



ICPAN 2023

ABSTRACT BOOK

Author Index

Author	Abstract Code(s)
Kaptain, Kirsten	P-02
Aalund Knudsen , Rikke	P-31
Andujo, Paulina	O-11
Anicoche, Maria	P-34
Anicoche , Maria Liza	O-06-P-05
Bader Larsen, Karlen	O-01, P-17
Bak, Emilie	O-19
Bakker, Marc	P-08
Bang Foss, Nicolai	O-07
Baunegaard Hvidberg, Lea	O-19
Bermann Wenneberg, Meggie	O-19, O-27-P-07
Beturne, Meg	P-18
Blomberg, Karin	P-35
Bower, Krista	P-16
Brady , Joni	O-33
Brady, Joni	O-18
Brauer, Lena	O-22
Breda, Kathleen	O-04-P-12
Buiter, Marlou	P-34
Bylund, Ami	O-07
Bøgelund Madsen, Rikke	P-25
Ceutz, Hanne	P-29
Chen, Ling	P-24
Christiansen, Karen Juelsgaard	P-10
Crocco, Ingrid	P-01
Cuenca, Joele	O-14
Dahlager, Lena	P-03
Dahlberg, Karuna	p-32
Dahlberg, Karuna	P-25, P27
Daley, Ingrid	O-24
Dandal, Marie-Antonette	P-03, P-13, P-26
Deacon, Ann-dre Lee	P-13
DeSilva, Rusela	P-34
Devantier, Louise	P-34
Dreyer, Pia	P-01
Dubreuil, Melanie	P-31
Duke, Kate	O-28
Elgaard, Signe	O-28
Eliassen Chatterton, Mariann	O-27-P-07
Eliassen Chatterton, Mariann	O-16-P-04, P-18
	P-20

Author	Abstract Code(s)
Elmqvist, Carina	O-09, P23
Erck, Kirsten	P-24
Eriksen, Sine	O-34
Eton, Sarah	O-20
Eton, Sarah	O-20, O-30
Jr Familiar, James	P-19
Färnert, May-Lena	O-29
Folden, Helle	O-27-P-07
Fossum, Susan	O-14
Fridlund, Bengt	O-09
Gamst-Jensen, Hejdi	P-33
Gamst-Jensen, Hejdi	O-19
General, Eddah	P-10
Gibert, Tabatha	O-35
Gilbert, Sebastien	O-21
Giordano, Terri	O-32
Glatt, Elizabeth	P-10
Gray, Kescia	P-15
Groenendijk, Okke	O-17
Groennebaek Tolsgaard, Martin	O-19
Gustafsson, Ingrid	O-09, P-23
Haa Pedersen, Berit	P-31
Hanlon, Suzanne	O-32
Hansell, Beth	O-15
Hansen, Anette	P-24
Harper, Alison	O-21
Harrington, Heather	P-13
Hasenkam, John Michael	P-01
Hedlund, Jakob	P-16
Henry, Denyse	P-03
Henry, Denyse	P-26
Henry, Denyse	P-13
Hjelmqvist, Hans	P-16
Hooper, Vallire	O-23-P-11
Houle, Katherine	O-33
Hugelius, Karin	O-24
Hughes, Elaine	O-35
Hullested Pedersen, Charlotte	p-32
Jaensson, Maria	P-25, P-27
Jaensson, Maria	P-16
Jaensson, Maria	O-24
Jensen, Jørgen	O-10
Karsø Pedersen, Anette	P-31
Kaspersen, Alexander Emil	P-01
Kingwell, Stephen	

Author	Abstract Code(s)
Kraghede, Rasmus Ellerup	P-01
Krarup, Jannie	P-18
Krøigaard, Mogens	P-24
Kvanner Aasvang, Eske	O-19
Lachapelle, Tanya	O-21, O-28
Larsen, Pia Gitte	O-13
Lecques, Jessica-Dominique	O-21
Lesage, Cheron	O-21
Lin, Zihal	O-28
Linding, Louise	P-09
Llerena, Sharon	O-25
Lough, Mary	P-10
Lund Elsberg, Lise	O-13, P-29
Malic, Claudia	O-28
Mamaril, Myrna	O-06-P-05
Mascetta, Alena	P-15
Maziak, Donna	O-21
Mcvey, Tracie	O-21
Meadows, Fina Michelle	O-02
Mikhailtsevich, Dmitry	P-03
Monterola, Matthew	O-02
Moss, Trine	P-20
Moss, Trine	P-18
Nathens, Avery	P-03
Nathens, Avery	P-26
Nilsson, Ulrica	O-24
Nilsson, Ulrica	O-18
Nilsson, Ulrica	P-27
Nowak, Agnieszka	P-13
Odom-Forren, Jan	O-23-P-11, P-14
Odom-Forren , Jan	O-18
Osborn, Katie	O-14
Parker, Amy	O-05
Pasgaard, Thomas	P-01
Patruno, Angela	P-28
Pedersen, Maria	O-14
Pedersen, Michael	P-01
Petersen, Johanne Juel	P-01
Pettersson, Anders	O-04-P-12
Rask, Mikael	O-09, P-23
Ring , Mette	O-18
Rodriguez , Maria del Mar	O-25
Rodriguez, Maria del Mar	P-28
Rogge, Cecilie	P-30
Rougeau, Cia	O-35

Author	Abstract Code(s)
Rowe, Lillyann	P-34
Sarcinello, Pamela	O-32
Sauve, Karen	O-21
Scalford, Deborah	O-31
Schildmeijer, Kristina	O-09, P-23
Sedyté Tofterup, Renata	P-18
Seely, Andrew	O-21
Sia, Lay	P-22
Smith, Carlo	P-13
Steffen, Elizabeth	O-03, P-02, P-06
Steffen, Elizabeth	O-03
Steffen, Elizabeth	P-06
Steffen, Elizabeth	P-02
Steiner-Johnsen, Hans Erik	O-27-P-07
Stenberg, Erik	P-25
Stoffels, Malou	O-12
Sundaresan, Sudhir	O-21
Sundqvist, Ann-Sofie	O-24
Søndergaard Nielsen, Anne-Mette	P-31
Sørensen, Maja	O-11
Taing, Elein	P-03
Tashman, Naomi	P-34
Thompson, Calvin	O-21
Van Kooten , Hanneke	O-18
Villeneuve, Patrick James	O-21
Vinther Nybye, Mette	P-20
Wagtmann Murberg, Birthe	O-16-P-04
WANG, XIAO (Jerome)	O-08-P-21, P-22
Webber, Kelly	O-06-P-05
Wente, Sarah	O-23-P-11
White, Alicia	O-35
Witthoeft, Kayla	O-26
Wong, Michelle	P-13
Yan, Leon	P-03

Oral presentations

O-01

Creating an Innovative Evidence-Based Practice (EBP) Healing Environment that Promotes Perianesthesia Nurse Resilience

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Introduction:

Weinberg Post Anesthesia Care Unit (PACU) is a very busy, high acuity, critical care area that has been described dim, noisy, and a non-therapeutic environment by nursing staff. This PACU is one of the busiest adult PACU units in the hospital and called "Grand Central Station." Staff identified the need to conduct an EBP Healing Environment Project that focused on innovative, therapeutic interventions to promote nurse resilience.

Method (EBP PICO Question/Searches/Appraisals):

What are the best therapeutic interventions to create a safe, caring, healing environment for promoting nurse resilience? P = Perianesthesia nurses; I – Therapeutic healing interventions; C = Compared to standard PACU nursing care; and O = Safe, caring, healing environment that promotes nurse resilience. PubMed, CINAHL, and Scopus databases identified 43 key articles relating to complementary techniques to promote relaxation, music therapy, guided imagery, massage therapy, noise reduction, light therapy, aromatherapy, and clean environment. Nineteen articles were leveled and appraised based on PICO: 8 Level I's, 6 Level III's, and 5 Level IVs with all 19 Quality "A" rating for strength of the evidence.

Results:

Evidence revealed: Promoting filtering light correlates with higher nurse satisfaction; decreased noise during agitated emergence reduces anxiety; listening to music reduces anxiety, music improves emotional well-being; guided imagery and massage therapy decrease anxiety and reduces musculoskeletal discomfort; and therapeutic touch was beneficial.

Conclusion:

Best practices included: Increased lighting, decreased noise, listening to music/guided imagery, practicing mindfulness, and massage therapy improved the perianesthesia healing environment and promoted nurse resilience through emotional/psychological well-being outcomes.

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Introduction:

Tracking educational progress of 200 staff members is an arduous process when using paper. To streamline and simplify educational tracing, educators wanted to test the use of digitizing nurse competencies in a way that was user friendly for nurses, educators and staff. It was hypothesized that the utilization of QR code technology would make staff education tracing easier and be endorsed by staff.

Methods:

Utilizing the Research Electronic Data Capture (REDCap) program, orientation checklists, initial competencies, and annual competencies were digitized and made accessible to users through QR code technology. Use of the electronic program was piloted with a small group of PACU trainees and preceptors. Prior to initial pilot testing, users received an in-service and reference guides on program use. After the pilot group's successful use of digital checklists, all perianesthesia staff members received training prior to using the electronic program for the annual nursing competencies.

Results:

After implementation of digitized forms, it has been shown that educators spend less time monitoring progress. By logging into the REDCap program and viewing the Record Status Dashboard, educators can see progress in real time. Upon completion of annual competencies, 133 users completed a survey regarding the use of digitized forms. 90.2% agreed digitized competency forms were easy to use. 89.5% agreed that they would like to see more items such as forms, educational resources, and surveys digitized.

Conclusion:

The use of QR code technology simplified the tracking of education and is highly supported by staff.

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O-03

Can You Hear Me? Communication: The Key to Improving Relationships Within Nursing

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Introduction:

Today's inability to communicate with each other has become a crisis. It has caused issues with staffing, and staff morale. Nurses are leaving the profession at an alarming rate. Could understanding the difference in people and ways to communicate effectively improve staff morale and staffing issues? Could this improved understanding help in educating our patients?

Methods:

A literature review of present best practices was done. A review of personality types and communication skills was completed. An educational PowerPoint was developed using the acronym AIM: Awareness, Interest, Motivation.

Results:

PowerPoint was presented at Perioperative Council for members. The information was then taken to the individual units for implementation. The PowerPoint was presented at the KSPAN Spring Conference (ASPAN state chapter). Morale has improved. Patients have commented how well we work together and encourage each other. They felt well taken care of. Patient satisfaction scores have exceeded benchmark. Only change in staff was one member moved to Phase I from Phase II.

Conclusions:

Understanding the differences in people help us to appreciate each other. Nurses in America have been seen as the most trusted profession for 22 of the past 23 years. The only time we were not first was in 2001 due to 9/11. First responders, and rightly so, knocked us out of first place. When the world is in crisis, they look to nurses to help find solutions. We can make that difference, by holding ourselves accountable by being what we want to see in others.

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O-04-P-12

Perioperative Hypothermia - What act as enablers and barriers for the execution of prevention and treatment?

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Introduction:

All patients who undergo surgery are at risk of becoming hypothermic if preventive and treatment-based measures are not taken. The authors experience it can be challenging in clinical work to get the perioperative team to routinely check the patients temperature and provide warming treatments in order to prevent perioperative hypothermia, as well as gain support from the hospital organization.

The aim of the study was to describe what enables and what act as barriers in the execution of prevention and treatment of perioperative hypothermia.

Method:

An integrative literature study with systematic literature search was conducted. The literature search was performed in the databases PubMed, CINAHL, Web of Science and PsycInfo. The search resulted in 14 qualitative and quantitative scientific articles, from nine different countries, which were analyzed according to Whittemore and Knafll (2005) integrative analysis method.

Result:

The result generated two themes and six categories. *Influencing factors: Knowledge of perioperative hypothermia, Guidelines for perioperative hypothermia, Implementation of guidelines and Access to adequate technical aids. Basic prerequisites: Perioperative team and Hospital organization.*

Conclusion:

In order to deliver good and safe care to all patients undergoing surgery, the literature review has shown that the perioperative team should have knowledge of perioperative hypothermia and work together in according to implemented guidelines with access to adequate technical aids in a supportive organization. The study further showed the cost-effectiveness of investing in adequate technical aids and implementing evidence-based guidelines.

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O-05

Take Evidence into Action (TEA™): OR to PACU Handoff

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Introduction:

Applying evidence in professional nursing requires a knowledge base of how to acquire credible information. One issue explored is OR to PACU handoff. Standardized handoffs have been shown to affect patient safety and employee satisfaction. Mandates from professional organizations require institutions to perform standardized handoff. How to implement evidence-based practice (EBP) is dependent on skill, so habitual or ritual norms can be questioned. This allows the nurse to perform interventions from necessary information. Standardized patient handoffs can be discussed and evaluated with quantitative and qualitative evidence.

Methods:

An in-depth look at two quantitative and one qualitative article is discussed. Terms such as synthesis, meta-synthesis, and meta-analysis, are explored. Introduction of research libraries and keyword choice is also noted. A description of the TEA™ analogy is given to bring in sensitivity to the diversity of how each nurse practices in thought and design of care.

Results:

Evidence shows that OR to PACU handoff standardization can individualize care and prevent error. Interprofessional collaboration shows increased patient satisfaction and nurse satisfaction.

Conclusion:

Empowering advocacy of the professional nurse to intervene with EBP contributes to professional nursing.

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O-06-P-05

Music Listening as a Postanesthesia Care Unit Nursing Intervention for Laparoscopic Radical Prostatectomy Patients: A Mixed Method Randomized Comparative Clinical Trial

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Introduction:

Laparoscopic radical prostatectomy surgery patients have reported severe pain post operatively and experienced psychological distress for potential urinary incontinence and sexual dysfunction. PACU nurses identified anxiety and pain management as the primary cause of patients' increased length of stay in PACU. The purpose of the study was to compare two methods of music listening interventions on anxiety, pain, heart rate, blood pressure, and oxygen saturation among post anesthesia care unit patients who are recovering from laparoscopic radical prostatectomy surgeries: a) patient-preferred music listening via Spotify selections; and b) relaxation breathing narrative over minimalistic hypnotic music.

Methodology:

After IRB approval, randomization of participants by computer-generated table of random numbers for effective balance between the two groups. A power analysis was calculated to have 77 male participants: Group I (n=37) and Group II (n=40). Inclusion criteria/exclusion criteria established. Nurses were blinded to study interventions. Study started in December 2019 and concluded in December 2020. Data collection began in PreOP and continued through PACU discharge criteria met.

Results:

Both Groups I and II had reduced pain scores at discharge as compared to PACU admission; both groups had significant reduction ($p=0.046$ Group I, and Group II ($p=0.002$), but changes for comparative groups (I and II) were not significant between the two groups ($p=0.53$).

Conclusion:

Study revealed both relaxation/breathing track and personally selected music can meaningfully improve patients' anxiety and PACU pain scores.

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O-07

Time-out for clinical reasoning

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Introduction:

As a nurse you are close to the patient. As a healthcare professional, you are always busy monitoring the clinical condition of your patient. You must not only think problem-oriented, but also think problem-solving for the patient in question. Your clinical reasoning and nursing leadership touches the core of the nursing profession: initiating and delivering well-thought-out and patient-centered care.

The Time-out application is an educational tool for learning clinical reasoning in professional practice and is universally applicable within all kinds of nursing specialties and care settings. The Time-out application is a guideline for conducting patient discussions in an unambiguous and practical manner and learning from them. By answering standardized questions for your patient, you learn to think like a healthcare professional.

Goal

The goal of the Time-out practice learning model is to teach clinical reasoning in practice, i.e. to:

- Developing everyone's basic skills > observing, analysing, communicating, realizing, evaluating and reflecting.
- Increasing everyone's biomedical knowledge base
- Developing everyone's insight into care > patient-oriented care
- Learning to think like a nurse > interprofessional

References:

The 'Time-out practice model' was deployed, tested and adjusted in several educational field labs in the period 2016 – 2021. These field labs took place in a general hospital (twice), in a large care institution for the mentally handicapped and in a nursing home setting. Ultimately, a Time-out application was developed that forms an unambiguous, practical and digital guideline in learning clinical reasoning

The Time-out practice model has been developed based on: Problem-based training, Experiential learning, Reflection Korthagen, 70-20-10, EPA targeted education, IPE Interprofessional Education, TBL, Team Based Learning, The will to know, Socratic conversation, Social Constructivism, SDT Self Determination Theory, Professional Code of Nursing, Vocational Training Profile nurses, Notes on Nursing of Florence Nightingale.

The Time-out model is described in the ProActive Nursing book: Insight into clinical problems, Boom publishers, 2022.

Bakker, M.C, Principal Lecturer Clinical Reasoning MEd, RN, Nurse Anesthetist, Educational Designer & Author
ProActive Nursing

O-08-P-21

Preventing and managing workplace violence in PACU

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Introduction:

Acute care nurses are more frequently at the risk of being hurt/injured by patient's violence either verbally or physically. It is not uncommon to see these "code gray" situations occurred in our high acuity PACU (Post Anesthesia Care Unit). Not all our nurses be ready to de-escalate these aggressive behaviors in the PACU. The Na-tional Institute for Occupational Safety and Health (NIOSH) clearly emphasized that, "Violence in the healthcare work-place is a major disruption to providing quality nurs-ing care and has a negative impact on the therapeutic setting."

Methods:

Conducting surveys among PACU nurses regarding their perceptions of the workplace violence including negative effects on patient care environment and nurses' well-being. The evidence based supporting articles were retrieved from JBI, CINAHL and PubMed databases.

Results:

The survey of nurses' perception on workplace violence was collected and analyzed. The workplace violence negatively affects quality nursing care and staff well-being. Identify those risk facts of the violence behaviors by recognizing any cues and warning signs in potentially violent patient. Emphasizing that the importance of necessary training and management support to prevent/manage the workplace violence.

Conclusion:

In all, the prevention and proper management of workplace violence has significant implication on our future nursing practice, quality patient care and staffs' well-being. This study could offer certain recommendation and review on current administrative plans and policies, nurse-patient communication, and staffs' focused training. "Zero tolerance" approach, proper staff education with effective communication/coping skills and comprehensive management support would help to better deal with the violence.

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O-09

Nurse anesthetist's perceptions of heat conservation measures

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Introduction:

Perioperative hypothermia is common, ranging from 26–77% [1-4]. Despite decades of knowledge about patient complications, what heat conservation measures could be used and international guidelines, there are still patients who become hypothermic. To increase the understanding why, there is a need to gain knowledge from several perspectives, one of which is that of nurse anesthetists. What can hinderance or enabling the use of heat conservation measures? The purpose is to describe nurse anesthetists' perceptions of the phenomenon of heat preservation measures in connection with surgery.

Method:

An inductive and descriptive design with a phenomenographic approach were used.

Result:

Nurse anesthetists understood the phenomenon in six different ways, presented as approaches; the preventive, the useable, the untenable, the caring, the adaptive and the routine care. All nurse anesthetists have the preventive approach, whose goal was to protect the patient. But all approaches coexisted in a flexible way, depending on the patient's situation.

Conclusion:

There is a high will and intention that can enable the nurse anesthetist to use heat conservation measures, in order to achieve their goal of preventing heat loss in patients. However, there are perceptions that are barriers such as doubts, lack of access to heat conservation measures or education, financial constraints, and habits. To change these barriers there are need for lifelong training/education and guidelines, and support from the organization. In addition, nurse anesthetists' programs must offer education in the area. Together, this can support nurse anesthetists to be able to work evidence-based.

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O-10

Culture and Continuity: handovers to the PACU

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Introduction:

Handovers of patients to the postanesthetic care unit (PACU) constitute for a risk of loss of continuity. Furthermore, nurse anaesthetists and PACU nurses differ in expectations of content of the handover, as well as no gold standard exists for handovers. Hence, this survey seeks to disclose how the quality of the handover and of the intraoperative documentation is perceived by the PACU nurse.

Method:

The PACU nurses completed a questionnaire for each admitted patient over a period of one week in November, 2021. 87 patients were admitted and 61 questionnaires were included (70 % response rate).

Result:

38 % of all handovers were perceived as not well structured.

In 32 % of all handovers there had been an intraoperative change of the nurse anaesthetist during surgery. Every second of these cases correlated with a significant higher number of unstructured handovers, a high speed of speech, and premature timing of the handover before the PACU nurse was ready.

Patient categories came from two separate surgical specialties. The patients from one of the these specialties had significantly higher numbers of poor positioning in the bed, lying exposed by insufficient clothes/bedclothes, having dirty bedclothes, and poorer documentation.

Conclusion:

The survey points to a need to develop a more structured handover, both to the PACU as well as intraoperatively.

The higher frequency of the above mentioned suboptimal care and documentation represented by one of the surgical specialties points to the importance of a nursing culture not losing sight of less vital, care-related areas.

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O-11

A Digital Care Guide for patients, who have undergone surgery for acute appendicitis - a great tool for both staff and patients

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Introduction:

A Digital Care Guide is a digital patient process for patients with acute appendicitis. Patients have access to information and receive important notifications regarding their process on an app from Emento(1). We are project managers and responsible for the content and updates. The content is conveyed in video, text, images and illustrations and is made in collaboration between nurses from the recovery room and the emergency room, surgeons and anesthesiologists. These patients are discharged directly from the recovery room to home in 1-3 hours after surgery. We wanted to find out, if a Digital Care Guide could benefit their patient process.

Method:

Our Digital Care Guide contains 10 topics with information, guiding the patient through the process of admission, operation, recovery and discharge after surgery for acute appendicitis.

When discharged to home, the Digital Care Guide have a chat function, where patients can chat with the recovery nurse 5 days from discharge(1).

We adjust the content when needed, based on feedback, interviews(2) and messages in the chat function.

Results:

The Digital Care Guide strengthens patients self-care(3) and empowerment(4). It provides increased safety and guidance for the patient when discharged from the recovery room(2).

The recovery nurse experience a release of resources and a reassurance of increased patient safety, hence the patient have a lifeline from home. There is also a reduction of 6 pages(5) of paper per patient, which benefits the environment.

Conclusion:

This Digital Care Guide is a valuable and efficient tool for staff, patients and the environment.

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5. [Blindtarmsbetændelse: Fjernelse af blindtarm - Aarhus Universitetshospital \(auh.dk\)](https://www.auh.dk)

O-12

Nation wide implementation of Entrustable Professional Activities in specialized nursing training in the Netherlands: process, and outcomes and future challenges

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Introduction:

Staff shortages, lack of career opportunities and training programs that poorly align with healthcare threaten the nursing workforce. Therefore, in the Netherlands a nationwide program was installed to design a flexible training system for specialized nursing training, based on Entrustable professional activities (EPAs) [1]. EPAs are units of professional practice that supervisors entrust students with once they achieve competency. The urge to redesign the system was exacerbated by the COVID pandemic, which dictated flexibility to allocate nurses to different wards.

Method:

Within a nationally coordinated project, project teams of practitioners, educators and policy makers, formulated professional activities that describe their nursing specialization. For each specialization, a distinction was made between 'core', 'specific', and 'transdisciplinary' EPAs. EPAs were described in terms of activities, knowledge and skills. A central committee monitored uniformity and interchangeability of EPAs between nursing specializations and developed a set of assessment instruments.

Results:

As of 2022, 35 nursing specializations have implemented EPA-based curricula, resulting in training programs that can be tailored to hospital's and individual needs. Transdisciplinary EPAs, such as a common trunk for all acute care specializations, increase opportunities for transfer. The program resulted in intensified collaboration between different schools and hospitals.

Discussion:

The nationwide EPA-program for specialized nursing training is a unique response to challenges in healthcare. EPA-based programs allow for tailor-made training programs that meet changing healthcare demands. The following years will provide insight into the novel training trajectories and positions that will be created within this system and their effect on nursing engagement.

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O-13

It's all about nurses working environment

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Introduction:

During the Covid period the nurses were distressed and did not have a place to relax and regain energy in quiet, pleasant surroundings. The staffroom was dull and clinical with lots of disturbances because of the design. Our vision was to create a room for recovery and conversation; to support the clinical supervisor and to invite professional reflection with students.

The interior design should support a multifunctional room for job interviews, meetings and teaching sessions, lunchbreaks, recovery and powernaps.

Method:

We started out by describing the project and made field observation to discover the problems. There were 98 disturbances in the staffroom during a working day related to lockers and kitchen.

We held workshops with architect, nurses, physiotherapist and students, and afterwards we arranged mock-ups in dialog with nurses. Among other things we moved the fridge to another room as well as cups and plates.

Our technical department helped removing lockers and the kitchen.

In the end we contacted local companies for small fundraisings and donations.

After finishing the project, we made field observation and interviews of staff.

Results:

We remodelled the room to a multifunctional room. It supports the relationship between clinical supervisor and students.

We reduced the disturbances by 75 % and created a place that provided peace of mind using elements of healing architecture.

Conclusion:

The new interior works as an energy booster and gives positive visual distraction to stimulate recovery, reduce stress, provide a better working environment and which in the end improves patient safety.

Nurse: "My pulse drops"

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O-14

Perioperative Nursing Education Re-imagined: Highlights and Challenges of Providing Nursing Education in Developing Countries During the Covid Pandemic

Susan Fossum ¹ Ingrid Crocco, Katie Osborn ², Maria Pedersen

¹ ReSurge International Sacramento United States

² Volunteer

Introduction:

Every nurse desires to make a positive impact on the nursing profession, using specific skills to promote a safe and healthy environment for their patients. Nurses living and working in developing countries have greater challenges - lack of resources including nurse staffing, overwhelming patient populations, lack of medical supplies/equipment, and minimal opportunities for education. ReSurge International, a non-profit humanitarian medical organization, provides free reconstructive surgical missions, teaching, training, and educational outreach throughout the globe with an emphasis on long-term sustainability and local capacity to increase impact. We will discuss the challenges and rewards that the authors, who volunteer with ReSurge, experienced during the Covid pandemic when providing nursing education face-to-face was not possible.

Methods:

Before Covid, nursing education was provided during medical mission visits when working alongside our international colleagues, via lectures, and precepting/mentoring by ReSurge PACU, OR and Nursing Educators. Covid brought a new set of challenges as travel outside the US stopped. Virtual education began. International colleagues provided a list of high-priority topics they wanted presented - virtual lectures and tools were developed to meet those requests.

Results:

Examples of nursing lectures/education and tools will be presented. These tools, designed to alert nursing staff to critical changes in their patients, include lifesaving interventions to initiate.

Conclusion:

In-person humanitarian trips have resumed. Success of the nursing virtual education program initiated the adoption of a hybrid teaching model that builds on and monitors the effectiveness of in-person training.

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O-15

The perioperative nurse discharge navigator: improving caregiver satisfaction, discharge comprehension and throughput for same day surgeries

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Introduction:

The Children's Hospital of Philadelphia performs on average 70 surgeries each day. One in five pediatric patients experience an adverse event related to poor caregiver comprehension of discharge instructions following surgery. Research has demonstrated that quality patient education in the perioperative environment leads to improved patient outcomes and caregiver satisfaction. The rapidly-paced environment of the post-operative area can lead to caregiver distraction during discharge teaching. Furthermore, patient throughput may be strained due to the immediacy of moving day surgery patients along the continuum. To improve caregiver and patient satisfaction, discharge comprehension and surgical flow, the Perioperative Nurse Discharge Navigator (PNDN) role was created.

Methods:

Multimodal methods were used to collect data. Two different surveys were created to evaluate the effectiveness of this new role and additional data was gathered through monthly Press Ganey Scores. Further data was analyzed by using a comparative time stamp pull from the electronic medical record.

Results:

98% of nurses felt that caregivers had better comprehension and 84% felt that it improved the timeliness of discharge.

100% of the caregivers had positive feedback and 98% suggested that it would help other parents.

Additionally, caregivers that received education from the PNDN were discharged from the PACU 37 minutes sooner than patients and families that received discharge instructions at the bedside during the post-operative phase of recovery.

Conclusion:

The role of a PNDN is valuable in improving discharge times from the recovery area, improving satisfaction and surgical throughput.

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O-16-P-04

Generic Paediatric Perioperative Protocol, used during the post Covid, RS virus amongst children.

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Introduction:

In 2018 the Hospital established a Perioperative Unit for children undergoing surgery or interventions that required anaesthesia. 6000 children per year, 65 % as perioperative patients. To obtain best practice, we developed Generic Perioperative Protocols: The practical course for a patient in the Unit A table showing the main topics for each procedure Criterion for discharge, standard prescriptions for pain management, contacts to the Hospital after discharge. In 2021 and 2022 Denmark experienced a RS Virus epidemic. Many children were hospitalised into the surgical wards leading to cancellations of surgical procedures. Due to well incorporated protocols, we decided to use them as a template to alterate the courses for other patients, to avoid cancellations.

Method:

Staff planned new perioperative courses

Weekly meetings with Head Nurses and Surgeons, deciding which patients could become perioperative patients, informing parents, new protocols for the Perioperative Unit.

Nursing coordinators in the Units helped each other with exchange of information and clinical knowledge.

Results:

Each year we prevented 150 patients from having their surgery cancelled, due to children admitted with RS Virus. The benefits are many. From the patients and families perspective it takes a lot of practical and emotional energy, when a child needs surgery. Cancellations are traumatic and problematic. Cancellations are costly, with unexploited capacity, and waiting list increasing.

Conclusion:

Our Protocols were proven useful during the epidemic, supporting nursing staff to be innovative in their clinical work. The experiences has led to changes for children undergoing procedures which previously would require hospitalisation.

References:

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O-17

Implementation of Entrustable Professional Activities (EPA) in education for specialized postoperative recovery nursing care.

Okke Groenendijk

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Introduction:

A nationwide programme was developed and implemented train acute care nurses for departments such as the intensive care, Cardiac care, Emergency Room or Recovery ward. The training consists of a joint basic acute care module followed by a graduation profile for each nursing specialization. For each specialization a distinction was made between 'core', 'specific', and 'transdisciplinary' EPAs. The theory that accompanies these EPA's was been determined nationally.

Method:

In order to obtain the nationally accredited recovery nurse diploma, you must also obtain the core recovery EPAs in addition to the basic acute care EPAs. Depending on the individual hospital setting each individual recovery department determines if 'specific' and 'transdisciplinary' EPAs a student follows.

We used the backwards design approach [1] to create de curriculum. We used the content of the EPA and together with clinical educational coordinators of affiliated hospitals we set the learning outcomes of each EPA.

Results:

As of April 2022 the EPA's are implemented in curriculum of postoperative recovery nurse training. The theory is complementary to the training in hospital. We have applied different working methods in the curriculum, such as response lectures, scenario training, escape room training and more to activate the student.

Discussion:

The focus of learning and testing is during internships in the hospital. This is a shift from before the arrival of the EPAs. This change requires the clinical nurse educators to organize workplace learning differently, but also requires an adjustment of the testing policy in theory.

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O-18

Stress of conscience among Swedish, Danish and Dutch perianaesthesia nurses having worked in a COVID-ICU during the Coronavirus pandemic

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Introduction:

Several studies have reported that working in a COVID-ICU impacted nurses' mental well-being. Yet little is known about how perianaesthesia nurses who have been working in a COVID-ICU perceived their stress of conscience. The aim of this study was to: (1) describe and compare stress related to troubled conscience among perianaesthesia nurses in three countries who have been working in a COVID-ICU during the pandemic, (2) compare their levels of troubled conscience between working in a COVID-ICU and their usual workplace, and (3) compare nurses that usually work in an ICU department with nurses who usually work outside of the ICU.

Methods:

A descriptive, international cross-sectional online survey including the Stress of Conscience Questionnaire was distributed between organizational member countries of the International Collaboration of PeriAnaesthesia Nurses.

Results:

A total of 246 nurses from three countries participated. Significant differences were found in stress of conscience when working in the Covid-ICU between Sweden 31.8 (8.6), Denmark 23.1 (8.6), and Netherlands 16.4 (6.5) $p < 0.001$. Significant differences were also found between nurses working in a COVID-ICU in contrast with their usual workplace: 23.1(5.6) versus 17.7(5.3), $p < 0.001$. The most stressful aspect of conscience reported was that work in the COVID-ICU was so demanding, nurses did not have sufficient energy to be involved with their family as much as they desired. No statistical differences were found between nurses that usually work in an ICU department with nurses who usually work outside of the ICU.

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O-19

Exploring diagnostic and management reasoning when discharging high-risk postoperative patients from the post-anesthesia care unit

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Introduction:

Discharge readiness from the post-anesthesia care unit (PACU) is often based on quantitative criterion-based discharge scores, such as the Aldrete score (1,2). Decisions regarding discharge versus extended stay influence PACU in- and outflow (3,4), ultimately affecting patient safety as premature discharge increases postoperative morbidity, mortality, and unplanned intensive care unit admissions (3). We explored clinicians' diagnostic and management reasoning when discharging high-risk patients from the PACU.

Method:

In this constructivist qualitative study, we conducted 20 semi-structured interviews with 12 PACU nurses and eight anesthesiologists from three University hospitals. Data were analyzed inductively through thematic analysis using Street-level bureaucracy theory as a framework.

Results:

Our initial analysis identified three themes: 1) Scripts of treatment and discharge, 2) Negotiation of PACU stay legitimacy, and 3) Adaptation and accountability. Our preliminary results suggest that public and organizational policies that demand increased flow in the PACU can challenge discharge decisions and conflict with professional standards and clinician autonomy. Clinicians adapt to contextual factors influencing the possibilities and legitimacy of a PACU stay, potentially leading to discharge decisions that generate a sense of inadequacy in patient care.

Conclusion:

Diagnostic reasoning serves as a dominant classification task for incoming PACU patients. Management reasoning seems automated for PACU stays that follow usual standards for the duration of stay and fulfillment of discharge criteria. However, for PACU stays that do not fulfill usual standards, management reasoning becomes dominant and professionally challenging as treatment and discharge decisions generate ambiguity and conflict concerning resources and patient safety.

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O-20

PITStop, implementation of a postoperative handover tool to improve the transition in care of the surgical patient from the anaesthetist and theatre nurse to the post anaesthetic care unit nurse: a quality improvement initiative

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Introduction:

The results and recommendations from research which identified current practice in handover from the theatre nurse to the PACU nurse in the New Zealand setting provided the impetus for quality improvement. The study recommended that for complete and safe verbal handover of the surgical patient to the PACU nurse, both effective systems and positive individual behaviours are required. The goal of the project was to introduce a protected pause in PACU to ensure the undivided attention of the PACU nurse during the anaesthetist and theatre nurse handover.

Method:

The PDSA quality framework guided the project.

Planning: search of the literature. The PITStop model [Patient Information Time, Stop (and Listen)] was created

Do: audit of the existing handover process from the anaesthetist to the PACU nurse. Education, advertising, and launch of the PITStop project.

Study: audit of the PITStop handover, comparison to pre-audit. Stakeholder survey

Act: Reviewing the PITStop process

Results:

A high degree of satisfaction and compliance with pausing for handover by a large majority of stakeholders. The PACU nurse was identified prior to handover and was enabled to actively listen. A systematic handover with engagement resulted in fewer omissions noted on documentation.

Conclusion:

PITStop is integral to effective safe handover in PACU. Team nursing has improved in PACU and collaboration with the handover team ensures an efficient PITStop. Strong leadership from the PACU team leader directing the arriving patient to a delegated PACU nurse has been identified as integral to PITStop's success.

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O-21

Implementation and safety of a same-day discharge program for minimally-invasive pulmonary resection: a pilot study

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Introduction:

Availability and allocation of post-surgical thoracic beds have been a barrier to performing some life-altering surgeries. Most lung (wedge) resection patients are admitted and then discharged the day after surgery. We have implemented a pilot study exploring the feasibility and safety of same-day discharge after minimally-invasive lung resection.

Method:

Ethics approval was obtained. All patients undergoing thoracoscopic wedge resection for a lung nodule or a primary/secondary malignancy were eligible for the study. Patients living outside the metropolitan area, with inadequate social support, poor pulmonary reserve (< 50% predicted), major comorbidities, redo interventions and cases with intraoperative complications were excluded. For the first ten patients of this pilot, emphasis was placed on case order, minimal PeriAnesthesia Phase 1 recovery for four hours and minimal Phase 2 observation for six hours. Daily nursing assessments were performed via the telehealth Virtual Recovery After Surgery (VRAS) program for an additional seven days post-discharged. A validated questionnaire (QoR-15) was used to capture patient-reported outcomes, and process efficiency metrics, unplanned admissions and other safety outcomes were captured prospectively. A multidisciplinary oversight committee regularly reviewed data and outcomes.

Result:

Thoracic Wedge Resection admitted patients averaged length of stay was 1.95 days compared to Same-day Wedge Resection patients with VRAS was 0.54 days. There was no emergency department visit or readmission for those implicated in the pilot study. An overall 94% satisfaction rate for the pilot study patients.

Conclusion:

Despite some nursing challenges and barriers, the same-day discharge of minimally-invasive lung resection highlighted feasibility and safety.

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O-22

New Perianaesthesia Nurse Development: A Systemized Education Program Exemplar

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Introduction:

Finding skilled perianaesthesia nurses is a global workforce concern and chronic problem for low-income countries having underdeveloped or nonexistent nursing education programs.¹ An international survey of practicing perianaesthesia nurses has shown variations in education and scope of practice, with some middle-income countries lacking the infrastructure to provide specialized nurse development.² Recruitment of experienced perianaesthesia nurses has become increasingly difficult for healthcare organizations over the past decade, and has seemingly worsened after a retirement wave stemming from the COVID-19 pandemic.

Method:

Nurse leaders recognized the need for a perianaesthesia nurse education program. A 16-week flipped classroom with mentored clinical immersion curriculum was developed and piloted. Throughout the program learners completed online modules prior to classroom seminar sessions, were paired with experienced preceptors and a unit based professional development mentor, and attended weekly hands-on simulation center classes with a perianaesthesia clinical educator. A final exam and program evaluation measured outcomes as each cohort completed its cycle. Results were reported to the education team and nursing leadership with improvements made after each program cycle based on evaluation data.

Result:

Enrollment increased with each new cohort. In total 24 RNs successfully transitioned into practice, several having achieved perianaesthesia board certification. Evaluations showed 100% “yes” psychological safety, informed program improvements, and validated the instructional approach.

Conclusion:

This proof of concept showed that introducing a dedicated systemwide perianesthesia nurse educator and implementing a hybrid adult learning strategy successfully prepared inexperienced RNs to independently practice in a perianaesthesia unit after completing the structured learning pathway.

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O-23-P-11

Perioperative Nurses' Experience During the COVID-19 Pandemic and Intent to Stay

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Introduction:

The COVID-19 pandemic created a crisis in perioperative nursing roles and responsibilities, the impact of which has not been explored. The aims of this study were to assess the perioperative nurse's work experience during the COVID-19 pandemic, and to evaluate the impact of their perceived stress, burnout, and job satisfaction on their intent to stay (ITS) in the workforce.

Methods:

The study included a descriptive, exploratory design using electronic survey methodology. Participants were recruited from AORN membership. The study was guided by the Job Demands-Resources model. The primary outcome variable was intent to stay. Data analysis included univariate and multivariate techniques.

Results:

The mean age of respondents (N = 1816) was 50; 92% were female; 54% reported a BSN as their highest degree. Over half were clinical nurses (59%) and the majority (64%) reported working in their usual unit during COVID. Nurses providing direct care to COVID patients reported significantly higher burnout and secondary traumatic stress ($p < 0.001$); however, there was no significant difference in ITS. Significant predictors of ITS included: CNOR certification, increased number of years as a perioperative nurse, higher compassion satisfaction, and positive perception of workload.

Conclusions:

Results support certification, years in practice, and higher compassion satisfaction and workload perception as positive predictors of ITS in the workforce. Institutional and policy support of actions enhancing these factors will directly contribute to the Social Determinants of Health in perioperative nurses through the enhancement of education access and quality, social and community context, and economic stability.

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O-24

Nurse competence and care in the postanesthesia care unit (PACU): Nurse's and patient's perspectives

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Introduction:

To create a safe PACU care, nurses need to have specific competence. There are few studies investigating PACU care from the nurse's perspective and there is limited knowledge about patients' experiences of early recovery and PACU care. Therefore, the aim was to describe PACU care and early recovery from the nurse's and the patient's perspectives.

Method:

Data was collected in two qualitative studies. Participants were recruited from two hospitals located in different parts of Sweden. Nurses were eligible if >1 year of experience from PACU care. Patients were eligible if the expected PACU stay was >2 hours. Semi structured individual interviews were carried out. In total 16 nurses and 14 patients were interviewed. Data were analysed using thematic analysis (1).

Result:*Nurse's perspectives*

Nurses described PACU care competence as *being adaptable in an ever-changing environment and creating safe care*. That included being independent, working jointly in the team, and to prioritize and make clinical decisions. To create a safe care possessing specific knowledge, acknowledging and reassuring the patient, and to work proactively were important factors (2).

Patient's perspectives

Patients described being in a *transition between surgery and ward*. That was captured in the subthemes *Being in-between points of care, Being in PACU surroundings, Being individually acknowledged, Feeling trust in the caring provided, Feeling dehumanized and abandoned* (3).

Conclusion:

Results from the studies highlight the importance of nurses possessing specific competence and acknowledging the patient to create a safe care, supporting the patient in the transition between surgery and ward.

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O-25

Assessing the language proficiency of our bilingual perianesthesia staff

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Introduction:

Clear communication between healthcare providers and patients with limited English proficiency (LEP) and their families is fundamental to ensure safe and equitable patient care. While the use of professional interpreters is well established in our perioperative units, LEP patients often request in-person language assistance from unqualified bilingual staff. These situations have led to communication errors and poor clinical outcomes. Assessing the linguistic competence of our bilingual staff in the healthcare context using our institution's Linguistic Clinical Communicator (LCC) assessment tool is advantageous to prevent misunderstandings when communicating health information with our diverse patient population.

Methods:

Conducted huddles to emphasize expectations and benefits of becoming an LCC on healthcare communication, interactions, and clinical outcomes. Conducted a survey to identify units' bilingual staff language proficiency level and their interest in becoming LCCs. Created a database to keep a record of approved LCCs. Publicly recognized those who successfully completed the LLC assessment.

Results:

89% (n=17) of (n=19) staff interested in taking the proficiency assessment are now approved LCCs. Increased availability of peer-peer support and confidence in the ability of LCCs to accurately communicate with LEP patients. Evidenced by a recent PACU emergency, where an LCC was readily available to provide language assistance between provider and patient, improving satisfaction for all involved.

Conclusion:

LCC assessment of current bilingual staff has proven an effective strategy to improve communication and overall patient, provider, and staff satisfaction in the PACU setting. Recommendation, ongoing identification, and assessment of new employees during onboarding.

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O-26

Decreasing Emergence Delirium in Pediatric Surgical Patients with IV Dexmedetomidine

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Prisma Health Clemson United States

Introduction:

The purpose is to determine if emergence-delirium in pediatric patients can be decreased by administering IV Dexmedetomidine prior to emergence. Dexmedetomidine is a versatile, selective alpha₂-receptor agonist. It works by activating specific CNS receptors to produce sedation, anxiolysis, and mild analgesia (Li et al, 2020). Dexmedetomidine is becoming increasingly popular in the critical care settings due to its ease of use in maintaining respiratory and hemodynamic stability. Peak effect seen approximately 15 minutes after administration and average half-life of 1.8 hours (Manning et al., 2020).

Methods:

The study took place over 12 weeks. Pediatric surgical patients were randomly divided into 2 groups: patients that would receive IV dexmedetomidine prior to emergence, and a control group that would not. Post-anesthesia nurses used the pediatric anesthesia emergence-delirium (PAED) scale to measure the patient's response upon emergence. A total of 39 patients were used in this study: 23 children received dexmedetomidine and 16 in the control group. Ages ranged from 16 months to 8-years-old.

Results:

The mean PAED score for patients in the control group was 10, with results ranging from 3 to 20. Patients receiving IV dexmedetomidine showed a mean PAED scale of 5.9, with results ranging from 0 to 12. Overall, the patients given IV dexmedetomidine prior to emergence showed a 41% lower score for emergence-delirium.

Conclusion:

Reduction in emergence-delirium can secondarily reduce the risk of injury to patients and staff, decrease parental anxiety, decreased PONV, a 71% reduction in analgesics, and improve satisfaction scores. (Manning et al, 2020).

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O-27-P-07

Continued professional development for peri anesthesia nurses - Development and implementation of an evidence-based educational program

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Introduction:

The cornerstone in preventing early postoperative deterioration and complications is highly skilled and well-educated post-anesthesia care unit (PACU) nurses (1), and accordingly, they require investments in their education. Thus, we aimed to develop and implement an evidence-based postgraduate education for PACU nurses based on the needs of the clinicians with a high focus on transferring knowledge to clinical settings.

Method:

We followed Kern's six steps of curriculum development as the framework. The learning objectives were identified through a national Delphi study (1)

Results:

We developed and implemented an evidence-based postgraduate education for PACU nurses throughout the Capital Region of Denmark. The education alternates between theory, simulation, clinical on-site learning with associated assignments, and a clinical project to improve PACU patient stay. The nurses were assessed with entrustable professional activities and an oral exam. We found that the nurses generally perceived the educational impact to be high by increasing their professional level, job satisfaction, and self-confidence and providing a sense of being a role model. On a broader level, the on-site clinical learning generated inquisitive curiosity and participation among their nursing colleagues in the clinical department.

Conclusion:

This form of nursing education, alternating between theory, simulation, and clinical on-site learning, develops professional and personal growth and simultaneously promotes a positive learning environment for all PACU nurses within the clinical setting. We believe that this insight would be valuable for nurses, policymakers, and others who are involved in nurse education and continuing professional development.

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O-28

The impact of nasal decontamination by photo-disinfection in preventing surgical site infection (SSI) in spine surgery

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Introduction:

SSI following spinal surgery is a major source of postoperative morbidity. The Ottawa Hospital, despite implementing an SSI prevention bundle, the SSI rate continues to range between 4-6%. A novel photo-disinfection technology was considered in the pilot stage to be added to the current SSI prevention bundle.

The aim is to identify if adding nasal photo-disinfection as the only changing factor will affect the SSI rate.

Methods:

The nasal photo-disinfection was implemented in all spine surgeries as part of a quality initiative (January 2022-December 2022). No other changes were made to the standard of care. A comparison cohort was selected for cases between October 2020-October 2021. The variables of interest were unadjusted SSI rate, readmission rates, return to emergency departments (ED), and % of antibiotics used 72 hours-30 days postoperatively.

Results:

920 spine surgeries were performed in 2022; the comparison cohort had 1192 cases. Steriwave photo-disinfection was documented for 93.3% of the cases. When compared with the preintervention cohort, the use of antibiotics was reduced by 1% ($p=0.511$), return to ED was reduced by 3.4% ($p=0.005$), and return to the operating room within 30 days was reduced by 1.7%. The readmission rate halved (from 7.0% to 3.4%) ($p < 0.001$). Intracohort analysis has shown that patients with photo-disinfection significantly reduced antibiotics administration (12.8% vs 23.1%, $p < 0.001$) compared to the cohort who didn't receive the Steriwave photo-disinfection.

Conclusion:

Preliminary results indicate that nasal decontamination by photo-disinfection technology impacts antibiotic use postoperatively, return to ED within 30 days, and readmission rates.

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O-29

How to maximize clinical education

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Introduction:

Specialist students in anesthesia nursing care from Karolinska Institute who attend training in anesthesia have 14 weeks of internship in their education. Many students feel that the time for their internship is too short. What can be done in the clinic environment to maximize learning and understanding of the work as a nurse anesthetist? How can the nurse anesthetist education of the future be created?

Methods:

The pedagogical model for students in anesthesia nursing care in our department is peer learning.

In addition, the students are working with anesthesia specific questions provided by the educational leader in a *team-based learning model*.

In our department students are also working with simulation outside the operating theatre. The simulation can be controlled and led by the students themselves.

Doctors undergoing specialization, lectures on anesthesia specific subjects for the students.

Instruments

Stenberg and Carlsson, CLES-T, Self-assessment.

Results:

The unit is considered to have a good learning environment, 4.6 in a 5.0 scale.

Conclusion:

The development of the anesthesia nursing care education must of course be done in agreement with the universities. Students must in addition be given the opportunity for individual development. Measures taken during clinical practice must of course be based on the student's learning goals. Student's internship must be hands-on, but clinical training can be varied with other methods. The lecture will describe work with several different interventions meant to improve learning. Evaluation of student's clinical education and learning activities will be presented.

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O-30

Clinical handover from the operating theatre nurse to the post anaesthetic care unit nurse: a New Zealand perspective

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Introduction:

To identify current practice in handover from the theatre nurse to the PACU nurse in the New Zealand perioperative setting. Specifically, to identify the degree of satisfaction of perioperative nurses with handover and whether cultural awareness is integrated into handover. Perceived enablers to effective nurse handover and barriers encountered during handover were sought.

Method:

A quantitative research design was chosen using descriptive statistics. Data collection via an online self-completed questionnaire elicited the opinion, observations and experiences of perioperative nurses from throughout New Zealand.

Results:

Overall, NZ perioperative nurses are satisfied with handover. They demonstrate cultural awareness and there appear to be systems, such as, standardised handover models integrated into practice, resulting in nurses working together to achieve safe patient care. The PACU nurse being required to multitask during handover was the barrier to verbal handover most agreed with in the study, whereas, having opportunity for the PACU nurse to seek clarification of information at the time of verbal handover was an important enabler.

Conclusion:

The results illustrate that perioperative nurses in NZ are experienced, adaptable in their practice and regularly engage in clinical handover. One recommendation to come from the study was for a formal 'handover pause' to be instigated in the PACU, so all the health professionals can actively engage in the communication process. Additionally, a structured handover and provision of education on how to conduct effective nurse-to-nurse handover were important to nurses.

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O-31

Centralized patient transportation services in a pediatric perianesthesia unit enables top of licensure work and improved efficiencies.

Deborah Scalford

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Introduction:

Patient transportation requests to and from the Perianesthesia Care Unit (PACU) at the Children's Hospital of Philadelphia (CHOP) was a manual process completed by a variety of staff that included core techs, nurses, and support staff. This manual system leads to opportunities for delays, patient mistakes, and staff not being utilized to the scope of their practice. Through implementing a centralized pediatric transportation system, patient throughput and revenue can be maximized along with increased patient and staff satisfaction. The goal was to reduce RN-supported transports from 99% to 35%, support staff-supported transports from 66% to 20% and transport time from inpatient units to PACU from 60 minutes to 45 minutes.

Method:

Developed a centralized transport pilot which included the following interventions:

Dedicated Family and Visitor services staff to transport patients to and from the PACU

Implement an EPIC transport command center module to request and track transports

Utilize a perioperative clinical pathway to guide which roles should support patient transportation based on patient conditions.

Pre and post-implementation surveys to validate use, effect, and satisfaction

Results:

Survey responses indicate improved staff and patient satisfaction and transport efficiencies

Nurse assistance with transports did not decrease to 35% during the pilot phase

CSA-assisted transports decreased from 66% to 36% during the pilot

Transports from the inpatient unit to PACU averaged 30 minutes

Conclusion:

Centralized patient transportation services positively impact:

Staff working at the top of licensure

Staff and patient satisfaction

Improved transportation efficiencies

Reducing safety risks through tech-based patient identification and tracking

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O-32

Tonsillectomy and Adenoidectomy Discharge Instructions-Introducing a multi-media approach.

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Introduction:

Research has shown that multimedia patient education can increase patient satisfaction and improve outcomes after surgery. At our institution an extensive library of patient/family written information on caring for children after surgery exists. However, other forms of education are limited. Use of videos for patient family education can facilitate knowledge, decrease anxiety prior to surgery, and it standardizes education and therefore improves patient outcomes.

Methods:

A video was designed for children undergoing tonsillectomy/adenoidectomy surgery. The script replicated the information presented in the written material. Goals for this video are to increase patient and family's knowledge on postoperative tonsillectomy/adenoidectomy care, to decrease caretaker phone calls and readmissions, and to standardize the educational content. The Patient Family Education material is provided to the family at the ENT visit when surgery is scheduled.

Results:

The completed video was added to the multimedia educational library and a QR code was designed and added to the written materials. After surgery patients and families are sent a survey to assess the use of the video and determine its efficacy. Primary results suggest that some families were unaware of the video or did not have time to view the material.

Conclusion:

Multimedia forms of education allow patients and families to view information before and after surgery on an electronic device. A test of change includes sharing the information thru the electronic health portal with a link that opens the video.

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O-33

Launching a Perianesthesia Nursing Certification to the International Community

Katherine Houle

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Abstract text:

The American Board of Perianesthesia Nursing Certification (ABPANC) is the only specialty nursing certification board supporting perianesthesia nursing. ABPANC currently sponsors the Certified Post Anesthesia Nurse (CPAN®) and the Certified Ambulatory Perianesthesia Nurse (CAPA®) credentials. ABPANC is accredited by the Accreditation Board of Specialty Nursing Certification (ABSNC).

For several years, the International Collaboration of PeriAnesthesia Nurses (ICPAN) has expressed interest in ABPANC offering our exams to perianesthesia nurses outside of the United States. ABPANC's mission statement is *"Elevating perianesthesia nursing excellence, knowledge, and patient advocacy through certification."* Implementing an international perianesthesia examination helps to fulfill our mission within the specialty nursing community.

In July 2022, our new board president, Katherine Houle, identified the exploration of an international certification as one of her strategic priorities. Recent conversations with ICPAN president Dr. Joni Brady led us to begin crafting a white paper on this topic. This paper defines our plan to launch an international perianesthesia certification in 2024.

Our research includes a survey of the member organizations of the American Board of Nursing Specialties (ABNS). Responses to this survey will provide insights into the eligibility requirements, clinical practice standards, candidate volumes, exam modalities, and other variables used by our

counterparts to launch an international certification. We also plan to survey the current members of the ICPAN regarding their interest in pursuing an international perianesthesia certification.

We hope to engage with the community of international perianesthesia nurses to share our findings, recommendations, and timeline for launch during the ICPAN 2023 Conference in Amsterdam.

References:

References: www.cpancapa.org

O-34

Inadequate emergence after non-cardiac surgery – a prospective observational study in 1000 patients

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Introduction:

The postanaesthetic phase is most often uncomplicated, but patients may experience inadequate emergence (IE) characterized by unrest, restlessness, aggressiveness, or in contrast sedation or lack of initiative. This may increase length of stay (LOS) and postoperative complications. The aim of this study was to investigate frequency, risk factors and consequences of IE.

Methods:

We conducted an observational cohort study including 1000 orthopaedic and abdominal surgical patients, screened with the Nursing Delirium Screening Scale (Nu-DESC) before anaesthesia and in the postoperative care unit. IE was defined as a Nu-DESC score ≥ 2 after surgery. Predictors included surgical procedure, type and duration of anaesthesia, age, ASA-score, sex and postoperative pain. Data was analysed using adjusted logistic regression and Wilcoxon rank sum test, the primary outcome being LOS.

Results;

IE occurred in 103 of 1000 patients (10.3%, 95% CI 8.6-12.3%). LOS was median 2 vs. 1 day in patients with and without IE, mean difference was 1.3 (SD 6.2) days ($P=0.036$). Thirty-day mortality was 2.9 vs. 1.0% ($P=0.92$) and admission to ICU 1.0 vs. 0.9% ($P=0.66$) in patients with and without IE.

Significant associations to IE were found for inhalational anaesthetics (OR 2.65; 95% CI: 1.57-4.46), duration of anaesthesia ≥ 2 hours (OR 1.98; 95% CI: 1.14-3.44), and ASA-score ≥ 3 (OR 2.74; 95% CI: 1.64-4.57).

Conclusion:

One out of ten patients had IE as defined by the Nu-DESC score, which was significantly associated with increased LOS. Longer duration of anaesthesia, inhalational anaesthesia and significant comorbidity ($ASA \geq 3$) were significantly associated to this.

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O-35

What is LAST and are you prepared?

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Introduction:

Local Anesthetic Systemic Toxicity (LAST) is a low-frequency, high-risk event that involves a rapid and potentially fatal response to local anesthesia. Ensuring that clinicians who care for these patients are familiar with the recognition and management of LAST is essential to safe practice. The purposes of this project were to standardize LAST management across multiple settings and to ensure sustained knowledge of recognition and management of LAST.

Method:

An interdisciplinary team (nurses and physicians) working in a high volume outpatient surgery center affiliated with an academic medical center conducted an evidence-based review to ensure that clinical practice guidelines were supported by the latest evidence, and followed this with development and implementation of a multi-modal educational intervention (patient simulation, a video, badge buddies, a computer-based learning module and LAST kits) to support nurses' preparation for managing this rare event. Improvement was measured using a 7-question knowledge quiz and qualitative feedback.

Result:

The guideline was implemented across all settings providing local anesthesia. During the first phase, all pre- and post-anesthesia nurses in the outpatient surgery center received the simulation, and were given access to the additional resources to maintain their knowledge. Scores on the quiz increased from 4.76 to 6.34 (pre-intervention vs. one month post-intervention) and remained high 9 months after the educational intervention (9 month score=6.19, $t=2.99$, $p=0.004$). Nurses reported feeling more confident and knowledgeable.

Conclusion:

Clear, evidence-based practice guidelines supplemented by multi-modal education can help ensure that nurses are prepared to encounter a low-frequency, high-risk event such as LAST.

Poster presentations

P-01

The benefit of sealing tracheostomy immediately after decannulation

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Introduction:

Tracheostomy is a common procedure in patients requiring mechanical ventilation. Tracheostomy decannulation is associated with several clinical challenges due to the remaining hole into the trachea. Recently, a new concept which enables intra-tracheal tracheostomy sealing was introduced. The concept provides an airtight sealing that potentially solves the issues with compromised airway physiology along with speech and hygienic concerns. We aimed to investigate the influence of intra-tracheal tracheostomy sealing on lung function and speech quality.

Methods:

Ten adult patients who underwent tracheotomy and had a tracheostomy tube inserted for a minimum of 7 days, were included. After decannulation a handheld temporary intra-tracheal tracheostomy sealing device was inserted. Spirometry was performed with sealed tracheostoma versus open tracheostoma. Likewise speech quality was assessed using a likert scale ranging from 1-5.

Results:

The mean age of patients was 59 ± 12 years. Mean FEV1 (Forced Expired Volume, first second) with 95% confidence interval was 553 (355-862) ml at baseline, and FEV1 increased to 785 (537-1149) ml after insertion of the device ($p=0.001$). Mean FVC (Forced Vital Capacity) with 95% CI at baseline was 660 (456-955) ml and volumes increased to 1166 (898-1514) ml with device in situ ($p<0.001$). Voice quality with open tracheostoma was 1.9 (1.0-2.9) increasing to 3.9 (3.0-4.9) during sealed tracheostoma ($p<0.01$).

Conclusions:

In this prospective feasibility study, we found that FEV1, FVC and speech improved significantly in decannulated patients after insertion of an intra-tracheal tracheostomy sealing device. A future therapeutic approach with immediate intra-tracheal sealing after decannulation seems promising.

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P-02

Snapshot – A Handoff Report Tool to Improve Bedside Reporting

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Introduction:

The handoff and transfer process requires a complete understanding of the patient's condition and status to ensure the patient's safety. Bedside handoff is evidence based and is known to reduce errors in patient care, ensure information is not forgotten, and decreases redundancy in care needs. Handoff promotes inclusion of important details and can decrease length of stay due to potential communication errors or inadvertent omission of information. Report completed at the bedside involves the patient and family in the care and promotes trust.

Methods:

A literature review was done of present best practices. A review of Joint Commission standards, hospital policy and ASPAN nursing standards was done to ensure compliance with those standards. Nurse input on their needs within a report were gathered. A tool was developed with the electronic medical record (EMR) for use in bedside reporting.

Results:

No harms reported due to lack of reporting between perioperative units. Increase in patient satisfaction scores concerning teamwork among staff and caring for patients needs/concerns. Increased inclusion of patients/families in care with bedside reporting.

Conclusion:

Use of a standardized report form for handoff improved continuity of care. Patients and families verbalized their appreciation of being included and heard in their care. An educational PowerPoint was developed and implemented for staff covering the importance of and requirements for safe handoff reporting. Education is key. Engaged nurses are empowered nurses. Empowering nurses as well as patients and families increases trust. This improved nurse/patient relationship increases patient satisfaction and outcomes.

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P-03

A New Model of Care: The High Intensity Surgical Short Stay Unit

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Introduction:

Our academic health sciences centre has a mandate for care of complex surgical oncology and trauma patients, putting significant strain on ICU capacity. The result has been a high rate of cancellations for elective surgical patients who require short term monitoring in a level 1 or 2 ICU. To mitigate these cancellations we needed to implement a different model of care to balance operational efficiencies without compromising quality of care. To accomplish this goal, we expanded our PACU to offset the demands on the two existing intensive care units supporting the recovery of these patients. This expanded unit was referred to as the High Intensity Surgical Short Stay Unit (HISSSU).

Method:

A customized operational model, patient eligibility criteria, clinical escalation pathways and evaluation metrics were developed. Frontline providers were hired and practice support tools specific to the selected patient population and the novel context of care were created, including standardized order sets, care plans, communication tools and staff rosters.

Results:

The creation of HISSSU has been instrumental in achieving a substantial decrease in cancellation rates of 30.58% over the period from 2018-2019 to 2021-2022. Also, Improved critical care capacity with a target for transfer to ICU set at 5%.

Conclusion:

The creation of HISSSU allowed a decrease in overall hospital surgical cancellations. The implementation of a workflow model reduced ICU capacity constraints, decreased surgical wait times and successful sustainment during COVID to present. The PACU nurses established better relationships with various surgical services, surgical flow, ward nurses, and interprofessional staff.

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P-06

ERAS: Enhanced Recovery After Surgery

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Introduction:

All patient's having surgery will have a stress response to the procedure. Understanding this response and establishing appropriate care to minimize the effects are key to a positive patient experience. By standardizing care, we can decrease complications, length of stay, use of intraoperative opioids and inpatient costs. We can also increase postoperative pain control, patient outcomes, and patient satisfaction.

Methods:

A literature review was done of present best practices. Input was received from all stakeholders: patients, surgeons, nurses, administrators. A standardized plan of care was developed. First implementation was with gynecology patients.

Results:

Hysterectomy patients are now discharged the day of surgery. No increase in readmission rates or complications at home reported. Patients state appreciation of inclusion in care and given tools to improve recovery prior to surgery.

Conclusion:

With the success of the implementation with gynecology patients, the program now includes colorectal cases. We have seen a decreased need in opioids postoperatively. A task force was formed to develop standard ERAS plans of care for specific surgical lines as well as general surgery.

References:

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Enhanced Recovery After Surgery St. Elizabeth

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P-08

"The good teaching process is not finished until the students has transferred what has been learned, to practice use" – A good competence development begins with clinical considerations before the micro-credentials, where the transfer of knowledge is trained.

Emilie Bak

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Introduction:

It's my task as a clinical supervisor to adapt micro-credentials to our department, to create the best learnings transfer from school to the clinic. The challenge in our postgraduate education, is that it must embrace a broad organizational framework consisting of many different departments. With the origin of these challenges, I've started using a 12-step method by Professor B. Wahlgren (2013), on how to improve learning outcome.

Method:

This method is theorized by the Professors Wahlgren and Aarkrog, in their book *Transfer* (2012), and if I may quote my own professors; *The good teaching process is not finished until the students has transferred what has been learned, to practice use*. This is by far one of the most important tasks in my work, because this education was established to increase the nurses' competence, and their ability to act more qualified. Therefore my ability to transform what they have learned in school, into our everyday practice, is essential to their and the organizations learning.

Conclusion:

Wahlgren states: "*If knowledge is tested in practice, the better the learning process, and probability of a chance in practice will appear*" Some of my new actions in my department, is therefore placing the micro-credentials, close to the tuition in school. Also, I'm having the students giving a presentation of their latest intuition optic or assignment, to the rest of the staff. And very important the application of knowledge in practice must be evaluated and requires critical reflection.

References:

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P-09

Sharing knowledge about the birth of a web-based journal addressing anesthesia-, critical care- and recovery nursing in Denmark Louise Linding, Department of Anesthesia - Post Anesthesia Care Unit - University Hospital Køge, Denmark

Louise Linding

University Hospital Køge PACU Næstved Denmark

Introduction:

Until 2019 there was no digital platforms for anesthesia-, critical care- and recoverynurses in Denmark, to share knowledge and experiences regarding clinical practice, research, education and events. A smaller group of nurses across the specialties and national Regions created a web-based journal addressing these areas of nursing to promote and share knowledge. Our ambition is to share experience about how this web-based journal was created in Denmark, to inspire other nurses to launch similar online journals.

Methods:

The editor group inherited a paper magazine published four times a year for the previous 20 years. A new constitution was drafted prior to transforming the paperjournal into an open-access web-based journal. To establish the online platform, an external expertise was purchased. The editorgroup was supported by the Danish Society of Anesthesia. The editors work volunteer, but there is some income from selling ads to medical companies. The subjects for articles is mostly obtained at conferences. The editors support the writers in developing their articles.

Results:

The website has been developed over the last 4 years. The numbers of articles within the categories research, clinical practice or storytelling increases continuously as the average number of readers increases. There has been up to 15.000 visits in single article. The website is becoming one of the key mediums for knowledgesharing for anesthesia-, critical care- and recoverynurses in Denmark.

Conclusion:

Supporting nurses in writing articles is important. Having an online platform addressing specific areas of nursing, makes it possible to promote and share knowledge wide

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Introduction:

Practice variation among nurses in the PACU (Post-anesthesia Care Unit) prolonged recovery times. Standardizing recovery using Stir-up Regimen¹ (deep breathing, coughing, repositioning, mobilization, pain and nausea management) within the first thirty minutes of Phase I was hypothesized to reduce recovery time. Nursing education content and methods were pivotal to drive practice change. Implementation science methods evaluated Stir-up Regimen adoption.^{2,3}

Methods:

Education methods: Knowles adult learning theory⁴ was used to design the education plan for over 200 nurses, with varying work experience, shift times, and unit locations.

Pre-implementation: Virtual presentations, video scenarios, huddle messages explaining immediate patient recovery goals and Stir-up Regimen.

During implementation: Just-in-Time review by a QR code linked to tip sheets, recorded presentations, and digital flyers. Tip sheets were posted in the PACUs.

Implementation science methods assessed practice adoption.^{2,3}

Online pre- and post-surveys: voluntary and anonymous

Bedside observations during initial thirty minutes of Phase I

EHR data analysis by Information Technology (IT) department

Qualitative feedback from surveys, observation tool, staff questions during huddles and in-services

Results:

Knowledge increased from 44% to 76% post-implementation.

Self-reported adoption increased from 43% to 83%.

Observations (n=61) confirmed most interventions were nurse-initiated versus patient-initiated.

A 4.9-minute overall reduction in mean Phase I recovery time compared to pre-implementation.

Qualitative feedback from nurses supported standardization of nursing practice.

No negative sequelae reported during the implementation.

Conclusion:

The combination of Knowles learning principles and implementation science successfully drove practice change to shorten recovery time. Consequently, Stir-up Regimen was added to the EHR and onboarding.

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P-13

The path to pressure ulcer prevention

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Introduction:

The surgical patient population is at an increased risk for developing hospital acquired pressure injuries (HAPIs). This increased risk is associated with intrinsic and extrinsic risk factors that include medical comorbidities, BMI, immobility, prolonged pressure during the intraoperative and immediate postoperative periods, and length of the surgical procedure. Corporate utilized assessment tool is not validated for use in perioperative areas/address risk factors.

Methods:

The organization identified that implementation of a validated tool allowing to appropriately assess patients' risk level as a priority. The *Munro Pressure Injury Risk Assessment Scale for Patients – Adults* was identified as the tool validated for the perioperative areas.

Results:

To achieve the goal of reducing HAIs and improving patient safety, several initiatives were implemented simultaneously. The assessment tool was updated with the "PRIDE" bundle interventions specific to the perioperative setting, Ross Tilley Burns Centre and Cardiovascular ICU. Extensive collaboration between the working group, staff, Dr Cassandra Munro and Molnlycke representatives supported development of the tool and assisted with the overall implementation and staff education. Staggered approach and pilot implementation allowed the teams to gain a better understanding of use and purpose of the new risk assessment tool.

Conclusion:

The goal to increase point of care capacity in HAI prevention, and integrating evidence based best practices, utilizing a peer to peer knowledge translation methodology and shift practice from treatment to prevention is closely monitored to assess successfulness of this practice change. Pressure injury audits, incident reporting and compliance with documentation are key areas being monitored.

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Introduction:

This lecture will review current trends in nursing including an impending global nursing shortage. We will also discuss known effects of the pandemic on nurses' physical and mental well-being including nurses' suicide and implications for perianesthesia nurses.

Methods:

Research studies will be used to support the evidence for the nursing shortage as well as the effects of the pandemic on nurses' physical and mental well-being including nurse suicide.

Results:

The evidence shows that the pandemic exacerbated issues that were already present in the workplace environment. The nursing shortage is real with a turnover of 21.7% hospital RNs in the U.S. In one meta-analysis more than 27% of the intensive care nurses worldwide had an intention to leave. In another systematic review, the authors found that 21.7% of healthcare workers experienced post-traumatic stress syndrome during a pandemic, 16.1% experienced anxiety, and 13.4% had a major depressive episode. We will discuss turnover, why nurses resign, and factors influencing retention. We will look at the risk factors and clinical implications of nurse suicide as well as programs for prevention. One study found that while male nurses completed suicide at a similar overall rate, female nurses committed suicide at 17.1/100,000 persons while the general population was 8.6/100,000. We will end with ways to provide self-care and improve well-being including implications for nursing leaders.

Conclusion:

It is important for nurses to understand the implications of a global pandemic on mental and physical health and how to mediate those factors.

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P-15

We get by with a little help from our fellow educators: surviving a supply shortage and two rollouts

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Introduction:

Fall 2021, a hospital-wide initiative was launched to discontinue Alaris pump use for all peripheral and paravertebral nerve catheter infusions, and initiate use of CADD-Solis pumps for patient safety. Upon the impending rollout date, a CADD-Solis tubing shortage emerged, and all nursing staff required orientation to use the yellow Alaris pump tubing for peripheral, paravertebral, and epidural catheters. Eight months afterwards, the original project was initiated using the CADD-Solis pumps, and additional staff education was implemented for administering peripheral and paravertebral nerve catheter infusions.

Method:

Initial project: Weekly meetings with the Medical-Surgical (MS) and Critical Care (CC) nurse educators.

Policy created, order sets, and staff education reviewed.

January 2022: [supply shortage] nurse educators developed a hospital education tip sheet.

Perianesthesia Care Unit (PACU) educators trained approximately 200 department nurses.

Charge Nurse Checklist developed; patient tracker utilized to trace all inpatients with a continuous catheter infusion; tip sheets emailed and placed in all nursing care units.

September 2022: New rollout, same process used for staff education and patient safety.

Result:

Frequent nursing rounds, emails, in-services, charge nurse training, and nursing unit champions helped the transition between both rollouts. For questions about pump set-up, additional in-services were provided; and Anesthesia Services were utilized for order clarification of infusions.

Conclusion:

By collaborating with fellow nurse educators and keeping an open line of communication, hospital-wide patient safety was maintained, and nursing staff remained error-free during both rollout periods.

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P-16

Student nurse anesthetists' learning during clinical practice in the operating room

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Introduction:

In Sweden, the need for registered nurse anesthetists is expected to increase [1]. Clinical practice is integrated in the education for student nurse anesthetists (SNAs) [2] and often takes place in the operating room (OR); a complex, high-risk environment [3]. Clinical practice is also a contributing factor for perceived stress among SNAs [4]. The aim was to identify supporting and hindering factors for SNAs learning in the operating room, from a students' and supervisors' perspective. The result from this study can generate new research questions, which can be used in a long run to optimize the clinical learning situation.

Method:

An integrated review design was selected with comprehensive searches in four databases: Medline, Cinahl, PsycInfo and ERIC. Data were analyzed inductively using constant comparison method.

Result:

Learning during clinical practice is described as a process influenced by learning activities outside the OR, events in the OR, students' personal factors and different interactions with team members. Supporting factors include being prepared before clinical practice, clear expectations, daily planning and communication, a good relationship with the supervisor and having constructive feedback. Hindering factors include supervision under time pressure, disruptive behaviors from team members and aspects of the physical learning environment like high room temperature.

Conclusion:

SNAs' learning situation in the OR resembles undergraduate nurses' learning during clinical practice. Unique for the OR as a learning environment is high degree of teamwork in a complex, high risk environment. Further research is warranted to explore the effect of teamwork on SNAs' learning.

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P-17

Expediting PACU Phase I Care: Improving Throughput

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Introduction:

Currently, the Weinberg Post Anesthesia Care Unit (PACU) Phase I length of stay (LOS) is an average of 2.5 hours (150 minutes) compared with the initial goal or benchmark of 1.5 hours (90 minutes) resulting in unavailability of PACU beds; OR holds; decrease patient, family and staff satisfaction; and increase cost of hospitalization. We implemented a quality improvement (QI) project to expedite PACU Phase I and streamline the throughput, including: exploring the work culture; developing high reliability team; introducing national benchmarks; identifying system challenges; implementing the PACU RN discharge per criteria protocol and the active recovery elements.

Method:

Utilizing Lean Sigma processes, developed SMART goal and key metric measure. Goal is to reduce PACU Phase I LOS from 150 minutes to 90 minutes by April 30, 2023. A3 is used to track progress and present results.

Results:

Tableau dashboard run reports to track Weinberg PACU Phase I LOS and nursing time reports to show compliance. To date, great improvements on PACU Phase I LOS is shown compared to September 2022 LOS.

Conclusion:

Data analysis done at end of each month and results disseminated to staff to continue to challenge clinical practice and help improve PACU LOS to increase patient, family and staff satisfaction. There is an opportunity to implement this QI project in other perianesthesia units. Changing the PACU culture involves gaining new insight, understanding, and adopting nursing methods of managing the patient's recovery care. Emancipated knowing requires constant reflection, vision for the future, and action to transform conditions.

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P-18

Changing from ICU to Perioperative admission for children undergoing Cranialfacial surgery and Cochlear implant surgery

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Introduction:

In 2018 the Hospital established a Perioperative Unit for children undergoing surgery or interventions that required anaesthesia.

It involved converting courses from admissions to Perioperative- and Semiperioperative procedures.

Previously, Cranialfacial surgery and Cochlear implant surgery, meant admission, overnight stay in ICU, and paediatric wards.

Children for Cranialfacial surgery meet in the Perioperative Unit and transfer to the paediatric Unit the morning after surgery. Children for Cochlear implants has a Perioperative stay.

Perioperative set up, Familycentred care and fewer transitions between Units, provides increased safety for the child and the family has fewer contacts within the Hospital.

Optimised teamwork amongst all involved professionals, mean increased quality and safety.

Fewer admission days, less staff involved and a higher resource exploitation adds a positive socioeconomical asset.

Methods:

All professionals in the Units involved were open for changes and exchange of knowledge.

Perioperative Nurses worked focused in compiling previous procedures, and making new protocols, standard prescriptions, supplemented by supportive follow up after the patient has been sent home from Hospital.

Results:

The outcome and quality for the patient remained at the same standard as previously.

Children avoided many different contacts at different Units. Further more, the interdisciplinary work has led to the development of an interactive App, Emento App, which guides the parents through the whole course for the child from referral to postoperative check ups.

Conclusion:

Fewer transitions leads to increased safety and higher satisfaction for the patients and family.

Furthermore we obtained the desired socioeconomical aims for the Hospital.

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P-19

Improving Postoperative Patient Flow in the Recovery Room Department

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Introduction:

This project aims to improve the patient flow in the eleven-bed recovery room department in a private orthopaedic clinic in north Dublin. Inefficient patient flow is an increasing problem in this hospital's recovery room department, where the author works as a nurse manager. Declining recovery room throughput as a result of the delay in collection interfered with the recovery room nurse's primary role, which is to provide immediate postoperative anaesthesia care, which led to delays in the operating room schedule, the normal flow of patients to the recovery room, and discharges to the nursing wards. As a result, postoperative beds in the recovery room are not always available to receive the theatre patients. The HSE People's Need Delivering Change Model (2018) led this organisational development project. The clinic's multidisciplinary team cooperated in the delivery and implementation of the change. The use of change management improvement tools for planning and analysis in the process supplemented the project. The researcher used process mapping, stakeholder analysis, SWOT analysis, and a Gantt chart to inform the aim and objectives of the project. The Institute for Healthcare Improvement Model for Improvement framework supported the project to outline the evaluation and measurement activity. Implementing a transport team validated the effectiveness of correcting postoperative patients' inefficient flow in the recovery room.

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Introduction:

During the Covid-19 pandemic, the Perioperative Nurses were challenged in their practice of Familycentret care, in relation to coping and distracting. The Hospital enforced restrictions, which had big implications. E.g. distance, least possible physical contact, only one parent with the child, no Hospital Clowns, no blowing bubbles, no singing for the children. The situation led to us having a need for ekstra tools to support the children coping.

Research show, that being Hospitalized, can have influence later in life.

We completed a PDSA project, around children and coping, and how we could support our colleagues in their nursing practice supporting and diverting the children during their perioperative stay.

Methods:

Questionnaire. "Model for Improvement", The PDSA Circle.

Results:

The staff had a need for increased focus on the topic "coping" and also a need for teaching around practical use of "Coping tools", e.g Virtual Reality, the Interactive game "Wheely" and hypnotherapy etc.

A collection of carefully chosen tools, and a chart with age divided ideas and inspiration was developed. The Perioperative Nurses gets support to her clinical look and professional judgment, meeting the patient and including the parents in a active role around the child.

Teaching, education and sparring has supported the proces.

Conclusion:

The collection of "Coping tools", has contributed to improving the Nursing Practice, for the benefit of children and their parents. The increased focus, has given children the best possible experience. It is now an integrated part of the Unit and will continue to be developed.

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P-22

Developing a RN to PCA e-Handoff tool to enhance an effective staff communication and patient care safety in PACU

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Introduction:

The Joint Commission stated that approximately 90% of sentinel events are due to communication errors. Improving communication among caregivers is an important National Patient Safety goal. The standardized nurse to nurse handoff method has been well-established for a long time but there is no standardized nurse to PCA handoff tool prior to this project. With management and IT team support, we would develop a centralized e-Handoff tool, supported by Apex system which can streamline the handoff process, and reduce the risk of communication gap during the discharge handoff.

Methods:

Initial Qualtrics survey was conducted among RNs and PCAs regarding the handoff tool. The educational implementation has gone through e-mails, staff meetings, face to face services and the tip sheets. When the e-Handoff tool is available after collaboratively working with IT team, a new Qualtrics survey with qualitative approach that collect and analyze staffs' perception and feedback will be followed.

Results:

The Standardized RN to PCA e-Handoff tool will streamline the handoff process during patient's discharge. The perception data and feedback from staffs regarding the e-Handoff tool will positively correlate with a better staffs' communication and accountability, and directly improve our patient care quality and safety.

Conclusion:

Therefore, an effective staff communication with standardized RN to PCA e-Handoff tool is the essential step for patient safety transfers and care quality. It can impact good teamwork and collaboration among staffs. A well-established, sustainable, and expandable e-handoff tool will better serve our mission, vision, and values during the patient care.

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How do patients experience warmth and coldness in connection with surgery?

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Introduction:

Patients are at risk of several adverse events if their body temperature falls below 36 °C, this can be prevented by providing heat conservation measures [1-3]. It is known that patients receiving forced air warming experience higher thermal comfort [4]. However, there is a lack of knowledge about how patients experience temperature in connection with their surgery. The aim is thus to describe the patients' lived experience of the phenomenon of warmth and coldness in connection with surgery.

Method:

A total of 16 patients from four hospitals were interviewed. Data were analyzed using reflective life-world research.

Result:

Patients felt that warmth and coldness fluctuated depending on place and time. They wanted to maintain their own unique temperature comfort and expected to receive the best care. When temperature discomfort arose, the need for change was greater if they froze, but they did not dare to speak up. Furthermore, if their need for warmth was met, there was a sense of calm and well-being.

Conclusion:

Patients often have a part of the body that is more sensitive to cold than another. Therefore, it is important that this body part receive extra heat to prevent further heat loss and avoid experiencing temperature discomfort in the whole body. Furthermore, patients need to be encouraged to say if they are cold or too hot. They do not know how the heat loss occurs in connection with surgery and thereby, need information about the importance of being warm throughout the perioperative period to avoid complications.

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Changing staff culture related to supplementary oxygen

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Introduction:

As hypoxia is harmful, supplementary oxygen (SOX) is recommended to patients with oxygen saturation (SpO₂) < 94 % in the Post Operative Care Unit (PACU). As newer studies¹ indicate that hyperoxia as well may increase morbidity and mortality a new national guideline² on SOX was to be implemented October 2020 (SOX should be reduced or terminated as soon as SpO₂ approaches 100 %).

Aim: To investigate whether implementation of the new guideline had persistent effect on the fraction of patients in the PACU given SOX > 15 minutes despite SpO₂ 100 %.

Method:

Over a three-week period PACU nurses were educated in the new guideline, own practice was discussed, workflow analyzed, and brush-up lesson in respiratory physiology were given.

Twice daily at two random observation times, blinded to nurses, the fraction of all patients in the PACU given SOX > 15 minutes despite SpO₂ 100 % was determined for a three-week pre-intervention period, during the intervention and for 15 weeks post-intervention. Post-intervention the weekly results of the observations were shown on a dashboard in nurses staff room, but not commented further. A follow-up period is planned April 2023.

Results:

In the pre-intervention period 23 of 125 patients (18%) received SOX despite SpO₂ ≥ 100%, The counts in intervention period were 18 of 217 (8%) and 30 of 911 (3%) in post-intervention period.

Conclusion:

Persistent educating, monitoring of behavior and repeating “why” in components of oxygen therapy has led to changed staff culture resulting in safer treatment with oxygen in the PACU.

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Introduction:

There is a lack of knowledge how people with low self-efficacy experience their postoperative recovery after bariatric surgery. This study's aim was to explore patients' experiences of their recovery after bariatric surgery, in those reporting low preoperative self-efficacy.

Method:

This was a qualitative inductive interview study. Individual interviews with eighteen participants were conducted approximately one year after the surgery. Data was analyzed using thematic analysis by Braun and Clark.

Results:

The analysis identified one theme and five sub-themes. Participants described they had to learn to handle their new situation that included learning to know their new body, handling thoughts about themselves, and to manage social relations. Social relations, support, successes, and challenges all influenced their self-efficacy. This affected their thoughts about adapting lifestyle changes, keeping the motivation, and handling setbacks

Conclusion:

Recovery one year after bariatric surgery is still an ongoing process that involves challenges in lifestyle changes and physical and psychological transformations. During the recovery process self-efficacy is not static and in transition. Clinical implications are tailored information and support from health care personnel is needed.

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Removing barriers: improving post anesthesia care unit (PACU) flow

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Introduction:

PACU provides care to patients from multiple specialty services and with varying needs for recovery service including post-procedural recovery. Inefficiencies in patient flow in the recovery phase of care can result in disrupted services to patients, stakeholder dissatisfaction and system challenges at the unit and hospital levels. To understand factors that inhibit/facilitate PACU efficiency, a performance improvement project was completed to identify gaps/opportunities to improve workflow.

Methods:

A quality Improvement (QI) evaluation was performed utilizing direct observation of inflow and outflow activities, interviews with frontline providers, operational leadership and program performance metrics. The metrics tracked included (time to transfer, reasons for transfer delay after recovery interval was completed, and resource availability factors). In December, 2022 collected data were reviewed with organizational stakeholder groups. These groups collaboratively developed multiple interventions and process modifications and addressed the areas identified as contributing to system inefficiencies.

Results:

After careful review, factors impacting PACU workflow could be attributed to 5 specific program components; lack of disposition bed in the ward areas, transfer of accountability, deviations from projected medical plan of care, and access to ancillary but critical services including patient transport and environmental services. Interventions designed to address from this evaluation focused on 5 areas.

Conclusion:

This comprehensive process review of PACU services has resulted in early improvement to all markers of efficiencies. The team continues to monitor these selected markers of efficiency and support sustainment of the new processes. System-based process improvement strategies have been identified. Post implementation data will be collected.

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Introduction:

There is no consensus about the type of instrument with which to assess postoperative recovery or the time points when assessments are most appropriate. Therefore a scoping review was performed with the aims: 1) To identify and describe instruments used in clinical trials to assess postoperative recovery; 2) to determine how, when, and the number of times postoperative recovery was measured; and 3) to explore whether the four dimensions of postoperative recovery are represented in the identified instruments.

Method:

A systematic literature search was conducted by a librarian in CINAHL Plus with Full Text, Ovid MEDLINE, and Web of Science. In total, 5015 studies were identified in the search. The selection process used Covidence systematic review software. The extracted data were summarized and presented in frequency and percent.

Results:

In total, 198 studies were included in the results. 1. We found 20 instruments measuring postoperative recovery. The most common instrument was different versions of Quality of Recovery n=162/198 (81.8%). 2. Most studies performed an assessment on postoperative day 1 (n=159/195, 81.5%). 3. Thirteen instruments covered physiological, psychological, social and habitual dimensions of postoperative recovery.

Conclusion:

Assessing recovery is important to evaluate and improve perioperative care. We emphasize the importance of choosing the right instrument for the concept studied and, if postoperative recovery is of interest, of assessing more than once. Ideally, instruments should include all four dimensions to cover the whole recovery process.

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“Tell Us How We’re Doing”: Putting Patient Satisfaction in the Patient’s Hands

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Abstract text:

Many nursing populations feel burned out and underappreciated in these post-pandemic years. We feel that, despite burnout, PACU nurses provide high quality patient care. Since hospital-led morale boosters fall short, we want more positive direct feedback for our nurses from our patients.

During a Patient Experience meeting, the idea of directly asking our patients to tell us how we’re doing was introduced. Patients spend many hours in recovery, with no entertainment but their phones.

We developed scannable individual patient bedside table signs with two QR codes. One code prompts them to rate two statements: “Nurses’ response to your concerns or questions” and “How well staff worked together to care for you”, as well as a box to leave feedback. The sign's reverse side has a “Thank an Employee” code.

We’re putting the power in their hands to directly give us feedback based off their current situation. Press Ganey surveys rely on a vague memory weeks later. We are also giving them the opportunity to directly thank staff involved with their care.

Bedside signs were placed and staff educated. In three months, we received 46 responses. Our beginning Press Ganey scores were 95.7 and 93.1, respectively, for each question. Three months post-implementation, the scores were 97.2 for both questions.

Patients often feel that their voices aren’t heard during their stay. By giving the patients a forum to freely express themselves, their appreciation (and frustrations) can be reflected back to the staff, improving the experience of all involved.

P-29

Green Recovery: reduce, reuse and recycle

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Abstract text:

Our way of providing healthcare must not come at the cost of living in an unhealthy environment in the future.

The Danish health-care system accounts for 6,3 % of Danish CO2 emission. Globally the health-care industry is the fifth largest contributor of CO2 emission.

Our region has a sustainability strategy: Our world, our responsibility. We focus on four groups: Transport 4%, Building and construction 9%, energy consumption 3% and procurement 84%.

We work in a Perianaesthesia care-unit (PACU) and we are represented in the steering group and as a local sustainability ambassador at Randers Regional Hospital.

In our PACU we have been focusing on procurement, specifically the largest post: clinical and medical equipment (30% of CO2 emissions).

In practice, we have been working on reducing plastic: replacing plastic cups with ceramic cups and glasses and collecting hard and soft plastic in order to reduce and recycle. We have reduced the number of waste bins by 70%. We have replaced plastic medicine cups with paper cups.

Furthermore, we have reduced the number and size of absorbent sheets in hospital beds, which prompted the manufacturer to make a thinner variant.

One of our goals is to reduce procurement by 30% within 2030 and therefore we have decided to remove tin foil and replace our disposable surgical wound kits with scissors for multiple uses.

We sort medicine boxes as cardboard, leaflets inside as paper and the plastic as hard plastic.

Our mission is to learn from each other and spread the good ideas.

References:

<https://www.overshootday.org/newsroom/country-overshoot-days/>

[Health care climate footprint report | Health Care Without Harm \(noharm-uscanada.org\)](https://www.noharm-uscanada.org/health-care-climate-footprint-report/)

P-30

Gamified simulation training with perioperative interdisciplinary teams: A brief observational study

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Introduction:

The board game “Decision Point” ® was developed to train staff in team cooperation to prevent adverse events. The goal of the game is to teach players cooperate and be aware of situations with an increased risk of adverse events. I had previous experience using the game with pre-graduate nursing students.

To experiment with gamified simulation training in a perioperative setting, I tested “Decision Point” ® in interdisciplinary groups composed of recovery-, anesthetic-, and surgical nurses, and anesthesiologists, as a supplementary method in our post graduate education. Could gamified simulation training provide similar learning outcomes in interdisciplinary professionals in the perioperative setting?

Method:

Simulation-based medical education is an educational activity that utilizes simulation aids to replicate clinical scenarios. Decision Point” ® is a simulation game that rewards cooperation, clinical prioritizing, and non-technical skills such as collaboration, decision making, and communication.

Results:

5 sessions with mixed teams

The teams learned the intended non-technical skills.

The teams gained new understandings of their respective professional roles.

The different perspectives on decision making allowed team members to understand the perspectives of colleagues with other specializations and how they prioritize.

The aspect of shared enjoyment was identified by participants as the catalyst for interdisciplinary understanding.

Conclusion:

Several learning goals were reached, but unexpectedly the high level of interdisciplinary understanding was facilitated by “having fun together”. I find that post-graduate gamified simulation-based training for medical training and team development is useful and will be a part of continuous professional development in the ward.

P-31

A colles fracture should be a simple surgical case but in practice a very complex acute pathway.

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Introduction:

Elective surgical pathways have improved over the past decade due to the fast-track-programmes, but patients desire more personalised and coordinated care and treatment. There is little knowledge of how patients' acute pathways are affected. The aim of this study is to explore how to optimise pre- and postoperative patient pathways with colles fracture in a Danish perioperative surgical home pathway.

Methods:

Field observations (60 hours) and 25 semi structured interviews with patients (one and three weeks and three months postoperatively) were undertaken during October 2021- July 2022 and three focus group interviews (14 healthcare professionals) were conducted.

Results:

A colles fracture is seen as uncomplicated by the healthcare professionals, but it was unclear who was responsible for the patients and they were in a bubble of uncertainty and not knowing whom to contact. On the day of surgery patients and healthcare professionals were frustrated because of significant waiting time and surgery cancellations, neither of them knew when to expect surgery. Fragmented and lack of information during the pathway made patients nervous and unprepared. Pain treatment was insufficient throughout the pathway. Healthcare professionals were embarrassed to represent a hospital with significant waiting time and cancellations.

Conclusion:

Patients wanted to have surgery with less waiting time and cancellations to get well faster, but it was a complex pathway organisation. Coordinated patient information could improve the smoothness of the pathways. Pain treatment has to be optimised in all parts of the pathway in order to be sufficient.

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Introduction:

North Zealand Hospital is a 400-bed hospital in the capital region of Denmark. In the Hospital 17.000 procedures are performed yearly and the hospital provides a variety of surgical services from gynecology, abdominal-, orthopedic to ENT surgery on adults aswell as Children. In PACU the nursing staff are mostly highly experienced with 10-15 years' experience, but new staff arrives regularly.

Most of the patients have been going tough surgery, but we see an increase number of patients coming to the ward, for pre-operative stabilization or insertion of blockade before surgery. The patient population is getting older and present more complexity. The management of ward identified a need for nursespecialists allocated, to each speciality.

The initiativ were met with skepticism from the staf in PACU.

Methods:

5 nurse specialists were recruited.

Their main tasks are:

Maintaining, and implementing guidelines

Resource/mentor for colleague's

Participation in network with nurses and doctors from the units of operation and anesthesia, and ward unit. They were assigned with a mandate, to test and implement changes.

Results:

The results of the cooperation were:

A mutual understanding of the patient pathway.

Acceleration in changes for optimizing pathway

MythBusters, wrong assumptions of other staff intentions, were stopped

Shortcut for communication between staff.

Skepticism regarding nurse specialists are totally gone.

Conclusion:

Nurse specialists were shown to be essential when building bridges in the work, to secure quality in patient pathways.

Recruitment of nurse specialists in PACU optimize patient pathways and the professionalism in PACU

P-33

What matters most to patients on the day of surgery – a pilot study using the flash mob design at seven Danish perioperative departments

Heidi Gamst-Jensen

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Introduction:

Truly patient-centered care needs to depart from what patients consider as important. Still, there is limited knowledge about what surgical patients consider essential on the day of surgery.

Method:

By using the flash mob design for 24 hours simultaneously at seven different departments in Denmark, we aimed to explore 1) what matters most to surgical patients preoperatively? 2) do patients' perceive that healthcare staff were aware of this? Cognitively intact adult patients scheduled for surgical procedures were eligible. Patients were enrolled when they arrived at the preparation area/operation room, and here informed consent was obtained. Hereafter, the REDCap survey was distributed by a QR-code.

Result:

A total of 131 patients responded. Patients' mean age was 54 years (median 56), 57% were female, 25% expected in-hospital post-operative recovery, and 91% underwent planned procedures. What mattered the most to the patients on the day of surgery varied widely from being: well-informed, not canceled, well anesthetized, safe, and seen as an individual to the staff acting calm and collected. Seventy percent had discussed this with the healthcare staff.

Conclusion:

The flash mob design is well suited for the perioperative setting and feasible for collecting large amounts of data quickly. As patients differed in what they considered most meaningful on the day of surgery, it is crucial to ask them in terms of ensuring genuinely patient-centered care.

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P-34

Up in 3 and Home in 1

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Introduction:

Cedars-Sinai performs over 1,500 TJR surgeries annually. Due to high hospital census, post-operative total joint patients would often wait in the PACU for hours for an inpatient room, which delayed mobilization. These delays have been associated with prolonged recovery and longer LOS. The goal was to increase the number of same-day and 23:59 discharges amongst post-operative total joint replacement (TJR) patients from March 2021 to June 2022, as measured by an increased number of same-day and 23:59 discharges obtained by data extraction from CS-Link.

Methods:

It was planned to open an Outpatient Stay Unit (OSU). An interdisciplinary orthopedic and perioperative team met to discuss and facilitate the daily operations of the OSU - ensuring the appropriate furniture and environment for patients as well as specialized equipment such as a car simulator and practice stairs. The goal is for patient to be Up in 3 hours, so they can go home in less than 1 day. Quantitative analysis was completed to study the unit's effectiveness. Pre-implementation data was obtained over a 12-month period (January 2019 to December 2019) from CS-Link, and post-implementation data was obtained over a 15-month period (March 2021-June 2022).

Results:

Pre-implementation, the total same-day and 23:59 discharges for post-operative primary TJR patients was 13%. Post-implementation, this number increased to 67%.

Conclusion:

The Outpatient Stay Unit was successful in decreasing length of stay amongst primary total joint patients. This multidisciplinary team has decompressed inpatient units within the hospital, facilitated early mobility, and increased early home discharges.

P-35

The Direct Impact of Climate Change on Surgical Patients and Actions Required to Mitigate this Global Phenomenon

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Introduction:

Climate change is a reality and the time for action is now. Every nurse desires to be prepared to care for patients in a knowledgeable, safe manner. Every practice setting is challenged with patients that have preexisting illnesses/conditions resulting from climate change that can affect their care. Education and awareness are vital for optimal care plans to be drafted and implemented. This poster will illustrate various illnesses/conditions requiring immediate attention, and necessary, collaborative initiatives that must be implemented for best outcomes to occur in the presence of challenges related to climate change.

Methods:

An innovative approach to this crisis can begin by adding a section on the patient intake sheet during a pre-surgical visit to determine if the patient has any illnesses/ conditions that exist in the general population. If yes, communication must occur promptly for additional patient needs to be met through collaborative actions of the interdisciplinary team prior to surgery, day of surgery and post-operative recovery.

Results:

Illnesses /conditions are clearly identified and the team collaborates to ensure that best practices are implemented, utilizing reliable trusted resources during the surgical continuum of care. The positive result of the surgical experience is enhanced by addressing climate change risks to ensure that safe patient care becomes a reality with this vulnerable population.

Conclusion:

The beginning of positive change begins when individuals and groups commit to recognizing challenges of the climate change crisis from the beginning of the surgical experience and unify efforts to combat it in innovative ways.

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