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NURSING JOURNAL

Volume 29, Issue 3

September 2011

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President's Message

I begin my term as the 14th ORNAC President with much enthusiasm following a successful 22nd ORNAC National Conference in Regina, SK. Congratulations to the National Conference Planning Committee for a superb job! Excellent educational sessions, dynamic speakers, and entertaining social events that truly showcased the Saskatchewan flavour and hospitality will be embedded in our memories for years to come. The involvement of our industry partners and key stakeholders was crucial to the conference's success. Thank you to all!

I am cognizant of the evolution that will occur over the next five years during ORNAC's latest period of transition. Our members have identified the need for change and with the guidance of ORNAC's Executive Director the Board has prioritized these needs and identified a path to follow. We will build on our past achievements while acknowledging and embracing our history. In collaboration with our stakeholders we will strengthen our position as leaders in perioperative practice and patient safety, and thereby further advocate for perioperative Registered Nurses. ORNAC will be led by policy and strategy toward a series of clear goals. The ORNAC Board of Directors, with representation from each province and the three affiliate members, will be accountable for the progress toward meaningful outcomes. Challenging the status quo can be uncomfortable but it is vital to advancement and success! ORNAC will elevate its profile to become further recognized as the leader in perioperative practice and patient safety – both nationally and internationally!

As we bring to life the strategic plan the input of all members will be vital to its success. This is a team approach! It is imperative that each ORNAC member be engaged and involved. As stated by Franklin Delano Roosevelt:

> *"It is a terrible thing to look over your shoulder when you are trying to lead – and find no one there."*[1]

This is an end to the existing ORNAC and will give rise to the new ORNAC! It may seem paradoxical, but it is true that transition starts with an ending. During the month of September a representative from each provincial group and each affiliate group will meet to discuss Board Governance. Board Governance depicts the structure of ORNAC. This includes provincial and affiliate representation as well as chairs or leads for all of our committees. This is the first important structural change as mandated by ORNAC members. ORNAC needs a structure that will support its mission and vision, ensure longevity, and meet the needs of its members in a cost-effective manner.

I recently received a book, from a fellow perioperative nurse, that focuses on managing transitions. This will be such as useful resource as ORNAC moves forward. While the process of change is situational the state of transition is psychological! Transition is a three phase process that begins with letting go.[2] This is the challenge that often requires assistance to help those involved deal with the loss. This is followed by an in-between time when the old is gone but the new is not quite fully operational. During this phase of psychological re-alignment will occur. And then ORNAC will emerge with a new identity, purpose and revitalized energy. Exciting times are ahead of us! Throughout my term as President I will keep you informed on our progress as the strategic plan is implemented. I challenge all perioperative nurses to become involved in their provincial group and to provide input. Together we will emerge as a united and a stronger organization!

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1. Anderson, P. *Great Quotes from Great Leaders*. New Jersey: Career Press 1997. Pg 10
2. Bridges, W. *Managing Transitions* (3rd ed). Philadelphia: Da Capa Press 2009.

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Mot de la president

J'amorce mon mandat à titre de 14e présidente de l'AIISOC avec beaucoup d'enthousiasme à la suite de la 22e conférence nationale de l'AIISOC à Regina, qui, d'ailleurs, a connu un grand succès. Toutes mes félicitations au comité de planification de la conférence nationale pour un excellent travail! Les séances éducatives de grande qualité, les conférenciers dynamiques et les événements sociaux divertissants, qui dépeignaient vraiment l'atmosphère et l'hospitalité de la Saskatchewan, resteront gravés dans nos mémoires durant plusieurs années. La participation de nos partenaires de l'industrie et des principaux intervenants a été essentielle au succès de la conférence. Un gros merci à tous!

Je suis consciente de l'évolution qui se déroulera au cours de cinq prochaines années dans le cadre de la toute dernière période de transition de l'AIISOC. Nos membres ont identifié le besoin pour des changements et avec la gouverne de la directrice générale de l'AIISOC, le conseil d'administration a établi l'ordre de priorité de ces besoins et proposé une marche à suivre. Nous mettrons à profit nos accomplissements passés tout en reconnaissant et en puisant dans notre histoire. Main dans la main avec nos intervenants, nous renforcerons notre position à titre de chef de file dans la pratique des soins périopératoires et la sécurité des patients, plaidant ainsi encore plus en faveur des infirmières et des infirmiers autorisés en soins périopératoires. L'AIISOC sera menée par des politiques et des stratégies dans le but d'atteindre une série d'objectifs clairement établis. Le conseil d'administration de l'AIISOC, les représentants de chacune des provinces et les trois membres affiliés seront responsables de l'évolution de notre transition afin que nous atteignissions des résultats significatifs. Contester le statu quo peut mettre mal à l'aise, mais c'est essentiel au développement et au succès! L'AIISOC rehaussera son statut afin d'être davantage reconnue à titre de chef de file dans la pratique des soins périopératoires et la sécurité des patients – tant à l'échelle nationale qu'internationale!

Alors que nous insufflons la vie au plan stratégique, la contribution de tous les membres sera vitale à son succès. C'est un travail d'équipe! Il est indispensable que chaque membre de l'AIISOC s'implique et participe. Comme l'a si bien dit Franklin Delano Roosevelt :

> « Qu'il est terrifiant de regarder par-dessus son épaule lorsque vous essayez de diriger – et de ne voir personne à votre suite »[1](Traduction libre de la traductrice)

Ainsi se termine l'existence de l'AIISOC, telle que nous l'avons connue. Nous assisterons maintenant à la naissance de la nouvelle AIISOC! Cela peut vous sembler paradoxal, mais il est vrai qu'une transition est souvent enclenchée par une fin. Au cours du mois de septembre, un représentant de chaque groupe provincial et de chaque groupe affilié se rencontreront afin de discuter de la gouvernance du conseil d'administration qui représente la structure de l'AIISOC. Ce qui comprend la représentation des groupes affiliés et provinciaux ainsi que la présidence et les postes prédominants de tous nos comités. C'est le premier changement structurel d'importance mandaté par les membres de l'AIISOC. L'AIISOC a besoin d'une structure qui appuiera sa mission et sa vision, assurera sa longévité et comblera les besoins de ses membres de façon rentable.

Tout dernièrement, une collègue, infirmière en soins périopératoires, m'a envoyé un livre dont le sujet est la gestion des transitions. Il s'avèrera sans aucun doute une ressource utile à mesure que l'AIISOC progressera. Bien que le processus de changement soit situationnel, l'état de la transition est bel et bien psychologique! Une transition est un processus en trois étapes qui débute par le fait de lâcher prise.[2] Les personnes impliquées requièrent souvent de l'aide à cette étape difficile pour gérer leur sentiment de vide. S'ensuit une phase intermédiaire; lorsque ce que l'on connaissait avant n'existe plus, mais ce qui le remplace n'est pas tout à fait opérationnel. C'est au cours de cette étape qu'un réajustement psychologique se produit. Enfin, l'AIISOC renaîtra, dotée d'une nouvelle identité, de nouveaux objectifs et d'une énergie renouvelée. L'avenir nous réserve beaucoup des moments stimulants! Tout au cours de mon mandat à titre de présidente, je vous communiquerai nos progrès au fur et à mesure de la mise en œuvre du plan stratégique. Je mets au défi toutes les infirmières et tous les infirmiers en soins périopératoires de s'impliquer au sein de leur organisme provincial et de partager leurs idées. L'union fait la force et ensemble, nous arriverons à former un organisme uni et solide!

Karen Frenette

Références :

1. Anderson, P. *Great Quotes from Great Leaders*. New Jersey: Career Press 1997. Pg 10
2. Bridges, W. *Managing Transitions* (3rd ed). Philadelphia: Da Capa Press 2009.

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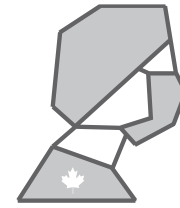

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LES PATIENTS MUNIS D'IMPLANTS COCHLÉAIRES EN SALLE D'OPÉRATION – ENJEUX ET PREOCCUPATIONS

Auteur : Dr. Brian W. Blakley, M.D., Ph. D., FRCSC est professeur et ancien doyen du Département d'oto-rhino-laryngologie de l'Université du Manitoba, à Winnipeg. Il se spécialise en otologie (pathologie de l'oreille) stimulant ses intérêts pour la chirurgie, la médecine et la recherche.

L'auteur a déclaré n'avoir aucune affiliation qui pourrait être perçue comme un conflit d'intérêts.

RÉSUMÉ

Les normes de sécurité pour les patients munis d'implants cochléaires sont difficiles à trouver. En fait, ces dernières sont en constante évolution à mesure que sont diffusés des renseignements supplémentaires. Cet article vous propose un aperçu des philosophies et des lignes directrices actuelles pour la plupart des interventions médicales/chirurgicales, avec une importance particulière accordée à l'environnement des salles d'opération, tel qu'indiqué par les trois fabricants autorisés à commercialiser les implants cochléaires au Canada.

INTRODUCTION

Le personnel des blocs opératoires rencontrent de plus en plus de patients munis d'implants cochléaires étant donné que les dispositifs sont plus répandus.[1,2] Les implants cochléaires nécessitent en tout temps un traitement soigneux, plus particulièrement en salle d'opération. À défaut de comprendre les risques et de minimiser les précautions, les patients pourraient souffrir d'une incapacité grave. Le but de cet article est de fournir de l'information de base sur ce qu'est un implant cochléaire et de résumer les recommandations actuelles quant à la sécurité des patients munis d'implants cochléaires en salle d'opération et en milieu hospitalier. Cet article ne traite pas de la chirurgie pour les implants cochléaires, des appareils de correction auditive implantables ni de tout autre type d'implants auditifs.

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 infirmières et des infirmiers de salle d'opération du Canada (AISSOC) de juin 2009, section 3, p. 173, Normes 2.28 et 2.2.9.

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PATIENTS WITH COCHLEAR IMPLANTS IN THE OR – ISSUES AND CONCERNS

***Author:** Dr. Brian W. Blakley, MD, PhD, FRCSC, is a professor and former chairman of the Department of Otolaryngology, University of Manitoba, in Winnipeg. He sub-specializes in otology (diseases of the ear) maintaining surgical, medical and research interests.*

The author has declared no affiliation that could be perceived as a conflict of interest.

ABSTRACT

Safety standards for patients with cochlear implants are difficult to find. Safety standards are, in fact, constantly evolving as more information becomes available. This article provides an overview of current philosophies and guidelines for most medical/surgical interventions, with emphasis on the operating room environment, as indicated by the three manufacturers authorized to market cochlear implants in Canada.

INTRODUCTION

Operating room staff are encountering more patients with cochlear implants as the devices are becoming more common.[1,2] Cochlear implants require careful treatment at all times and particularly in the operating room. Failure to understand the risks and take simple precautions can result in severe disability to patients. The purpose of this article is to provide basic information on what a cochlear implant is and to summarize the current recommendations for operating room and hospital safety for patients with cochlear implants. This article does not discuss cochlear implant surgery, implantable hearing aids or other types of implants used in the ear.

What is a cochlear implant and why is it special?

The cochlea changes sound into nerve impulses and is the organ in the ear responsible for hearing. For those with some types of hearing loss that are too severe to benefit from a conventional hearing aid a cochlear implant can be effective in restoring communication ability. The cochlear implant is the first device that can uses electrical stimulation to replace a natural sensation in humans.[2] A cochlear implant is not a hearing aid – it stimulates the inner ear differently. A hearing aid picks up sound with a microphone, amplifies the sound and stimulates the ear with louder sound. A cochlear implant picks up sound with a microphone but stimulates the cochlea with electrical impulses. The main difference between a cochlear implant and a hearing aid is that the implant stimulates the cochlea electrically rather than with sound as in a hearing aid.

Currently there are three companies authorized to manufacture and market cochlear implants in Canada. All three companies are marketing cochlear implants with similar components. Individuals with newer cochlear implants use a device that looks similar to a behind-the-ear hearing aid but patients with older models utilize a sound processor (also called a speech processor) worn on the belt. Cochlear implant systems have both internal and external components that are hard-wired together. The internal and external components communicate via FM electrical signals transmitted across the skin[2] (See Figure 1).

INTERNAL components are surgically implanted, not visible externally, and not removable without surgery.

1) The receiver system includes an internal magnet to match the external magnet in the transmitter system. The internal and external magnets on each side of the skin hold the receiver coil in place to pick up the FM electrical signals from the external transmitter; and
2) The implant itself is worn under the skin and conducts electrical stimulation down into the cochlea through many electrodes. The number of electrodes in the cochlea varies and may be up to 24.[3-7]

EXTERNAL components are removable and worn externally.

1) Microphone;
2) Sound processor containing a small computer to analyse sound from the microphone; and
3) Transmitter system that is a circular disk containing a magnet to hold the device in the proper place, and an electrical coil to transmit FM electrical signals across the skin to the internal components.

The implant itself must be placed surgically and requires the external components in order to function. If the external components are removed the patient cannot hear but the internal components are still present and at risk. This is important in the operating room.

Who uses a cochlear implant?

The general indication for cochlear implantation is sensorineural or nerve-related hearing loss that is too severe to benefit significantly from a hearing aid.[1] There are specific criteria from hearing test data and evaluations and these vary for adults and children. For some patients, inability to understand speech even when sound is loud enough is the main reason for the implant. Some

cochlear implant patients have rudimentary hearing.

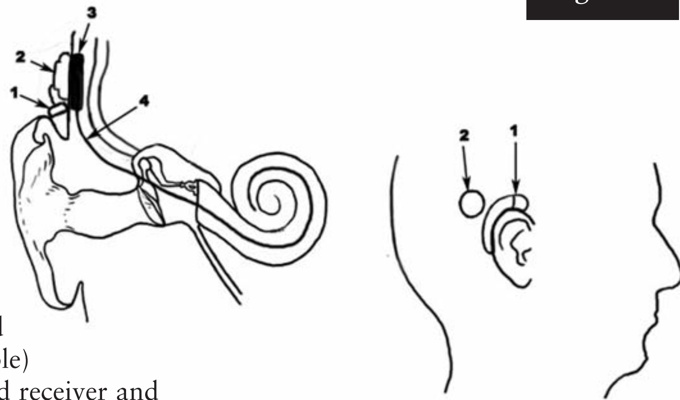
Unlike with a hearing aid patient, if the external components of a cochlear implant are removed the patient is essentially deaf and no further communication is possible. This can be frightening for patients in the strange environment of the operating room. It is no longer possible for the patient to hear reassurances or explanations from the OR staff. For this reason the external components should be left in place as long as possible in the OR. External components should be removed only after, or just prior to, induction of general anaesthesia. Local or regional anaesthesia may present problems particularly if electrosurgery is being used near the implant area. Removal of the external device precludes auditory communication during the procedure. General anaesthesia might, in some situations, be preferable for patients with cochlear implants.

TYPICAL COCHLEAR IMPLANT

Figure 1

Cochlear implants vary in appearance, but all currently have:

a) **External** (removable) components:
1) sound processor and microphone,
2) transmitter system and
b) **Internal** (non-removable) components; 3) implanted receiver and
4) electrodes entering the cochlea.



Preparation for and Risks of Surgery:

It seems wise to start in the pre-op holding area by having the patient show the staff how to remove and turn off the device. This is not difficult or dangerous although it can be strange to handle a device that attaches to a patient with a magnet. Individuals with cochlear implants are experts in the removal and care of their devices and are usually happy and willing to show care-givers what to do. They will want to be sure that the device will be removed before the possible use of electrocautery (or other situations that pose a risk, as outlined below). Individuals with cochlear implants are generally intelligent (reasonable cognitive ability is required to learn to use the device) and will usually be aware of some of the risks they face in surgery. As trauma, intubation, and other situations may impair the ability of the patient to communicate it is important that staff are also familiar with the device.

What situations are risky for patients with cochlear implants? Cochlear implants are electromagnetic devices so any medical intervention that involves magnetism or electrical stimulation, or any combination of both, requires careful consideration. Following the path of least resistance, an electrocautery current may travel down the electrode array. The large electrical energy burst will usually destroy any of the remaining delicate cochlear hair cells. This destruction may make the implant useless, or at best reduce its effectiveness, thus creating a disability for the patient. Bipolar cautery is less risky but still of concern. Radioactive isotopes (particularly gamma-rays), magnetic resonance imaging (MRI) scans, and any possible physical movement of the device also pose potential problems. Ordinary X-rays, blood work, and drugs are safe for implants.

Continued on Page 27

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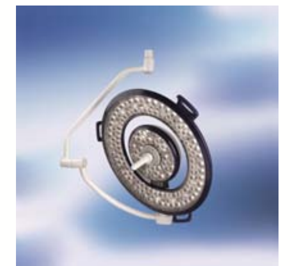

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"ELEVATING THE FIELD OF PERIOPERATIVE NURSING" – MAY 8-13, 2011, REGINA, SK.

The Queensbury Convention Centre at Evraz Place in Regina and many downtown hotels were hubs of activity as perioperative Registered Nurses and representatives from various industry partners gathered for the 22nd National Operating Room Nurses Association of Canada (ORNAC) Conference. Days of educational sessions with presenters from around the world, early morning educational sessions (with breakfast and coffee!!!!!!!!!!!), opportunities to learn about new trends and see innovative technology from our industry partners and, of course, time to enjoy Saskatchewan hospitality was the order of the week.

By/par: S. Booty-Sebastian

ORNAC Executive Director Catherine Harley

The conference planning committee and volunteers were pleased and proud to bring Saskatchewan flair to this event. During the opening ceremonies greetings were extended from the city of Regina, the government of Saskatchewan, the Saskatchewan Registered Nurses Association, the Canadian Nurses Association, the Canadian Medical Association, the European Operating Room Nurses Association, the National Exhibitor Advisory Committee and Bonnie McLeod, President of the Operating Room Nurses Association of Canada (ORNAC). World champion hoop dancer, Terrance Littletent, dazzled us with his skill and coordination in the first nation's tradition of hoop dancing. The ORNAC conference print was unveiled by artist Doug Welykholowa and Bonnie McLeod. This year's print, entitled "Standing Tall", depicts a Regina-area grain elevator that is used to store the harvest and serves a beacon for travelers across the prairies. The painting also reflects the character of perioperative nurses across Canada. We have had to "stand tall" and strive to improve our practice in the face of rapidly changing technology and work environments, while providing the safest possible patient-centered care, as our patients put their faith and trust in us to be their advocate throughout their perioperative journey.

By/par: S. Booty-Sebastian

ORNAC Board members manning the ORNAC booth on the Exhibitor floor

The weeks' educational sessions were offered in both English and French and were challenging, compelling and definitely thought provoking. Thank you to our sponsors for the valuable addition of the Sunday pre-conference workshops.

Speakers during this week shared their knowledge, research and the challenges the face in the day-to-day of perioperative nursing. Tuesday to Thursday our industry partners displayed new technology and innovations and gave us a preview of perioperative nursing in the future.

Learning opportunities were also provided through the many poster presentations displayed in the exhibitor hall. Thank you one and all for the opportunity to learn new ways to expand and enhance our work environments.

By/par: S. Booty-Sebastian

Exhibitor floor

As the saying goes "all work and no play....." And so we did, indeed, find time to play. Beginning Sunday evening at the welcome reception we received a formal welcome from "the QUEEN" aka Donna Sanders a SK perioperative Registered Nurse. Monday night we "Dressed for the West" and explored the Saskatchewan Science Centre while our steak was cooked on a pitchfork. Tuesday we donned our costumes for a night at the movies. And costumes there were!!! Our friends from the US, The Laryngospasms, entertained us with songs written or altered to describe the Operating Room experience and spasms of laughter filled the hall. Our final evening together featured a Little Taste of Saskatchewan in both the evenings' meal and the entertainment -- a fabulous dance party featuring Regina's Rory Allen and his "Tribute to the King". He did look like Elvis, sang like Elvis and had the Elvis moves. He also gave out some traditional Elvis scarves!

To end the conference on Friday (the 13th that is) the Honourable Pamela Wallin challenged us to be all that we can be in our perioperative setting, to reach for the highest, and to strive for the best. Our closing speaker was Dr. Wayne Halliwell who conveyed the need for perioperative Registered Nurses to "stand tall" and make their voices heard as we strive for safe and optimal patient care. The Honorable Dr. Gordon L. Barnhart, Lieutenant Governor of Saskatchewan, encouraged us to return to our homes with a pride in being Registered Nurses and tasked us with caring for Canadians in a way that leads to a healthy Canada.

By/par: S. Booty-Sebastian

The Laryngospasms entertain the crowd

The session closed with the Awards presentation to colleagues, the transfer of the "Chain of Office", from outgoing ORNAC President Bonnie McLeod to incoming President Karen Frenette, and the introduction of the 2011-2013 ORNAC Executive. Bonnie announced that the 23rd National Conference will be held in Ottawa, April 22-26, 2013.

The goal of hosting a National Conference in Saskatchewan was achieved through the dedication and hard work of the SK organizing committee members and volunteers. Thank you to the delegates and industry partners for attending this event and see you in Ottawa in 2013!

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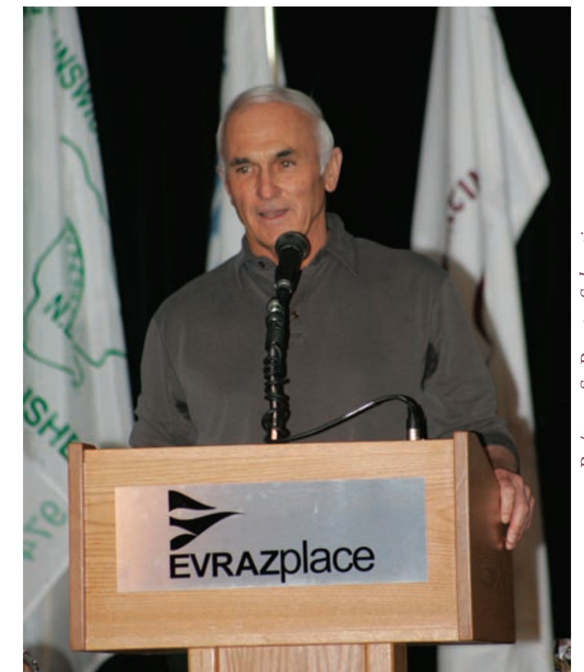
AIISOC 2011 – 22e conférence nationale

« Améliorer le domaine des soins périopératoires » – 8 au 13 mai 2011, Regina, SK.

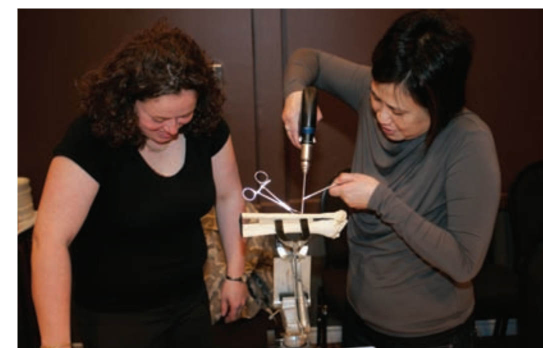
Le centre des congrès Queensbury Convention Centre de la place Evraz à Regina et de nombreux hôtels du centre-ville se sont transformés en centres d'activités alors que s'y rassemblaient des infirmières et des infirmiers autorisés en soins périopératoires et des représentants de divers partenaires industriels pour la 22e conférence nationale de l'Association des infirmières et infirmiers de salles d'opération du Canada (AIISOC). À l'agenda de la semaine : des journées de séances éducatives avec des présentateurs d'à travers le monde, des séances éducatives pour les lève-tôt (avec déjeuner et café!!!!!!!!!!!), des occasions de se renseigner sur les nouvelles tendances et de voir les technologies novatrices de nos partenaires de l'industrie et, bien sûr, du temps pour profiter de l'hospitalité de la Saskatchewan.



By/par: S. Booty-Sebastian

Le conférencier de clôture, le Dr Wayne Halliwell

Le comité de la planification de la conférence et les bénévoles étaient heureux et fiers de donner à cet événement une touche typiquement saskatchewanaise. Lors des cérémonies d'ouverture, la ville de Regina, le gouvernement de la Saskatchewan, l'Association des infirmières et des infirmiers autorisés de la Saskatchewan, l'Association des infirmières et infirmiers du Canada, l'Association médicale canadienne, la European Operating Room Nurses Association, le National Exhibitor Advisory Committee ainsi que Bonnie McLeod, présidente de l'Association des infirmières et infirmiers de salles d'opération du Canada (AIISOC), ont transmis leurs salutations. Le champion du monde de danse du cerceau, Terrance Littletent, nous a éblouis avec ses aptitudes et sa coordination lors d'un spectacle de danse traditionnelle du cerceau des Premières nations. Le tableau de la conférence de l'AIISOC a été dévoilé par l'artiste Doug Welykholowa et Bonnie McLeod. Le tableau de cette année, intitulé « Standing Tall », dépeint un silo-élévateur de la région de Regina qui est utilisé pour stocker les récoltes et qui sert de point de repère aux voyageurs des Prairies. Il symbolise également le caractère des infirmières et des infirmiers en soins périopératoires du Canada. Nous avons dû garder la tête haute et nous efforcer d'améliorer notre pratique face à la technologie et les milieux de travail qui évoluent rapidement. Nous devons continuer à offrir des soins axés sur les patients les plus sécuritaires possible, étant donné que nos patients mettent leurs espoirs en nous et nous font confiance quand vient le temps de prendre leur défense au cours de leur séjour en soins périopératoires.



By/par: S. Booty-Sebastian

Des délégués participent à l'atelier préliminaire sur l'orthopédie

Les séances éducatives de la semaine étaient stimulantes, passionnantes et assurément inspirantes, en plus d'être offertes à la fois en anglais et en français. Un merci sincère à nos promoteurs pour l'ajout très utile des ateliers préliminaires du dimanche.

Tout au cours de la semaine, les conférenciers ont partagé leurs connaissances, leurs recherches et les défis auxquels ils font face dans leur pratique quotidienne de soins périopératoires. Du mardi au jeudi, nos partenaires de l'industrie ont présenté les nouvelles technologies et innovations dans le domaine et nous ont donné un avant-goût de ce à quoi ressembleront les soins périopératoires de l'avenir.

Grâce aux nombreuses présentations par affiches qui ornaient le hall d'exposition, les participants pouvaient profiter de maintes possibilités d'apprentissage. Merci à tous sans exception pour ces occasions d'apprendre de nouvelles façons de développer et d'améliorer nos environnements de travail.

Comme le dit le dicton : « Au long aller, petit fardeau pèse », et ainsi donc pour décharger notre esprit, nous avons trouvé le temps de nous amuser. Dès le dimanche soir, lors de la réception de bienvenue, « la REINE », alias Donna Sanders, une infirmière autorisée en soins périopératoires de la Saskatchewan, nous a souhaité la bienvenue. Lundi soir, nous nous sommes déguisés pour l'Ouest et avons exploré le centre des sciences de la Saskatchewan tandis que nos biftecks étaient en train de griller sur une fourche. Mardi, nous avons délaissé nos costumes pour une soirée au cinéma et les costumes nous y ont retrouvés!!! Nos amis des États-Unis, la troupe The Laryngospasms, nous ont divertis avec des chansons écrites ou modifiées afin de décrire les expériences en salles d'opération, ce qui a créé des spasmes de rires partout en salle. Notre dernière soirée ensemble nous a donné un petit avant-goût de la vie en Saskatchewan, tant dans notre assiette que du côté des divertissements, où nous avons eu droit à une fabuleuse fête dansante mettant en vedette Rory Allen de Regina et son « Hommage au King ». Allen ressemblait vraiment à Elvis, il chantait et dansait comme lui et a même distribué des foulards traditionnels d'Elvis!

By/par: S. Booty-Sebastian

Des délégués costumés lors de la soirée au cinéma

Pour clore la conférence le vendredi (qui était un vendredi 13 en passant), l'Honorable Pamela Wallin nous a mis au défi de toujours faire de notre mieux dans le cadre des soins périopératoires que nous offrons, de viser la perfection et de nous efforcer à atteindre l'excellence. Notre conférencier de clôture était le Dr Wayne Halliwell, qui a communiqué le besoin pour les infirmières et les infirmiers autorisés en soins périopératoires de garder la tête haute et de se faire entendre alors que nous nous efforçons d'offrir à nos patients des soins sécuritaires et de grande qualité. L'Honorable Dr Gordon L. Barnhart, lieutenant-gouverneur de la Saskatchewan, nous a encouragés à retourner à la maison en étant fiers d'être des infirmières et des infirmiers autorisés et nous a chargés de prendre soin des Canadiens et des Canadiennes en vue d'un Canada soit plus sain.

La séance s'est terminée par la présentation des prix, le transfert de la « chaîne de fonction » de la présidente sortante de l'AIISOC, Bonnie McLeod, à la nouvelle présidente, Karen Frenette, et par l'introduction du conseil de direction de l'AIISOC pour 2011-2013. Bonnie a annoncé que la 23e conférence nationale se tiendrait à Ottawa, du 22 au 26 avril 2013.

Notre objectif de tenir cette conférence nationale en Saskatchewan a été atteint grâce au dévouement et au bon travail des membres du comité organisateur ainsi que des bénévoles de la Saskatchewan. Nous tenons à remercier les délégués et les partenaires de l'industrie pour avoir participé en grand nombre à cet événement et nous sommes impatients de vous revoir à Ottawa en 2013!

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2011 Award and Bursary Presentations

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Anita Esson, ORNAC Awards Chair, presenting the Johnson & Johnson Drake-Thompson Writing Award to Cheryl Stella (Okoli) Ugoalah.

Muriel Shewchuk presenting the ORNAC - Muriel Shewchuk Leadership Award to Vanna Wasson from NB.

ORNAC Johnson & Johnson Medical Products Bursary for OR Nurses was awarded to Pamela Railton. Anita Esson, ORNAC Awards Chair, made the presentation to Muriel Shewchuk as Pamela was not in attendance.

Anita Esson, ORNAC Awards Chair, presenting the ORNAC Johnson & Johnson Medical Products Bursary for OR Nurses to Dorothy Dewar of PEI.

Pictured are the 3 ORNAC Writing Contest winners - Deborah Roberts, Anne Chang, and Tara Babin - with Anita Esson, ORNAC Awards Chair.

Lorne Flower Memorial Award was awarded to Marlene Weeks. Anita Esson, ORNAC Awards Chair, presented the award to Rupinder Khotar, ORNAC's President-Elect, as Marlene was not in attendance.

The Medline Canada Mentorship Award being presented by Zack Pocklington, Executive Vice President of Medline Canada, and Anita Esson, ORNAC Awards Chair, to Barbara Jenkins from NB and Theresa Burton from NS.

The Isabelle Adams Excellence in Perioperative Nursing Award being presented to Barbara Jenkins, from NB, by Karen Frenette, the 2009 recipient of this Award, and Anita Esson, ORNAC Awards Chair.

***The RMAC Patient Safety Award** was presented to **Joan Porteous** (photo not available).*

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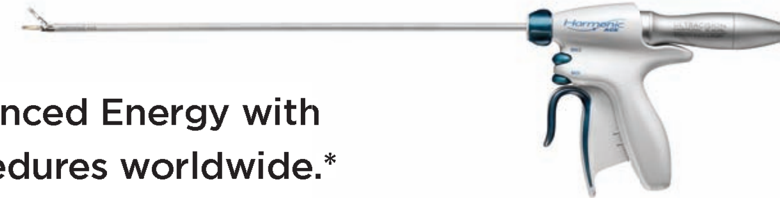

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IMPORTANT NOTICE

ORNAC STANDARDS, GUIDELINES, AND POSITION STATEMENTS FOR PERIOPERATIVE REGISTERED NURSING PRACTICE, 10TH Ed.

Please note there have been some errors identified in the 10th edition of the Standards. For further information, please go to the ORNAC website at www.ORNAC.ca.

ORNAC IN ACTION

THE ORNAC STRATEGIC PLAN: 2011-2015

ORNAC has, by building on past achievements & responding to environmental trends, developed a five year strategic plan. This plan sets a direction that will, in collaboration with stakeholders, strengthen the national vision of leadership in perioperative practice & patient safety by advocating for perioperative registered nurses, patients, and patients families.

ORNAC will focus on three main strategic priorities:

1. Demonstrate leadership in patient safety;
2. Enable best practices in perioperative patient care; and
3. Advance perioperative nursing career development & leadership to create effective perioperative teams.

The nine month strategic planning process has been completed and has resulted in the approval of an ORNAC Strategic Plan, to be implemented from 2011 to 2015, by the ORNAC Board of Directors during the ORNAC Conference in Regina, May 2011. The strategic planning process began in August, 2010, when representatives from each province and ORNAC affiliate group (CORL, RNFANC and PNEC) met in Ottawa. The group worked through a strategic planning process with facilitator Catherine Harley, the ORNAC Executive Director. Following this session a communication was sent to the ORNAC provincial members to notify them of this forthcoming strategic plan.

A draft strategic plan was developed and presented back to the ORNAC Board in November 2010. Board approval was given to circulate the draft plan to members within each province in order to obtain feedback. The response from the provincial members was, overall, quite strong. In March 2011, the strategic plan was refined based on the feedback of the provincial members. The final five year ORNAC Strategic Plan was approved by the ORNAC Board in May 2011.

Through effective governance, ORNAC will implement the Strategic Plan 2011-2015 and thus will be positioned to make a strong impact

By/par: S. Booty-Sebastian

Outgoing ORNAC Executive – Alaine Young, Karen Frenette, Bonnie McLeod, Linda Socha, and Sue Styles

on perioperative practice within the Canadian healthcare system & internationally.

The revised ORNAC Mission and Vision Statements are as follows:

ORNAC Mission Statement

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

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

ORNAC Vision Statement:

The Operating Room Nurses Association of Canada (ORNAC) is the leader in perioperative practice & patient safety through a strong, unified national association that enhances and advances the practice of perioperative Registered Nurses & Associates.

Short version of vision statement: The leader in perioperative practice & patient safety.

A one year operational plan has been written to support the first year implementation of the strategic plan. In future editions of CORNJ this 'ORNAC in Action' section will report on the activities of ORNAC under its five pillars:

1. National Conference Planning;
2. Professional Practice;
3. Advocacy;
4. Research and Informatics; and
5. Marketing.

We look forward to the implementation of the ORNAC Strategic Plan and to getting members involved through active participation.

Please also note - ORNAC is a federation of the provincial Operating Room groups. In many provinces the annual membership drive is underway. It is time to renew membership with your provincial association and you can do so by going to www.ORNAC.ca and selecting "Our Organization" and then choosing your provincial chapter.

ORNAC always welcomes your comments, feedback and input on matters relating to perioperative nursing practice. To contact us or for timely news/announcements about ORNAC activities visit www.ORNAC.ca.

L'AIISOC EN ACTION

LE PLAN STRATÉGIQUE DE L'AIISOC POUR 2011-2015

Mettant à profit ses accomplissements passés et réagissant aux tendances environnementales, l'AIISOC a élaboré un plan stratégique quinquennal. Ce plan établit notre orientation qui, en collaboration avec des intervenants, solidifie notre vision nationale de leadership dans la pratique de soins périopératoires et la sécurité des patients en défendant les droits des infirmières et des infirmiers autorisés en soins périopératoires ainsi que ceux des patients et de leur famille.

L'AIISOC se concentrera sur trois principales priorités stratégiques :

By/par: S. Booty-Sebastian

Conseil d'administration et conseil de direction de l'AIISOC

1. Faire preuve de leadership dans le domaine de la sécurité des patients
2. Faciliter les pratiques exemplaires dans les soins périopératoires apportés aux patients; et
3. Faire progresser le perfectionnement et le leadership dans la pratique professionnelle des soins périopératoires afin de créer des équipes périopératoires efficaces

Le processus de planification stratégique qui a duré neuf mois a pris fin et a mené à l'approbation du plan stratégique de l'AIISOC pour 2011-2015 par le conseil d'administration de l'AIISOC lors de la conférence de l'AIISOC qui a eu lieu à Regina en mai 2011. Le processus de planification stratégique avait commencé en août 2010, lorsque des délégués de chacune des provinces et des représentants des organismes affiliés à l'AIISOC (LCSO, RNFANC et ESPC) s'étaient rencontrés à Ottawa. Le groupe, avec l'aide de l'animatrice, la directrice générale de l'AIISOC, Catherine Harley, avait élaboré un processus de planification stratégique. Après cette séance, un communiqué avait été envoyé aux membres provinciaux de l'AIISOC pour les aviser de ce plan stratégique en voie d'élaboration.

Un plan stratégique a été ébauché et présenté à nouveau au conseil d'administration de l'AIISOC en novembre 2010. Le conseil a approuvé la circulation de cette ébauche au sein des membres de chaque province afin d'obtenir leur rétroaction. En général, la réponse de la part des membres provinciaux a été foudroyante. En mars 2011, le plan stratégique a été peaufiné en se basant sur la rétroaction des membres provinciaux. Le plan

L'AIISOC EN ACTION (CONT.)

By/par: S. Booty-Sebastian

Standards Committee members

stratégique final de l'AIISOC d'une durée de cinq ans a été approuvé par le conseil d'administration de l'AIISOC en mai 2011.

Grâce à une gouvernance efficace, l'AIISOC pourra mettre en œuvre le plan stratégique de 2011-2015 et sera ainsi en mesure de produire un impact positif sur la pratique des soins périopératoires au sein du système de soins de santé canadien et international.

Voici les énoncés de mission et de vision révisés de l'AIISOC :

Énoncé de 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 l'avancement de l'excellence quant à la distribution de soins périopératoires sécuritaires à nos patients
- Au développement professionnel, à l'amélioration des compétences et l'amélioration sur le plan personnel des membres de l'AIISOC; et
- À la progression de la pratique professionnelle des soins périopératoires à l'échelle régionale, provinciale, nationale et internationale.

Énoncé de vision de l'AIISOC :

L'Association des infirmières et des infirmiers de salles d'opération du Canada (AIISOC) est chef de file dans le domaine de la pratique des soins périopératoires et de la sécurité des patients grâce à une association nationale solide et unie qui améliore et fait progresser la pratique des infirmières et des infirmiers autorisés en soins périopératoires et des associés.

Un plan opérationnel d'un an a été rédigé afin d'appuyer la mise en œuvre du plan stratégique durant la première année. Dans les éditions futures de la RAIISOC, la présente section, intitulée « L'AIISOC en action », vous informera des activités de l'AIISOC en les divisant par ses cinq piliers :

1. Planification de la conférence nationale;
2. Pratique professionnelle;
3. Défense des droits;
4. Recherche et informatique; et
5. Marketing.

Nous sommes impatients de mettre en œuvre le plan stratégique de l'AIISOC et que les membres s'y impliquent de façon active.

Veuillez également prendre note que l'AIISOC est une fédération des groupes provinciaux en salle d'opération. Dans plusieurs provinces, la campagne annuelle d'adhésion est en cours. Il est maintenant temps de renouveler votre adhésion auprès de votre association provinciale, ce que vous pouvez faire en visitant le site www.AIISOC.ca et en sélectionnant l'onglet « Notre organisme », puis en sélectionnant votre section provinciale.

L'AIISOC apprécie toujours vos commentaires, votre rétroaction et vos idées quant aux questions liées à la pratique des soins périopératoires. Pour communiquer avec nous ou pour connaître les nouvelles ou les avis concernant les activités de l'AIISOC, visitez www.AIISOC.ca.

By/par: S. Booty-Sebastian

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Newfoundland & Labrador	Corner Brook, NL	October 13-15, 2011
Alberta	Red Deer, AB	October 26-29, 2011
Manitoba		March 2012 Workshop
British Columbia	Nanaimo, BC	April 25-28, 2012
Ontario	Toronto, ON	June 16 - 20, 2012
25th Atlantic Conference	Charlottetown, PEI	September 26-28, 2012
Quebec	Quebec City, QC	Oct 31-Nov 2, 2012

ORNAC CONFERENCES www.ORNAC.ca

23rd National	Ottawa ON	April 22-26, 2013

INTERNATIONAL CONFERENCES

AfPP (www.afpp.org.uk)	Bournemouth, UK	October 1, 2011
AORN (www.AORN.org)	New Orleans, LA	March 24-29, 2012
EORNA	Lisboa, Portugal	April 26-29, 2012

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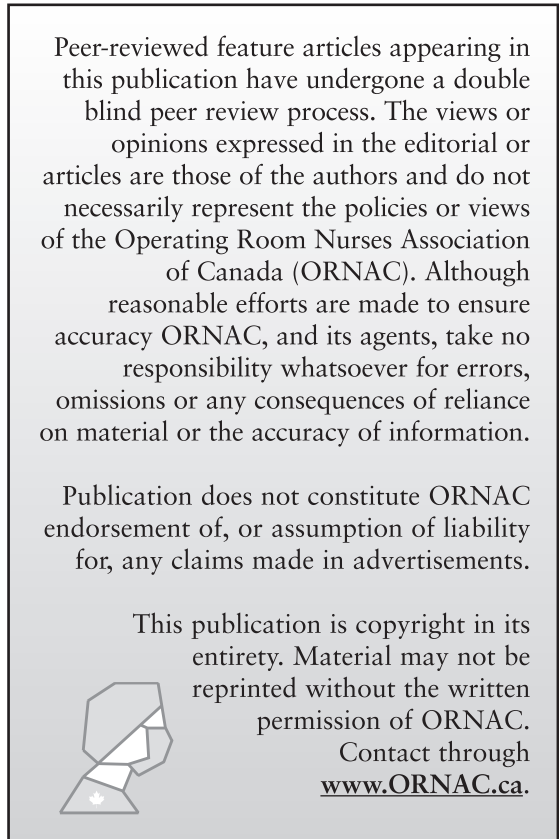

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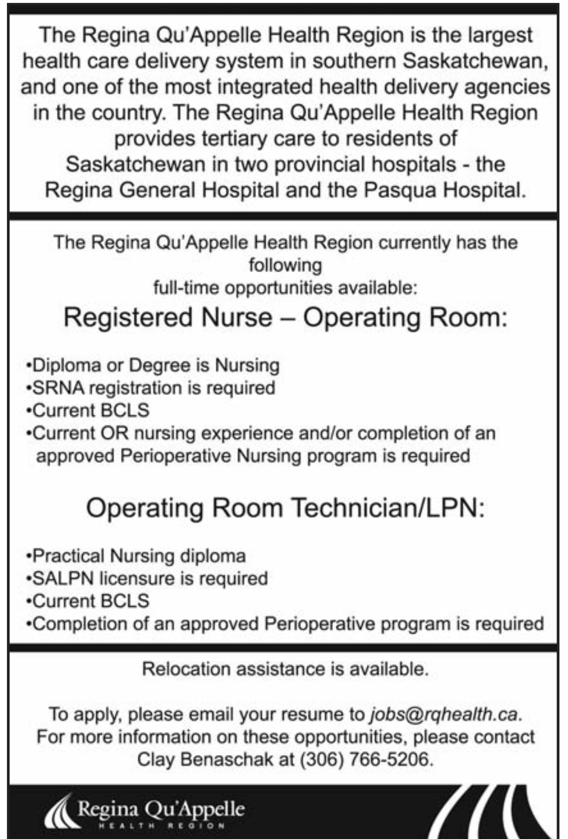

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See Table 1 for the current recommendations for precautions during medical procedures.

SOME OF THE COMMON OPERATING ROOM OR MEDICAL INTERVENTIONS THAT MAY BE OF CONCERN FOR COCHLEAR IMPLANTS INCLUDE THE FOLLOWING:

Electrosurgery means the cutting or destruction of tissue by electrical current. The concern with electrosurgery is the powerful current needed to achieve haemostasis, or cut tissue, may flow down the implant into the cochlea and damage the remaining, delicate remaining functional cochlear tissue. With monopolar electrocautery, a current passes from an electrode to ground through the patient's body by the path of least electrical resistance.[8] A cochlear implant, as it is an electronic device, may provide the path of least resistance. For this reason, monopolar electrocautery should not be used above the clavicle in patients with cochlear implants. Bipolar electrocautery uses high frequency current passing between two poles that are typically close together. One manufacturer recommends that bipolar cautery not be used closer than 3 cm[6] and another manufacturer recommends it not be used closer than 1cm from the implant.[7,8] The grounding pad should be placed on the torso or thigh and the patient's head should be electrically isolated from the operating room table.[7] Chemical haemostatic agents, for example silver nitrate ($AgNO^3$), do not pose a risk to cochlear implants.

Ultrasound is the application of high frequency sound waves that are well above the frequencies detectable by human hearing (250-2000 kilohertz).[5] All sound, including ultrasound, consists of the movement of molecules so there may be concern with cochlear implants. Ultrasound waves are reflected off soft tissue structures to image tissues under the skin surface. Diagnostic ultrasound can be used to image structures such as pregnant uteri, abscesses, and soft tissue masses. Ultrasound is also used therapeutically, with much greater energy, to stimulate tissues as an adjunct to physical therapy, to clean teeth in dental labs, in lithotripsy to break up kidney stones, and in cataract surgery (phacoemulsification).[8] Ultrasound should not be used in the area of the implant site but is otherwise safe for cochlear implants.

Neurostimulation, in this article, refers to the implantation of an electrical stimulation device for the purpose of relieving pain.[9] Most often the hardware, electrodes, and batteries are surgically implanted. In other cases radio-frequency stimulators are implanted and have some external components. Electrical stimulation of a cochlear implant would be undesirable so neurostimulation should not be used over the implant site. Otherwise it is safe for patients with cochlear implants.

Diathermy. There are three types of diathermy in medical practice:

1) radio frequency (shortwave) diathermy;
2) microwave diathermy; and
3) ultrasound.

Diathermy produces heat in various locations in the body in order to treat a variety of conditions such as muscle pains, strains and arthritis. Shortwave diathermy is often used to treat areas with large tissue mass such as a hip. Microwave diathermy is applied to superficial areas because its waves do not penetrate as deeply as shortwave. Ultrasound diathermy is probably most commonly used to treat athletic injuries and in physiotherapy. In some countries the word "diathermy" may be used to refer to what is called "electrocautery" in North America.

Manufacturers' recommendations regarding diathermy differ. Two of the Canadian companies recommend that diathermy not be used at all in cochlear implant patients.[7,8] The third recommends that diathermy not be used within 3 cm of implant.[6] Ultrasound diathermy may usually be used below the clavicles.

Electroconvulsive therapy (ECT) refers to the delivery of a large electrical stimulus to the brain in order to treat psychiatric disorders such as depression. This electrical stimulus can be dangerous to cochlear implant devices and

cochlear tissue. All 3 manufacturers recommend avoiding the use of ECT on cochlear implant patients.[6,7,8]

Radiation therapy utilizes ionizing radiation to treat cancer. Ionizing radiation is dangerous for cochlear implants so the manufacturers recommend that radiation therapy not be used within 3 cm of implant.[10-12] Gamma knife therapy is of particular concern because gamma rays are destructive to the atomic grid of cochlear implants but are commonly used to treat acoustic neuromas. Acoustic neuroma is a common cause of deafness. Some models of cochlear implant are safer for radiation than others but they vary. When this therapy is to be used the gamma knife team should contact the manufacturer and discuss the situation for that model.

Radioisotope therapy is commonly used to treat some cancers, particularly with brachytherapy. Medical radioisotopes usually emit gamma-, beta-, or alpha-rays depending on the isotope[4] Gamma-rays can damage the implant. Do not use gamma-rays in the head and neck of patients with cochlear implants. Beta- or alpha-rays may be used if they are not brought physically close to the implant.[4,6-8] This concern would be particularly important in the use of radioisotope therapy, such as brachytherapy for tongue or head and neck tumours that may be delivered intra-operatively, because gamma-radiation is produced. The area of the implant should not be exposed to gamma-emitting situations such as placing an open brachy therapy radioisotope source, intended for another body area, near the ear. These situations would also violate accepted standards for handling isotopes.

Plasma knife / coblation involves the creation of a plasma field, near tissue, by applying radiofrequency electromagnetic stimulus to a bipolar electrode array adjacent to a conducting medium such as saline.[13] Recommendations for coblation are similar to bipolar electrocautery. One manufacturer recommends that coblation not be used within 3 cm[6] of the implant, the other two recommend a distance of 1 cm.[7,8] Tonsillectomies may be performed with coblation in patients with cochlear implants.[14,15]

Radiofrequency ablation refers to the use of a bipolar stimulation of tissue.[5] Tumours of the liver, and sometimes the kidney and bone, may be treated in this way using a minimally invasive procedure. Under CT-guidance a needle is inserted into the tumour. Then the tumour is heated by the bipolar electrodes. Radiofrequency ablation is also used to ablate tissue in the heart, such as abnormal conducting pathways, to correct arrhythmias. The device consists of a housed needle electrode delivered via catheter. One electrode is the needle and the other is the housing. In cochlear implant patients, radiofrequency ablation should not be used in the head and neck. The grounding pad should be on the torso or thigh.[16]

Magnetic resonance imaging (MRI) scans pose significant potential problems for patients with cochlear implants. The MRI is a strong magnetic device and the cochlear implant is an electromagnetic device so we should expect that MRI on a patient with a cochlear implant would result in problems. This is a challenge as the need for an MRI scan arises frequently because tumours such as acoustic neuromas cause deafness and the MRI is the most useful way to diagnose these benign tumours. Other brain pathology is often suspected in persons with profound hearing loss and can best be diagnosed with MRI. Manufacturers have been trying to solve MRI/cochlear implant problems with varying degrees of success. The best advice for routine use is to check with the manufacturer before each use. Most cochlear implants are safe in MRI scans up to 1.5 tesla.[17] Even if the MRI is safe, the magnet in the cochlear implant causes degradation of the MRI image up to 5 cm around the implant. Some, but not all, models have surgically removable magnets.[6,17-23]

Usually the patient is well aware of the manufacturer and type of implant, but situations could arise where the patient is unable to communicate this information. A simple lateral skull X-ray may help locate this information as many implants are designed so that information on the implant can be read on an X-ray.[6]

CONCLUSION:

In summary, cochlear implants should not be feared but they should be understood. They are the first of many high-tech devices that more patients are now utilizing. For many people they are wonderful devices that add to the quality of life. Thoughtful consideration in the areas of device care and safety may prevent a serious misfortune. As with everything in the operating room, common sense is important in this area. There may be unanticipated situations where precautions are unknown. Knowledge changes over time so it is important to always err on the side of caution in order to prevent a serious complication.

Further information on this topic can be found at www.medel.com, www.advancedbionics.com and www.cochlear.com.

Table 1 SUMMARY OF OPERATING ROOM SAFETY RECOMMENDATIONS FOR COCHLEAR IMPLANTS [6-8]

Modality	Current Recommendations, cautions regarding cochlear implants*
Monopolar cautery	Do not use above the clavicles. Grounding pad on torso or thigh
Bipolar cautery	Do not use within 3 cm of a Med-El or 1 cm of Cochlear Corp or Advanced Bionics implant
ultrasound	Do not use in the area of the implant
Neurostimulation (ie. For pain control)	Do not use near the implant site
Diathermy – electromagnetic	Electromagnetic or microwave – Do not use at all (Cochlear Corp). not use within 3 cm of implant (Med-El and Advanced Bionics).
Diathermy ultrasonic	May be used below the clavicles as for ultrasound
Electroconvulsive therapy (ECT)	Do not use in cochlear implant patients. ECT damages the implant and tissues.
Radiation therapy – external beam	Do not radiate within 3 cm of the implant For gamma knife call manufacturer of the implant
Radioisotope therapy (eg. Brachytherapy)	Do not use γ-rays in head and neck. γ-rays can damage the implant. β- or α-rays are OK but do not bring them close to the implant.
Plasma knife - coblation	Do not use within 3 cm of implant.
Radiofrequency ablation	Do not use in head and neck. Place grounding pad on torso or thigh.
MRI scans	Check with manufacturer for each case. Remember that the image will likely be degraded. Some internal magnets can be surgically removed.
Any procedure	Consider the possibility of damage to the implant and use caution if unsure.

**Information as of January, 2010 - B.W. Blakley*

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009). *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (9th edition). Section 3, pg 173, Standards 2.28 and 2.2.9.

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