic technique, instrument equipment challenges, and deficient skills. Take appropriate and timely corrective action. Follow through in the interests of patient safety and respect for the needs of the entire surgical team. Communicate issues to the appropriate leadership members to support Quality Improvement processes.
- **Distraction and Noise Reduction:** Maintain a quiet respectful environment! Be alert to noise and conversations, music, phones that can distract the surgeon and team. Increased noise levels add to risk of errors, impact-focused concentration, and add to stress.
- **CHANGE-OVER!** Manage the Change-Over between surgical procedures / patients to the minute! Every day – every procedure! Change-over is a major issue in OR’s resulting in a major waste of time translating to dollars, resources, immense frustration, inefficiency, cancelled cases, and reduced credibility for the Department/ Team . Ensure everyone understands the critical nature, knows the benchmarks, discusses the issues, takes actions to consistently maintain best practice. Acknowledge and thank everyone that assists the team in meeting the expected times. Efficient, approved, safe Change Over practices must be sustained.
- **Self-Assessment of Performance:** Reflect on “how the case/day went, what issues arose, and how can the team improve, did I instill respect, trust, and confidence among the team?” Will the team look forward to working with me tomorrow?” The RN’s commitment to excellence is a choice... you can make it so!

SCRUB REGISTERED NURSE ROLE - EXPECTED EXCELLENCE

“You can make or break a surgeon’s day/experience”

- **PRE-PREP - Be Prepared!** Spend time in MDR assembling and disassembling complex devices.
- **Surgical Procedure Knowledge:** It is essential to understand the details of the surgical procedure being performed, which includes the tissue layers of surgical anatomy, advancing to the site of the procedure, the structures and sequential steps involved in the procedure, and the tissue closure steps. In addition instruments/devices associated with each tissue layer and step in the procedure as well as the various surgeon specific or anatomical/disease and surgical alternatives. Textbooks, vendor information, and online computer sites are excellent resources for anatomy and surgical procedures.
- **Procedure Card Contents:** Have full knowledge and understanding of how to skillfully use/teach instruments, devices, equipment and supplies on the Procedure Card/Pick List. Monitor items not used on the case – refer to leaders to remove or place on a PRN/Do Not Open section to reduce waste/ save time/costs.
- **Hand Signals:** Conversation during surgery should be at a minimum. Learn and respond immediately to surgeon hand signals. Do not distract the surgeons by verbally requesting additional items but use/establish hand signals with the circulator.
- **Table Setups:** Be on time! Rapidly, scrub, gown and glove – no idle chat or time wasters. Establish the sterile set-up with confidence, efficiency, and strict aseptic

Be on time! Rapidly,
scrub, gown and
glove – no idle chat
or time wasters.

technique. Accept items carefully, aseptically, and firmly from the circulator. Watch for potential contamination from package edges. Precisely, and safely, place sterile items in the appropriate standard location handle only once. Ensure circulators are not reaching over your sterile table when dispensing supplies/drugs/solutions.

- **Drapes:** Ensure drapes are easily accessed by the team and organized to the order of use.
- **Mayo Stand:** Immediately place a well-organized standardized Mayo stand in position. The tray should have sequential layers of side towels, ESU cord, suction tube, towel clips, and opening sponges. The scrub nurse should be able to start the procedure from the Mayo tray and allow the circulator to move the instrument table into position in a timely manner. Scrub nurses shall not move instrument tables!
- **Surgical Count:** Prepare for, and assertively take an equal part in, the surgical count ensure all detailed sequences occur. Ensure the circulator holds the record so that you can review the accuracy of the number of items. As items are added during the case ensure you actually visualize and read the number recorded to reduce the risk of count errors due to not recording. Remember both scrub and circulating nurses are legally responsible for an accurate complete surgical count! The count record needs to be able to stand alone as an accurate “story” of how many, who counted, who added what, and the end result.
- **Instill Surgeon Confidence:** Imagine what is running through the surgeons mind as he scrubs and assesses the scrub and circulating staff in the room. Your skill level, knowledge, reputation and commitment to excellence will show. Never say “I have never done this before” – try to imagine the resulting concern, frustration and perhaps panic and stress. Introduce yourself quietly, perhaps state “I have followed the Procedure Card” and ask, “do you want to scan my table, for any additional needs?” Exude confidence, attentiveness, interest and appropriate conversation/questions.
- **Focused Attention:** The scrub nurse needs to be thinking three to four steps ahead of the surgeon to ensure all instrument, devices, sutures etc. are ready. The scrub nurse also needs to be prepared for options the surgeon may require. Hence always have an item in both hands as to place the correct item in the surgeon’s hand. Delays, as a result of needing to search, can cause a great deal of stress and frustration. Ensure focused attention throughout the case – learn from every experience! Be brave – at an opportune time ask the surgeon what you could have done to improve.
- **End-of- Case, Dismantling and Change-Over:** Ensure your full focus and attention are on the surgical team to expedite the case and minimize anaesthetic time. Ensure all items are available for closure and completion. Maintain an organized instrument table to ensure ease and sequential dismantling to prevent injury with sharps or contamination. Damage to fine instruments, loss of reusable items into waste or laundry, or inappropriate management of biohazard adds to the chaos, cost, injury and errors. Load the soiled items in the transport cart in a standardized manner for MDR safety and efficiency. Assist support staff in a respectful manner, with a rapid, efficient and safe Change-Over.

Summary

As described, the responsibilities of the Perioperative RN are extensive, complex, time-sensitive, can impact a large number of patients and multi-professionals. In a time of tremendous pressures in health care, with patient safety as a focus, there is an expectation of practice excellence throughout. Registered Nurses need to determine if they can, or are willing to, achieve excellence of practice in the OR. Our reason for being is “THE PATIENT”. Strategize how you will achieve the bar of excellence and in the words of Wayne Gretzky - “skate to where the puck will be.” Shower your environment with positive sprinklings of star performance – the return professional profits are immeasurable.

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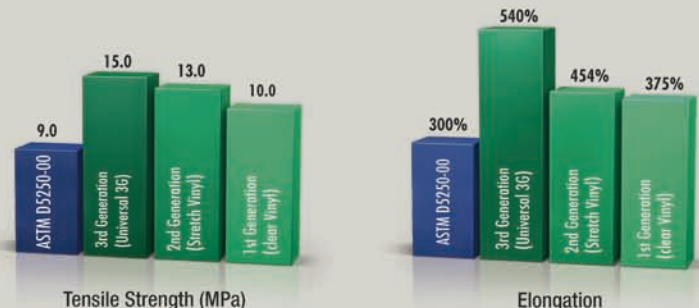
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* Data on file.

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