March 2013
Volume 31, Issue 1

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;
- A 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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PRESIDENT'S MESSAGE

Karen Frenette, RN, BN, MN, CPN(C), ORNAC President is the Surgical Suite Nurse Manager at Chaleur Regional Hospital, Bathurst, NB, a part time instructor for the University of New Brunswick Faculty of Nursing, Bathurst Campus, and the past Chair of the ORNAC Research Committee.

The ORNAC pillar structure will become fully implemented, under the new Board, with the five pillars of National Conference Planning, Professional Practice, Advocacy, Research and Informatics, and Marketing.

It is with mixed emotions that I to write this message. It seems like just yesterday that I embarked on this wonderful journey as the ORNAC President… and now my term is nearing completion. My final message, in the next issue of the journal, will be written jointly with your incoming President.

Change and transition have been key words throughout my term. My first President's Message, in June 2011, was published in the Canadian Operating Room Nursing Journal (CORNJ) and my final message is appearing in the NEW ORNAC Journal. The dedication of ORNAC's volunteer Editorial Board Chair, Executive Director, and Editor/Publisher has brought this new journal from vision to fruition! This is but one example of the changes that have occurred during my term as President. Many of the changes in progress may not, as of yet, be evident to the ORNAC membership. These changes will be put in place over the next few years as we continue to implement ORNAC's strategic plan. ORNAC will become a stronger and more viable organization as it evolves to meet the needs of Canadian Perioperative Registered Nurses as well as the requirements of the new Canada Not-for-Profit Corporations Act.

A major change to the ORNAC Board structure will be voted on during the April Board Meeting. The proposal on the table would streamline the Board structure, from its current 23 Board Members and 5 Executive Members, to 13 Board Members and 4 Executive Members. This new structure was developed, and has been accepted in principle, by the current ORNAC Board. Each provincial perioperative organization and the 3 affiliate members will continue to be represented, and to have a vote, at the ORNAC table. If ratified the transition to the new structure will occur, with the transfer of the President's chain of office, at the conclusion of the 2013 ORNAC National & International Conference with IFPN.

The ORNAC pillar structure will become fully implemented, under the new Board, with the five pillars of National Conference Planning, Professional Practice, Advocacy, Research and Informatics, and Marketing. Perioperative nurses across Canada will have increased opportunities, under this new structure, to become involved in ORNAC. Areas such as Perioperative Education, ORNAC Standards Development, and Leadership are but a few where volunteers will be needed. Express your area of interest to your provincial representatives on the ORNAC Board and become involved! ORNAC will, throughout the transition period, keep the membership informed about the progress via this Journal or the ORNAC website. Remember this is YOUR association and we always welcome your input!

The 2013 ORNAC National & International Conference with IFPN, in Ottawa, will become a reality in the very near future (April 21-25, 2013)! The Conference Planning Committee has been working diligently to plan an exciting conference. The wide variety of Canadian and international speakers will present on an array of topics to meet the educational needs and interests of all delegates. The social events will appeal to all and showcase Canadian culture and our nation's capital. Our industry partners continue to provide their invaluable contribution and will display their latest technology. The ORNAC Board & Executive look forward to seeing you at the Conference!

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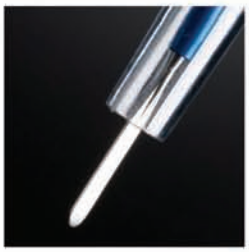

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MOT DE LA PRESIDENT

Karen Frenette, IA, B.Sc.Inf., M.Sc.Inf., CSP/C, la President de l'AIISOC est infirmière-gestionnaire du bloc opératoire de l'Hôpital régional Chaleur, à Bathurst, au N.-B., chargée de cours à temps partiel pour la faculté de soins infirmiers de l'Université du Nouveau- Brunswick au campus de Bathurst et ancienne présidente du Comité de recherche de l'AIISOC.

C'est avec des sentiments mitigés que je vous écris ce message. Il me semble que c'était hier que je me suis jointe à cette merveilleuse aventure en tant que présidente de l'AIISOC… et maintenant, mon mandat tire à sa fin. Mon dernier message qui paraîtra dans le prochain numéro de la revue sera rédigé en collaboration avec votre future présidente.

Changements et transition ont été les mots-clés tout au cours de mon mandat. Mon premier message, en juin 2011, a été publié dans la Revue de l'Association des infirmières et infirmiers de salles d'opération du Canada (RAIISOC) et le dernier apparaîtra dans la NOUVELLE Revue de l'AIISOC. Le dévouement de bénévoles, telles la présidente du comité de rédaction et la directrice générale de l'AIISOC ainsi que la rédactrice en chef, a permis de concrétiser cette nouvelle revue! Ce n'est qu'un exemple des changements réalisés au cours de mon mandat de présidente. Plusieurs des changements en cours peuvent, pour l'instant, ne pas sembler évidents aux membres de l'AIISOC. Ces changements seront peu à peu mis en place dans les prochaines années, à mesure que nous continuerons de mettre en œuvre le plan stratégique de l'AIISOC. Votre association deviendra plus solide et plus durable à mesure qu'elle évoluera pour répondre aux besoins des infirmières et des infirmiers canadiens en soins périopératoires ainsi qu'aux exigences de la nouvelle loi canadienne régissant les organismes sans but lucratif.

Un changement important au sein de la structure du conseil d'administration de l'AIISOC sera voté lors de la réunion du conseil d'administration du mois d'avril. La proposition à l'examen simplifierait la structure du conseil dont les membres du conseil d'administration passeraient de 23 à 13 et dont les membres du conseil de direction passeraient de 5 à 4. Cette nouvelle structure a été examinée et a été acceptée en principe par le conseil d'administration actuel de l'AIISOC. Chaque organisme provincial en soins périopératoires et les trois membres affiliés continueront d'être représentés et d'avoir le droit de vote à la table de l'AIISOC. Si cette proposition est entérinée, la transition vers la nouvelle structure se produira et la présidente transférera les insignes de sa charge à la fin de la Conférence nationale et internationale 2013 de l'AIISOC avec l'IFPN.

La structure des piliers de l'AIISOC sera entièrement mise en place sous la direction du nouveau conseil d'administration, avec les cinq piliers représentant la planification des conférences nationales, la pratique professionnelle, la défense des droits, la recherche et l'informatique et le marketing. Sous cette nouvelle structure, les infirmières et les infirmiers en soins périopératoires de partout au Canada bénéficieront d'opportunités accrues pour s'impliquer auprès de l'AIISOC. L'éducation en soins périopératoires, le développement des normes de l'AIISOC et le leadership ne sont que quelques-uns des domaines où des bénévoles seront recherchés. Mentionnez le domaine qui vous intéresse à vos représentants provinciaux faisant partie du conseil d'administration de l'AIISOC et impliquez-vous! Tout au cours de la période de transition, l'AIISOC gardera les membres informés des progrès par l'entremise de sa revue ou du site Web de l'AIISOC. N'oubliez pas : l'AIISOC est VOTRE association et nous apprécions toujours vos commentaires!

La conférence nationale et internationale 2013 de l'AIISOC avec l'IFPN, à Ottawa, aura lieu très bientôt (du 21 au 25 avril 2013)! Le comité de la planification des conférences nationales a travaillé d'arrache-pied pour organiser une conférence passionnante. Une grande variété de conférenciers canadiens et internationaux aborderont toute une gamme de sujets afin de répondre aux besoins en éducation et aux divers intérêts de tous les délégués. Les activités sociales plairont sans aucun doute à tous et à toutes et dresseront un portrait de la culture canadienne et de la capitale nationale. Nos partenaires de l'industrie seront également au rendez-vous pour offrir leur précieuse contribution et présenter la toute dernière technologie dans notre domaine. Les membres du conseil d'administration et de la direction de l'AIISOC sont impatients de vous rencontrer lors de cette conférence!

La structure des piliers de l'AIISOC sera entièrement mise en place sous la direction du nouveau conseil d'administration, avec les cinq piliers représentant la planification des conférences nationales, la pratique professionnelle, la défense des droits, la recherche et l'informatique et le marketing.

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La date limite pour soumettre les mises en candidature est le 15 janvier.

Pour de plus amples renseignements, veuillez visiter www.AIISOC.ca

et cliquer sur le lien Bursaries, Grants & Awards
(disponible en anglais seulement)

EXECUTIVE DIRECTOR'S MESSAGE

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

Strategic Plan Implementation: Focus on Governance Transitioning to the New Canada Not-for-Profit Corporations Act

The new Canada Not-for-Profit Corporations Act (CNCA) was assented to June 23, 2009 and came into force on October 17, 2011. The Canada Not-for-profit Corporations Regulations were, in addition, adopted on October 6, 2011 and also came into force on October 17, 2011.

The new Act and Regulations introduce a new legislative framework for the federal incorporation of not-for-profit corporations and provides for continuance within these corporations. It acts as a "comprehensive rule book" replacing much of the detail that was previously required in By-laws and gives associations latitude to accept the default requirements in the legislation or to set rules to fit its own circumstances and practice. Part II of the previous Canada Corporations Act, under which ORNAC was incorporated, dates back to 1917. Corporations Canada has been working on modernizing the Canadian legislation on not-for-profit corporations for the last 20 years. For ORNAC it was important to analyze the new Act due to its technical nature. The continuance process was identified in the ORNAC Strategic Plan as an ideal time for re-examining the letters patent (including objects) and By-laws to ensure that the existing provisions conform to the CNCA and to take advantage of many of the modern provisions contained in the CNCA.

The new Act and Regulations introduce a new legislative framework for the federal incorporation of not-for-profit corporations and provides for continuance within these corporations.

Not-for-Profit Corporations, such as the Operating Room Nurses Association of Canada (ORNAC), currently existing under Part II of the Canada Corporations Act (CCA) were given a three year period from October 17, 2011 to apply for a continuance under the CNCA (the requirement for continuing as a non-profit corporation). If an existing Part II CCA corporation is not continued under the CNCA before October 18, 2014, Corporations Canada will, upon first giving notice in writing to the corporation and to each of its directors, dissolve that corporation. ORNAC developed a critical path to have the Articles of Continuance and the By-laws revised to conform to the CNCA and ready for approval by the Board of Directors and the ORNAC membership by April 20, 2013 (18 months in advance of the deadline). Initially it seemed like three years was a long period of time but, of course, it takes a great deal of time to draft the documents and go through lengthy review and legal consultation process for governance changes and the review of the CNCA in the context of existing objects, by-laws and governance structure. The ORNAC Board of Directors has made this matter a high priority.

As part of the continuance process ORNAC will, under the new Act, no longer have letters patent (the written

EXECUTIVE DIRECTOR'S MESSAGE cont. on page 14

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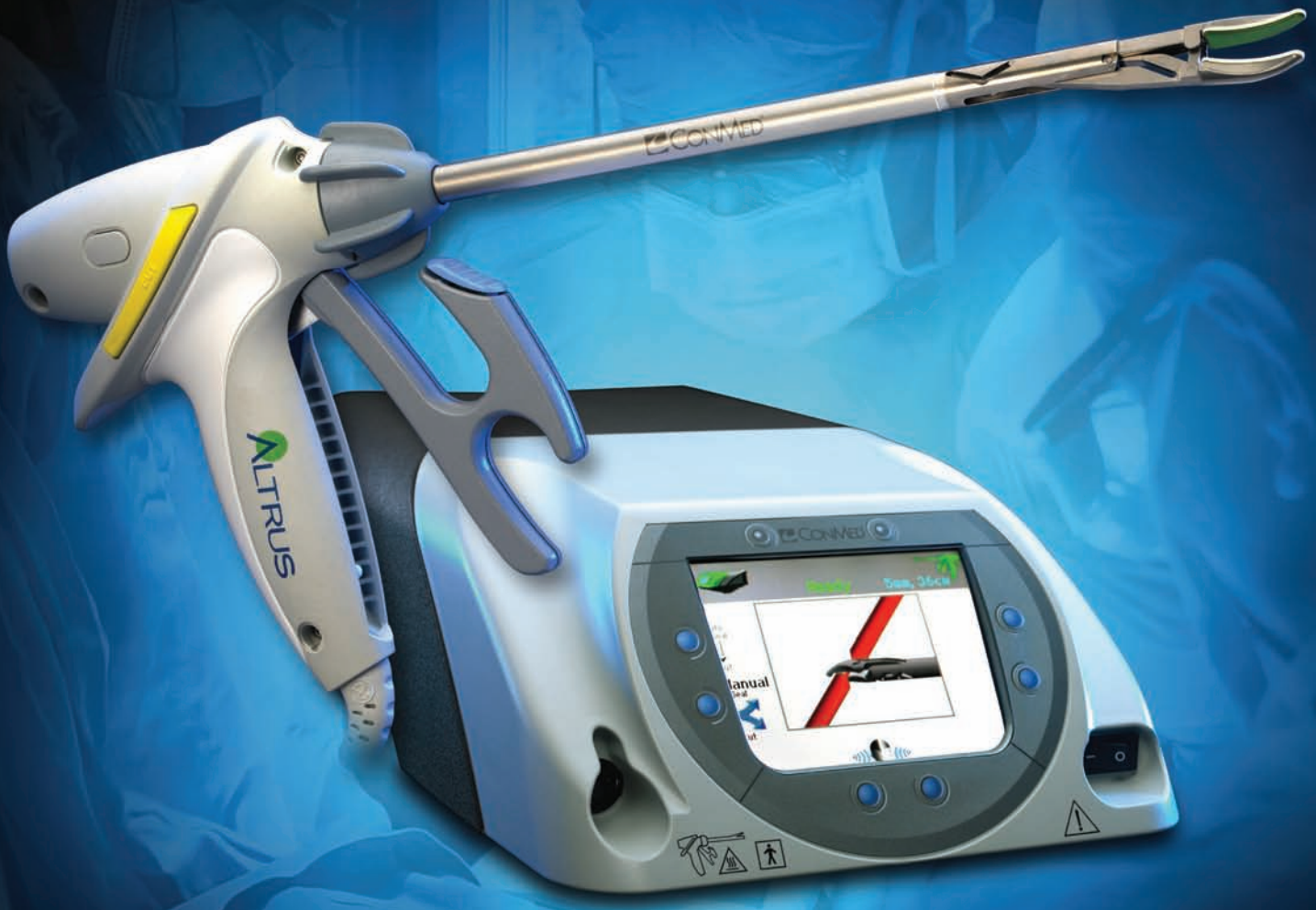

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MESSAGE DE LA DIRECTRICE GÉNÉRALE

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

Mise en œuvre du plan stratégique : Point de mire sur la gouvernance Transition vers la nouvelle loi canadienne régissant les organismes sans but lucratif

La nouvelle loi canadienne régissant les organismes sans but lucratif a été passée le 23 juin 2009 et est entrée en vigueur le 17 octobre 2011. De plus, les règlements pour les organismes sans but lucratif ont été adoptés le 6 octobre 2011 et sont entrés en vigueur à la même date, soit le 17 octobre 2011.

Cette nouvelle loi et ces nouveaux règlements instaurent un nouveau cadre législatif pour les organismes sans but lucratif voulant se constituer en société de régime fédéral et stipulent la prorogation au sein de ces organismes. Ils servent de « livre de règlements exhaustif », remplaçant la plupart des détails auparavant requis par les règlements administratifs tout en donnant aux associations une plus grande latitude pour accepter les exigences par défaut de la législation ou fixer des règles qui conviendront à leurs propres circonstances et pratique. Le deuxième article de l'ancienne loi canadienne régissant les organismes sans but lucratif sous lequel l'AIISOC était incorporé datait de 1917. Corporations Canada s'efforce depuis les vingt dernières années de moderniser la législation canadienne régissant les organismes sans but lucratif. Pour l'AIISOC, il était important d'examiner la nouvelle loi en raison de son caractère technique. Le processus de prorogation a été identifié dans le plan stratégique de l'AIISOC comme étant le moment idéal pour réexaminer les lettres patentes (y compris la mission) et les règlements administratifs afin de s'assurer que les dispositions existantes se conformaient à la nouvelle loi canadienne régissant les organismes sans but lucratif ainsi que pour profiter des nombreuses dispositions modernes que propose cette nouvelle loi.

Les organismes sans but lucratif, comme l'Association des infirmières et infirmiers de salles d'opération du Canada (AIISOC), qui sont actuellement régis par le deuxième article de la Loi canadienne sur les corporations, disposaient d'une période de trois ans, à partir du 17 octobre 2011 pour faire une demande de prorogation sous la nouvelle loi (obligatoire pour continuer à administrer un organisme sans but lucratif). Si un organisme régit sous le deuxième article de la Loi des corporations ne se conforme pas à la nouvelle loi régissant les organismes sans but lucratif avant le 18 octobre 2014, Corporations Canada, après avoir remis à l'organisme et à chacun de ses administrateurs un avis par écrit, dissoudra cet organisme. L'AIISOC a donc élaboré un chemin critique pour que les clauses de prorogation et les règlements

Cette nouvelle loi et ces nouveaux règlements instaurent un nouveau cadre législatif pour les organismes sans but lucratif voulant se constituer en société de régime fédéral et stipulent la prorogation au sein de ces organismes.

administratifs soient révisés afin de se conformer à la nouvelle loi régissant les organismes sans but lucratif et que ces derniers soient prêts à être approuvés par le conseil d'administration et les membres de l'AIISOC au plus tard le 20 avril 2013 (18 mois avant la date limite). Le délai de trois ans nous a d'abord paru très long, mais bien sûr, l'ébauche des documents, leur révision en profondeur, le processus de consultation juridique pour les changements de gouvernance ainsi que la révision de la nouvelle loi dans le contexte de la mission, des règlements administratifs et de la structure de la gouvernance existants nécessitent énormément de temps. Le conseil d'administration de l'AIISOC a hissé cette tâche au sommet de ces priorités.

Dans le cadre du processus de prorogation, l'AIISOC, sous la nouvelle loi, ne possédera plus de lettres patentes (texte qui, émis par le gouverneur en Conseil, établit un droit ou qui confère un pouvoir) ou une mission (les objectifs d'une association). Les clauses de prorogation comprendront dorénavant un énoncé des objectifs de l'AIISOC et toutes restrictions concernant les activités de l'AIISOC.

Sous l'article 211 de la nouvelle loi canadienne régissant les organismes sans but lucratif, l'AIISOC doit faire une demande pour un certificat de prorogation. Les renseignements suivants doivent être inclus dans les clauses de prorogation :

1. le nom de l'organisme;
2. la province ou le territoire où se situe le siège social de l'organisme;
3. les catégories ou groupes de membres que l'organisme est autorisé à constituer et, s'il y a deux catégories ou groupes ou plus, les droits de vote liés à ces catégories ou groupes;
4. le nombre minimal et maximal d'administrateurs ou un nombre fixe d'administrateurs;
5. toute restriction concernant les activités que l'organisme peut mener;
6. un énoncé des buts de l'organisme;
7. tout énoncé relatif à la distribution du reliquat des biens après la liquidation et le règlement des dettes de l'organisation;
8. toute disposition additionnelle que l'organisme pourrait vouloir inclure.

Parallèlement à la préparation des clauses de prorogation, l'AIISOC élabore également ses nouveaux règlements administratifs qui se conformeront à la nouvelle loi. Cette dernière stipule quelques dispositions obligatoires qui seront comprises dans les règlements administratifs. De plus, la nouvelle loi prévoit certaines dispositions par défaut qui entreront en vigueur si un organisme n'inclut pas ces dispositions dans ces clauses ou règlements administratifs. En résumé, les règlements administratifs existants de l'AIISOC devront être modifiés pour d'abord se conformer à la nouvelle loi, puis pour que l'AIISIC puisse profiter pleinement des dispositions bénéfiques de la nouvelle loi régissant les organismes sans but lucratif.

Une bonne gouvernance est la pierre angulaire d'un organisme national solide et durable. Les membres de l'AIISOC doivent savoir que l'AIISOC a mis en place les mesures adéquates qui l'aideront à tracer la voie et à développer des modèles d'affaires durables pour l'avenir. Plus de renseignements seront disponibles après la réunion du conseil d'administration de l'AIISOC qui se tiendra le 20 avril 2013, à Ottawa. Pour toute question concernant cette nouvelle loi, n'hésitez pas à me contacter.

Une bonne gouvernance est la pierre angulaire d'un organisme national solide et durable.

EXECUTIVE DIRECTORS MESSAGE (cont. from page #10)

order issued by a monarch that generally grants a right or status to a corporation) or objects (the purposes or intention of the association). The Articles of Continuance will now, instead, include a statement of ORNAC's purposes and any restrictions on ORNAC's activities.

The CNCA requires that ORNAC apply for a certificate of continuance under section 211 of the CNCA. The following information must be included in the Articles of Continuance:

1. the name of the corporation;
2. the province or territory of the corporation's registered office;
3. classes or groups of members the corporation is authorized to establish and, if there are two or more classes or groups, any voting rights attaching to each of those classes or groups;
4. the minimum and maximum number of directors or a fixed number of directors;
5. any restrictions on the activities that the corporation may carry on;
6. a statement of purpose of the corporation;
7. any statement regarding distribution of property remaining on liquidation after the discharge of any liabilities of the corporation; and
8. any additional provisions that the corporation may want included.

At the same time that ORNAC has been preparing the Articles of Continuance it has also been preparing new By-laws that conform to the CNCA. The CNCA contains some mandatory provisions that will be included in the By-laws. The CNCA also contains certain default provisions that will apply if a CNCA corporation does not address these provisions in its articles or By-laws. In summary, ORNAC's existing By-laws will have to be amended to, first, comply with the CNCA and, secondly, to take full advantage of the beneficial provisions contained in the CNCA.

Good governance is the cornerstone of a strong and sustainable national organization. ORNAC members need to know that ORNAC has put in place the right rules to help chart a safe path and develop sustainable business patterns for the future. There will be more information available after the April 20, 2013 ORNAC Board of Directors meeting in Ottawa. If you have any questions on this new Act please don't hesitate to contact me.

Good governance is the cornerstone of a strong and sustainable national organization.

L'ÉVACUATION D'UN BLOC OPÉRATOIRE EST UN PROCESSUS COMPLEXE : QUI FAIT QUOI?

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 présidé le groupe de planification multidisciplinaire 2011 du centre pour la simulation de l'évacuation des salles d'opération du bloc opératoire actuel. En 1993, elle avait aidé à faciliter la simulation de l'évacuation des salles d'opération de l'ancien bloc opératoire.*

Les normes de l'AIISOC relatives à cet article figurent dans la publication Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés (9e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AIISOC) de juin 2009, section 4, p.331 à 333, Normes 1.4 – 1.4.9.

RÉSUMÉ :

En 2007, à la suite du déménagement de tout le département du bloc opératoire pour adultes du Winnipeg Health Sciences Centre et pour se conformer aux exigences du code de prévention des incendies, il a été nécessaire de réévaluer et de modifier le plan d'évacuation en place, de simuler et de tester ces modifications au sein du nouvel environnement.

La planification d'une simulation d'évacuation en cas d'incendie d'un important bloc opératoire tertiaire est un processus très complexe qui nécessite beaucoup de planification et de souci du détail. Une approche multidisciplinaire est à préconiser étant donné que de nombreux départements sont concernés. Les leçons tirées de l'expérience d'un site pourraient bénéficier à d'autres. L'objectif de cet article est de fournir quelques exemples de planification et des lignes directrices pouvant être utilisés par d'autres sites qui entament ce processus important.

Les photos de cet article ont été incluses pour rehausser la présentation visuelle et il se peut qu'elles ne soient pas conformes aux normes de l'AIISOC.

KEYWORDS: OR FIRE DRILL, EVACUATION PLANNING, EVACUATION SIMULATION.

EVACUATING AN OR IS A COMPLEX PROCESS: WHO DOES WHAT?

Author: *Joan Porteous IA, B.S.Inf., CSP(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 chaired the centre's 2011 multidisciplinary OR evacuation simulation planning group in the OR's current location. In 1993 she helped facilitate an OR evacuation simulation in the OR's former*

ABSTRACT:

It became necessary, following the relocation of the entire Winnipeg Health Sciences Centre Adult OR department in 2007 and in consideration of fire code regulations, to re-evaluate and modify the existing evacuation plan and to simulate, and test, these modifications in the new environment.

Planning a fire evacuation simulation for a large tertiary OR is a very complex process and involves a great deal of planning and attention to detail. It requires a multidisciplinary approach as it involves many departments. Learning about one site's experiences may benefit others. The goal of this article is to provide some planning examples and guidelines for use by sites that are beginning to undertake this important process.

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Photos in this article have been included for visual appeal and may not conform with ORNAC Standards.

INTRODUCTION:

Theatre personnel review their volunteer patient's medical profile.

Most operating room fires begin either on or in the patient.[1] As a result many OR staff do not consider scenarios that would result in the evacuation of an entire OR department. Such a scenario might, however, result if a fire ignited in a theatre's infrastructure, such as in the service arm or a sterilizer located inside a theatre[2,3] when there would be a risk of the fire spreading via built-in components that are linked to other theatres.

Evacuation processes may need to be revised at different points of time as a result of various changes within the OR environment. When the operating room department at the Winnipeg Health Sciences Centre was re-located to a new building it was determined that we needed to re-evaluate the existing evacuation plan and determine if it would still be efficient and effective in the new environment.

The purpose of this article is to share the author's experiences during the planning of a fire evacuation simulation, in a large 13-theatre OR in a tertiary hospital. Evacuation planning quickly became a challenging and complex process. A multidisciplinary planning team, with representatives from all departments involved, was essential in order to develop a smooth, efficient evacuation process.

A primary objective of this simulation was to see if the existing fire evacuation plans worked in a non-threatening situation.

Planning Process:

A date and time were scheduled, several months in advance of the mock evacuation drill, for a fire evacuation simulation to take place during surgical grand rounds and anaesthesia rounds. By incorporating this simulation in to the educational rounds activity, it became more convenient for physicians to participate in the mock evacuation.

The plan involved participation from other departments including the post-anaesthesia care unit (PACU), Fire Safety, Medical Device Reprocessing (MDR), Security, Engineering, Patient Transport, Maintenance, and the Paediatric OR (located in an adjoining building). The first step in planning a mock code green was, as a result, to create an interdisciplinary planning team. This team consisted of anaesthetists; nurses; surgeons; several staff from the OR and post-anaesthesia care unit (PACU) including the director, managers and educators; equipment management personnel; and the site's fire safety officer.

Conducting evacuation simulations, on a regular basis, is a requirement identified by the National Fire Code of Canada, section 2.8.2.[4] A primary objective of this simulation was to see if the existing fire evacuation plans worked in a non-threatening situation. The goal was to search for system inefficiencies, strengthen the existing evacuation plan and optimize the safety of patients and personnel in a code green situation.

The plan included having ten theatres operating, with a variety of surgical procedures underway and at different

Charge nurse and anaesthetist plan theatre destinations

stages in the surgery, in order to best replicate the situation at any given time on a regular elective slate. The daily OR theatre staffing assignment was created ahead of time. Personnel reported for work and, as per usual, went into their assigned theatres at the start of their shift. Inside the theatre they found a written mock case scenario that included health information about a patient, the stage of surgery, monitoring of equipment in use, etc.

The mock fire started in an electrical and gas supply service arm located in one operating theatre. The fire's place of origin resulted in a need for all theatres to be evacuated due to the risk of the fire spreading to the service arms in other theatres via the oxygen and electrical channels. The code red quickly became a code green! The scenario deliberately extreme, in order to push our evacuation plan to the limit, but was also reasonably realistic.

The mock evacuation included some volunteers who acted as surgical patients who were awake at the time of the fire. In other theatres, clinical simulation mannequins were used to represent the patients. These mannequins were accompanied by technicians who were able to change vital signs, etc. The "mannequin patients" provided clinical challenges, to each surgical team, by exhibiting various signs and symptoms during the code. The critical thinking, that was required on the part of the team, enhanced the educational value of the exercise for participants and allowed both the physicians and the nurses to use the evacuation experience toward educational credits. Each volunteer patient was provided with a short, written, medical history. In theatres where the patient was still awake the surgical teams were challenged to manage their anxious patients while maintaining their safety and conducting the evacuation.

The fire began about 10 minutes after the theatres were staffed allowing each team the opportunity to meet their volunteer patient, or learn about the mannequin, and become familiar with their theatre's case scenario.

The Code Red…

The evacuation planners were the only individuals who knew in which theatre the fire was to occur. Dry ice was placed in that theatre, without the team's knowledge, to simulate smoke in the vicinity of the service arm. The hospital engineers and maintenance staff manipulated the fire alarm system for the mock evacuation and enabled the theatre nurse to actually pull the closest fire alarm. The second stage fire alarm was also activated and had been manipulated so that it would only be heard in the OR in order to avoid disturbing neighbouring departments. The noisy environment created by the fire alarm helped make the situation as realistic as possible! Personnel in the fire theatre were also able to actually shut off the medical gas supply lever-valves located on the outside wall of the theatre.

The team in the theatre with the fire evacuated immediately. They were instructed on their evacuation destination as they exited the theatre.

…Quickly Became a Code Green!!!

Because of the risk that the fire would spread to other service arms, via the infrastructure, the decision was made to call a code green evacuation. The challenge then became communicating from the control desk to each theatre. The theatres' intercom broadcast system could not be used because theatre personnel would not hear the message over the sound of the fire alarm. The following communication plan was developed to address this issue:

The critical thinking, that was required on the part of the team, enhanced the educational value of the exercise for participants and allowed both the physicians and the nurses to use the evacuation experience toward educational credits.

- The charge nurse delegated responsibilities to three nurses who each went into four ORs (to cover off the total of 12 participating theatres) with the following written script:
  - o "There is a fire in theatre ____"
  - o "You will need to evacuate shortly, please prepare to do so"
  - o "Do not leave until you are given your destination…we will tell you in a few minutes"
  - o "What stage of surgery are you at?"
  - o "How stable is your patient?"

Each nurse was given a sheet of paper, containing this, script to ensure they communicated all the required information and on which they could also make notes. The information gathered by each nurse was reported to the charge nurse and charge anaesthetist who quickly assigned evacuation destinations. Criteria for determining destinations were based on the patient's situation. Patients who were:

- o Awake, preoperative and stable were returned to their unit of origin;
- o Packed, stable and required ventilation were evacuated to PACU and/or Surgical Intensive Care Unit (SICU) for intensive monitoring; and
- o Ventilated patients and those requiring immediate continuation of surgery were evacuated to the Trauma OR located in the Emergency Department or to other OR departments at the site including the Children's Hospital OR and Women's Hospital OR.

The fire safety officer arrived in the OR following the Code Red call, and determined the safest time limit for the evacuation. The same three nurses were sent back to each of their four theatres and used the following script:

- "Your destination is _____"
- "You should evacuate within approximately _____ minutes"
- "Report back by telephone when you arrive"

Evacuation times for each theatre varied according to each patient's unique situation but, in all cases, each team attempted to meet the time limit that had been identified by the fire safety officer.

Three individuals (clerks and nurses) were appointed by the charge nurse to answer telephone calls at the OR control desk. Part of their role was to document the details of telephone calls from OR teams who had reached their designated evacuation destination, with their patients, and were reporting back. It was important for the charge nurse and anaesthetist to know if those teams had the required resources readily available in order to safely manage their patients. It was also critical that the charge nurse and anaesthetist were able to confirm that all personnel, from all theatres, were safely out of the OR.

General surgery team evacuate with their patient.

In order to ensure that adequate information was obtained from each surgical team, all personnel answering telephones at the OR desk were given fill-in-the-blank evacuation destination report forms. The purpose of the form was to ensure the individual receiving the telephone call obtained essential information including:

- Theatre;
- Patient's name;
- Patient's status;
- Names of personnel present at the evacuation destination; and
- Supplies required.

EVACUATING AN OR cont. on page 30

INTERNATIONAL ALLIANCE FOR PERIOPERATIVE BEST PRACTICE

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IFPN
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The Ottawa Convention Center — Ottawa, Ontario, Canada

ORNAC National & International Conference with IFPN

Preliminary Program

April 21 - 25, 2013

Social Events:

Monday:
Canadian Cultural Evening

Tuesday:
Ottawa Amazing Race (registration required)

Dine Around

Wednesday:
Morning Run/Walk of Ottawa

ORNAC's 30th Anniversary Party

Thursday:
Haunted Walk of Ottawa (registration required)

Sunday, April 21

1300 - 1500 **Opening Ceremonies**

1530 - 1700 **Keynote Speaker**: "Risk Management – Don't Take Chances; Manage Risks" Dr. Dave Williams (Canada) Record-breaking Astronaut and Aquanaut.

1730 - 2100 Grand Opening of Exhibits

Monday, April 22

0600 - 730 Breakfast Session – "Breast Cancer Awareness" (sponsored by Medline Canada) - Dr. Marla Shapiro

0800 - 0930 **"International approaches to patient safety: Lessons learned, ongoing challenges, perioperative opportunity"** - Jane Reid (England) & Dr. Marty Makary (USA)

1000 - 1100 **"Thinking Ahead of the Surgeon: Non-technical Skills for Scrub Nurses"** Rhona Flin (Scotland)

1100 - 1500 Exhibits, Posters, Lunch

1500 - 1630 **Concurrent Sessions:**

A) Establishing Perioperative Nursing Programs (Panel) - Elijah Ahlquist (Canada), Ioannis Koutelekos (Greece), Valentina Sarkisova (Russia).

B) Establishing a Provincial Peritoneal Malignancy Program in Ontario - Ulla Grant & Heather Lithgow (Canada)

C) A Clinical Perioperative Nurse & Nursing Research: How Do They Mix? - Coleen Newland (Canada)

D) Inadvertant Perioperative Hypothermia - Dr. Claude LaFlamme (Canada). Sponsored by 3M Infection Prevention.

Tuesday, April 23

0630 - 0800 Breakfast Session "Multidisciplinary Approach to ERAS (Enhanced Recovery After Surgery) Program" (sponsored by Covidien) - Dr. Liane Feldman, Donna Stanbridge, and Debbie Watson (Canada).

0830 – 0930 **Concurrent Sessions:**

A) Training and integration of new perioperative nursing graduates - Dominique Lanquetin & Irandohkt Affraie (France)

B) Come Fly with Me: Experiences of a Perioperative Nurse Caring for Wounded Warriors on a Cargo Plane - Lt Col Jeanne LaFountain (USA)

C) Authentic Leadership: Developing the Leader Within - Lesia Yasinski (Canada)

D) 360^0 Minimally Invasive Surgery (MIS) Endonasal, Pituitary, & Skull Base Approaches - Dr. Amin Kassam (Canada)

1000 - 1100 **Concurrent Sessions:**

A) Networking an Essential Skill for the Perioperative Nurse - Jane Reid (England) & Mary Jo Steiert (USA)

B) Improving Communication and Collaborative is Improving Safe Perioperative Care - Mercedes Bilbao (Portugal)

C) The Serendipity of Perioperative Certification - Deborah Roberts, Lyanne Faucher, and Glenda Tapp (Canada)

D) The Changing Role of the Perioperative Nurse in Robotic Assisted Laparoscopic Surgery - Jan Fitchett & Stuart Lealess (Canada)

1100 - 1500 Exhibits, Posters, Lunch

1500 – 1615 Sterilization Best Practices: Are you following the MFG's IFU's? - Chuck Hughes (sponsored by Keir Surgical)

Wednesday, April 24

0630 - 0800 Breakfast Session – "Recent Advances in Surgical Site Infection" Sponsored by Johnson & Johnson Medical Products.

0830 - 0930 **Concurrent Sessions:**

A) The Future of Healthcare: Comparing US and Canada to the World - Patrick Voight & Naralyn Baluyot (USA)

B) Contact Precautions: Time for Change - Claudette Hector & Lisa Horton (Canada)

C) Factors Contributing to Job Satisfaction and Organizational Commitment, Career Commitment and Perioperative Nurses - Kesook Yoon (Korea)

D) An International Alliance that Promotes Best Practice in Perioperative Nursing in Africa - Mary Knight, Helen Vandoremalen, Jean Naude, Marilyn Flynn, and Linda Whyte (Canada)

1000 - 1100 **Concurrent Sessions:**

A) Approach of a university hospital for the standardization and implementation of best practices in transplantation) - Anne Tremblay & Micheline Bouchard

B) Internationally Educated Perioperative Nurses: A Firsthand Experience from Asia, Europe, and the Middle East - Bernadette Chiu, Chris Mulford & Carmen Petre (Canada)

C) The Relationship Between Patient Safety Culture and Perceived Organization-Based Self-Esteem Among Nurses: An Examination Based on Operating Centres of three Hospitals - Elmira Piiritalo (Estonia)

D) The Global Effort for Best Practices in Smoke Evacuation: What's Wrong? - Kay Ball (USA) (sponsored by AMT Electrosurgery)

1100 - 1300 Exhibits, Posters, Lunch

1300 - 1400 **Concurrent Sessions:**

A) Improving Patient Safety by Reducing SSI's: Translating Wound Care Best Practice to the OR in Support of Uneventful Hospital Stay - Christine Murphy (Canada)

B) Simulation in Surgical Suites - Sue Barnes & Linda Rae (Canada)

C) Don't Myth the Facts on HIV - Greg Riehl (Canada)

D) The Unique Benefits & Challenges of a Culturally Diverse Healthcare Team Serving a Diverse Cultural Community - Kathy Bruce & Nurallah Rahim (Canada)

1430 - 1530 **Concurrent Sessions:**

A) Perioperative Nurses: Finding Meaning from their Experiences in Multi-Organ Procurement Surgery - Zaneta Smith (Australia)

B) Pre-Operative Skin Preparation and Surgical Site Infection: What To Do? - Paule Poulin, Kelly Chapman, Lynda McGahan, Gabrielle Zimmerman, Lea Austen, and Trevor Schuler (Canada)

C) An Australian Perspective of Education in Perioperative Practice - Carolyn Ellis (Australia)

D) Using SSSL Checklist as a Framework for Initiating Continuing Education to Perioperative Nurses in Developing Countries - Genelle Leifso (Canada)

1530 - 1630 **Concurrent Sessions:**

A) Understanding Spirituality: Perspective of Perioperative Registered Nurses in Canada - Sue Styles (Canada)

B) Training for Safe Behaviours in the Operating Room - Kate Woodhead (England)

C) Leadership in the OR - Monique Van Hiel (Belgium)

D) Accreditation Canada: Initiatives on Patient Safety - Karen Kieley (Canada)

Thursday, April 25

0645 – 0815 Breakfast Session – Adding some "SENSE" to Laparoscopic Surgery (sponsored by ConMed)

0830 - 0930 – **Concurrent Sessions:**

A) Criteria for choosing an organizational model for modern operating theatres: specialization or versatility? - Francoise Delsa (Belgium)

Effective communication between anaesthesia and surgery guarantee improved safety of the patient) - Sandrine Mathieu & Mylene Bott (France)

B) Hooray for Hybrid: Perioperative Learning in a Flipped Classroom - Debra Clendinneng (Canada)

C) Perioperative Dialogue: A New Addition in Perioperative Nursing - Yvonne Tornqvist (Sweden)

D) Team Building in the OR and SPD: Ways to Improve Productivity, Performance and Job Satisfaction - Deb Spratt (USA)

1000 - 1100 **Concurrent Sessions:**

A) Overcoming Barriers to Acute Pain Management - Eloise Carr (Canada)

B) Leadership in Papua New Guinea: The dream, the reality, the future - Phyllis Davis (Australia)

C) Perioperative Care of the Pregnant Patient While in Surgery - Margaret Menegon & Biddy Chang (Canada)

D) Cardiac Arrest with Roles Defined (CARD) - Joanna Schubert and Dr. Simone Crooks (Canada)

1100 - 1145 **ORNAC Town Hall Meeting**

1300 - 1400 **The Secret to Perioperative Nursing Excellence: Taking Care of Yourself First** - Kay Ball (USA)

1400-1500 **"Leadership: A Humanistic Approach"** - Lt. Gen. Roméo Dallaire (Canada) former commander of a UN peace-keeping force in Rwanda.

1515 - 1630 **Closing Ceremonies**

For additional details or to REGISTER visit www.ORNAC.ca/conference/social.phtml

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Ultramed Inc.

Updated January 15, 2013.
This list does not reflect booths booked after this date.

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Ottawa, Ontario, Canada

Conférence nationale et internationale de l'AIISOC avec l'IFPN

Programme préliminaire

21 au 25 avril 2013

Événements sociaux :

Lundi :
Soirée culturelle canadienne

Mardi :
Course à Ottawa (inscription obligatoire)

Souper dans divers restaurants

Mercredi :
Activité de course ou de marche à Ottawa

Célébration pour le 30e anniversaire de l'AIISOC

Jeudi :
Excursion aux maisons hantées d'Ottawa (inscription obligatoire)

Dimanche 21 avril

13 h à 15 h **Cérémonie d'ouverture**

15 h 30 à 17 h **Conférencier d'honneur : « La gestion du risque – Ne prenez aucune chance; gérez les risques » -** Dr Dave Williams (Canada), astronaute et aquanaute qui a brisé des records.

17 h 30 à 21 h Grande ouverture de l'exposition

Lundi 22 avril

6 h à 7 h 30 Petit déjeuner éducatif - « Breast Cancer Awareness » (commandité par Medline Canada)

8 h à 9 h 30 **« Approches internationales à la sécurité des patients : Les leçons que nous en avons tirées, les défis continuels et les opportunités en soins périopératoires » -** Jane Reid (Angleterre) et Dr Marty Makary (É.-U.)

10 h à 11 h **« Anticiper les gestes du chirurgien : compétences non techniques des infirmières en service interne »** - Rhona Flin (Écosse)

11 h à 15 h Exposition, affiches, dîner

15 h à 16 h 30 **Séances simultanées :**

A) Establishing Perioperative Nursing Programs (groupe d'experts) - Elijah Ahlquist (Canada), Ioannis Koutelekos (Grèce), Valentina Sarkisova (Russie).

B) Establishing a Provincial Peritoneal Malignancy Program in Ontario - Ulla Grant et Heather Lithgow (Canada)

C) A Clinical Perioperative Nurse & Nursing Research: How Do They Mix? - Coleen Newland (Canada)

D) Inadvertant Perioperative Hypothermia - Dr. Claude LaFlamme (Canada). Commandité par la section de prévention des infections de 3M.

Mardi 23 avril

6 h 30 à 8 h Petit déjeuner éducatif - « Multidisciplinary Approach to ERAS (Enhanced Recovery After Surgery) Program » (commandité par Covidien) - Dr. Liane Feldman, Donna Stanbridge, and Donna Watson (Canada).

8 h 30 à 9 h 30 **Séances simultanées :**

A) « Formation et intégration en bloc opératoire des infirmières/infirmiers nouvellement diplômé(e)s » - Dominique Lanquetin et Irandohkt Affraie (France)

B) Come Fly With Me: Experiences of a Perioperative Nurse Caring for Wounded Warriors on a Cargo Plane - Lcol Jeanne LaFountain (É.U.)

C) Authentic Leadership: Developing the Leader Within - Lesia Yasinski (Canada)

D) 3600 Minimally Invasive Surgery (MIS) Endonasal, Pituitary, & Skull Base Approaches - Dr Amin Kassam (Canada)

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C) The Serendipity of Perioperative Certification - Deborah Roberts, Lyanne Faucher et Glenda Tapp (Canada)

D) The Changing Role of the Perioperative Nurse in Robotic Assisted Laparoscopic Surgery - Jan Fitchett et Stuart Lealess (Canada)

11 h à 15 h Exposition, affiches, dîner

15 h à 16 h 15 **« Pratiques exemplaires en**

stérilisation : respectez-vous le mode d'emploi des fabricants » - Chuck Hughes (commandité par Keir Surgical)

Mercredi 24 avril

6 h 30 à 8 h Petit déjeuner éducatif - « Recent Advances in Surgical Site Infection » commandité par Johnson & Johnson Medical Products.

8 h 30 à 9 h 30 **Séances simultanées :**

A) The Future of Healthcare: Comparing US and Canada to the World - Patrick Voight et Naralyn Baluyot (É.-U.)

B) Contact Precautions: Time for Change - Claudette Hector et Lisa Horton (Canada)

C) Factors Contributing to Job Satisfaction and Organizational Commitment, Career Commitment and Perioperative Nurses - Kesook Yoon (Corée)

D) An International Alliance that Promotes Best Practice in Perioperative Nursing in Africa - Mary Knight, Helen Vandoremalen, Jean Naude, Marilyn Flynn et Linda Whyte (Canada)

10 h à 11 h **Séances simultanées :**

A) « Démarche d'un centre hospitalier universitaire pour la normalisation et l'implantation des pratiques exemplaires en transplantation » - Anne Tremblay et Micheline Bouchard

B) Internationally Educated Perioperative Nurses: A Firsthand Experience from Asia, Europe, and the Middle East - Bernadette Chiu, Chris Mulford et Carmen Petre (Canada)

C) The Relationship Between Patient Safety Culture and Perceived Organization-Based Self-Esteem Among Nurses: An Examination Based on Operating Centres of three Hospitals - Elmira Piiritalo (Estonie)

D) The Global Effort for Best Practices in Smoke Evacuation: What's Wrong? - Kay Ball (É.-U.) (commandité par AMT Electrosurgery)

11 h à 13 h Exposition, affiches, dîner

13 h à 14 h **Séances simultanées :**

A) Improving Patient Safety by Reducing SSI's: Translating Wound Care Best Practice to the OR in Support of Uneventful Hospital Stay - Christine Murphy (Canada)

B) Simulation in Surgical Suites - Sue Barnes et Linda Rae (Canada)

C) Don't Myth the Facts on HIV - Greg Riehl (Canada)

D) The Unique Benefits & Challenges of a Culturally Diverse Healthcare Team Serving a Diverse Cultural Community - Kathy Bruce et Nurallah Rahim (Canada)

14 h 30 à 15 h 30 **Séances simultanées :**

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B) Pre-Operative Skin Preparation and Surgical Site Infection: What To Do? - Paule Poulin, Kelly Chapman, Lynda McGahan, Gabrielle Zimmerman, Lea Austen et Trevor Schuler (Canada)

C) An Australian Perspective of Education in Perioperative Practice - Carolyn Ellis (Australie)

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15 h 30 à 16 h 30 **Séances simultanées :**

A) Understanding Spirituality: Perspective of Perioperative Registered Nurses in Canada - Sue Styles (Canada)

B) Training for Safe Behaviours in the Operating Room - Kate Woodhead (Angleterre)

C) Leadership in the OR - Monique Van Hiel (Belgique)

D) Accreditation Canada: Initiatives on Patient Safety - Karen Kieley (Canada)

Jeudi 25 avril

6 h 45 à 8 h 15 Petit déjeuner éducatif - « Adding some "SENSE" to Laparoscopic Surgery » (commandité par ConMed)

8 h 30 à 9 h 30 **Séances simultanées :**

A) « Critères de choix d'un modèle organisationnel pour les blocs opératoires modernes : polyvalence ou spécialisation ? » - Françoise Delsa (Belgique) ET - « Une Communication Efficace Entre Anésthesie et Chirugie Garantie une Meilleure Sécurité du Patient » - Sandrine Mathieu et Mylene Bott (France)

B) Hooray for Hybrid: Perioperative Learning in a Flipped Classroom - Debra Clendinneng (Canada)

C) Perioperative Dialogue: A New Addition in Perioperative Nursing - Yvonne Tornqvist (Suède)

D) Team Building in the OR and SPD: Ways to Improve Productivity, Performance and Job Satisfaction - Deb Spratt (É.-U.)

10 h à 11 h **Séances simultanées :**

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C) Perioperative Care of the Pregnant Patient While in Surgery - Margaret Menegon et Biddy Chang (Canada)

D) Cardiac Arrest with Roles Defined (CARD) - Joanna Schubert et Dr. Simone Crooks (Canada)

11 h à 11 h 45 **Séance de discussion ouverte de l'AIISOC**

13 h à 14 h **« Le secret de l'excellence en matière de soins périopératoires : prendre soi de soi-même en priorité »** - Kay Ball (É.-U.)

14 h à 15 h **« Une approche humaine du leadership »** - Lgén. Roméo Dallaire (Canada), ancien commandant de la force de maintien de la paix des Nations unies au Rwanda.

15 h 15 à 16 h 30 Cérémonie de clôture

Les séances dont le titre est en français seront présentées en français ou avec traduction en français. Toutes les autres séances sont en anglais seulement.

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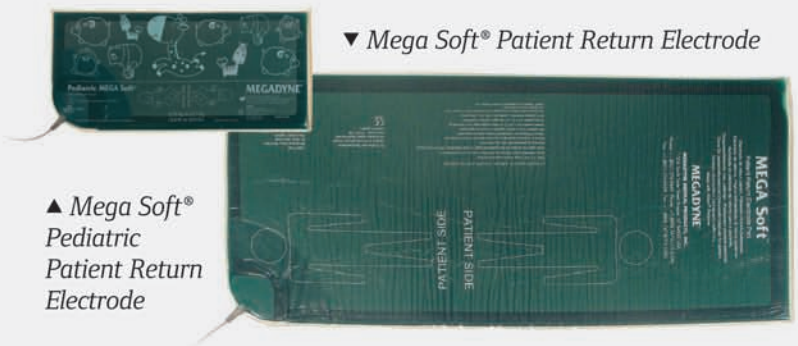

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It is important to establish specific evacuation routes for the perioperative environment.[5] A laminated fire evacuation floor plan, showing evacuation routes, had, for this reason, been posted in each theatre when the OR Department was first moved in to the new building. On the back of this evacuation floor plan were the following directives for the staff:

Before leaving the theatre:
- Turn off and disconnect the anaesthetic machine from the service arm;
- Shut off the medical gas supply lines supplying the theatre;
- Take anaesthesia medications, patient's chart and any supplies/ equipment that you will need;
- Place wet towels along the bottom of the door in the theatre with a fire/smoke;
- DO NOT RETURN to the theatre without checking with fire personnel;
- Telephone the OR control centre and report back when you arrive at your evacuation destination;

The above key steps should be easily accessible and serve as an excellent reminder to anyone in any theatre, at any time, should the need to evacuate ever occur.

The team was appreciative of the fact that the completion of activities had been clearly communicated to the team leader. This 'closed-loop' communication, among team members, ensured that individuals who were designated to perform a certain task reported back to the team leader upon completion.

ENT team evacuate with their patient.

Surgical teams in each theatre safely evacuated and transported patients to assigned destinations. Some teams with critical patients (i.e. aorta clamped, spine open, moderate bleeding) took their patients to available theatres in the adjacent Children's OR and to the trauma OR theatre located in the emergency department. Medical Device Reprocessing (MDR) staff brought requested supplies and surgeries were continued. Stable intra-operative patients had open incisions packed/covered and were evacuated to PACU or SICU for intensive monitoring and to await an opportunity to finish the surgery in an available theatre.

Following arrival at their evacuation destinations, and after telephoning the OR control centre to give a verbal report, each surgical team, including their volunteer patients, conducted a debriefing during which team processes and inefficiencies were discussed.

The debriefing included addressing the following questions:
- Was patient transport equipment easily available?
- Did you account for all personnel when reporting back to the OR?
- Was the decision to evacuate communicated in a clear manner?
- Were you able to identify the safest route?
- Did the team maintain closed-loop communication?
- Was the team working on a common plan?
- Did the team identify necessary resources for their patient?
- Did the team effectively share resources with other teams?
- Did the team remain aware of the relevant events/factors in their environment?
- Did the team effectively delegate roles and tasks?
- Was there a clear leader?
- Did the team support the leader?
- What are suggestions for improvements?

As the PACU is the OR area of safe refuge, in the event of an evacuation, PACU personnel were major participants in the evacuation. They also utilized the event to test their

capacity and capability to respond to a code green in the OR. PACU needed to discharge patients, as possible, in order to create spaces for stable patients who would arrive from the OR and await theatre space to complete their surgical procedures. The PACU staff needed to ensure they would have enough ventilators, and other equipment, readily available. PACU personnel adapted to the sudden surplus of "incoming" and worked closely with each surgical team to safely continue care for patients.

MDR personnel also participated in the mock code green and tested their processes to ensure timely delivery of essential supplies to our surgical evacuation destinations.

Mock Evacuation Volunteers:

Volunteers were most helpful in this mock evacuation and provided objective perspectives.

Volunteer Patients:

The volunteer patients completed a questionnaire following the evacuation exercise. Questions included:
- Did the surgical team act in a calm, organized manner?
- Did you feel safe?
- Did you receive clear explanations?
- Did you understand what was happening?
- What were your concerns as a 'patient'?

Observers:

Observers were positioned in the hallways, at the OR fire control centre, and in the theatre with the fire. Each observer completed a questionnaire that included some of the following questions:

- Did personnel act in a calm, organized manner?
- Was the responsibility for decision-making clear?
- Were staff members alerted to the situation in a timely manner?
- Did personnel follow the fire evacuation plan?
- Did equipment function properly?
- What was the time lapse from when the code green was activated until the OR was completely evacuated?
- Did you identify any unexpected problems?
- Were transportation routes clear of all obstacles?
- Did any unnecessary traffic occur?
- Were adequate personnel available to transport patients?
- In the theatre with the fire:
  - o Did theatre personnel activate RACE?
    - Rescue the individuals involved in the fire
    - Activate the fire alarm
    - Confine the fire
    - Extinguish the fire and evacuate if required
  - o Did theatre personnel activate the fire alarm in a timely manner?
  - o Did the surgical team act in a cohesive manner?

- Did theatre personnel shut off the medical gas supply to the theatre?
- Were there any equipment problems and was equipment available in a timely manner?
- Was the evacuation route appropriate?

The code green simulation exercise concluded with written observation summaries from participants. A general debriefing for all participants and observers was also conducted. The information gathered from so many perspectives will be extremely valuable tools for learning from this experience, strengthening the OR evacuation plan, and improving communication and any other inefficiencies.

After the Evacuation is Complete:

After the OR is evacuated, the planning focus shifts to the patients and teams at the evacuation destination sites. These teams will be contacted by the charge nurse to assess their needs while they wait for the opportunity to complete the surgery. The charge nurse also coordinates plans regarding the provision of supplies and equipment until OR space becomes available to complete the surgery. MDR and OR support personnel may take on the important role of delivering supplies and equipment to the evacuated surgical teams.

Post-Evacuation Evaluation:

An evacuation simulation is implemented in order to assess if the OR department is prepared to effectively implement a code green. The following post-evacuation assessment questions should be considered by the planning committee:

- Is the existing OR Contingency Plan effective?
- Are the plan's communication processes, during the code, reliable and effective?
- Are all the supplies and resources, as required to carry out a safe and timely evacuation of all theatres, readily available?
- Do participants have the knowledge, skills, and resources they need to work safely and efficiently during the a code green?

Education is a Priority:

All perioperative personnel should be educated about how to implement their department's evacuation plan.[5,7] ORNAC identifies that education should occur during initial orientation and be reviewed on a regular basis and that practice drills be conducted routinely.[7]

One of the goals of this evacuation simulation exercise was to facilitate as educational opportunities for as many individuals, as possible, including to those staff who were not at work on the day of the simulation. To this end, education began two weeks prior to the simulation. Pre evacuation education involved preparing participants for the simulation. It also ensured that staff members who would not be working on the day of the evacuation were also able to learn about the process. The evacuation contingency plan was reviewed with staff, roles were discussed, fire procedures reviewed, medical gas shut-off valve sites were toured, evacuation routes identified, and the actions to take before leaving a theatre were reviewed. This ensured that all personnel were as prepared as possible to actively participate in the simulation and get the most benefit from their experiences.

All perioperative personnel should be educated about how to implement their department's evacuation plan.[5,7]

EVACUATING AN OR cont. on page 36

Join ORNAC's 30th Anniversary Celebration!!

The Operating Room Nurses Association of Canada (ORNAC) invites all delegates of the 2013 ORNAC & IFPN Conference to attend ORNAC's 30th Anniversary Celebration.

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AGENDA: APRIL 21–25, 2013

APRIL 21
- Opening ceremonies
- Plenary Sessions
- Exhibits opening

APRIL 22
- Breakfast
- Educational Sessions
- Canadian Cultural Evening Event

APRIL 23
- Breakfast
- Educational Sessions
- Ottawa Amazing Race
- Ottawa Dine Around

APRIL 24
- Run/Walk Event
- Breakfast
- Educational Sessions
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4. Fournir de nouvelles façons d'intégrer les politiques et les données probantes dans la pratique clinique
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21 AVRIL
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- Séances plénières
- Ouverture du hall d'exposition

22 AVRIL
- Petit déjeuner
- Séances éducatives
- Soirée culturelle canadienne

23 AVRIL
- Petit déjeuner
- Séances éducatives
- Course à Ottawa
- Souper dans divers restaurants

24 AVRIL
- Activité de course ou de marche
- Petit déjeuner
- Séances éducatives
- Célébration pour le 30e anniversaire de l'AIISOC

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- Séances plénières et éducatives
- Excursion aux maisons hantées d'Ottawa

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Table 1

PERSONNEL ROLES DURING AN OR EVACUATION

Charge Nurse:

The immediate role of the charge nurse in the event of a code green is documented on written guidelines in our OR Department Contingency. During this mock evacuation the role included:

- Ensure the nearest fire alarm pull station is activated;
- Document the time of the fire;
- Initiate a Code Red by dialling 55 and informing the emergency operator;
- If the fire is uncontrolled, activate the second stage fire alarm;
- Notify the team in the fire area of their evacuation destination;
- Determine the need to initiate a code green for complete OR evacuation;
- If required, initiate a Code green by dialling 55 and informing the emergency operator;
- Delegate someone to:
    - o Call the charge anaesthetist to come to the OR desk stat;
    - o Call Security to inform of the need to evacuate;
    - o Call PACU to clear spaces;
    - o Call pre-operative holding area to send patients back to units and to clear spaces for OR patients;
    - o Call other OR departments to determine the availability of theatres;
    - o Check if trauma OR in the Emergency Department is available; and
    - o Call MDR and inform them to stand by.

  (Note: The telephone numbers for each of the above areas are included on the written guidelines.)
- Send nurses into each theatre to inform of need to evacuate and determine status;
- Work with charge anaesthetist to plan each theatre's evacuation destination;
- Send evacuation information into each theatre with same nurses;
- Call available OR departments, PACU, and pre-operative holding area to let them know if and when surgical teams will be arriving;
- When fire safety personnel arrive at the OR, following the code red call, they may determine the need to set up an alternate command centre if the OR desk area is at risk. In this instance transfer incoming calls to the PACU control desk which will operate as the alternate command centre;
- Delegate someone to go to the visitor waiting room, which is external to the OR, to update family, etc;
- Send excess staff to the lounge (located external to the main OR). From this central point PACU and OR can access help from this pool of excess staff as required; and
- Give a copy of the destination report form to clerks operating telephones.

Charge Anaesthetist:

- Obtain a pre-evacuation theatre status report from the charge nurse;
- Immediately plan the evacuation destinations for each theatre;
- Obtain written destination reports, from personnel answering telephones at the control centre, as called in by evacuated teams; and
- Assess OR teams that have evacuated into OR theatres in other departments

Clerks at the OR Control Area:

- Follow the charge nurse's instructions; and
- Assist with accurate counts of evacuated patients and staff as per daily staffing assignment sheet, OR slate; and destination reports.

Pre-operative Holding Area Personnel:

- Send preoperative patients back to the nursing unit as directed by OR charge nurse; and
- Utilize staff resource pool from staff lounge to assist with patient transport if required; and
- Report to OR charge nurse for other assignment as appropriate.

Theatre Staff:

- Nurses:
  - o If the fire is in your theatre's service arm or other infrastructure:
    - • Remove any burning equipment from patient or use theatre's fire extinguisher to extinguish the fire if this can be done without risk of personal injury;
    - • Determine if it is necessary to evacuate immediately. If so:
    - • Activate the fire alarm;
    - • Turn off medical gas supply valves to theatre when no longer in use;
    - • Follow guidelines below; and
    - • Assign someone to place wet towels along the outside bottom of theatre doors to contain smoke after evacuation.
  - o Appoint a team captain;
  - o Gather surgical supplies as needed;
  - o Ensure the surgical incision is covered with sterile drape;
  - o Disconnect anaesthesia machine and unplug electrical equipment when no longer being used;
  - o Assist with moving the anaesthetic machine out of the theatre or assist with to gather medications and supplies;
  - o Prepare to transfer the patient onto a stretcher or unlock the OR bed and transport the bed with the patient on it (Note: If the evacuation destination is on another floor do not transport the patient on the OR bed as the wheels will jam in the elevator floor opening and ramps can be difficult to use);[6] and
  - o Following arrival at your destination, telephone the OR control desk number, and report the patient's status, equipment or supply needs, names of individuals who have left the OR with you and any other relevant information

- **Anaesthetist**
  - o Ventilate the patient using air and use IV medications to maintain anaesthesia;
  - o Turn off oxygen and nitrous oxide sources;
  - o Prepare to maintain respirations and monitoring during transport;
  - o Gather monitoring supplies including medications as needed; and
  - o Ensure anaesthetic machine is turned off and disconnected prior to leaving.

- **Surgeon**
  - o Responsible for giving the final order to move the patient; and
  - o Direct and assist movement of patient out of OR.

- **Support Staff (i.e. Perioperative Aides)**
  - o Report to assigned theatre;
  - o Assist with obtaining supplies, stretchers, etc;
  - o Assist with patient transfer;
  - o Help to clear corridors if required; and
  - o Following transfer, report to charge nurse for other assignments.

Medical Device Reprocessing Department:

- All staff immediately return to MDR;
- Staff will form teams to respond to needs of the operating rooms being evacuated to theatres external to the main OR department (in the case of our facility there were threeexternal theatres):
  - o Trauma OR
  - o Children's OR
  - o MS3 (lumps and bumps) OR
- Each team will carry a different telephone and be responsible for bringing supplies to each of the 3 OR locations.

Post Anaesthesia Care Unit (PACU):

- Discharge patients to preoperative wards where possible;
- Discharge stable patients to preoperative holding area for less intensive monitoring as appropriate;
- Utilize the OR personnel resource pool in lounge as required; and
- Ensure availability of ventilators and other equipment; and
- Report to OR charge nurse for other assignment as time permits.

Security Department:

- Immediately report to the OR ; and
- Assist as required.

Debriefing is an important component of all simulation exercises. In addition to the individual team debriefing sessions conducted by participants, immediately after evacuation, all OR personnel (including staff who were not on duty during the simulation) also participated in a general debriefing session that took place the week after the simulation.

Results:

Following the first evacuation simulation, some modifications were made to the original OR Code Green Contingency plan – mainly in relation to the communication process. A second simulation was conducted, three months later, with much smoother results. Evacuation simulations shall, in the future, occur every three years, and evacuation reviews shall occur on an annual basis. This will ensure compliance with fire code regulations and ensure that a functional efficient evacuation process remains in place.

The roles of different personnel, as outlined in the evacuation plan, were considered to be effective. A few shortages of equipment were identified during the debriefing and plans were put in place to resolve these issues. It was determined that clear signs needed to be posted to identify medical gas shut off sites for each theatre. Utilizing individual messengers (the three nurses) to disseminate information between theatres and the charge nurse was considered to have worked well.

One of the most important lessons during this process was that clear communication is critical during an evacuation. Roles need to be clearly identified and clear communication was essential both for the transfer of information to and from the theatre and when teams were reporting back from evacuation destinations. Clear concise closed-loop communication between team members, inside each theatre, and the appointment of a team leader were also considered extremely important.

All individuals involved in the evacuation simulation reported that it was an excellent learning experience. The future and regular performances of evacuation simulations will ensure all staff will eventually have the opportunity to participate and that the evacuation processes and the code green contingency plan will become familiar to all.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (May 2011) Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (10th edition). Section 4, pg(s) 260-262, standard(s) 1.4 – 1.4.9.

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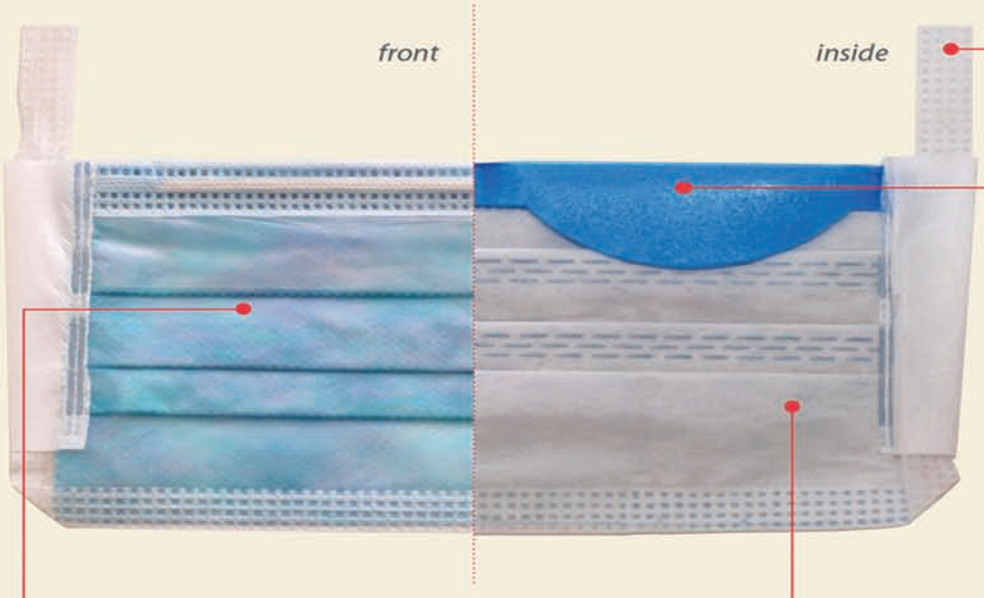

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Excellent breathability:
Constructed for excellent breathability, providing a cool and comfortable fit.

CardinalHealthCanada

For more information, please contact us at **1.888.291.5033**

3G Third Generation Vinyl Gloves

Strength. Comfort. Protection.

Just as effective as nitrile for most uses

When transitioning to a latex-free environment to provide greater staff and patient safety, comfortable and reliable exam gloves are a must. Nitrile is often the material of choice because of its strength and chemical resistance. These qualities, however, are not necessary for every task. Curad 3G Vinyl Gloves are a more cost-effective alternative, offering the sensitivity and comfort of nitrile without the higher price.

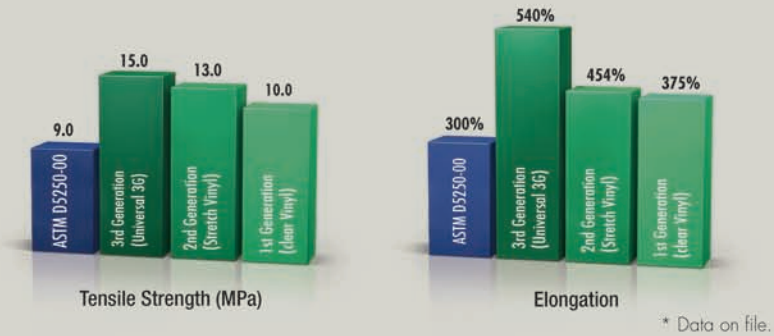
What Makes Curad 3G Vinyl Gloves Different?

A proprietary formulation of ultra-high weight resins and special softening and strengthening agents offer strength, comfort and barrier protection other vinyl gloves cannot.

3G Vinyl + Nitrile Savings without compromise

Did you know that Curad 3G Vinyl Gloves are safe and effective for up to 80% of all hospital tasks? Hospitals that switch to a vinyl/nitrile blend save up to 19% without compromising comfort, safety or effectiveness.

3G gloves surpass ASTM standards for tensile strength and elongation*, as shown below:



* Data on file.

For more information contact canada@medline.com